ROYAL COMMISSION INTO AGED CARE QUALITY AND SAFETY
COUNSEL ASSISTING'S SUBMISSIONS ON WORKFORCE

PART 1 Introduction

1. The Royal Commissioners are relevantly required to inquire into:

   - what the Australian government can do 'to strengthen the system of aged care services to ensure that the services provide are of *high quality* [emphasis added] and safe';[1] and
   - how to ensure that aged care services are person-centred.[2]

2. In meeting those terms of reference, the Royal Commissioners are directed to have regard to

   > 'the critical role of the aged care workforce in delivering *high quality,* [emphasis added] safe, person-centred care, and the need for close partnerships with families, carers and others providing care and support.[3]

3. These submissions are directed to assist you to fulfil those terms of reference.

4. Along with members of the Royal Commission's staff, I had the privilege on Wednesday of this week to visit an aged care home in regional Victoria. We were struck by two things: first, the obvious frailty of the residents in the home, the majority of whom were afflicted by dementia. Secondly, the compassion and love with which the staff were caring for those residents and the obvious joy they derived from their difficult and vital work.

5. The staff in our aged care homes are not well paid. There are all too often not enough of them to provide the care they would like to – for example, to sit and have a chat over a cup of tea. Many work in stressful and sometimes unsafe workplaces. Some are untrained; others have inadequate training.

6. As a community we owe these workers a lot. These submissions are aimed at improving their working lives so that our elderly citizens can receive safe care of the quality that they should receive in a country as rich as ours.

7. Our submissions are informed by the following principles:

   - an approved provider of residential aged care services should have to meet mandatory minimum staffing requirements;
   - registered nurses (including nurse practitioners) should make up a greater proportion of the care workforce than is presently the case;
   - all aged care workers should receive better training;

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[1] Royal Commission into Aged Care Quality and Safety, Terms of Reference, para (d).

[2] Royal Commission into Aged Care Quality and Safety, Terms of Reference, para (e).

[3] Royal Commission into Aged Care Quality and Safety, Terms of Reference, Para (j).

- unregulated care workers should be subject to a registration process with a minimum mandatory qualification as an entry requirement;
- the care workforce should be better remunerated and should work in safe workplaces;
- the organisations for which they work should be better managed and governed; and
- the Australian government should provide practical leadership.

8. The implementation of the recommendations we propose today as a holistic package will, over time, make aged care a more attractive sector in which to work. This will help to retain the current workforce and attract new workers to the sector. In conjunction with recommendations about system design, funding and finance, regulation, provider governance, the role of the Commonwealth and other areas which Counsel Assisting will be proposing in the coming months, the implementation of the recommendations we propose today should result in improved quality and safety of aged care for elderly Australians.

9. At the Royal Commission's hearing in Perth, which focussed on person and relationship centred care, an internationally recognised aged care expert, Dr Lisa Trigg, gave evidence. Dr Trigg has studied aged care systems around the world including Australia's. She explained that:

> To deliver really excellent relationship centred care, care workers have to be more than just respected. They have to be valued and supported.[4]

10. Also at the Perth Hearing, the Royal Commissioners were informed about the importance of attracting the right people to work in aged care. Mr Jason Burton, Head of Dementia Practice and Innovation at Alzheimer's WA, explained that in recruiting care staff he looks for warmth in a person'.[5] Staff without the right empathic attributes are unlikely to succeed.

11. Ms Kate Rice, a manager of 18 years' experience at aged care provider Wintringham, emphasised that care workers must have the right attitude and commitment. They can be trained to provide good care. Ms Rice told the Royal Commissioners:

> I am excited about working in aged care. I love it. So I think if I love it, I want to find other people who are equally as excited as me.[6]

12. The Royal Commissioners have heard from a number of other workers who spoke of their passion for working in aged care. For example, at our Darwin

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4 Royal Commission into Aged Care Quality and Safety, Interim Report, vol 2, p 187. Dr Trigg referred to the work of Tom Kitwood who in turn coined the phrase 'the caring organisation' to describe aged care providers that emphasise the wellbeing of their employees.

5 Transcript, Perth Hearing, Jason Burton, 25 June 2019 at T2409.25-38.

6 Transcript, Perth Hearing, Kate Rice25 June 2019 at T2465.38-40.

hearing, Ms Sharai Johnson, a Larrakia woman who is the aged care co-ordinator at Larrakia Nation spoke of the rewarding nature of aged care work:

> What makes it so rewarding is that you know that you're impacting – you're having a positive impact on each individual's life, daily life, their daily living, and if you can be that one person to make that change on a daily basis, then that's a wonderful outcome, not only for my personal satisfaction, my professional development, and giving that back to the community, giving that back to the workforce and also mentoring younger staff members, just the younger generation in general, showing them that aged care is – it's a great place to be. It is a wonderful place to be. It is so rewarding, and you know what? You just keep going every day.[7]

13. The challenge for the aged care sector is to attract more 'Kate Rices' and more 'Sharai Johnsons' and retain them. The Royal Commissioners' interim report, published late last year noted that:

> A 2011 report by the Productivity Commission predicted that the aged care workforce will need to have at least doubled by 2050 to meet the projected target of 980,000 workers, and that 3.5 million Australians will be accessing aged care services every year, largely through community-based services. A coordinated approach to workforce planning is required to create a much larger workforce with the skills to care for people with forms of dementia and significant levels of frailty or impairment in home or residential settings.[8]

14. The Royal Commissioners' interim report observed that Australia's demography is changing. The 'aged care dependency ratio' measures the number of people of traditional working age (15-64) for every person aged 85 or older. In 1978 the ratio was 101.4 people of traditional working age to every person aged 85 or older. By 2018 the ratio was 32.5 to 1. It is estimated that the decline over the next four decades will be even starker.

15. By 2058, there will only be 14.6 people aged between 15 and 64 for every person aged over 85.[9] These trends have implications for the aged care sector's ability to attract the many new workers it needs in the future. We may need to look outside Australia to fill some roles.

16. Without such an approach, the aged care system, which we described in our third Melbourne hearing as under serious strain, is at risk of collapsing. Addressing the significant challenges will require new thinking; it will require policy makers and the sector to take some risks. Not every initiative will succeed. This must be accepted. What future generations will not forgive is an unwillingness to learn from the mistakes of the past.

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7 Transcript, Darwin and Cairns Hearing, Sharai Johnson, 12 July 2019 at T3425.34-41.

8 Royal Commission into Aged Care Quality and Safety, Interim report vol 2, p 218.

9 D J Cullen, *Estimating Key Parameters for Long Term Care Insurance in Australia. In Proceedings of the 25th Colloquium of Superannuation Researchers*, 2017.

17. A further complicating consideration is that, in its search for a significantly increased workforce, the aged care sector is competing with both the acute health sector and the disability workforce. Both of these sectors are growing for many of the same reasons that explain the growth in demand for aged care.[10] Australia's aging population is challenging for a number of sectors.

18. In the Royal Commission's Melbourne hearing about workforce in October last year, it heard from the Assistant Branch Secretary of the Australian Nursing and Midwifery Federation (**ANMF**), Paul Gilbert. Mr Gilbert commenced working as an enrolled nurse in what was then called a 'nursing home' in the mid 1980's. At that time, the workforce was made up nearly exclusively of enrolled and registered nurses.[11]

19. Mr Gilbert has worked as a union representative with the ANMF since 1992. He has had 35 years' experience of the challenges faced by the aged care workforce. His evidence was that many of the problems we confront in 2020 have been around for many years. During his time with the ANMF, Mr Gilbert has worked largely with the aged care sector representing his union's members in both the private and public sector in Victoria. When asked by Counsel Assisting to identify the issues that resonate from the ground up; that were the concerns of his members on a consistent basis. His succinct answer was this:

> Not enough staff. Not enough staff; simple as that.[12]

20. Mr Gilbert's witness statement provides the Royal Commissioners with a detailed account of attempts to improve the terms and conditions of employment of aged care workers over his 35 years in the sector.[13] He said that when it comes to staffing numbers in aged care, it is 'time to stop kicking the can down the road'.[14]

21. Counsel Assisting agree.

22. We submit that, if the Royal Commissioners goal is to make recommendations to achieve high quality, safe and person-centred aged care services, as it must be, then the time for real action on staffing numbers and mix, skill levels, remuneration, conditions of work and registration of the unregulated portion of the aged care workforce is now.

23. As we will explain, these issues have been the subject of numerous inquiries and recommendations over the last two decades. These inquiries have repeatedly recognised the same problems and often made the same recommendations to address those problems. Despite this the problems

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10 Royal Commission into Aged Care Quality and Safety, Background Paper 2 (2019), p 32.

11 Exhibit 11-21, Melbourne Hearing 3, Statement of Paul Gilbert, WIT.0430.0001.0001 at [9].

12 Transcript, Melbourne 3 hearing, Paul Gilbert, 16 October 2019 at T5975.46-47

13 Exhibit 11-21, Melbourne Hearing 3, Statement of Paul Gilbert, WIT.0430.0001.0001 at [4]-[10].

14 Transcript, Melbourne 3 Hearing, Paul Gilbert, 16 October 2019 at T6017.8

have persisted and in many ways have become more entrenched. This is of course a pattern that bedevils the entire aged care sector.[15] These submissions are aimed at assisting you, Commissioners, to address those problems in a way that will benefit residents in aged care now and in the future, their families, those working in aged care, providers of aged care and ultimately the nation as a whole.

24. I need to say something about the scope of the submissions we are making today. The first important point to make is that they are limited to workforce questions. Counsel Assisting, along with all of those working for the Royal Commission, appreciate that the serious problems of our aged care system documented in the Royal Commissioners' interim report will not be fixed by reform that is solely concerned with the aged care workforce. Such reform is, in our submission a necessary but not sufficient answer to those problems. Reform is needed in many aspects of the system including regulation, governance and funding. The workshop you held a fortnight ago Commissioners examined some proposed big picture changes to the design of the system. That work will be ongoing in the months ahead. The submissions we make today are but one piece of a complex puzzle. To take one obvious example, significant increases in funding will be needed to pay for the additional staff that will be needed to meet the minimum ratios that we propose.

25. The second preliminary matter to raise is that these submissions are primarily focussed on the residential aged care sector. While we address the workforce challenges of the provision of aged care in the home in a number of parts of the submissions, we consider that the homecare workforce raises a number of unique challenges which are better addressed in a separate set of submissions which we will deliver later this year. We consider that there are, and will continue to be, significant differences between workforce policy in a residential aged care context, which will increasingly be dementia-related and end-of-life clinical care focussed, and aged care in a home care context. The two settings are very different and call for different and tailored policy responses.

26. Numbers alone will not guarantee high quality care. As well as the right number of staff, there needs to be the right skill mix to provide the care needed by the particular residents. The quality of the staff must also be high. Staff with the right aptitude but also the right attitude to provide the relationship-based care that is person centred. They are the hallmarks of quality aged care. Finally the staff must themselves be cared for and valued. The evidence before the Royal Commissioners is that if all of those features are in place, care that is of a high standard and is safe should follow.

27. Before I address you on five specific areas and outline the recommendations that we your Counsel Assisting team consider you should make, two

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[15] Royal Commission into Aged Care Quality and Safety, Interim Report, vol 1, chapter 2.

contextual matters are worthy of special mention. The first concerns the changing nature of the residential aged care sector; the second concerns the role of nurses in our aged care system. As will be seen the two are related.

Are care needs increasing?

28. The overwhelming weight of evidence given to the Royal Commissioners by general practitioners, geriatricians, nurses, academics, policymakers, advocacy bodies, residents and their families, carers, aged care workers and aged care providers suggests that the care needs of people in residential aged care have increased significantly in recent years.[16]

29. As a witness in the Darwin Hearing described it with reference to her mother's experience in care:

> The aged care sector has undergone a monumental shift over the past decade but reform has not kept pace. When Mum entered the system the majority of residents were low care. The facility was essentially a supporting living arrangement where meals, laundry, cleaning and medical services were provided but normal life continued to a substantive degree. By the time Mum was deemed high care the centre had also morphed, much like a frog in boiling water, into a secure dementia facility where the doors no longer opened without code access, and hoists,

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16 See, for example, Exhibit 1-9, Adelaide Hearing 1, Statement of Paul Versteege (Combined Pensioners and Superannuants Association of NSW Inc), 7 February 2019, WIT.0009.0001.0001 at 0012 [63]; Exhibit 1-15, Adelaide Hearing 1, Statement of Deborah Parker (Australian College of Nursing), WIT.0017.0001.0001 at 0009; Exhibit 1-16, Adelaide Hearing 1, Statement of Annie Butler (Australian Nursing and Midwifery Federation), WIT.0020.0001.0001 at 0002; Exhibit 1-23, Adelaide Hearing 1, Statement of Glenys Beauchamp (Secretary, Commonwealth Department of Health), WIT.0022.0001.0001 at 0029 [124]; Exhibit 1-38, Adelaide Hearing 1, Statement of Janet Mary Anderson (Commissioner, Aged Care Quality and Safety Commission), WIT.0023.0001.0001 at 0031 [125]; Exhibit 1-40, Adelaide Hearing 1, Statement of Dr Harry Nespolon (President, RACGP), WIT.0016.0001.0001 at 0011-0012; Exhibit 1-45, Adelaide Hearing 1, Statement of Patricia Lee Sparrow (CEO Aged & Community Services Australia), WIT.0014.0001.0001 at 0005 [27]; Exhibit 1-46, Adelaide Hearing 1, Statement of Sean Rooney (CEO of Leading Aged Services Australia Ltd), WIT.0013.0001.0001 at 0006 [52], 0007 [55-56]; Exhibit 1-50, Adelaide Hearing 1, Statement of Nicholas George Mersiades (Director of Aged Care, Catholic Health Australia), WIT.0011.0001.0001 at 0019; Exhibit 1-56, Adelaide Hearing 1, Statement of Anthony Bartone (President, Australian Medical Association), WIT.0015.0001.0001 at 0004 [24]; Exhibit 1-54, Adelaide Hearing 1, Statement of Matthew Graham Richter (CEO, Aged Care Guild), WIT.0012.0001.0001 at 0007-0008 [3.2]; Exhibit 3-49, Sydney Hearing, Statement of Professor Elizabeth Ruby Anne Beattie (Queensland University of Technology), WIT.0119.0001.0001 at 0011 [34]; Exhibit 3-48, Sydney Hearing, Statement of Professor Constance Dimity Pond (University of Newcastle), WIT.0118.0001.0001 at 0019 [85]; Exhibit 3-55, Sydney Hearing, Statement of Professor Brendan Francis Murphy (Chief Medical Officer, Commonwealth Department of Health), WIT.0129.0001.0001 at 0013 [39]; Exhibit 3-80, Sydney Hearing, Statement of Professor Henry Brodaty (Psychogeriatrician, University of New South Wales), WIT.0116.0001.0001 at 0003 [18]; Exhibit 14-12, Canberra Hearing, Statement of Dr Carolyn Hullick and Dr Ellen Burkett (Geriatric Emergency Medicine Section of the Australasian College for Emergency Medicine), WIT.1298.0001.0001 at 0005 [25]; Exhibit 14-20, Canberra Hearing, Statement of Judith Lynne Gardener (Clinical Care Manager at RACF), WIT.1312.0001.0001 at 0003 [15]; Exhibit 14-26, Canberra Hearing, Statement of Leonard Charles Gray (Professor in Geriatric Medicine at UQ), WIT.0619.0001.0001 at 0010 [56].

> electric hospital beds and medical paraphernalia were the norm. The situation had effectively reversed with the majority of residents high care patients and around half suffering some form of dementia. Their needs are greater than ever before and the work of the carer so much more important.[17]

30. The Resource Utilisation and Classification Study (**RUCS**), undertaken for the Department of Health by the Australian Health Services Research Institute at the University of Wollongong, undertook profiling of approximately 5,000 people receiving aged care for classification development purposes.

31. Professor Eagar, who led the study, gave evidence in Melbourne Hearing 3. Professor Eagar pointed to compelling evidence from the Study that shows the majority of residents currently in residential aged care are very frail and have significant care needs.[18]

32. Professor Eagar referred to the aged care residents who were assessed as part of the RUCS studies and noted that the cohort was 'a representative sample of residents living in residential aged care across Australia in 2018'.[19] The overall finding from the studies 'is that residents are typically very frail with significant care needs'.[20] Specifically:

- only 15% of the residents are independently mobile;
- 35% cannot mobilise at all and are therefore at highest risk of pressure injuries;[21]
- nearly 90% need assistance with bathing and showering;
- nearly two thirds need assistance with eating;
- 80% need assistance with toileting; and
- about 2/3 need support because of communication problems.[22]

33. In her evidence, Professor Eagar proposed a focus on clinical care in residential aged care in response to those needs. She said:

> … when people describe residential aged care as a person's home, it is somehow implying that it's a lifestyle choice rather than people are going into residential aged care now because they are so frail or have other

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17 Transcript, Darwin and Cairns Hearing, Lisa Backhouse, 11 July 2019 at T3204.15-26.

18 Exhibit 11-2, Melbourne Hearing 3, Statement of Professor Kathy Eagar, WIT.0459.0001.0006 at [25]-[27].

19 Exhibit 11-2, Melbourne Hearing 3, Statement of Professor Kathy Eagar, WIT.0459.0001.0006 at [23].

20 Exhibit 11-2, Melbourne Hearing 3, Statement of Professor Kathy Eagar, WIT.0459.0001.0006 at [25].

21 Exhibit 11-2, Melbourne Hearing 3, Statement of Professor Kathy Eagar, WIT.0459.0001.0006 at [26].

22 Exhibit 11-2, Melbourne Hearing 3, Statement of Professor Kathy Eagar, WIT.0459.0001.0006 at [31].

> significant care needs that they can no longer be at home**. The population currently in care needs more clinical skills, not less** [emphasis added].[23]

34. Professor Eagar's view is supported by other evidence before the Royal Commissioners. For example, in 2004-5, 62.9% of people in residential aged care were classified as having high care needs; by 2016 this proportion had increased to 92%.[24] In 2020 it is no doubt higher and rising.

35. Modern medicine has developed to a stage where Australians live longer, despite multiple medical illnesses.[25] The people most in need of residential aged care, therefore, are likely to be frailer and sicker, and the complexity of their care needs greater. To use one example, in 2015, over half of people living in residential aged care had five to eight long-term health conditions, while one in five had nine or more conditions.[26]

36. Also significant to the delivery of aged care services is the expected increase in the number of people with dementia as a leading cause of disability in older Australians. An estimated 365,000 Australians had dementia in 2017, 99% of whom were aged 60 and over.

37. Australia does not have national data that can provide reliable prevalence estimates of dementia. Estimates about the current and future prevalence of dementia are primarily based on continued ageing of the population and the assumption that the age specific prevalence of dementia will remain consistent. Nevertheless, the Australian Institute of Health and Welfare estimates that in 2018, some 376,000 Australians had dementia. The total number is estimated to increase to over 500,000 by 2030.[27]

38. The rise in scope and complexity of health care needs for people in residential aged care can also be attributed to people entering that environment later in their life than previously. Over the last 10 years, entry to permanent residential aged care has tended to take place later in life.

39. These general health trends need to be understood in the context of an aged care system that has changed significantly over the last 20-25 years. Over this period, we have a seen a shift away from people entering care with lower needs and for social reasons. People now enter aged care at a later stage, due in part to the effectiveness of home care in supporting individuals to live

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23 Transcript, Melbourne Hearing 3, Kathleen Eagar, 14 October 2019 at T5776.45-5777.2.

24 Commonwealth of Australia, *Report on the Operation of the Aged Care Act 1997 – 1 July 2004 to 30 June 2005*, 2005, p 13;

25 Exhibit 3-55, Sydney Hearing, Statement of Professor Brendan Francis Murphy (Chief Medical Officer, Commonwealth Department of Health), WIT.0129.0001.0001 at 0013 [39].

26 Australian Bureau of Statistics, *4430.0 - Disability, Ageing and Carers, Australia: Summary of Findings, 2015*, Australian Government, 2016, https://www.abs.gov.au/ausstats/abs@.nsf/Previousproducts/4430.0Main%20Features302015?opendocument&tabname=Summary&prodno=4430.0&issue=2015&num=&view=, viewed 20 February 2020.

27 Australian Institute of Health and Welfare, *Australia's welfare 2017: in brief*, 2017.

at home for longer.[28] People with lower acuity prefer to remain supported at home for as long as possible and so the proportion of lower needs care recipients in residential care is declining.

40. These trends have been borne out in evidence during the Royal Commission's public hearings. For example, Ms Butler from the Australian Nursing and Midwifery Foundation noted that there is 'this drift towards residential aged care now being more subacute facilities…'.[29] This point was echoed by Mr Peter Jenkin, a palliative care specialist, in the Canberra Hearing. Mr Jenkin noted that:

> I think we've moved very much from a social model of – a housing-model of – in aged-care to what really is subacute care these days, and people are coming in older, sicker, frailer, multi morbidities and are needing much more care, and they're coming – because of that they're coming in –significant numbers of them needing palliative care in the first instance.[30]

41. Mr Jenkin's evidence was echoed by Ms Nikki Johnstone, a nurse practitioner working in a palliative aged care specialist team at a hospice, Clare Holland House, in the ACT.[31] Ms Johnstone told the Royal Commissioners in Canberra that:

> Everybody who is in residential aged-care is there because they have a complexity of need. So low function, high disability and needing help with activities of daily living. People don't end up in residential aged-care, usually, by choice. They're there because of their care needs, and they can no longer stay at home to be safe. So I would argue that every single person in residential aged care has palliative-care needs.[32]

The importance of registered nurses in aged care

42. Aged care workforce census data shows that Registered Nurses comprised 21% of the residential direct care workforce in 2003, but this proportion had dropped to 14.9% by 2016.[33] This represents a decrease of more than 25%. The proportion of enrolled nurses had dropped from 14.4% to 9.3% over the same period. The proportion of direct care employees working in allied health had dropped from 7.6% to 4%.

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28 Exhibit 1-45, Adelaide Hearing 1, Statement of Patricia Lee Sparrow (CEO Aged & Community Services Australia), WIT.0014.0001.0001 at 0005 [27].

29 Transcript, Adelaide Hearing 1, Annie Butler (Australian Nursing and Midwifery Federation), 13 February 2019 at T273.10-20.

30 Transcript, Canberra Hearing, Peter Jenkin, 11 December 2019 at T7447.2-7.

31 Ms Johnstone's extensive experience in providing palliative care services in residential aged care settings is set out in paragraphs [5]-[14] of Exhibit 14-24, Canberra Hearing, Statement of Nikki Johnstone, WIT.1316.0001.0001.

32 Transcript, Canberra Hearing, Nikki Johnstone, 11 December 2019 at T7448.9-14.

33 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 148, AHS.0001.0001.0001 at 0010.

43. In contrast, the proportion of the residential direct care workforce who are unregistered and in many cases unqualified personal carer workers increased from 56.5% to 71.5% over the same period.[34] These trends are revealed in the graph now displayed on the screen from the AMA submission to the Royal Commissioners.[35]

44. To be clear, the care work that was performed by qualified nurses, physiotherapists, speech pathologists, etc. is now being performed by unqualified, unregistered and in many cases untrained personal care workers. It is hardly surprising in these circumstances that the Royal Commissioners have received thousands of submissions by members of the public complaining about the substandard care being provided in residential aged care.

45. These trends are also revealed in other data. That data reveals that in 2010, 19% of direct care in those aged care facilities caring for those residents with the highest care needs was delivered by RNs. By 2019, this had dropped to 12%.[36]

Why does the exodus of nurses from our aged care system matter?

46. Dr Deborah Parker, Professor of Aged Care (Dementia) at the University of Technology, Sydney and Chair of the Ageing Policy Chapter of the Australian College of Nursing gave evidence in Adelaide Hearing 1.[37] Dr Parker explained that:

> The College of Nursing holds that view that care delivered in Residential Aged Care Facilities must be led by Registered Nurses. Due to the growing prevalence of co-morbidities associated with physical and cognitive decline, polypharmacy, and greater professional accountability, increasingly the residential aged care population requires more complex care that can only be provided under the direct supervision of RNs.[38]

47. After referring to the RN scope of practice, Dr Parker explained that:

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34 National Institute of Labour Studies, *2016 National aged care workforce census and survey—the aged care workforce*, 2017, p 13, reproduced as Table 1 in Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 148, AHS.0001.0001.0001 at 0009-0010.

35 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 148, AHS.0001.0001.0001 at 0017.

36 StewartBrown, *Aged care financial performance survey – sector report*, September 2019, http://www.stewartbrown.com.au/images/documents/StewartBrown---ACFPS-Sector-Financial-Performance-Report-September-2019.pdf, accessed 2 February 2020, p 13, 28.

37 Exhibit 1-15, Adelaide Hearing 1, Statement of Deborah Parker, WIT.0017.0001.0001.

38 Exhibit 1-15, Adelaide Hearing 1, Statement of Deborah Parker, WIT.0017.0001.0001 at 0010; see also Australian College of Nursing, *Regulation of the Unregulated Health Care Workforce across the Health Care System – A White Paper by ACN 2019*, 2019, p 17.

> RNs provide frontline leadership in the delivery of nursing care and in the coordination, delegation and supervision of care provided by Enrolled Nurses (ENs) and unregulated healthcare workers ….[39]

48. Dr Parker concluded:

> The continuous presence of an RN is essential to ensure the timely access to effective nursing assessment and comprehensive nursing care, and the evaluation of that care.[40]

49. Dr Parker proposed that the Royal Commissioners recommend that 'The Australian government should mandate that an RN be on-site and available at all times in RACFs as a minimum'.[41]

50. Counsel Assisting endorse this proposal. While we recognise that the evidence shows that residential aged care is best provided by multi-disciplinary teams involving a range of medical professionals including doctors, nurse practitioners, allied health practitioners and others, we submit that for too long the role of nurses, especially registered nurses, has been downplayed in our aged care system. We submit that this is one of the mistakes of the past that must be confronted if the aged care system is to provide high quality and safe care in the future.

51. This evidence about the crucial role of RNs in residential aged care is supported by considerable evidence before the Royal Commissioners.

52. Mr Rob Bonner of the ANMF who also has several decades of experience of the aged care sector, explained that:

> …holistic care in residential aged care facilities is led by Registered Nurses and provided by Registered Nurses (including nurse practitioners), Enrolled Nurses and Personal Care Assistants. Which role undertakes, or should undertake the nursing care is dependent upon the complexity of the intervention, and qualification and skill required to meet the assessed need, as determined by the Registered Nurse.[42]

53. Importantly, Ms Angela Raguz, registered nurse and general manager of residential aged care, Hammond Care reminded us at the Darwin Hearing that nurses contribute most to aged care when they are nursing and not performing other work:

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39 Exhibit 1-15, Adelaide Hearing 1, Statement of Deborah Parker, WIT.0017.0001.0001 at 0010.

40 Exhibit 1-15, Adelaide Hearing 1, Statement of Deborah Parker, WIT.0017.0001.0001 at 0010.

41 Exhibit 1-15, Adelaide Hearing 1, Statement of Deborah Parker, WIT.0017.0001.0001 at 0010.

42 Exhibit 11-28, Melbourne Hearing 3, Statement of Rob Bonner, WIT.0488.0001.0001 at 0012 [18]; see also Exhibit 1-16, Adelaide Hearing 1, Statement of Annie Butler, WIT.0200.0001.0001 at 0004 [23], [24].

> … it's how our registered nurse staff are maximising their clinical potential rather than being all things to all people within a system, from roster managers, to budget controllers, to ordering stock, to deciding whether or not the care staff in the tea room need to be reprimanded for their behaviour. The role of the nurse, I believe, should focus on what that clinical expertise brings rather than doing it all.[43]

54. The vital importance of registered nurses being rostered to work in residential aged care facilities at all times was brought home by a recent Coronial case in Victoria.[44] John Reimers died on 17 December 2016 at the Mayflower Residential Aged Care facility in Reservoir. Mr Riemers had fallen from his wheelchair and his head had become trapped in the bottom drawer of his bedside drawers.

55. In her findings dated 23 August 2019, the Coroner found that the enrolled nurse and a personal care attendant on duty had not adequately cared for Mr Riemers between the time of his fall and the time an ambulance attended, by which time Mr Riemers had died. The quality of the first aid he received was inadequate. The Coroner found that there was no registered nurse rostered on duty that night although there was one on call. The Coroner questioned both the training of the care worker and the leadership abilities of the enrolled nurse.

56. In handing down her findings, Coroner Jamieson concluded that the circumstances of Mr Riemer's death:

> … have highlighted a concerning norm in aged care: staffing to patient ratios administered at minimalistic levels which places the delivery of appropriate care at risk. Additionally, the delivery of appropriate care is being further compromised by an industry approach to employing enrolled nurses to act in charge of their shift. In many cases, the enrolled nurses are supported only by a minimally trained group of care providers, who by their mere dominance of presence in the sector, give the impression that they have the status of a profession.[45]

57. The Coroner recommended:

> … that the Federal and State Government Health Departments legislate minimum ratios of nursing staff to patients/residents of aged care facilities as prescribed by the aforementioned national standards. [46]

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43 Transcript, Darwin and Cairns Hearing, Angela Raguz, 17 July 2019 at T3790.35-39.

44 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 171, RCD.9999.0231.0034.

45 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 171, RCD.9999.0231.0034 at 0064.

46 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 171, RCD.9999.0231.0034 at 0075 (Recommendation 4).

What's in a name?

58. It may be no coincidence that the reduction in the proportion of nurses in the aged care workforce noted by the Coroner has coincided with a change in the name of our aged care homes from the comforting and familiar 'nursing homes' to the impersonal 'residential aged care facilities'. Perhaps it is time to accept that the term 'nursing home' was the right one all along.

The Structure of these submissions

59. The structure of these submissions is as follows. We commence in Part 2 with a detailed examination of staffing numbers and mix and propose a new legally enforceable requirement for mandatory minimum staffing levels in Australian residential aged care for the first time since the passage of the *Aged Care Act* in 1997.

60. In Part 3, we address the need to improve the education, skills and training of aged care workers. A discussion of the ways in which the unregistered portion of the workforce can be professionalised by compulsory registration appears in the Part 4 of our submissions. This is followed in Part 5 by a discussion of the terms and conditions of employment of aged care workers.

61. Part 6 examines the important question of leadership and workforce planning and proposes some recommendations for improvements.

A Consultative Inquiry

62. The Royal Commissioners have been very well supported by the public and we are very grateful for that. As at 14 February 2020, the Royal Commissioners had received a total of 8,058 submissions. Of these, 54% have raised concerns about substandard or unsafe aged care facilities and 53% have raised concerns about staffing issues including ratios.

63. In addition, many of those members of the public who have attended the community forums organised by the Royal Commissioners have raised these same concerns.

64. Witnesses at our public hearings have been selected from those who have made submissions and those who have attended our public events. As I explained at Melbourne Hearing 3 in October last year, 85% of the 296 witnesses who had given evidence during our 55 days of public hearings had raised concerns about the aged care workforce. Since then we have held further public hearings and that trend has continued.

65. In preparing these submissions, we have been guided by the evidence that has been presented to the Royal Commissioners and the latest Australian and international research. We have produced a very long document because we have tried to do justice to the wealth of evidence at our disposal. We have also taken account of previous reports and inquiries where appropriate.

66. The length of the submissions makes reading them out in full impractical. I will merely note what we have written in some parts and read out others. We rely on the entire document which we commend to you. The full submissions will appear on the Royal Commission's website today.

PART 2 Staffing numbers and mix

67. The Royal Commissioners indicated in their Interim Report that:

> Our Final Report will give close consideration to options to ensure staffing levels, and the mix of staffing, are sufficient to ensure quality and safe care.[47]

68. In this part of our submissions, we examine those options and ultimately conclude that the most efficacious way of ensuring high quality and safe aged care in a residential setting is by imposing requirements on the providers of that care to have a minimum number of care staff in a mix that takes into account the care needs of their residents. We submit that the evidence demonstrates that requiring minimum staffing numbers is a necessary but not sufficient step towards improving the quality and safety of aged care. The other steps specific to the workforce include improved training, better management and more attractive terms and conditions of employment. More broadly, these workforce reforms cannot expect to be effective unless they are introduced as part of a package of reforms that addresses other aspects of our aged care system including its overall design, how it is funded and financed, provider governance and regulation.

There are too few workers in aged care

69. In earlier hearings, the Royal Commissioners heard from care recipients, family members workers, providers and academics that aged care services do not have enough staff[48] and that the staff who are working do not have the required skills and training to assist the vulnerable people in their care.[49]

70. The Royal Commissioners have heard the sworn testimony of many family members of elderly people in care. These deeply moving accounts

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47 Royal Commission into Aged Care Quality and Safety, Interim Report, vol 1, page 231.

48 For example, Transcript, Brisbane Hearing, Sarah Holland-Batt, 7 August 2019 at T5988.40-42; Transcript, Broome Hearing, Faye Dean, 17 June 2019 at T1976.30-32; Transcript, Darwin and Cairns Hearing, Elsie Scott, 17 July 2019 at T3738.27-30; Transcript, Darwin and Cairns Hearing, FA, 17 July 2019 at T3774.27-36; Transcript, Darwin and Cairns Hearing, Hayley Ryan, 11 July 2019 at T3342.2-4; Transcript, Darwin and Cairns Hearing, Johanna Aalberts-Henderson, 15 July 2019 at T3473.23-24; Transcript, Darwin and Cairns Hearing, Lisa Jones, 17 July 2019 at T3736.31-33, Transcript, Darwin and Cairns Hearing, Paul Cohen, 10 July 2019 at T3165.25-33; Transcript, Darwin and Cairns Hearing, Timothy Deverell, 16 July 2019 at T3625.23-27; Transcript, Perth Hearing, Anthony O'Donnell, 25 June 2019 at T2477.5-7; Transcript, Perth Hearing, Emma Murphy, 26 June 2019 at T2519.29-30; Transcript, Sydney Hearing, DJ,13 May 2019 at T1488.09-15; Transcript, Sydney Hearing, Kathryn Nobes, 8 May 2019 at T1422.31-35; Transcript, Sydney Hearing, Susan Walton, 15 May 2019 at T1691.5-18.

49 For example, Transcript, Adelaide Hearing 1, Deborah Parker,13 February 2019 at T228.29-41; Transcript, Adelaide Hearing 1, John McCallum, 11 February 2019 at T96.28-34; Transcript, Adelaide Hearing 2, Anna Hansen, 19 March 2019 at T830.20-30; Transcript, Broome Hearing, Yvonne Grosser, 17 June 2019 at T1998.1-10; Transcript, Perth Hearing, Dale Fisher, 26 June 2019 at T2561.12-15; Transcript, Darwin and Cairns Hearing, Sandy Green, 17 July 2019 at T3791.12-16; Transcript, Sydney Hearing, Joseph Ibrahim, 16 May 2019 at T1796.22-25;

demonstrate the reality behind the statistics. I will now refer to a small selection of those accounts.

71. The first account is from Ms Lisa Backhouse who gave evidence at our Darwin Hearing in July 2019. Ms Backhouse described her mother's experience of two residential care facilities in New South Wales between 2016 and 2019. She had just explained how her mother had a fall in 2018 and then told the Royal Commissioners that:

> In the months leading up to this incident I had been increasingly concerned about the number of times Mum was found on the floor by nursing home staff. Staffing levels had reached such a low level that carers were unable to perform basic duties. Early in 2018 I had a series of conversations with staff at the facility about checking on Mum more frequently during the afternoons. I recall on one particular day I asked a carer during a conversation in the facility's hallway to please check on Mum in her room to try and prevent her being found on the floor. I was told, 'I'm sorry but I just don't have time'.
>
> …
>
> I had noticed that Mum was on the floor in the motion-activated video that was recorded by the surveillance camera and contacted the facility. I was informed that staff had not attended to Mum earlier because they were assisting the family of a recently deceased resident. The video footage shows that Mum is soiled and was trying to mobilise. She is not able to use the call bell to request help independently.
>
> …
>
> The facility management has apologised and staff have been counselled regarding this incident. However, this is indicative of a much wider systemic issue – that of failure of staff to attend in a timely way following sensor or call button alerts. I have experienced this personally innumerable times and across different centres. It is also a common complaint of other residents and family members.
>
> Adequate staffing levels should be provided to allow for a contingency including the management of priority situations without the safety and wellbeing of other residents being compromised.
>
> This issue goes directly to the need to mandate staff to resident ratios to ensure adequate numbers of staff are available at all times. Without this being enforced, facilities are able to not replace staff who are unwell or fail to attend shifts resulting in cost savings to the providers to the detriment of residents' safety and wellbeing.
>
> Politicians are great at kicking the can down the road delaying public policy imperatives such as mandating minimum staff to resident ratios. Ask any family member of an aged care resident and they will tell you that you can shoot a cannon down the empty corridors on weekend and

> afternoon shifts in particular. I have observed that residents are often left sitting in chairs all day long, more often than not in soaking incontinency aids, lying on the floor unable to mobilise after falls, unable to reach fluids, or with spills covering them. Sometimes, they have pressure sores and infections that go unnoticed in the busy task-focused environment. Even the best facilities operating a staff to resident ratio of around one to eight. That means the most basic care needs such as bathing, dressing, feeding and toileting are just being met. Sometimes not. There is no playtime for true care where humanitarian and comfort needs are also met in a proactive way.[50]

72. The second brief extract is from the evidence of a witness referred to as 'DJ' at the Sydney Hearing. DJ's mother was in a residential aged care facility and she told us that:

> There was no one around to help my mum. I ran around the facility doing laps of the corridors trying to find a nurse or just someone to assist. I felt quite panicked at this stage, and my sister and I were pretty much were taking turns running around looking for help and then one of us would stay with Mum. This went on for at least 30 minutes before we could find someone to help us. Even when we were able to find people, we felt they did not know how to handle the situation.[51]

73. One of the most heart-breaking accounts given to the Royal Commissioners was by Ms Diane Daniels at the Hobart Hearing. Ms Daniels' mother was in a residential aged care facility in South Hobart in 2017. Ms Daniels had described to us a meeting that she had with facility management to discuss her mother's care and her concerns about staffing levels. She went on:

> On Tuesday the 14th of March 2017, 11 days after this meeting, I sent an email to [facility manager] David Neal and regional support manager, Elizabeth Wesols, explaining that on Sunday at 11.50 am Mum had somehow hit a redial button on her phone and called me. Mum did not realise that she had done this. I could hear that Mum was calling out for a nurse and getting more agitated. Because it was lunchtime, I thought someone would come into Mum's room, but I could hear that no one did. I waited, but Mum began sobbing and saying 'I wish I was out of it.' And this broke my heart.[52]

74. This is a very small selection of similar accounts that the Royal Commissioners have heard since they commenced their work in early 2019. If there is one constant theme running through all of the hearings, it is the concern raised with us about the lack of appropriately trained staff in

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50 Exhibit 6-20, Darwin and Cairns Hearing, Statement of Lisa Maree Backhouse, WIT.0221.0001.0001 at 0009 [15], [32]-[33], [35]-[36] and [52].

51 Transcript, Sydney hearing, DJ, 13 May 2019 at T1488.09-15.

52 Transcript, Hobart Hearing, Diane Daniels, 13 November 2019 at T6907.11-18.

residential aged care facilities and the impact of the staff shortages on the quality of care.

75. We have also heard from many people who work in aged care.

76. For example, a highly experienced RN working in a residential aged care facility with residents with very high care needs (who also happens to be a former Commonwealth public servant) made a submission to the Royal Commissioners in which she said:

> Being a registered nurse in aged care, I'm sure, is one of the busiest and more physically demanding jobs. How does the system account for RNs only being able to complete their work by literally running from one task to the next? How does the system pick up care procedures like dressings, that should be done in 10 mins, being completed in 3 – because that is the only time possible. How does the system pick up the effect of only being able to spend a couple of minutes sorting out client requests, because any delay in getting the work schedule completed, can never be regained. This is the reality for RNs in AC.
>
> …
>
> I have worked as an Executive level public servant. I have now returned to nursing – and get paid about 30% less than I did as a public servant**.** I do the work because I love it and I feel needed and useful. Please compare my work on an average shift at 0700. I am required to give out complex medication over three medication rounds to 30 people. That is around 70 medication transactions per shift. I must be 100% accurate. I supervise the work of 6 PCAs and I need to be constantly aware of what they are doing; and provide advice and mentoring when they have problems. The work schedule is just achievable if the day is entirely regular. I rush all of the time. I cannot spend time talking to clients. If anything untoward happens – for instance a client needs to go to hospital, the only way I can make up the work is by working overtime. Overtime is a daily occurrence at the facility I work in – because we all care about the clients.
>
> …
>
> There is something wrong with the system. At the moment aged care is being supported through the work of (largely women) around my age – 57 years. Our bodies cannot hold out forever! Our skills and experience are hard to replace.[53]

Surveys by Trade Unions

77. We have also received evidence from the trade unions with members working in the aged care sector. This has included survey evidence in which

[53] Anonymous submission to the Royal Commission into Aged Care Quality and Safety, AWF.001.01735.

workers in aged care were asked to identify concerns they had about their work.

78. The Australian Nursing and Midwives Federation (**ANMF**) represents registered nurses working in aged care. The ANMF conducted its 'National Aged Care Survey' in May 2019.[54] 2,775 staff working in the aged care sector from all States and Territories answered at least one question.[55] In summary, the survey results indicated that:

- The greatest concern of almost 91% (n = 2,517) of respondents was 'having adequate staffing levels for meeting basic care needs for residents'.[56]
- 82.5% (n = 2,285) were concerned about having adequate staffing levels for providing high care'.[57]
- Dementia management (62.5%, n = 1,731) and 'levels of experience and qualifications held by nursing staff' (61%, n = 1,690) were also concerns expressed.[58]
- Inadequate staffing in aged care was noted by 89% (n = 2,406). This was an increase from the 2016 results where 72.9% indicated that staffing was inadequate.[59]
- 39.1% (n = 1.079) of respondents identified workloads as the main factor that hindered efforts to recruit and retain staff.[60]
- 42.6% of respondents reported multiple reductions in staff hours in the last year;
- 75% of respondents reported they had to start early or stay late to finish work on an unpaid basis;[61]

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54 Exhibit 11-1, Melbourne Hearing 3, General tender bundle, tab 6, RCD.9999.0203.0054.

55 Exhibit 11-1, Melbourne Hearing 3, General tender bundle, tab 6, RCD.9999.0203.0054 at 0062

56 Exhibit 11-1, Melbourne Hearing 3, General tender bundle, tab 6, RCD.9999.0203.0054 at 0062.

57 Exhibit 11-1, Melbourne Hearing 3, General tender bundle, tab 6, RCD.9999.0203.0054 at 0062.

58 Exhibit 11-1, Melbourne Hearing 3, General tender bundle, tab 6, RCD.9999.0203.0054 at 0062.

59 Exhibit 11-1, Melbourne Hearing 3, General tender bundle, tab 6, RCD.9999.0203.0054 at 0062.

60 Exhibit 11-1, Melbourne Hearing 3, General tender bundle, tab 6, RCD.9999.0203.0054 at 0062-0063

61 Exhibit 11-21, Melbourne Hearing 3, Statement of Paul Gilbert, WIT.0430.0001.0001 at 0027 [148].

- 80% of respondents reported better staffing ratios would have prevented some hospital transfers.[62]
- 87.5% of respondents reported that mandated minimum ratios would make residential aged care a more attractive place to work.[63]

79. The Health Workers' Union represents care workers and some enrolled nurses in aged care.[64] It conducted a survey of its members in July 2019 and received 1,645 responses.[65] The results show that:

- 54% were from personal care workers.[66]
- Other respondents included those who worked as food services assistants (137); leisure and lifestyle workers (115) and cleaners (71).[67]
- 68% worked in the private sector and 23% worked in the public sector.[68]
- 72% worked part time with only 20% working full time. 7% were casuals.[69]
- 82% indicated they were concerned about staffing levels and workload in their workplace.[70]
- Of these, 68% 'considered that the position had 'worsened or worsened significantly in the last 12-18 months'. Further, 'these significant concerns correlated strongly with participants (sic) responses to the level of care they felt they were able to provide…'.[71]

Is there a link between substandard care and staffing levels and mix?

80. Our hearings to date have revealed the disturbing extent of substandard care, that there are not enough staff, there's never enough time to do the

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62 Exhibit 11-21, Melbourne Hearing 3, Statement of Paul Gilbert, WIT.0430.0001.0001 at 0027 [150].

63 Exhibit 11-21, Melbourne Hearing 3, Statement of Paul Gilbert, WIT.0430.0001.0001 at 0028 [151].

64 See Exhibit 11-20, Melbourne Hearing 3, Statement of Lisa Alcock, WIT.0463.0001.0001 at 0002-.0004 [11]-[19].

65 Exhibit 11-1, Melbourne Hearing 3, General tender bundle, tab 5, HWU.0001.0001.0001.

66 Exhibit 11-1, Melbourne Hearing 3, General tender bundle, tab 5, HWU.0001.0001.0001 at 0002 and 0006.

67 Exhibit 11-1, Melbourne Hearing 3, General tender bundle, tab 5, HWU.0001.0001.0001 at 0006.

68 Exhibit 11-1, Melbourne Hearing 3, General tender bundle, tab 5, HWU.0001.0001.0001 at 0007.

69 Exhibit 11-1, Melbourne Hearing 3, General tender bundle, tab 5, HWU.0001.0001.0001 at 0008.

70 Exhibit 11-1, Melbourne Hearing 3, General tender bundle, tab 5, HWU.0001.0001.0001 at 0009 and .0021-.0023.

71 Exhibit 11-1, Melbourne Hearing 3, General tender bundle, tab 5, HWU.0001.0001.0001 at 0009-.0012.

work, that aged care workers work in poor and sometimes unsafe conditions and lack the training they need to do the work required of them. We summarise that evidence by reference to the discrete care domains that were the subject of expert evidence in the Royal Commission's public hearings.

Continence Care

81. In the Darwin Hearing, the Royal Commissioners heard from two internationally recognised witnesses with clinical and academic expertise in the management of continence in frail older adults, Dr Joan Ostaczkwiewicz of Deakin University and Professor Michael Murray who is the National President of the Continence Foundation of Australia.

82. Giving evidence as a panel, the two witnesses told the Royal Commissioners that:

- Minimising the impact of continence-related problems substantially improves the quality of life for older people.[72] Presently, there is no guidance offered on incontinence and dementia, the result of which is a 'broad scale lack of awareness of incontinence as a problem and its causes and that leads to people accepting it to be a problem of old age and something that you can't do anything about, which is just not the case.'[73]
- 71% of the residential aged care population have urinary or faecal incontinence or both. A failure to provide continence care and management and to minimise the impact of continence related problems are significant factors in precipitating admission into residential aged care. It is therefore very important that older people have access to continence services, continence nurses and assessment services.[74]
- Of the 71% of the aged care population who are incontinent, many are incontinent because they have a physiological problem with their bladder or because they can't get the assistance they need to get to the care they need. Clinical incontinence can increase the risk of falls and affect skin integrity from incontinence associated dermatitis, which in turn increases the risk of pressure injuries. Aged care workers are aware of the link between incontinence and falls 'and often put in place strategies to restrict residents' movement so that they don't get up to go to the toilet.'[75]

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72 Transcript, Darwin and Cairns Hearing, Associate Professor Murray, 11 July 2019, T-3277, 25 – 29.

73 Transcript, Darwin and Cairns Hearing, Dr Joan Ostaszikiewicz, 11 July 2019, T3277.39-44.

74 Transcript, Darwin and Cairns Hearing, Associate Professor Murray, 11 July 2019, T3278.32-38.

75 Transcript, Darwin and Cairns Hearing, Dr Joan Ostaszikiewicz, 11 July 2019, T3281.33-47, T32821-7.

- There are 'studies which show an association between incontinence and depression in older people and a reduced quality of life'.[76]
- The rates of disability incontinence, which is incontinence caused by the inability to reach and use the toilet or a receptacle, can be reduced by being responsive to the needs of older people, and for older people with dementia, being aware of behavioural cues. 'Good staff' are able to do this. It is 'problematic' when staff don't know the residents very well, for instance agency staff or if that information is not communicated.'[77]
- There is a need to improve the level of staffing along with the level of education and training, the level of oversight and the level of clinical governance.[78] It is the mix and the leadership which are 'always the things that are most critical in any good care environment'. [79]
- Personal care workers, 'largely, are the ones providing direct continence care'.[80] The education of personal care workers, which prepares personal care workers for work in aged care, and they do not contain any core units or competences related that would equip them with knowledge and skills to actively prevent – implement strategies for incontinence. (Personal care workers) are not equipped to do anything other than to just manage the incontinence.[81]

83. In a supplementary statement, Dr Ostaszkwiewicz added the further evidence that:

> [a] recent analysis of data from 5,271 aged care recipients from 534 residential aged care homes (termed long-term care hospitals) in Korea found a significant association between the number of Registered Nurses (RNs) and care recipients' continence (Yoan et al., 2012), i.e. the higher the number of RNs relative to other nursing staff, the higher the rates of continence. This finding remained valid after controlling for six other organisational factors i.e. facility location, ownership type, operating period, number of beds, doctor staffing level, nurse staffing level. It is consistent with other research showing RN staffing is a differentiating

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76 Transcript, Darwin and Cairns Hearing, Dr Joan Ostaszikiewicz, 11 July 2019, T3282.9-10.

77 Transcript, Darwin and Cairns Hearing, Dr Joan Ostaszikiewicz, 11 July 2019, T3282.26-43.

78 Transcript, Darwin and Cairns Hearing, Associate Professor Murray, 11 July 2019, T3291.13-38.

79 Transcript, Darwin and Cairns Hearing, Associate Professor Murray, 11 July 2019, T3291.13-38.

80 Transcript, Darwin and Cairns Hearing, Dr Joan Ostaszikiewicz,11 July 2019, T3289.1718.

81 Transcript, Darwin and Cairns Hearing, Dr Joan Ostaszikiewicz, 11 July 2019, T-3289.24-30.

factor in the quality of care in long-term care (Arling et al., 2007; Spilsbury et al., 2011).[82]

84. In her oral evidence, she also told us of other research including that by US researcher Schnelle:

> … who found that we needed – I think it's three to four – no, one staff member to three to four residents in order to provide two-hourly toileting assistance. Now, we don't obviously staff places at those rates. But the other thing that's interesting is that, obviously, residents need different levels of assistance. So if you can reach and use the toilet on your own, you don't need a staff member to help you, that's fine. But some residents need one staff member, some need two, and some need a lifting machine to reach and use the toilet.
>
> And there's a researcher from the UK that looked at the time difference involved for these three groups. So for a person who just needs one staff member to assist them, it's something like 11 minutes. And if they need a lifting machine and two staff members, it's 33 minutes. So all of us here in this room will probably void four to six times a day and once at night. That's normal bladder function. So if you multiply that by seven, it means that a person who needs assistance from one person would need at least an hour of staff support over a 24-hour period. But if they need a lifting machine to get to the toilet and two staff members that adds up to about four hours of staff time. Well, it's actually eight hours if you are talking about two staff members. So you can see the difficulty of actually providing levels of assistance that people need. So staff find pragmatic ways to deal with this problem because they have to manage it.

85. Dr Ostaszkiewicz explained that by this, she meant that '[t]here is a high level of overuse and indiscriminate use of incontinence products in aged care'.[83]

Falls

86. Dr Frances Batchelor, physiotherapist and researcher at the National Aging Research Institute gave evidence about the risk of falls faced by elderly people. She referred to the inter-relationship between incontinence and the risk of falls by referring to a resident who:

> … might feel the need to go to the toilet, they might call for assistance but they're not sure how long it's going to take for that assistance to arrive. … And so instead of waiting, which might be the safe option, they might take themselves to the toilet and, therefore, expose themselves to the risk of falls. The second way is if an incontinent episode has

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82 Exhibit 6-26, Darwin and Cairns Hearing, Supplementary witness statement of Joan Ostaszkiewicz, WIT.0222.0002.0001 at [14].

83 Transcript, Darwin and Cairns Hearing, Dr Joan Ostaszkiewicz, 11 July 2019, T3283.18-45.

occurred, so urinary incontinence, for example - - - - - in the bathroom, that poses a slip hazard.[84]

87. Dr Batchelor referred to staffing numbers when she asked us to:

> imagine the situation at night where a care worker is assisting someone to the toilet and someone else calls for assistance. It doesn't matter how much knowledge or skills they have, they can't be in two places at the one time. So they will need to make a decision about whether they leave the resident who they're with - - - - - - and go to the other resident and weigh up, you know, a challenging decision to make. So I do believe that we need increase staffing resources as a way of reducing falls within residential aged care.[85]

88. Dr Batchelor also explained the importance of care workers receiving training in the subtle indicators that a person's falls risk is increasing as part of broader training that provides care workers with 'an understanding of how falls risk factors interact with other issues, and we've heard a lot about joining the dots'.[86]

Wound Care

89. Haylee Maree Ryan of Wounds Australia explained that, because the treatment of pressure injuries has become common in residential aged care facilities, an increased workload results.[87] Associate Professor Geoffrey Sussman, Clinical Wound Consultant at the Austin Hospital, explained that a resident at risk of such an injury will benefit from early intervention with quite simple and inexpensive treatments to prevent the problem, as contrasted with managing the problem.[88]

90. Misdiagnosis is an important factor in how resident's wounds are treated.[89] For wounds to be prevented and managed effectively, residents need to be regularly assessed by care staff to look for even small indicators that there may be an issue, or conduct a good quality history of the resident if there are comorbidities.

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84 Transcript, Darwin and Cairns Hearing, Dr Frances Batchelor, 16 July 2019, T3706.30-43.

85 Transcript, Darwin and Cairns Hearing, Dr Frances Batchelor, 16 July 2019, T3723.24-34.

86 Transcript, Darwin and Cairns Hearing, Dr Frances Batchelor, 16 July 2019, T3723.40-3724.2

87 Transcript, Darwin and Cairns Hearing, Hayley Ryan, 11 July 2019, T3329.46 – 47, T3230.2 – 3.

88 Transcript, Darwin and Cairns Hearing, Associate Professor Sussman, 11 July 2019, T-3330.23 – 24.

89 Transcript, Darwin and Cairns Hearing, Associate Professor Sussman, Hayley Ryan, 11 July 2019 T-3330.11 – 17, T333.19 – 21.

91. Associate Professor Sussman explained that aged care workers lack the basic skills to care for wounds.[90] Improving aged care worker training on wound care, combined with increasing the numbers of aged care workers would allow aged care workers to have the time to deliver appropriate and evidence based care on pressure injuries before they develop into a larger and painful acute care problem requiring drastic intervention, which is avoidable in the first place.[91]

92. Ms Catherine Sharp, a wound consultant with many years of treating the wounds of elderly people in residential aged care facilities, was asked by Counsel Assisting how she would like to see wound care in aged care improved. She said, 'we need many more staff'.

93. Ms Sharp explained that wound care is very labour intensive 'especially if there's some dementia.' She gave a number of examples of how she needs to be assisted by care staff and informed the Royal Commissioners that, in her experience, 'there's not enough care staff anywhere'.[92]

Nutrition

94. The Royal Commissioners heard from a number of witnesses with expertise in nutrition during the Cairns Hearing. Dr Iuliano, a nutritionist at the Department of Medicine, University of Melbourne has completed a large-scale nutrition study involving 60 residential aged care facilities with 4,000 residents.[93] The study was aimed at identifying barriers to the provision of adequate nutrition in residential aged care.

95. Based on that study, she concluded that there is a lack of education in the food service staff.[94] Dieticians and the clinical application of nutrition should be included as part of the team of health professionals in aged care, which forms part of the education and training of the aged care sector.[95]

96. The consequence of a failure to incorporate nutrition needs into the care approach for older people is poorer health outcomes for residents, including risk of malnutrition, i.e. substandard care.

97. Residential aged care facilities do not have the skill and knowledge to implement changes needed that would support resident nutrition.[96] There is

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90 Transcript, Darwin Hearing, Associate Professor Sussman, 11 July 2019, T3339.25 – 28, T3339.44.

91 Transcript, Darwin and Cairns Hearing, Associate Professor Sussman, 11 July 2019, T3344.32-37

92 Transcript, Darwin and Cairns Hearing, Catherine Sharpe, 11 July 2019, T3303.1-20.

93 Transcript, Darwin and Cairns Hearing, Dr Iuliano, 16 July 2019 at T3658.12-30

94 Transcript, Darwin and Cairns Hearing, Dr Iuliano, 16 July 2019 at T3658.44-45, T3659.1-3.

95 Transcript, Darwin and Cairns Hearing, Robert Hunt,16 July 2019 at T3668.10-38.

96 Transcript, Darwin and Cairns Hearing, Robert Hunt, 16 July 2019 at T3671.26-33.

therefore a need to include and/or improve the training of the aged care workforce in respect of nutrition.

98. Timothy Deverell, who has worked in senior positions as a chef in aged care facilities, considered that there is a lack of staff working in the kitchens in residential aged care.[97] Whilst every kitchen is different, there ought to be an increase in the number of people working in the kitchens of residential aged care facilities.

Dental care

99. Ms Adrienne Lewis is the Project Manager, aged care at the South Australian Dental Service.

100. Oral health care is treated as a task akin to personal grooming, and where aged care workers are rushed for time, it can be easily overlooked.[98] Ms Lewis has extensive experience in studying the oral health of elderly people in residential aged care.

101. Ms Lewis told the Royal Commissioners that there is a lack of oral health content in training for aged care workers in residential and home based care.[99]

102. There is a lack of insight into the high risk consequences of poor oral health. Which comes from a lack of insight which comes from a lack of education among the care workforce.[100] The consequences are tooth decay, gum diseases, which can be prevented but if left untreated can lead to hospitalisations, which would otherwise be preventable.[101]

103. There is a need to include oral health as part of the training of aged care workers.

104. The numbers of aged care workers working at a residential aged care facility (or in home based care) ought to be increased so that personal care attendants are able to take the time to attend to a resident (or home care client's) oral health care needs as part of the core care they deliver.

Palliative care

105. Dr Elizabeth Reymond, an experienced palliative care physician, who has worked exclusively in the field of palliative care since 2003, gave evidence at the Perth Hearing as part of a panel. Dr Reymond told us that:

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97 Transcript, Darwin and Cairns Hearing, Timothy Deverall, 16 July 2019 at T3625. 23-27.

98 Transcript, Darwin and Cairns Hearing, Adrienne Lewis, 16 July 2019 at T3687.47, T3688,1-7

99 Transcript, Darwin and Cairns Hearing, Adrienne Lewis, 16 July 2019 at T3695.20-27

100 Transcript, Darwin and Cairns Hearing, Adrienne Lewis, 16 July 2019 at T3686.10 –11, T3686.20-24.

101 Transcript, Darwin and Cairns Hearing, Adrienne Lewis, 16 July 2019 at T3688.19–23.

> …Death is the universal health outcome, the aged care system, whatever the aged care service, they (the aged care workforce) should have a level of competence, a capacity for palliative care.[102]

106. Each of the panellists considered that the capacity to deliver palliative care by the aged care workforce is presently lacking.[103]

107. They considered that the capacity to delivery palliative care should feature as part of the skill mix and balance of skills in aged care.[104] Further, it ought to be mandated as part of the training of the aged care workforce.[105] In addition, there is a need to invest in and regular the staff/resident numbers: it is impossible for care workers to provide the care necessary on the current numbers.[106]

A question of philosophy

108. In 2019, the Royal Commissioners engaged Professor Kathy Eagar, Director, Australian Health Services Research Institute, University of Wollongong[107] to produce a report entitled 'How Australian residential aged care staffing levels compare with international and national benchmarks'.[108] Professor Eagar, who is one of six co-authors of the report and is the Director of Australian Health Services Research Institute was the first witness called by Counsel Assisting in Melbourne Hearing 3.

109. We submit that this report is a very important part of the evidence before the Royal Commissioners. It grapples directly with the key issues concerning the relationship between quality and safety of care on the one hand and staffing levels on the other. It is practical in approach and acknowledges that the adequacy of staffing levels is just one necessary component of the overall reform needed in our aged care system.

110. The report commences with an examination of the 'changing policy context' of the Australian aged care sector in the last 30 years.[109] Two important features of that context are worthy of special note:

> The introduction of the *Aged Care Act 1997* sought to reframe the role of residential aged care services as being people's 'homes' and to move

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102 Transcript, Perth Hearing, Dr Reymond, 27 June 2019at T2765.25-27.

103 Exhibit 5-7, Perth hearing, General tender bundle, tab 68, RCD.9999.0092.0001 at [14]-[23].

104 Transcript, Perth Hearing, Dr Fisher, 27 June 2019 at T2765.40–45.

105 Transcript, Perth Hearing, Dr Fisher, 27 June 2019 at T2766.1–4 .

106 Transcript, Perth Hearing, Dr Elizabeth Reymond, 27 June 2019 at T2771.26–42.

107 The work of AHSRI is summarized in Exhibit 11-2, Melbourne Hearing 3, Statement of Kathleen Eagar, 4 October 2019, WIT.0459.0001.0001 at .0002 [8]-[11].

108 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 148, AHS.0001.0001.0001.

109 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 148, AHS.0001.0001.0001 at 0007-0008.

> away from the institutionalized model of care that previously dominated the sector.
>
> The Act also included provisions to underpin the expansion of community aged care services to allow older people to stay living in their homes longer which, in turn, has resulted in people having much higher levels and/or complexity of need by the time they enter residential aged care.[110]

111. The report explains that:

> This re-conceptualisation of residential aged care as a 'home' has inadvertently encouraged the development of a workforce that is less clinically skilled and oriented with greater reliance on lower skilled personal care workers. Similarly, there has been limited incentive for either government or the sector to invest in systems that routinely capture and monitor resident needs or outcomes over time.[111]

112. Professor Eagar was asked by Counsel Assisting to expand on the first sentence in this passage. She replied that 'when people describe residential aged care as a person's home, it is somehow implying that it's a lifestyle choice rather than people are going into residential aged care now because they are so frail or have other significant care needs that they can no longer be at home. The population currently in care needs more clinical skills not less.'[112]

113. Referring to the Commonwealth government sponsored 2016 Aged Care Workforce Survey, the report notes that overall, there has been a reduction in the proportion of direct care employees in the total residential aged care workforce since the first such survey was undertaken in 2003, from 74% in 2003 to 65 per cent in 2016.[113]

114. Professor Eagar drew the Royal Commissioners' attention to the trends revealed by the 4-yearly aged care workforce summarised earlier in our introductory remarks. This is the marked decrease in the proportion of the aged care workforce who are nurses, especially registered nurses.

115. Before one can consider how to respond to the developments described by Professor Eagar and experienced by so many of our direct experience witnesses, it is necessary to understand how those developments have come about.

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110 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 148, AHS.0001.0001.0001 at 0007.

111 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 148, AHS.0001.0001.0001 at 0008.

112 Transcript, Melbourne Hearing 3, Kathleen Eagar, 14 October 2019 at T5776.45-5777.2.

113 National Institute of Labour Studies, *2016 National aged care workforce census and survey—the aged care workforce*, 2017, p 12.

116. Professor Eagar, who drew specific attention to these changes in the University of Wollongong report,[114] was asked about these trends by Counsel Assisting. She explained that the staffing changes that had occurred in aged care over the last two decades had resulted in 'more staff with minimal training' working as direct care providers.[115] As noted above, this occurred as part of a policy of making residential aged care more 'homely'. When asked by Commissioner Pagone if the driver for these changes had been 'to provide homeliness' or 'as an economic driver about returns on investments', Professor Eagar replied:

> I think the driver was actually economic, but it was also a driver from consumers that they wanted a more socially engaged, less institutional, a less patronising model of care.
>
> So I think its combination but I think it has been an unholy set of interests that have come together to have a deskilled workforce and I'm not sure that consumers would actually believe that the workforce has actually given them what they wanted a less institutional feel.
>
> I think the reduction in health professionals has been largely economic.[116]

117. This evidence is very concerning. Professor Eagar, who has had years of experience as an observer of our aged care and health sectors, has told the Royal Commissioners that aged care providers have deliberately reduced their ability to cater for the clinical and health needs of the residents in their care by replacing qualified nurses with minimally qualified personal care workers.

118. And as noted above, this has occurred at the very time that the clinical and health needs of those residents has been *increasing*. What's more, this process has been overseen by policy makers who must have been aware that it was occurring because the trends were clear from the 4-yearly government-run workforce surveys, and has been permitted by successive aged care regulators. It represents the de-regulated aged care market in operation. As a former Commonwealth public servant who was part of implementing these changes in 1998, and who made a submission to the Royal Commissioners explained, it stemmed from what she described as 'the 'religion' … that the *Aged Care Act* was 'outputs based' and did not stipulate 'inputs' …'.[117]

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114 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 148, AHS.0001.0001.0001 at .0009-.0010.

115 Transcript, Melbourne Hearing 3, Kathleen Eagar, 14 October 2019 at T5777.22.

116 Transcript, Melbourne Hearing 3, Kathleen Eagar, 14 October 2019 at T5778.1-21.

117 AWF.001.01735.0001 at 0001.

119. This incentive to de-skill the staffing mix in residential aged care was identified in the much-lauded 2011 report by the Productivity Commission, *Caring for Older Australia*:

> …under current arrangements, providers in seeking to minimize costs, have an incentive (particularly in an environment of high occupancy rates) to employ a high proportion of lower qualified (and therefore less expensive) care workers. A high proportion of lower qualified workers means that nurses working in aged care facilities can experience excessive workloads where they spend a large proportion of their time on administrative tasks (as they are effectively managers) rather than on caring. This in turn can drive nurses away from aged care to acute care settings.[118]

120. Further, and perhaps most concerningly of all, it was precisely what the government of the day was warned would happen when it introduced the *Aged Care Act 1997* (Cth).

121. In 1997, the Senate Community Affairs References Committee Report on Funding of Aged Care Institutions[119] examined the impact on quality and equity arising from the proposed changes to aged care arrangements announced in the 1996–97 Federal Budget and the *Aged Care Bill 1997* (Cth). In our submission, this report is particularly important to the work of the Royal Commissioners because it provides an understanding of how the *Aged Care Act 1997*(Cth) took the form that it did.

122. The Committee examined the implications of the fundamental change in funding arrangements proposed by the *Aged Care Bill 1997* (Cth).[120] The previous arrangements required nursing homes to acquit a portion of their funding (the Care Aggregated Module, **CAM**) against expenditure on direct care staff and duties, with the intention of both ensuring quality of care and providing nursing homes with 'more flexibility in setting staffing levels'.[121] The proposed change would see nursing home operators 'receive a single non-acquitted payment for each resident instead of the existing funding structure based on CAM, Standard Aggregated Module (**SAM**) [which covered expenditure of food, electricity, etc.] and Other Cost Reimbursed Expenditure (**OCRE**)'.[122] The new payment was originally called the Resident

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118 Exhibit 1-32 and Exhibit 1-33, Adelaide Hearing 1, RCD.9999.0011.1031 and RCD.9999.0011.1261.

119 www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/1996-99/aged/report/index.

120 The Committee's terms of reference are set out on p. 1 of Senate Community Affairs References Committee, 'Report on Funding of Aged Care Institutions', June 1997. Term of reference (f) required the Committee to consider the effect of the proposed changes on 'ensuring that the quality of care is protected in nursing homes'.

121 Senate Community Affairs References Committee, 'Report on Funding of Aged Care Institutions', June 1997 at para 4.2 (p 53).

122 Senate Community Affairs References Committee, 'Report on Funding of Aged Care Institutions', 1997, para 4.5 (p 54).

Classification Scale. It was in turn replaced by the Aged Care Funding Instrument (**ACFI**) in March 2008.

123. In a submission about the abolition of CAM funding, the NSW Nurses' Association expressed the concern that 'under the proposed system there is a real danger that proprietors will attempt to maximize profits by deskilling their workforce and thereby compromising care given to residents'.[123] The Committee accepted this evidence and recommended that 'nursing homes continue to be required to acquit that proportion of their funding expended on nursing and personal care'.[124]

124. On the question of ensuring that nursing homes employ appropriately qualified nursing staff, the report noted that, 'as a result of comments provided on an exposure draft of the *Aged Care Bill 1997* (Cth), Division 54 was amended to include a requirement that nursing homes 'maintain an adequate number of appropriately skilled staff to ensure that the needs of care recipients are met'.[125] This is now s 54(1)(b) of the *Aged Care Act 1997* (Cth). The report noted the concerns expressed by the NSW College of Nursing about the absence of any definition of the terms 'appropriate' and 'adequate' and that:

> Without those terms being defined we simply cannot guarantee the safety and high standard quality care that is dictated by their needs, because not only do they require qualified registered nurse care to a great extent…but it cannot be given without those nurses employed, and more so, without nurses who have specialized qualifications in the area.[126]

125. The NSW College of Nursing had drawn to the Committee's attention that 'there are increasing numbers of people being admitted to nursing homes with severe multisystem disorders and illnesses that require the equivalent of services that are provided by acute medical units in teaching hospitals'.[127] This trend has continued unabated in the subsequent 23 years. Henderson and Willis argue that one of the implications of the 1997 Act is that the Act

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123 Submission No 34 (ANF and NSW Nurses' Association), p 10 cited at Senate Community Affairs References Committee, 'Report on Funding of Aged Care Institutions', 1997, para 4.16 (p 56).

124 Senate Community Affairs References Committee, 'Report on Funding of Aged Care Institutions', 1997, rec. 18, page 63.

125 Senate Community Affairs References Committee, 'Report on Funding of Aged Care Institutions', 1997, para 4.24 (p 58).

126 Senate Community Affairs References Committee, 'Report on Funding of Aged Care Institutions', 1997, para 4.25 (p 58).

127 Senate Community Affairs References Committee, 'Report on Funding of Aged Care Institutions', 1997, para 4.23, (p 58).

'enabled cost savings through replacement of nursing staff with care workers'.[128]

126. The report noted the evidence from the NSW Nurses' Association that under the proposed reforms 'nursing staff numbers, skills and the level of experience and expertise will be systematically reduced, that non-nursing staff will be forced to carry the role of nurses, and that, in the end care for residents will suffer'.[129]

127. Given their relevance to the work of the Royal Commissioners in 2020, the Committee's conclusions and recommendations published in 1997 are worth setting out in full:

> 4.48 The Committee believes that that the Government's aged care reform proposals have the potential to compromise the standards of care in aged care facilities. The present arrangements for quality of care in nursing homes and hostels have achieved a substantial improvement in residents' quality of care and quality of life. The Committee regrets that the full details of the new quality assurance system based on accreditation is not yet available.
>
> 4.49 The Committee also has particular concerns at the proposed abolition of CAM funding and the introduction of a single non-acquittable payment system and the fact that the proposed reform package does not contain adequate provisions to ensure that proper levels of care will be delivered by appropriately skilled and trained staff to residents of aged care facilities.

128. The Committee made three recommendations that are relevant:

> Recommendation 18: The Committee recommends that nursing homes continue to be required to acquit that proportion of their funding expended on nursing and personal care.
>
> Recommendation 19: The Committee recommends that the accreditation standards and quality assurance system provide for the employment of appropriately skilled and trained nursing staff to ensure that quality of care is maintained in aged care facilities.
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> Recommendation 20: The Committee recommends that the Aged Care Standards Agency monitor the ratio of trained nursing staff per resident in

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128 J. Henderson and E.Willis, 'The Marketisation of Aged Care: The Impact of Aged Care Reform in Australia', in Navigating Private and Public Healthcare: Experiences of Patients, Doctors and Policy Makers, Publisher: Palgrave Macmillan (2019), p 3.

129 Senate Community Affairs References Committee, 'Report on Funding of Aged Care Institutions', 1997, para 4.27 (p 59); see also para 4.28.

> nursing homes through a transparent reporting procedure which would signal significant change in the ratio.[130]

129. The recommendations of this Inquiry were not accepted by the Government of the day. The Government's response to the Committee's report is recorded in Hansard on 2 December 1997. Senator Ian Campbell, Parliamentary Secretary to the Treasurer, presenting the Government's response to the Committee's report said:

> The Senate passed the Aged Care Bill on 27 June 1997 which then received Royal Assent on 7 July 1997. The Government does not intend to respond further to this report.

130. Mr Paul Versteege told the Royal Commissioners at Adelaide Hearing 1, '… leaving it up to individual facilities to determine what constitutes appropriate staffing levels and what constitutes an appropriate staff qualification mix, has had the predictable consequence that qualified-nurse staffing levels have declined'.[131] This appears to be the case.

131. Professor Eagar's evidence was that the 'philosophical approach' which conceptualised residential aged care facilities as homes has 'become a justification for failing to prioritise clinical governance and care. In turn this has hampered the development of evidence-based policy development and resourcing'. Taken together, 'these factors have worked against the development of a credible evidence base regarding the needs of residents in care'.[132] Opponents of minimum staffing ratios rely to this day on the characterisation of residential aged care as 'a home, not a hospital'.[133] They ignore history.

132. Further, as Professor Eagar noted:

> …the more successful we are in providing genuine options for people to stay in their own home, the more the cohort who go to residential care will be extremely high need.[134]

133. In the Royal Commissioners' Interim Report it is clearly stated that the aged care system must do much more to assist people to age in their own homes.[135] If the government gives effect to this view as it has committed to doing, it must also ensure that those who ultimately become too frail to be assisted in their own homes are appropriately cared for in residential care.

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130 Senate Community Affairs References Committee, 'Report on Funding of Aged Care Institutions', 1997, p 63.

131 Exhibit 1-9, Adelaide Hearing 1, Witness statement of Paul Versteege, WIT.0009.0001.0001 at [51].

132 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 148, AHS.0001.0001.0001 at 0037.

133 Exhibit 11-1, Melbourne hearing 3, General Tender Bundle, tab 13, AWF.001.02143.01.

134 Transcript, Melbourne Hearing 3, Kathleen Eagar, 14 October 2019 at T5793.21-23.

135 Royal Commission into Aged Care Quality and Safety, Interim Report, vol 1, p 162-164.

Minimum staffing ratios

RECOMMENDATION 1

An approved provider of a residential aged care facility should be required by law to have a minimum ratio of care staff to residents working at all times. The ratio should be set at the level that is necessary to provide high quality and safe care to the residents in its facility and should be based on the following:

- It must be sufficient to achieve a 4 star rating under the current CMS staffing star rating as adjusted for Australian conditions.[136]
- Average case-mixed total care minutes of between 186 and 265 minutes per resident per day from a trained workforce comprising nurses (including registered and enrolled nurses), and personal care workers.
- A minimum of 30 minutes of registered nurse care time per resident per day.
- In addition, at least 22 minutes of allied health care per resident per day.
- That there is a registered nurse (RN) present on each shift and available to direct or provide care subject to limited exceptions.

134. Counsel Assisting are proposing mandated staff ratios to address staffing and skills mix in aged care facilities. The Royal Commissioners have heard evidence from advocates for and opponents of mandatory staff ratios.

135. Two key arguments in favour of ratios are that:

- staffing levels have been unacceptable low for years and a mandated minimum staffing ratio is required to lift staffing levels;
- if staffing levels are mandated by legislation, it will be difficult for them to be whittled away in budget cycles or by fiscal pressures

136. Arguments against ratios, or issues that make implementation of mandatory ratios challenging, include:

- Staffing ratios cannot be set until there is clarity around the expectations and aims of residential aged care facilities. This point was made by a number of providers and provider peaks in submissions to the Royal Commissioners.[137]

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136 i.e. with an allowance for allied health.

137 Melbourne Hearing 3, Submissions from Benetas (AWF.001.04726.00001) and LASA (AWF.650.00089.0001).

- As noted by LASA: 'It is hard to identify the staffing required to deliver good care when we cannot clearly agree on what good care looks like'.[138]
- Staffing ratios will vary depending on the model of care. For example, while ratios may be able to be implemented in institutional settings, there may be challenges translating them to cottage style aged care, which we would like to see increase.[139]
- Related to this, having a set staffing ratio could stifle innovation around models of care.
- We do not currently have sufficient understanding of the range of care models in Australia to set an appropriate staff ratios.

137. The Royal Commissioners have received a range of views in evidence.

138. The report of the Aged Care Workforce Strategy Taskforce, chaired by Professor Pollaers, reached the view that the view that:

> there is no single optimum number of staff, or combination of staff qualifications, that will result in quality aged care in all circumstances. Rather, the number of staff required will change according to the varying needs of those individuals; the service or facility size and design; the way work is organised, including the extent to which services are outsourced; and, ultimately, the business model.[140]

139. However, in the context of Adelaide Hearing 1, Professor Pollaers advocated for mandated minimum staff ratios:

> …the only way we can be sure that every elderly Australian has access to the safe and best practice care they deserve is to legislate minimum staffing ratios in aged care that deliver the holistic care plans required. This is not about nurse ratios but the full suite of skills required to deliver holistic care.[141]

140. The ANMF, through Ms Annie Butler in Adelaide Hearing 1 and Mr Rob Bonner in Melbourne Hearing 3 have proposed mandated minimum staffing levels. The ANMF supported the implementation of mandatory staffing arrangements with stipulated direct care hours, nurse ratios and staff mix

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138 LASA's submission to Royal Commissioners following MH3 (AWF.650.00089.0001).

139 In its submission to the Royal Commissioners after Melbourne Hearing 3, HammondCare noted that in small cottage-style care facilities, they employ mutli-skilled workers, which makes staffing ratios challenging: Submission of HammondCare to the Royal Commission, citing Harrison, 2019, "Alternative staffing structures in a clustered, domestic model of residential aged care in Australia", Australian Journal on Ageing 38 (Supp) 68-74. Similar issues were also raised by Mercy Health, which has a care companion model and relies on having multi-skilled employees (AWF.650.00019.0001).

140 Ibid, p 49.

141 Exhibit 1-64, Adelaide Hearing 1, Response of Professor John Pollaers, 20 February 2019, ACW.9999.0001.0001 at 0019 [4].

requirements. It was proposed that a skill mix should be composed of 30% registered nurses, 20% enrolled nurses and 50% personal carers.

141. In submissions to the Royal Commissioners a number of the unions supported legislated staffing ratios. In particular, the HSU was supportive of mandated staff ratios across a number of profession. It recommended a mandated minimum staffing model to meet the total care needs of all residents.[142]

142. The Royal Commissioners have also heard views from those who do not support mandatory staffing ratios. Those opposing staff ratios include:

- Ms Patricia Sparrow, as CEO of Aged and Community Services Australia, did not support ratios, preferring a transparency model instead. This is discussed further below, as transparency is also an important part of Counsel Assisting's recommendations.
- Dr Lisa Trigg, who gave evidence in the Perth Hearing, noted that:

  Targets for staffing ratios carry the same risk of ritual compliance as other input or process measures, where providers hit the target but miss the point … Tackling the issues of the low status of workers, poor pay and poor employment practice is likely to make a much greater contribution to the quality of care in Australia than fixed staffing ratios. This does not mean that staffing should not be an important part of the accreditation process. However, rather than rigid ratios, the focus of the accreditation process should be to ensure that the provider has the correct mix of training and skills and is adequately resourced to deliver high-quality care.[143]
- Mr Mersiades, the Director of Aged Care, Catholic Health Australia, expressed the organisation's opposition to mandated staffing ratios. In evidence before the Royal Commissioners, Mr Mersiades noted there were a number of alternative ways to address workforce issues. Alternative solutions to the current issue of staffing included[144]:
  - A campaign to significantly upskill personal care workers. Proper upskilling, whereby personal care workers obtain the necessary qualifications, will address issues of incompetence.
  - Increase remuneration of personal care workers and the interface between residential aged care and the wider health sector. Mr Mersiades identified the current aged care system as fragmented. Improvements in these areas will promote better delivery of care.

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142 Health Services Union submission post Melbourne Hearing 3, AWF.650.0053.0002.

143 Exhibit 5-40, Perth Hearing, Witness Statement of Lisa Jane Trigg, 4 June 2019, WIT.0156.0001.0023 at .0022-0023 [129] – [132].

144 Transcript, Adelaide Hearing 1, Nicolas Mersiades, 19 February 2019, T481.8.

143. In its submission to the Royal Commissioners after Melbourne Hearing 3, HammondCare noted that in small cottage-style care facilities, they employ mutli-skilled workers, which makes staffing ratios challenging.[145]

What is the right level of staffing and skills mix?

US Centers for Medicare and Medicaid Services research

144. Professor Charlene Harrington has written at length since 2000 about the case for staff ratios. Her view is that 'the best approach is to set strict nurse staffing standards so that nursing homes are required to meet minimum staffing levels and to adjust staffing to meet resident needs'.[146]

145. Professor Harrington cites the 2001 CMS study to identify optimal staffing levels as a robust indicator of what is required to achieve good quality care and that mandating this is a minimum requirement is endorsed by many organisations in the United States.[147] Professor Harrington refers to it as the 'gold standard on minimum staffing levels since 2001'.[148]'

146. Research undertaken on behalf of the Centers for Medicare and Medicaid Services (CMS) in the United States from 2001 substantiated a case for prescribed staffing levels.[149] The CMS Phase I study found a strong relationship between staffing and quality. The CMS Phase II study identified the following staffing mix and direct care hour thresholds required to meet the recommended government standard of 4.1 hours per resident day of total direct care. The threshold ranges depend on the acuity of the resident population.

147. The only research that has been conducted since 2001 to assess the validity of these staffing levels with respect to changes in resident acuity or other needs was conducted by Schnelle and others in 2016.[150] This study sought to:

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145 Submission of HammondCare to the Royal Commissioners, citing Harrison, 2019, "Alternative staffing structures in a clustered, domestic model of residential aged care in Australia", *Australian Journal on Ageing* 38 (Supp) 68-74. Similar issues were also raised by Mercy Health, which has a care companion model and relies on having multi-skilled employees (AWF.650.00019.001).

146 C Harrington and F Jacobsen, 'Nursing Homes in Industrialized Countries' in P Armstrong and H Armstrong, 'The Privatization of Care: the Case of Nursing Homes', 2020, p 188.

147 ibid, p 179.

148 Exhibit 15-1, Adelaide Hearing 3, Statement of Professor Harrington, 10 February 2020, RCD.0011.0042.0001 at .0005.

149 Abt Associates Inc., 'Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Report to Congress: Phase II Final, Volume I', 2001, Centers for Medicare and Medicaid Services, Baltimore, MD.

150 JF Schnelle, LD Schroyer, AA Saraf and SF Simmons, 'Determining nurse aide staffing requirements to provide care based on resident workload: A discrete event simulation model', 2016, Journal of American Medical Directors Association 17, pp 970-977.

- describe the relationship between activities of daily living (ADL) workload and the level of nurse aide staffing reported by nursing homes***;*** and
- to use a discrete event simulation model to determine the relationship between ADL workload and nurse aide staffing necessary for consistent, timely ADL care.

148. The study found that the nurse aide staffing required for ADL care that would result in a rate of care omissions below 10 per cent ranged from 2.8 hours to 3.6 hours per resident per day, depending on the ADL workload levels in the home. This is an increase in the minimum certified nursing assistant hours per resident per day identified in the 2001 CMS study.

Australian research

149. In the Australian context, research that has been undertaken to identify a minimum staffing and skill mix has been undertake by Flinders University (for the ANMF) and the University of Wollongong.

Flinders University – National Aged Care Staffing and Skills Mix Project Report (2016)

150. Flinders University was engaged by the Australian Nursing and Midwifery Federation (**ANMF**) to identify a minimum staffing and skills mix for residential aged care settings. This work is the most prominent Australian research effort to establish an evidence base for reform.[151]

151. The Total Residential Aged and Restorative Care Staffing and Skills Mix Model© established a series of resident complexity profiles and the staffing resources and skills mix required to deliver care over a 24-hour period.

152. The model is based on data from three studies on resident care needs, facility characteristics and time required for direct and indirect personal and nursing care activities. The key data elements (resident and facility profiles, timings for direct and indirect interventions and activities, intervention frequency and minimum skill sets required) were integrated and modelled and a staffing methodology resource calculation was applied. The modelling yielded six initial residential care profiles and the resource calculation yielded indicative resident (nursing and personal care) hours per day. These six resident profiles represent categories of resident care needs.

153. Three activities were conducted to evaluate the model and methodology.[152] Based on the findings of these studies, the total resident nursing and

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151 Exhibit 1-20, Adelaide Hearing 1, National Aged Care Staffing and Skills Mix Project Report, 2016, Chapter 2, ANM.0001.0001.3151.

152 These activities were: Focus groups with residential aged care staff, a MISSCARE survey and review by a panel of experts (Delphi Survey). Researchers who undertook a MISSCARE survey to evaluate the model and methodology used the MISSCARE survey data to investigate the nature of missed care in residential aged care settings and the contributing factors. They found that unscheduled tasks such as answering call bells and taking residents to the toilet were most likely to be missed, with staffing numbers identified

personal care time required to ensure safe residential and restorative care was calculated using a statistical formula.

154. Importantly, the ANMF's estimates for daily care hours for each resident type were based on the amount of time ideally required given the resident's characteristics, rather than the actual time taken in environments where there may be staffing constraints.[153]

155. The researchers concluded that aged care residents should be receiving an average of four hours and 18 minutes of care per day for safe residential and restorative care. The ANMF proposed that mandated staffing arrangements with minimum direct care hours, nurse ratios and staff mix needs to be implemented over a transition period from 2019 to 2025. The proposed skill mix requirement is 30 per cent registered nurse, 20 per cent enrolled nurse and 50 per cent personal carer.[154]

University of Wollongong – How Australia residential aged care staffing levels compare with international and national benchmarks (2019)

156. Research was undertaken by the University of Wollongong (**UoW**) on behalf of the Royal Commissioners to compare the staffing levels in Australian residential aged care facilities to relevant international benchmarks. It was identified through a literature review that the USA's CMS Five-Star Quality Rating System for Nursing Homes was the most appropriate for comparison with the Australian system.

157. Data from the Resource Utilisation Classification Study (RUCS) was used for analysis due to the absence of a case-mix adjusted funding model in Australia. The RUCS data was then case-mix adjusted at the facility level based on resident assessments that were undertaken as part of the RUCS rather based on Aged Care Funding Instrument (ACFI). The reason for using RUCS data was due to the view held by UoW that ACFI does not provide a sound basis for case-mix adjustment as it does not satisfactorily discriminate between residents based on their care needs.

158. Based on the RUCS data:

- the current average care time per resident per day in Australian residential aged care facilities is 180 minutes including 36 minutes of RN care time

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as the primary reason for missed care. J Henderson, E Wilis, L Xiao and I Blackman, 'Missed care in Residential Aged Care in Australia: an exploratory study', Collegian, 2016, 24, pp 411-416.

153 Transcript, Melbourne Hearing 3, Robert Bonner, 16 October 2019, T6041.25-30.

154 Australian Nursing and Midwifery Federation, *The Plan: Aged care ratios make economic* sense, http://anmf.org.au/documents/reports/Aged_Care_Ratios_Make_Economic_Sense.pdf, viewed 24 November 2019; Exhibit 1-16, Adelaide Hearing 1, Statement of Annie Butler, 1 February 2019, - WIT.0020.0001.0001 at 0006 [39]-[47]; Exhibit 11-6, Melbourne Hearing 3, Statement of Rob Bonner, 2 October 2019, WIT.0443.0001.0001 at 0025 [64]-[65].

- to achieve the three-star rating under the CMS, Australian facilities would need to deliver a minimum of 215 minutes of direct care per resident per day including 30 minutes of RN care
- to achieve the four-star rating under the CMS, Australian facilities would need to deliver a minimum of 242 minutes of care.

159. In the study, data from 88 facilities was included in the UoW report analysis to determine the adequacy of staffing levels. Weightings were used to derive population estimates representative of the distribution of residents across all facilities in Australia.[155]

160. The UoW report presents a 5-star system to rate the adequacy of staffing levels in residential aged care facilities. As part of the study, Professor Eagar and her team examined international and national benchmarks. They considered aged care staffing requirements in the U.S.A., Canada, the U.K., Germany, Japan, the Netherlands, New Zealand and the States of Victoria and Queensland.[156] They '… eliminated those countries where you couldn't draw meaningful comparisons' with Australia because their aged care systems were significantly different (New Zealand and the U.K.).[157] They then eliminated from their examination countries where they were 'not confident that the people in [their] residential aged care facilities …are representative of residents in Australia'.[158]

161. Ultimately, the authors of the study examined closely the staffing of the residential aged care sectors in the USA, Germany and the Canadian province of British Columbia. Ultimately, the USA was chosen as the best comparator for the reasons explained by Professor Eagar:

> I've been a very loud critic of the American health care system but on this occasion, I think that we do have lessons we can learn from America. America started looking research, looking at the relationship between staff levels and resident outcomes back in 2001. It adopted a national system back then. It has maintained research every single year, and it updates the results of that research every year. So it's contemporary. There are 25,000 homes who are funded under those arrangements. It is so well-established in the States that nobody even questions it any more because the evidence is so strong.
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> The other thing that's really important is that it does adjust for the mix of residents and that for us was one of the essential criteria for selection.

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155 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 148, AHS.0001.0001.0001 at 0024.

156 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 148, AHS.0001.0001.0001 at 0017.

157 Transcript, Melbourne Hearing 3, Kathleen Eagar, 14 October 2019 at T5779.28-36.

158 Transcript, Melbourne Hearing 3, Kathleen Eagar, 14 October 2019 at T5780.5-10.

> The other issue for me, which I thought was important is that it doesn't just address minimum staffing. It also addresses appropriate staffing. [159]

162. As the report explains:

> The CMS system has been, and continues to be, well-researched which provides it with a strong evidence base. It is well-established having been in operation for over a decade across a large number of aged care services. Further, there is strong acceptance within the sector of the system due to its transparency and because it is casemix-adjusted and regularly updated to ensure that ratings are contemporary.[160]

163. For these reasons, the report considered that the US model 'provides a basis on which to build a contemporary Australian aged care staffing model that could be progressively refined and tailored to the range of care needs – nursing, personal and allied health - of Australian aged care residents'. [161] The report therefore compared Australian facilities against the American system.[162]

164. The American system takes into account both nursing hours and total care hours. It does so in a manner that gives additional weight to nursing hours. As Professor Eagar explained, '30 minutes of registered nursing time is not equal to 30 minutes of a personal care worker'. It is 'absolutely worth more'…'it costs more but it's worth more too'.[163] As the evidence of Professor Harrington this morning explained, this is consistent with a very substantial body of American research.

165. The system is flexible in that it permits several different combinations of nursing and care staff to reach the same star rating level. As the University of Wollongong report explains, the system 'allows homes some flexibility around their specific skill mix' while still ensuring a minimum level of care.[164] For example, as can be seen from the table now on the screen, there are nine staffing combinations that can be employed to obtain a three star rating; six combinations will achieve a four star rating and two different combinations will be ascribed a five star rating.[165]

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159 Transcript, Melbourne Hearing 3, Kathleen Eagar, 14 October 2019 at T5781.21-33.

160 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 148, AHS.0001.0001.0001 at .0037-0038.

161 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 148, AHS.0001.0001.0001 at 0038.

162 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 148, AHS.0001.0001.0001 at 0024.

163 Transcript, Melbourne Hearing 3, Kathleen Eagar, 14 October 2019 at T5787.28-43.

164 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 148, AHS.0001.0001.0001 at 0023.

165 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 148, AHS.0001.0001.0001 at 0023.

166. To break this down a little further, a home could achieve a four star staffing rating by employing registered nurses in sufficient numbers to provide each of its residents on average with 31 minutes of nursing care per day provided that the total number of care minutes provided is an average of at least 264 minutes (4 hours and 24 minutes). 3 hours and 53 minutes of care would have to be provided by staff who are not registered nurses, e.g. personal care workers.

167. Alternatively four stars could be achieved by decreasing the total daily care time to 186 minutes (3 hours and 6 minutes) provided that at least 63 minutes of that care is provided by registered nurses. Only 2 hours and 3 minutes of care time would need to be provided by staff who are not registered nurses to achieve the four star rating.

168. Professor Eagar's evidence is that this sort of system allows for homes to have a quite different mix of staff in each home, depending on the unique needs of their residents.[166]

169. In the US, staff time and daily resident data are submitted by nursing homes and then case-mix adjusted to account for differences in the resident mix and enable comparison between facilities. Case-mix adjusted hours in the US are calculated according to the equation below.[167]

> Case-mix-adjusted hours = (Hours reported / Case-mix hours) * National Average Hours

170. Both RN time and total direct care time are rated separately on a scale of one to five with the 'cut-points' for each staff level, which are updated regularly by the CMS. The case-mix adjusted cut points per resident per day at each star level as at April 2019 are shown below.[168]

CMS staff cut points: minutes/resident/day

Staff type	**1 star**	**2 stars**	**3 stars**	**4 stars**	**5 stars**
RN	< 19	19 – 30	30 - 44	44 - 63	≥ 63
Total	< 186	186 – 215	215 - 242	242 - 264	≥ 264

171. The overall staff rating is then based on an average star level between RN and total staff time, 'rounded towards' the RN rating. For example, a facility

166 Transcript, Melbourne Hearing 3, Kathleen Eagar, 14 October 2019 at T5789.01-08.

167 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 148, AHS.0001.0001.0001 at 0022

168 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 148, AHS.0001.0001.0001 at 0022. The relevant figures for 2018 are set out in Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 201, as explained by Professor Eagar at Transcript, Melbourne Hearing 3, Kathleen Eagar, 14 October 2019 at T5784-5.

with a RN rating of three stars and a total direct care staff rating of two would be given a combined rating of three (3+2=2.5 then rounded up to the RN rating of 3).[169]

University of Wollongong star ratings by casemix adjusted care minutes per resident[170]

RN rating and minutes		**Total care staff rating and minutes (RN, LPN and nurse aide*)**				
		1	**2**	**3**	**4**	**5**
		< 186	186 - 215	215 - 242	242 - 264	≥264
1	< 19	★	★	★★	★★	★★★
2	19 -30	★★	★★	★★	★★★	★★★
3	30 – 44	★★ **(Australian average)**	★★★	★★★	★★★	★★★★
4	44 – 63	★★★	★★★	★★★★	★★★★	★★★★
5	≥ 63	★★★	★★★★	★★★★	★★★★★★	★★★★★

**nurse aide role equivalent to Australian Personal Care Worker*

172. Professor Eagar explained that in the US system the median cut-point between two and three stars is the point at which a facility is 'more likely than not to have quality problems'. As such, she told us her judgement was that aged care homes that have a rating of 1 or 2 stars have an 'unacceptable level of staffing'.

173. Those with 3 stars have an 'acceptable level', those with 4 stars have a 'good level' and those with 5 stars have 'best practice levels' of staffing. [171]

169 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 148, AHS.0001.0001.0001 at 0023.

170 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 150, AHS.0001.0001.0109 at 0121.

171 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 148, AHS.0001.0001.0001 at 0038; Transcript, Melbourne Hearing 3, Kathleen Eagar, 14 October 2019 at T5792.17-25.

174. Using this methodology, Professor Eagar told the Royal Commissioners that more than half (57.6%) of Australian residents receive care in aged care homes that have unacceptable levels of staffing (1 and 2 stars). She explained that in order to bring staffing levels up to 3 stars across the board, an increase of 37.3% more staff hours as an average across the relevant facilities would be required. This would translate into an additional of 20% in total care staff hours across Australia.[172]

175. Only 15.8% (or one in six) of residents in Australia's aged care facilities are currently cared for by staff in sufficient numbers and mix to attract four stars. The report explains:

> For all residents to receive at least 4 stars (which we consider good practice) requires an overall increase of 37.2% in total care staffing.[173]

176. Only 1.4% of Australian residents are in facilities rated 5 star (best practice) for registered nurse staffing.[174]

177. Based on the RUCS data:

a. The current average care time per resident per day in Australian residential aged care facilities is 180 minutes including 36 minutes of RN care time.

b. To achieve the three-star rating under the CMS, Australian facilities would need to deliver a minimum of 215 minutes of direct care per resident per day including 30 minutes of RN care.

c. To achieve the four-star rating under the CMS, Australian facilities would need to deliver a minimum of 242 minutes of care.

178. Professor Eagar explained that a central element of this system would be that the thresholds for star ratings would need to be consistently evaluated.[175] She said that:

> the thresholds won't ever come down whilst people in our community want to stay at home and whilst we provide systems of support which allow them to do so.[176]

Allied Health

179. Professor Eagar considers that a significant limitation of the US system is that it does not include allied health staffing levels.[177] Professor Eagar noted

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172 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 148, AHS.0001.0001.0001 at 0038.

173 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 148, AHS.0001.0001.0001 at 0039.

174 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 148, AHS.0001.0001.0001 at 0025.

175 Transcript, Melbourne Hearing 3, Kathleen Eagar, 14 October 2019 at T5782.45-5783.2

176 Transcript, Melbourne Hearing 3, Kathleen Eagar, 14 October 2019 at T5793.09-30.

177 Transcript, Melbourne Hearing 3, Kathleen Eagar, 14 October 2019 at T5783.6-7.

that the system in the Canadian province of British Columbia does include allied health. She considers an Australian system could be designed by considering the US and British Columbian systems in combination. [178]

180. The University of Wollongong report notes that the system in British Columbia recommends that residents receive an average of 22 minutes of allied health services per day. The current Australian average (8 minutes of allied health care per day) is well below this. Achieving the level recommended in British Columbia would require a 175% increase in allied health staffing.[179]

181. Professor Eagar said she would make further adjustments to any star ratings model if it were to be adopted in Australia. She would have a model using the 3 domains used in the United States of staffing levels, accreditation reporting and quality indicators and add to them measures of consumer and carer experience for a balanced 'score card' of a facility.[180]

182. As noted earlier, the Royal Commissioners' terms of reference require them to make recommendations for 'high quality care'.[181] On Professor Eagar's view, 'high quality care' would probably be at least four stars. We submit that this is clearly what our system should be aiming for. We submit that, if we are to provide genuinely high quality care to our elderly citizens in residential care, all of our facilities should have at least a four star staffing. To use the language of s 54 of the *Aged Care Act 1997* (Cth), only a facility that receives a four star rating should be considered to have an 'adequate number of appropriately skilled and staff sufficient to ensure that the care needs of care recipients are met'.

183. Because of the significance of Professor Eagar's evidence, we set out the conclusion to her witness statement in full:

> 52 This research was commissioned by the Royal Commission into Aged Care Quality and Safety against a background of numerous examples of poor quality care experienced by older people living in aged care. A recurring theme has been the lack of staffing to meet the wide-ranging and increasingly complex needs of residents. The results of our research clearly support these assertions.
>
> 53 It is clear from this analysis and the evidence being presented to the Commission that there is a need for additional investment in care

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178 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 148, AHS.0001.0001.0001 at 0039.

179 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 148, AHS.0001.0001.0001 at 0039.

180 Transcript, Melbourne Hearing 3, Kathleen Eagar, 14 October 2019 at T5782.10-17 and T5782.45-5783.2.

181 Royal Commission into Aged Care Quality and Safety, Terms of Reference, paras (c), (d), (j).

> funding, the majority of which is required to improve the staffing mix and to increase staffing levels to an acceptable standard.
>
> 54 I recommend that increased funding be provided as one element of a comprehensive reform of the total aged care funding model.
>
> 55 In advocating strongly for increased funding, I am also advocating for a fundamental change in both policy and culture. It is no longer acceptable to conceptualise residential aged care facilities simply as a person's home. Residents in Australian aged care facilities have a right to be safe and to receive clinically competent and adequate care. This care needs to be provided within a non-institutional environment that is respectful of individual choices and that affords every resident the opportunity to be socially engaged to the extent possible. There does not need to be a trade-off between a social model of care and a clinically competent model. Residents have a right to both.[182]

184. Counsel Assisting submit that the Royal Commissioners should follow this prescription for reform of both aged care policy and culture. Without those changes, more money alone will not repair the system that was described as 'cruel and harmful' in the Interim Report.[183]

Counsel Assisting's proposed mandatory minimum staff ratio

185. Counsel Assisting's submission in relation to staff ratios is that are that a model should be adopted that would attain a 4 star rating under the current CMS staffing star rating.

186. Professor Eagar told the Royal Commissioners that in her judgment, 3 stars is acceptable and 4 stars is good. In her statement, she indicated that:

> 3 stars is the level below which facilities are likely to experience quality problems.[184]

187. Counsel Assisting considers that mandatory minimum staffing levels should be structures to require facilities to staff at a level that would be enable them to attain a 4 star CMS rating.

188. In the analysis set out in the University of Wollongong report, there are 6 combinations of RN minutes and total care minutes that will achieve 4 stars. This gives providers a level of flexibility in terms of how they reach the mandatory minimum staffing levels.

189. In addition to nursing and personal care staff, facilities should be required to provide minimum levels of allied health care. Professor Eagar noted that one

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182 Exhibit 11-2, Melbourne Hearing 3, Statement of Kathleen Eagar, 4 October 2019, WIT.0459.0001.0001 at .0012-0013 [52]-[55]

183 Royal Commission into Aged Care Quality and Safety, Interim Report, vol 1, p 1.

184 Exhibit 11-2, Melbourne Hearing 3, Statement of Kathleen Eagar, 4 October 2019, WIT.0459.0001.0001 at [43].

of the weaknesses of the US system is that 'allied health is missing'.[185] The Royal Commissioners received evidence about the importance of allied health, and in Counsel Assisting's submissions it needs to be built into the mandatory minimum staffing ratio.

The challenges in Rural and Remote Regions

190. There is evidence before the Royal Commissioners about the particular staffing challenges faced by aged care providers in rural and remote settings. For example, in the Perth Hearing, the Royal Commissioners heard from Ms Gaye Whitford, an aged care co-ordinator working in regional South Australia. Ms Whitford referred to the difficulties she has in recruiting care staff. She has difficulties accessing allied health workers and geriatricians.[186] Similarly, there was evidence in the Melbourne 3 Hearing about a newly constructed aged care facility in Western Australia which could not be opened because of an inability to find the staff.[187] Chris Marmarelis, the CEO of provider the Whiddon group referred the Commission in the Perth Hearing to the difficulties of employing nurses in remote locations such as Bourke in New South Wales.[188]

191. These challenges were recognised by the Aged Care Workforce Strategy Taskforce as part of 'Strategic Action 11: Establishing a Remote Accord'.[189] The Taskforce sets out a blueprint for action by both the aged care sector and the Commonwealth government which we submit the Royal Commisison should endorse. We note in particular the four important actions identifed for implementaiton by the Australin government.[190]

192. This evidence raises a broader issue about the financial viability of many aged care providers in rural and remote Australia. These challenges impact disproportionately on the Aboriginal and Torres Strait Islander communities and will be the subject of seperate submissions by the Counsel Assisiting team later in the year.[191] In those circumstances, it is inappropriate to try and deal with those complex issues in any detail at this time.

193. Having said that, we make a number of high level submissions on this topic.

194. First, Australia can not have two aged care systems. If one accepts that adequate staffing is vital to ensure that care recipients receive high quality

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185 Transcript, Melbourne Hearing 3, Kathleen Eagar, 14 October 2019 at T-5783.7.

186 Royal Commission into Aged Care Quality and Safety, Interim report, vol 2, p 188.

187 Exhibit 11-31, Melbourne Hearing 3, Witness Statement of Toni Leanne Hawkins, WIT.0453.0001.0001 at 0002-0003.

188 Transcript, Perth Hearing, Chris Marmarelis, 25 June 2019 at T2433.9-11; T2435.20-23.

189 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 205, ACW.9999.0001.0022 at .0109 – 0112.

190 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 205, ACW.9999.0001.0022 at 0112.

191 See generally Royal Commission into Aged Care Quality and Safety, Interim Report, vol 1, pp 184-190.

and safe aged care, that must hold true whether the care recipients are in suburban Sydney or remote Western Australia. Other laws aimed at ensuring safety, such as those concerned with workplace health and safety, apply in an identical fashion in all Australian workplaces regardless of the financial health of a particular employer. So do minimum wage laws. Aged care laws should be no different.

195. Secondly, the Victorian laws that impose mandatory staffing ratios on public sector aged care providers do provide for variation by local agreement if there are legitimate challenges in meeting the ratios. Ms Peake, the Secretary of the Victorian Department of Health, explained that:

> This allows the health service to vary the staffing requirements, with the primary consideration being the impact on the quality of patient care (as noted at section 32). Other conditions that need to be considered are outlined at s6 of the Regulations.[192]

196. It may be necessary to provide a similar mechanism in the Commonwealth statute for legitimate cases of need. The Royal Commissioners welcome submissions on that question.

197. Thirdly, as part of a broader strategy of assisting providers of aged care services in remote and regional areas to remain finacially viable, there may be a role for the Commonwealth government to provide targetted financial assistance to enable minimum staffing ratios to be met. We note that the government has recently announced a fund of $50 million to assist struggling providers. The broader issue of what forms of assistance is most appropriate and how it can best be targetted will be the subject of later submissions by Counsel Assisting and it would be unhelpful to say more about that subject at this juncture.

198. Finally, the Royal Commissioners have heard evidence of innovative approaches to attracting, training and retaining care staff in rural and remote settings. In Melbourne Hearing 3, the Royal Commissioners were told of an innitiative by an aged care provider in Shepparton, Victoria. Kerrie Rivett, the CEO of Shepparton Retirement Villages, explained how she had unsuccessfully sought funding from several government sources to establish a local training program aimed at providing employment for young people in aged care.

199. Ms Rivett told the Royal Commisison that:

> I was looking at developing a traineeship model, and we have developed the traineeship model, and we implemented it in an abridged version, but what I was looking at is employing a group of young people, and they'll be – like becoming apprentices in the workplace, and that – we actually bring the TAFE colleges into the workplace to do the training, and they

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192 Exhibit 11-29, Melbourne Hearing 3, Statement of Kym Lee-Anne Peake, WIT.0481.0001.0001 at .0021 [140].

> would be supernumerary for six months, and then they would actually go into the rosters for six months. The course would be over a nine-month period, the PCW course, and then at the end they would be trained and work-ready to fully go into the workplace.
>
> Now, we have initially done the first round and the board approved the funding of some of that and I know Sandra does some of this, and all nine kids have actually been fully employed and are actually happy in the workplace and are fully work-ready. But we were after around 1.7 million to actually implement, you know, having 56 young unemployed people employed and over a three-year period. And we were unsuccessful in getting some of that funding, and I tried multiple, multiple areas to try and attract that kind of funding, yes.[193]

200. This is an example of what appears to be a well thought out, costed initiative from the aged care sector that has withered on the vine for lack of government support. Later in these submissions we will refer to the need for the Commonwealth government to be an active leader in this field. This is an example of what we mean.

201. Ms Rivett was asked by Counsel Assisting if 'a Commonwealth Government fund that was available to support appropriately evaluated proposals like that [would] be something the industry would welcome'? Her response was*:*

> Like a HR innovation fund would – yes, I think that would be extremely beneficial to the industry, yes.[194]

202. In her evidence during Melbourne Hearing 3, Ms Rivett also suggested that:

> The recent initiative of the Victorian government to provide subsidies to teachers to work in rural and remote areas should also be given serious consideration for the aged care sector.[195]

203. Counsel Assisting strongly endorse this idea. It could be done as part of a broader government campaign developed in conjuction with the sector to attract people to work in aged care especially in rural and remote locations, many of which experience high unemployment.

204. A good example of such a campaign is the internet-based 'everyday is different' initiative which is being promoted by the Department of Health and Social Care in the United Kingdom. It includes inspiring stories about people working in caring roles as well as links to job opportunities and other resources. It could quite easily be adapted for Australian conditions and reproduced in the form of an application for smart phone use. This would not

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193 Transcript, Melbourne Hearing 3, Kerri Rivett, 17 October 2019 at T6177.7-22.

194 Transcript, Melbourne Hearing 3, Kerri Rivett, 17 October 2019 at T6177.24-29.

195 Exhibit 11-61, Melbourne Hearing 3, Statement of Kerri Rivett, WIT.0441.0001.0001 at [65].

be costly and would be a tangible, practical demonstration of Commonwealth government leadership.

205. Such an initiative could build on the evidence the Royal Commissioners have heard about the wonderful opportunities that are presented for the proferssional development of general practiotioners, nurses, allied health workers and other workers of working in remote communities. In the Broome Hearing, a general manager of an aged care facility in far north Queensland referred to the 'amazing experience and challenge that people have in working in these [remote] locations'.[196] Gaye Whitford, an aged care worker, described to the Perth Hearing the lack of incentive for professionals to advance their careers in rural areas.

A Registered Nurse on each shift

206. The recommendation also contains a requirement for there to be a registered nurse on every shift.

207. As noted above, the Royal Commissioners have heard that there is a lack of nursing staff in residential aged care and it is sometimes non-existent. In addition, there is research which shows a relationship between increased RN staffing and care quality outcomes.

208. In Adelaide Hearing 1, Dr Anthony Bartone from the AMA advocated for the implementation of minimum acceptable staffing ratios. As part of this, he advocated for on-site 24 hours nurse availability.[197]

209. The proposal for an RN on every shift was supported by a number of the submissions made in response to the call for workforce submissions after Melbourne Hearing 3.[198]

210. Other jurisdictions also have requirements around having registered nurses on duty:

- In Ontario legislation requires that there is at least one registered nurse on duty in residential care facilities.[199] In Alberta, there must be at least two staff members on site at all times including one registered nurse.[200]
- In the United States, there is a requirement for there to be a nurse to be on duty at all times. The *Nursing Home Reform Act 1987* contains a requirement for a

196 Transcript, Broome Hearing, Tamra Bridges, 17 June 2019 at T2020.33-45.

197 Exhibit 1-56, Adelaide Hearing 1, Statement of Dr Anthony Bartone, 18 February 2019, WIT.0015.0001.0001 at 0006 [32.3].

198 See submissions of Dementia Australia (AWF.650.00047.0001), Professional Carers Association of Australia (AWF.650.00043.0001), Society of Hospital Pharmacists Australia (AWF.650.00042.0001) and Quality Aged Care Action Group (AWF.650.00040.0001).

199 Registered Nurses' Association of Ontario, 'Transforming long-term care to keep residents healthy and safe. 2018'.

200 Government of Alberta, Nursing Homes Operation Regulation: Alberta Regulation 258/1985. 2017, Alberta Queen's Printer, Government of Alberta: Edmonton, Alberta.

Licenced Practical Nurse to be on duty at all times and a Registered Nurse to be present at least eight hours a day, seven days a week.

- The Victorian Government introduced staff ratios in health services in 2000 through the Victorian Department of Health Enterprise Agreement.[201] In 2015, Victoria legislated nurse to patient ratios as a means of supporting appropriate care and quality of life for public sector aged care residents and to support workforce recruitment and retention.[202]

211. In 2018, the House of Representatives Standing Committee on Health, Aged Care and Sport inquired into the effectiveness and adequacy of regulatory protections for the quality and safety of residents in aged care facilities.[203] Among other things, the Committee recommended that the Government legislate to ensure that residential aged care facilities provide for a minimum of one Registered Nurse to be on site at all times in order to meet the complex care needs of residents.[204]

212. As we heard from Professor Harrington, nurse staffing levels are the most important factor that determines the quality of care provided by nursing homes.[205]

213. Counsel Assisting therefore consider that it appropriate to require that there be a registered nurse on every shift.

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201 State Government of Victoria - Department of Health 2012, Nurses and Midwives (Victorian Public Sector Health) Enterprise Agreement 2012-2016, Department of Health, Victoria.

202 Exhibit 11-29, Melbourne Hearing 3, Statement of Kym Lee-Anne Peake, 4 October, 2019, WIT.0481.0001.0001 at 0005 [33]; Exhibit 11-29, Melbourne Hearing 3, Further information in relation to Kym Lee-Anne Peake's statement, WIT.0488.0001.0001 at 0004.

203 House of Representatives Standing Committee on Health, Aged Care and Sport, 'Report on the Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia', 2018.

204 ibid., p 51.

205 Exhibit 15-1, Adelaide Hearing 3, Statement of Professor Harrington, 10 February 2020, RCD.0011.0042.0001 at .0005.

Increased transparency

RECOMMENDATION 2

All approved providers must provide the Department with quarterly staffing levels for registered and enrolled nurses, allied health and other care staff by shift in residential care.

The Department must publish this information at a service level. There needs to be clear explanatory material for older people and their families and carers to access to enable them to understand the published information and compare services.

214. Harrington and Jacobsen (2020) note that 'transparency can be a first step toward improving staffing levels and should encourage political action to improve staffing standards'.[206]

215. Benefits of transparency are that it can address information asymmetries, allows consumers to make informed decisions about quality of care, force health care providers to compete on quality, and create incentives for providers to improve quality of care.

216. In evidence in Adelaide Hearing 1, Patricia Sparrow in her capacity as CEO of ACSA, advocated for a system in which information concerning staffing and staffing models is publicised. This would enable potential consumers to gain insight into the type of care the facility could provide.

217. In a submission to the Royal Commissioners, the Health Services Union noted that:

> Mandatory reporting on allocation of funding must be introduced alongside requirements for organisations to disclose the number of staff and skills mix employed, and on what employment arrangements, in relation to care needs profiles. Increased penalty, reporting and compliance measures regarding funding transparency must be introduced and overseen by the Aged Care Quality and Safety Commission.[207]

218. As we heard in evidence from Professor Harrington, in the United States, since 2008, the CMS Nursing Home Compare system has been used to rate all nursing homes certified by Medicare and Medicaid. The intent of this system is to provide an easy way to assess nursing home quality and make meaningful distinctions between high and low performing nursing homes.[208] Facilities are rated between one and five stars across three domains: health inspections, staffing, and quality measures. The staffing domain uses

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206 Ibid., p 189.

207 Health Services Union submission post Melbourne Hearing 3 (AWF.650.00053.0002).

208 Centers for Medicare and Medicaid Services, 'Design for Nursing Home Compare Five-Star Quality Rating System: Technical Users' Guide', 2019, Baltimore, MD.

casemix-adjusted staffing levels to determine the star rating. This is done to account for the complexity profile of residents which may differ between facilities. Ratings for every home are publicly reported in the CMS Nursing Home Compare website.

219. Along with the ratings, up until 2018, the Nursing Home Compare site included the number of hours of care on average provided to each resident per day by nursing staff as reported by a facility.[209] This data was reported by facilities.

220. In 2017, CMS began to require nursing home to submit payroll based staffing data on a quarterly basis.[210] This new payroll-based data revealed large daily staffing fluctuations, low weekend staffing, and daily staffing levels often below CMS expectations. Payroll based staffing data was found to provide a more accurate and complete staffing picture for CMS and consumers. After implementation of the new reporting system, 70 per cent of homes were found to have lower staffing than previously reported, with a 12 per cent lower staffing on average.[211]

221. CMS began using the payroll based data as the source for staffing information in Nursing Home Compare and the Five-Star Quality Rating System in April 2018.[212]

222. A study by Werner et al (2016) found that the introduction of the CMS Nursing Home Compare star rating system in 2008 was associated with a significant change in consumer demand for low and high-scoring facilities. Between 2005 and 2010, one star facilities typically lost eight per cent of their market share and five star facilities gained over six per cent of their market share. The study findings also indicated that the use of simpler summary measures via a star rating (in lieu of a larger volume of information in nursing home report cards) was associated with greater consumer engagement with the reported information.[213]

223. In 2017, the Senate Community Affairs References Committee reported on its inquiry into Australia's aged care sector workforce. The inquiry sought to assess the workforce impacts of current and expected changes to the aged care service sector, and to advise on workforce changes required to deliver

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209 Exhibit 15-1, Adelaide Hearing 3, Statement of Professor Harrington, 10 February 2020, RCD.0011.0042.0001 at 0004.

210 Exhibit 15-1, Adelaide Hearing 3, Statement of Professor Harrington, 10 February 2020, RCD.0011.0042.0001 at 0006.0007.

211 Exhibit 15-1, Adelaide Hearing 3, Statement of Professor Harrington, 10 February 2020, RCD.0011.0042.0001 at 0007.

212 F Geng, DG Stevenson and DC Grabowski, 'Daily Nursing Home Staffing Levels Highly Variable, Often Below CMS Expectations', Health Affairs, 2019, 7, pp 1095-1100.

213 RM Werner, RT Konetzka and D Polsky, 'Changes in Consumer Demand Following Public Reporting of Summary Quality Ratings: An Evaluation in Nursing Homes', Health Services Research, 2016, 51:3, Part II, pp 1291;1304.

aged care services into the future.[214] The inquiry recommended the publication of service provider staff to client ratios.[215]

224. In its development of a comprehensive workforce strategy for the aged care sector,[216] the Aged Care Workforce Strategy Taskforce considered the specific issue of how organisations should plan their staffing levels and mix to ensure care quality. The Taskforce recommended that the means by which aged care organisations estimate and plan their staffing arrangements should be standardised, rather than imposing standardised staffing levels or mix. Importantly for these submissions, it also proposed that organisations be required to publish their models and hours of care.[217]

225. There has also been consideration of staffing transparency by the Standing Committee on Health, Aged Care and Sport, which was referred the *Aged Care Amendment (Staffing Ratio Disclosure) Bill 2018* (Cth), a Private Members Bill introduced by the Hon Rebekha Sharkie MP. The Committee found that the majority of the evidence it received suggested there is 'in principle community support for greater transparency, accountability and comparability' of data concerning aged care staffing levels'.[218]

226. Transparency measures have recently been legislated in Queensland. From 5 December 2019, the *Health Transparency Act 2019* (Qld) provides a legislative framework for collecting and publishing information about public and private hospitals and residential aged care facilities. Under this legislation, all Queensland's aged care facilities, including the state's estimated 400 private facilities, can voluntarily report their daily resident care hours and staffing skill mix, among other information. Although it will not be compulsory to report the information, facilities that fail to do so will be named on a public website.

227. For these reasons, Counsel Assisting submit that the Royal Commissioners should recommend that:

- All approved providers must provide the Department with quarterly staffing levels for registered and enrolled nurses, allied health and other care staff by shift in residential care.
- The Department must publish this information at a service level. There needs to be clear explanatory material for older people and their families and carers to access to enable them to understand the published information and compare services.

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214 Senate Community Affairs References Committee, 'Future of Australia's aged care sector workforce', 2017, p 1.

215 ibid., p 101–110.

216 Aged Care Workforce Taskforce, 'A Matter of Care Australia's Aged Care Workforce Strategy', 2018.

217 ibid., p 53.

218 ibid., p 11.

Other measures

228. Mandatory minimum ratios and transparency are not the only measures that should be put in place to improve staffing.

Benchmarking and star ratings

229. It is important that the mandatory minimum staffing levels do not result in otherwise good providers entering a 'race to the bottom'[219] and only meeting those minimum standards.

230. Mechanisms will need to be developed that encourage providers to continuously improve.

231. In addition, as new staffing models develop, and with more research and improved data to better understand the impacts of increased staffing, there will be new 'best practice' around staffing.

232. In this regard, consideration will be given to the regulator having standards that support providers to achieve 'best practice' rather than just minimum staffing standards. In other words, standards or benchmarks that sit at a different and higher level to the mandatory staffing requirements.

233. In a submission to the Royal Commissioners following Melbourne Hearing 3, Leading Aged Services Australia (**LASA**) propose an 'if not, why not' approach to monitoring compliance with staffing benchmarks. That is, benchmarks could be non-binding and services could choose to have fewer staff or a different staff mix to the benchmark, but they would be required to justify their decision.[220]

234. Assessment against the standards or benchmarks could also feed into a star ratings system, or public reporting of staffing levels. As discussed above, transparency can be a very effective driver of improvement. It can unleash competitive forces that drive quality improvement instead of quality declines.[221]

Evaluation of staffing levels

235. As noted above, the Royal Commissioners heard arguments that we do not yet have the research, data or modelling to develop a staffing methodology against which staffing levels could be mandated. In Adelaide Hearing 1, Dr Bartone of the AMA called for:

> independent research relating to modelling for an effective staffing ratio should be undertaken. This would allow a minimum acceptable staffing

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219 Exhibit 11-21, Melbourne Hearing 3, Statement of Paul Gilbert, WIT.0430.0001.0001 at 0021 [124].

220 LASA submission, AWF.650.00089.

221 Exhibit 15-1, Adelaide Hearing 3, Statement of Professor Harrington, 10 February 2020, RCD.0011.0042.0001 at .0008.

ratio to be determined, according to a residential aged care facility's resident population.

236. A number of submissions following Melbourne Hearing 3 refer to the need to undertake research in order to develop a model that can determine staffing levels.[222] The Health Services Union recommends:

> That in consultation with the sector, the Federal Government develop a mandated minimum staffing model for aged care that meets the total care needs of all residents, including physical, social and emotional needs, provided by a workforce skilled to deliver such care.[223]

237. While Counsel Assisting proposes a staffing levels consistent with the model put forward by Kathy Eagar, who proposes the use of a model based on the CMS system to evaluate current Australian staffing levels, we also note Professor Eagar's advice that it is a model that could be 'progressively refined and adapted in Australia to inform staffing levels'.[224]

238. Evaluation and recalibration of the mandatory minimum staffing levels is something that should be incorporated.

The need for increased funding

239. It goes without saying that the proposal for mandatory minimum staffing levels cannot be achieved within the current funding envelope.

240. This is a recommendation that would clearly have significant funding implications.

241. The Australian government subsidised the residential aged care sector in the amount of $12.3 billion in 2017-18. Of this, $10.8 billion (87.8%) was provided under the ACFI funding model for personal and nursing care services for permanent residents. As the University of Wollongong report explains:

> in general, ACFI funding is directly translated into staffing costs of personal care assistants (PCAs), Assistants in Nursing (AINs), Enrolled Nurses (ENs) and Registered Nurses (RNs).[225]

242. The Aged Care Workforce Strategy Taskforce report estimated that 'between 55 per cent and 60 per cent of provider expenses are employee related'.[226] This may be an understatement with the true figure being over 70%. As was observed by Mr Versteege of the Combined Pensioners and Superannuants

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222 See submission of IRT AWF.650.00058.0001.

223 Health Services Union submission AWF.650.00053.0002.

224 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 148, AHS.0001.0001.0001 at 0001.

225 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 148, AHS.0001.0001.0001 at 0009.

226 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 205, ACW.9999.0001.0022.

Association of NSW in his evidence to the Royal Commissioners, it is therefore surprising that 'the Department of Health is able to set ACFI fees at all without, apparently, having a standardised calculation of staffing costs in the care delivery for which it determines the fees'.[227]

243. We note that research conducted for the Royal Commissioners by Flinders University demonstrates that Australia's expenditure on aged care is low by comparison to similar advanced economies. The authors estimate Australia's expenditure of 1.2% of GDP was one of the lowest of among a group of 22 comparable countries which spent an average of 2.5% of GDP.[228] In some countries such as Denmark and Sweden, the aged care expenditure was about 4% of GDP.

244. The same study concluded that, by international comparison, Australia has a high proportion of its older people in residential institutions (19.7%).[229]

245. Finally, the authors concluded that:

> Australia appears to provide lower levels of nurses in relation to care recipients in residential settings than the US, Canada, Germany and Switzerland.[230]

246. The Aged Care Workforce Strategy Taskforce report referred to an indicative analysis undertaken by the Korn Ferry Hay Group who were asked to cost the savings that could be expected from the implementation of the Strategic Actions. The report estimates that, by taking an integrated program approach across the industry, there is a potential productivity saving for industry of an estimated $488 million per annum. This is summarised as follows:

a. there would be annual cost savings (on average) from reduced workforce turnover (20 per cent to 12 per cent) of $311 million; and

b. annual cost savings (on average) from reduced workforce absenteeism (5 per cent each year) of $177 million.[231]

247. More importantly, there will be improved care outcomes and potentially dramatic improvements in the quality of life of both elderly citizens and their families, as illustrated by reference to two case studies examined by the Royal Commissioners in their 2019 public hearings. In each case study, both the aged care regulator and the Royal Commissioners concluded that sub-

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227 Exhibit 1-9, Adelaide Hearing 1, Witness statement of Paul Versteege, WIT.0009.0001.0001 at [60].

228 Dyer et al (2019) *Review of International Systems for Long-Term Care of Older People.* Flinders University, at p 43

229 Dyer et al (2019) *Review of International Systems for Long-Term Care of Older People.* Flinders University, p75.

230 Dyer et al (2019) *Review of International Systems for Long-Term Care of Older People.* Flinders University, p75.

231 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 205, ACW.9999.0001.0022 at .129.

standard care had been provided by an approved residential aged care provider. In each case there was also a finding that the provider's staffing was inadequate.

248. The first is a case study examined in our Perth hearings. The late Vincent Paranthoine was diagnosed as suffering from a malignant spindle cell sarcoma while resident at an aged care facility in Sydney in 2017.[232] A sarcoma is a particularly painful cancer which in Mr Paranthoine's case was incurable. The Royal Commissioners heard of the anguish suffered by both Mr Paranthoine and has daughter Shannon Ruddock due to the poor pain relief and inadequate palliative care provided by the care staff at the facility. In her evidence, Ms Ruddock complained that 'there were not enough staff …to care for residents such as my father with complex needs, and the staff were not trained to provide appropriate palliative care…'.[233] She explained that she was not able to enjoy the last weeks of her father's life because she felt she had to engage 'in a battle' with the provider over his care.[234]

249. Ultimately, high quality end of life care was provided to Mr Paranthoine at Calvary Hospital. The Royal Commissioners concluded that 'there were not enough staff working at [the facility during the relevant period] to provide an adequate standard of care for Mr Paranthoine'. An adequate number of appropriately trained care staff at the facility would have enabled Ms Ruddock to enjoy the last few weeks of her father's life.

250. The evidence in the second case study was that the late Mrs Bertha Aalberts sustained a leg injury when she fell at the residential aged care facility in which she was living in Victoria in July 2018.[235] After receiving some treatment in hospital Mrs Aalberts was discharged back to the facility with a need for ongoing care of her leg wound. Within weeks she returned to hospital where she died soon after. Mrs Aalbert's daughter, herself a registered nurse, spoke of her 'ice cold rage' when she saw the extent of her mother's wound at the hospital. The Royal Commissioners concluded that contrary to accepted medical practices, the dressings were changed by personal care workers instead of by registered nurses or otherwise suitably qualified staff.[236]

251. The Royal Commissioners also concluded that:

> the numbers and skills of staff … were insufficient to provide for Mrs Aalbert's proper care. There were no registered nurses working …during either the afternoon shift or the night shift for 60 residents with significant

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232 Royal Commission into Aged Care Quality and Safety, Interim Report, vol 2, pp 207-221.

233 Royal Commission into Aged Care Quality and Safety, Interim Report, vol 2, p 218.

234 Royal Commission into Aged Care Quality and Safety, Interim report, vol 2, p 216.

235 Royal Commission into Aged Care Quality and Safety, Interim report, vol 2, pp 314-331.

236 Royal Commission into Aged Care Quality and Safety, Interim report, vol 2, p 322.

care needs, many of whom, like Mrs Aalberts, required extensive medical care on a daily basis'.[237]

252. An adequate number of suitably qualified staff would have ensured that Mrs Aalberts received the high quality care she needed, may well have avoided her transfer to hospital and would have saved her daughter much anguish.

253. Based on the evidence before the Royal Commissioners and the submissions it has received, there are many other examples of substandard care just like these two. All of the benefits of adequate staffing to our elderly people and their families may not be able to have a monetary value ascribed to them but they are very clear and valuable nonetheless.

254. The Royal Commission's staff are investigating a range of funding and finance questions associated with the recommendations currently under consideration including this one. Counsel Assisting will make detailed submissions about those matters later in the year.

255. Opponents of minimum staffing ratios raise concerns about the ability of providers in rural and regional areas to attract the necessary staff to meet the requirements. Counsel Assisting recognizes that this is a legitimate argument.

Lessons from the early childhood sector

256. It is perhaps surprising to learn that, although there are no minimum staffing requirements in Australia's aged care system, there are stringent requirements in our child care system. Given that both systems involve care for the vulnerable and both are heavy reliant on taxpayer subsidies, we consider it is appropriate briefly to consider the background to staffing ratios in the child care sector. What are the lessons for aged care if any?

257. A number of the reforms to the Early Childhood Care Sector were instituted with the introduction of the *Education and Care Services National Law Act 2010.* A key aspect of the reform agenda was the introduction of educator-to-child ratios.

258. Under s 169(1) of the *Education and Care Services National Law Act*,[238] an approved provider offering early childhood education and care must adhere to the mandatory educator-to-child ratios. The ratios are incorporated in the National Regulations.[239] It is a criminal offence punishable by a fine to fail to comply with this requirement. A corresponding requirement is imposed on the 'nominated supervisor' of each provider.[240]

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237 Royal Commission into Aged Care Quality and Safety, Interim report, vol 2, p 327.

238 The National Law is reproduced as a schedule to the implementing Acts of the States and Territories – see, e.g., *Education and Care Services National Law Act 2010* (Vic.).

239 See *Education and Care Services National Regulations*, reg 122-3.

240 National Law, s 169(3).

259. Section 169(2) requires a provider to ensure that each educator educating and caring for children for the service meets the qualification requirements…'. Again, a corresponding requirement is imposed on the 'nominated supervisor' of each provider.[241]

260. The staffing ratios have changed over time. For example, from January 2020, a second early childhood teacher, or a suitably qualified person, is required in long day care services and pre-schools/kindergartens catering for more than 60 children pre-school age or under.[242]

Lessons for aged care

261. Reforms resulted in upskilling. The Early Childhood Education and Care (**ECEC**) reforms have prompted upskilling of the ECEC workforce, to meet the required qualification levels.

262. Reforms may have contributed to turnover – Thorpe (2012)[243] found that expectations of higher qualifications to meet National Quality Framework Standards were a contributing factor to worker turnover in the ECEC sector. This is a risk that needs to be kept in mind when implementing reforms in relation to qualifications

263. Increased qualifications have not been met with increased wages – In their analysis of ECEC workforce reforms, Cumming et al (2015)[244] highlight that a focus on improving professionalism through qualifications and credentials alone is insufficient for longer term workforce sustainability. They cite a 2011 report from the Productivity Commission[245] which emphasised the importance of pay and conditions, both absolute, and relative to other occupations as a key incentive for workers to gain qualifications, enter a workforce, upgrade their qualifications and remain in the workforce.

264. Cumming et al (2015) add that if calls for improving the professional status of a workforce are not matched by tangible benefits to workers such as improved remuneration, their undervaluation may be perpetuated.[246] This

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241 National Law, s 169(4).

242 National Quality Framework, *Additional staffing requirement from 1 January 2020*, 2019, https://www.acecqa.gov.au/qualification-requirements/additional-staffing-requirement-1-january-2020, viewed 17 September 2019.

243 K Thorpe, P Millear, A Petriwskyj A, et al., 'Can a childcare practicum encourage degree qualified staff to enter the childcare workforce?', 2012, Contemporary Issues in Early Childhood, 13(4): 317–327.

244 T Cumming, J Sumsion and S Wong, 'Rethinking early childhood workforce sustainability in the context of Australia's early childhood education and care reforms', *International Journal of Child Care and Education Policy*, 2015, Vol 9, No 2, p 12.

245 Productivity Commission, 'Early childhood development workforce', 2011, http://www.pc.gov.au/projects/study/educationworkforce/early-childhood/report, accessed 2 January 2020.

246 T Cumming, J Sumsion and S Wong, 'Rethinking early childhood workforce sustainability in the context of Australia's early childhood education and care reforms', *International Journal of Child Care and Education Policy*, 2015, Vol 9, No 2, p 9.

observation is particularly relevant to personal carers in the aged care workforce, given that, like early childhood educators, their pathway to improved professionalisation is from a low baseline in terms of status, labour market power and career opportunities

265. While seeking to improve the professional status of aged care workers may be expected to improve the quality of care they deliver, an issue for consideration is how worker compensation or reward can be achieved, its cost and who pays for it. Cumming et al (2015) point out that without government sponsored (if not funded) measures that support wage equity, the question of 'who pays?' for a professional workforce continues to be displaced to the market to determine.[247] As discussed in part 5 below, like the ECEC sector, in aged care, the likelihood that wage equity is addressed through market mechanisms or existing labour instruments is remote as it is seen as counter to the interests of employers and service recipients.

Conclusion

266. In addition to directly improving the quality and safety of residential aged care, the implementation of minimum staffing requirements is likely to contribute to improvements in indirect ways. As Mr Paul Versteege told Adelaide Hearing 1:

> A subsidiary – but critical outcome of introducing staffing ratios would be an increase in staff satisfaction and overall improvement in the stability of the workforce as staff would be supported to provide care of a high quality and this is a key aspect of job satisfaction.[248]

267. This view is supported by the evidence before the Royal Commissioners about the views of those currently working in aged care as expressed in surveys conducted by their unions. As was noted earlier in these submissions, aged care nurses and personal care workers consistently raise concerns about the impact of staff shortages and workloads on the ability to attract and retain aged care workers. Similarly, there is a great deal of evidence before the Royal Commissioners that link workforce continuity and stability on the one hand with high quality, relationship-centred care on the other.[249]

268. The significant shift in the staffing mix described earlier in these submissions mix has occurred against a backdrop of the *Aged Care Act 1997* (Cth) which requires that providers maintain 'an adequate number of appropriately skilled and staff sufficient to ensure that the care needs of care recipients are met'. It is difficult to see how the aged care sector as a whole can have been

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247 ibid, p 9.

248 Exhibit 1-9, Adelaide Hearing 1, Witness statement of Paul Versteege (Combined Pensioners and Superannuants association of NSW Inc), WIT.0009.0001.0001 at 0013 [68].

249 Royal Commission into Aged Care Quality and Safety, *Interim Report,* Vol 2 at pp 63-65 and 181-188.

meeting that standard during this period when they were reducing the number of nurses (especially registered nurses) while caring for residents with an increasing acuity profile.

269. We submit to the Royal Commissioners that any re-design of the aged care system that does not remove the incentive that presently exists for providers to reduce the number of nurses they employ to cut their costs will necessarily fail. To achieve high quality aged care, the employment and rostering decisions made by providers must be focused solely on providing care to the appropriate level. The regulatory environment must be aimed at achieving the same outcome.

PART 3 Transforming aged care education and training

270. In addition to having the right numbers of aged care workers, it is vitally important to ensure that those workers have the correct skills and qualifications.

271. In the Royal Commissioners' public hearings, witnesses have explained how Australia's ageing population, combined with some deficiencies in the education of our aged care workforce, are leading to an acute shortage of appropriately skilled and qualified aged care workers. The majority of the aged care workforce is trained through the vocational education and training (**VET**) system. Universities provide general training for undergraduate allied health professionals, doctors and nurses and these courses focus to varying degrees on the needs of elderly Australians.

272. Transforming aged care education and training is crucial to the availability of a well-trained aged care workforce, which in turn can provide high quality care for, and ensure the safety of, older Australians in aged care.

273. The Royal Commissioners have the opportunity to set the policy parameters to provide aged care workers, including personal care workers, nurses and other health professionals, with the training and support that they need to have a fulfilling career, with opportunities for professional development and an attractive career trajectory. There is a need to:

a. attract the right people to aged care, with opportunities for traineeships, on the job training and placements;

b. support those without qualifications to complete at least Certificate III level training;

c. create environments where continuous learning is encouraged thus ensuring that aged care workers are always developing their skills; and

d. provide opportunities for personal care workers to progress on to a Certificate IV or Diploma level training, to transition to the tertiary sector, or to move laterally to other opportunities in the sector.

274. These submissions propose a number of recommendation that the Royal Commissioners should make in relation to skills and training. They relate to:

- mandatory minimum training for paid care work in aged care;
- review of job design;
- improved career pathways; and
- aged care focused training and specialisation opportunities in the medical and nursing courses.

275. We will address each of these in turn.

The need for better training

276. Transforming aged care education and training is not just about building career paths, as important as that is. High quality training is important if Australia is to have an aged care workforce that can provide high quality care for, and ensure the safety of, older Australians in aged care.

277. The Royal Commissioners have received evidence about a lack of training in a number of key areas. We have referred to this evidence earlier in our submissions. The evidence reveals gaps in training in a range of areas including:

a. continence management;

b. wound care;

c. falls prevention;

d. oral health and hygiene;

e. palliative care; and

f. dementia care.

Background – VET sector

278. As noted, within the aged care workforce, Personal Care Workers and Enrolled Nurses are able to obtain qualifications from the VET sector. The most common current VET qualifications in the aged care sector are the:

- Certificate III in Individual Support;
- Certificate IV in Ageing Support; and
- Diploma of Nursing.

VET system architecture

279. It is necessary to say a little about the complex VET sector because any reform of education and training in aged care must occur within that broader VET system.

280. The Australian and State and Territory governments have joint responsibility for the VET sector.[250] At a ministerial level, the VET sector is overseen by the Council of Australian Government (**COAG**) Skills Council.

281. The States and Territories are largely responsible for the delivery and operation of VET in their own jurisdictions,[251] including the establishment of

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250 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 4, RCD.9999.0181.0001 at 0021.

251 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 4, RCD.9999.0181.0001 at 0021.

TAFE institutes, funding of Registered Training Organisations (**RTOs**), and the regulation of training contracts (apprenticeships and traineeships).

282. The Australian Government is responsible for the regulation of RTOs (other than in Western Australia and Victoria, which have not referred the relevant powers), providing income contingent loans through the VET Student Loans program, providing support services for employers, apprentices and trainees, and funding VET data collection and research through the National Centre for Vocational Education and Research.

283. The Australian Skills Quality Authority (**ASQA**) registers training providers, monitors compliance with national standards and investigates quality concerns for all States and Territories that have referred their powers.[252]

284. The Australian Industry and Skills Committee (**AISC**) comprises government-appointed industry representatives from the Commonwealth and each State and Territory, and advises the COAG Skills Council on policy directions and decision making in the national training system. It is also responsible for coordinating the development of training packages.[253]

285. A training package is a set of nationally endorsed standards and qualifications for recognising and assessing the skills of workers in a specific industry, industry sector or enterprise. Training packages are developed by Industry Reference Committees (**IRCs**) working with Skill Service Organisations (**SSOs**), to ensure that industry skill requirements are reflected in the national training system. IRCs vary in size and are made up of people who are representative of the particular sector of the economy. They report to the AISC, which refers training packages to the COAG Skills Council for final approval.

286. The relevant IRCs for the aged care sector are the Aged Services IRC and the Enrolled Nursing IRC. These bodies engage with industry and develop qualifications for the Community Services and Health training packages respectively.[254] They are supported by the SkillsIQ SSO.

Certificate III in Individual Support

287. SkillsIQ is in the process of reviewing the Certificate III in Individual Support on behalf of the Aged Services IRC. This follows a recommendation from the Aged Care Workforce Strategy Taskforce that the electives in this

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252 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 4, RCD.9999.0181.0001 at 0021. In Victoria and Western Australia, ASQA only regulates providers who enrol international students or are multi-jurisdictional providers. The remaining RTOs are registered either with the Victorian Registration and Qualifications Authority or the Training Accreditation Council, Western Australia.

253 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 4, RCD.9999.0181.0001 at 0021.

254 Australian Industry and Skills Committee, *Industry Reference Committees*, Australian Government, 2019, https://www.aisc.net.au/content/industry-reference-committees, viewed 13 February 2020.

qualification should be reviewed and consideration given to increasing the number of core units.[255]

288. Following initial consultations, the Aged Services IRC advised stakeholders in December 2019 that it:

289. planned to reduce significantly the number of permitted electives in the Certificate III in Individual Support to ensure they are much more targeted towards the skills that workers will need in the aged care sector;

290. had agreed with the Disability Support IRC that a single qualification for use by workers in the aged care and disability sectors is more appropriate than sector specific qualifications; and

291. would release discussion papers through its Special Interest Advisory Committees between February and April 2020 to progress further work on aged care qualifications on work placements, the skills aged care workers need to support consumer-directed care, pathways to transition from the VET sector to higher education, and nutrition in the aged care sector.[256]

Diploma of Nursing

292. In addition to these developments, at the direction of the Enrolled Nursing IRC, SkillsIQ is undertaking a review of the skills needs of Enrolled Nurses to inform potential changes to the current Diploma and Advanced Diploma of Nursing.[257] This is in response to key skills shortfalls identified by industry in relation to pediatrics, gerontology, palliative care and the administration of medications. SkillsIQ is currently consulting on draft training package products designed to address these skills shortfalls.

293. The staff of the Royal Commission will continue to monitor the work of these two Industry Reference Committees for the remainder of the Royal Commission's life.

294. As Enrolled Nurses are a part of a registered profession under the *Health Practitioner Regulation National Law*, the accreditation of enrolled nursing qualifications is regulated by the Nursing and Midwifery Board of Australia (**NMBA**). The Australian Nursing and Midwifery Accreditation Council (**ANMAC**) is responsible for accrediting a program of study for the nursing profession and the NMBA approves the program of study for the purposes of

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255 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 205, ACW.9999.0001.0001 at 0062.

256 R Bonner, *Proposed Next Steps – Aged Services Industry Reference Committee in 2020*, SkillsIQ, 2019, https://www.skillsiq.com.au/site/DefaultSite/filesystem/documents/From_the_Aged_Services_Industry_Reference_Committee.pdf, viewed 13 February 2020.

257 SkillsIQ, *Enrolled Nursing: Draft 1 Consultation Open*, 2020, https://www.skillsiq.com.au/CurrentProjectsandCaseStudies/EnrolledNursingTPD, viewed 14 February 2020.

registration. The NMBA works closely with ANMAC to implement the National Registration and Accreditation Scheme.[258]

Strengthening Skills – the Joyce Review

295. On 28 November 2018, the Australian Government announced an independent review of the VET sector as a whole. *Strengthening Skills: Expert Review of Australia's Vocational Education and Training System* (**the Joyce Review**) was released on 2 April 2019. The Joyce Review made a number of recommendations relevant to skills and training within the aged care sector, including:

a. the need to develop strong qualification pathways in growing areas of employment, including higher-level diplomas and apprenticeships;[259]

b. setting benchmark hours specifying the average amount of training required for a new learner with no experience in the industry to develop the requirement competency;[260]

c. the establishment of Skills Organisations owned by industry to control the qualification development process (replacing the role currently performed by the AISC, SSOs and IRCs as described earlier), assess the skills needs in their industry, market to prospective students, and endorse preferred training providers;[261]

d. encouraging the use of short-form credentials such as skill sets or micro-credentials to provide more flexible training options;[262]

e. the establishment of a National Skills Commission to administer Australian Government funding to the VET sector, and develop regional skills demand forecasts to plan investment in the VET sector;[263] and

f. the establishment of a National Careers Institute within the National Skills Commission, to provide an authoritative source of information on vocational careers and undertake a major multi-year public marketing

[258] Exhibit 11-65, Melbourne Hearing 3, Statement of Kylie Anne Ward, WIT.0483.0001.0001 at 0003-0004 [10]-[12].

[259] Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 4, RCD.9999.0181.0001 at 0039.

[260] Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 4, RCD.9999.0181.0001 at 0051.

[261] Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 4, RCD.9999.0181.0001 at 0051-0063.

[262] Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 4, RCD.9999.0181.0001 at 0070.

[263] Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 4, RCD.9999.0181.0001 at 0078-0079.

> campaign to improve the reputation and attractiveness of VET careers across Australia.[264]

Aged care issues with the VET system

296. These Joyce Review recommendations relate to issues that were raised at this Royal Commission's Melbourne Hearing 3, which considered how best to deliver aged care services in a sustainable way, including through investment in the aged care workforce.

297. The proposal for benchmark hours reflects concerns about the quality of VET qualifications. Ms Sandra Hill OAM, CEO of Benetas, gave evidence that:

> Inconsistent governance in the RTO sector has led to inconsistent quality of qualifications offered. Certificate Ill qualified people are often not job ready despite completing a qualification including placement hours. This results in hidden costs to providers to retrain employees, and in some cases employees quit soon after commencement because the job wasn't what they thought it would be. Certificate Ill level qualifications appeal to people who do not hold existing qualifications, and can access government funding to complete a low cost qualification. There are significant cost barriers to people who may be a great fit for the sector, but hold existing qualifications in a different field at or above the Certificate Ill level. [265]

298. The recommended establishment of Skills Organisations by the Joyce Review is intended to speed up the development of qualification and training packages and make them more responsive to industry need. Ms Michelle (Mish) Eastman, a member of the Aged Services Industry Reference Committee, TAFE Directors Australia representative and Executive Director, Swinburne University (TAFE Division), said of this process:

> It's very slow, even now with our new requirements as the IRC, for example, and having made some recommended changes to what the Certificate III level Individual Support [qualification] will look like, that now has to then go back out around with consultation with all of the state and territory committees and seek advice and validation or not from all of those before it can then go up to the AISC committee …[266]

299. This evidence is obviously concerning. While consultation with relevant people is obviously vital, it would appear that the cumbersome and somewhat bureaucratic processes that are being followed are inhibiting real change.

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[264] Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 4, RCD.9999.0181.0001 at 0091-0094.

[265] Exhibit 11-59, Melbourne Hearing 3, Statement of Sandra Hills, WIT.0450.0001.0001 at 0011 [62]-[63].

[266] Transcript, Melbourne Hearing 3, Michelle (Mish) Eastman, 14 October 2019 at T5870.43-T5870.2.

Government response to the Joyce Review

300. The Australian Government's immediate response to the Joyce Review in the 2019-20 Budget was the 'Delivering Skills for Today and Tomorrow' package, which includes:

a. the establishment of a National Skills Commission to oversee the Australian Government's investment in VET, and

b. piloting Skills Organisations in two key industries, including Human Services Care, to test 'end to end' training solutions and enhance the role and leadership of industry in the skills pipeline (including in the training package development process).[267]

301. In particular, the government appear to envisage that the Human Services Care Skills Organisation will play a role in identifying skills needs and qualifications development, potentially duplicating the activities of the Aged Services IRC.[268]

302. There was evidence about this at Melbourne Hearing 3. Mr Rob Bonner, the Deputy Chair of the Aged Service IRC, said that it would disrupt the work of the Aged Services IRC, may pose a risk to the implementation of the Aged Care Workforce Strategy's Strategic Actions relating to vocational education and training, and that the IRC was not consulted about the proposal. He told the Royal Commissioners that:

> We are one year into a three-year change process for qualifications for this sector, and government is proposing we start again by a new parallel training organisation taking responsibility for the same area…So we would be saying to government, if you want to pilot this model, do it somewhere else rather than crossing over into an area that has a critical workforce need that we are only just into addressing.[269]

303. Ms Eastman was also critical of the planned Human Services Skills Organisation pilot. [270]

Conclusion about the Joyce Review

304. The recommendations from the Joyce Review and associated announcements have the potential to address a number of important issues affecting skills and training in the aged care sector.

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267 Department of Education, Skills and Employment, *Delivering Skills for Today and Tomorrow*, Australian Government, https://www.employment.gov.au/delivering-skills-today-and-tomorrow, viewed 14 February 2020.

268 Department of Education, Skills and Employment, *Skills Organisations: Human Services Care*, Australian Government, https://www.employment.gov.au/HumanServicesCare, viewed 14 February 2020.

269 Transcript, Melbourne Hearing 3, Rob Bonner, 14 October 2019 at T5867.45.

270 Transcript, Melbourne Hearing 3, Michelle Eastman, 14 October 2019 at T5868.20.

305. However, the Joyce Review was released over 10 months ago and there are still important questions about the future of the VET system left unanswered by the Government's response to date.

306. The 'Delivering Skills for Today and Tomorrow' package does not address many of the recommendations contained in the Joyce Review that will impact on the skills and training arrangements for the aged care sector.

307. Those recommendations it does address, particularly establishment of the Human Services Care Skills Organisation pilot, create the potential for inconsistencies and duplication of effort given the Aged Services IRC will continue to operate and have carriage of important pieces of work.

308. However, there are a number of key recommendations that clearly relate to the VET sector and skills and training of personal care workers. Therefore Commissioners, over the coming months, staff of the Royal Commission will closely monitor the work that is occurring around reforms to skills and training that will impact on the aged care sector.

Mandatory minimum qualifications – Certificate III

309. The first proposed recommendation in this Part relates to mandatory minimum qualifications for personal care workers.

Minimum qualifications for personal care workers

RECOMMENDATION 3

The Certificate III in Individual Support (Ageing) should be the minimum mandatory qualification required for personal care workers performing paid work in aged care (including residential, home-based, respite, restorative and palliative care).

310. There is a need to lift the skills and training of personal care workers and build the capacity of the workforce to provide high quality and safe care. This recommendation is aimed at achieving this.

311. The recommendation is also part of a suite of measures that aim to professionalise the workforce and ensure that the work it performs is appropriately recognised and valued. We submit that this is critical if aged care is to become a sector that can attract and retain a capable, caring workforce in sufficient numbers to meet Australia's growing needs.

312. There is currently no formal industry standard for an entry level qualification to work as a personal care worker. This means that not all personal care workers have the basic level of education and training to provide safe and effective care services to older people.

313. According to 2016 data, around two-thirds (67%) of the personal care workers in residential care settings have a relevant Certificate III level

qualification.[271] This has stayed relatively constant since 2003. Around 12 per cent of personal care workers have no post-secondary qualifications at all.[272]

314. Between 2003 and 2012, the proportion of personal care workers working in residential aged care settings who had completed a Certificate IV in Aged Care increased. However, 2016 data indicates that between 2012 and 2016, the proportion of personal care workers who had a Certificate IV did not change significantly. As of 2016, 23 per cent of personal care workers in residential aged care settings had completed a Certificate IV in Aged Care.[273]

315. The Royal Commissioners heard from Ms Trewin of Box Hill Institute that when students undertake a placement, some providers give students guaranteed employment when they have finished the Certificate III, so that does not encourage them to go on to a Certificate IV.[274]

316. For personal care workers working in home care, just over one half (51%) had a Certificate III in Aged Care in 2016, and just over one quarter (27%) had a Certificate III in Home and Community Care. A minority (15%) had a Certificate IV in Aged Care or Service Coordination.[275]

317. There is evidence on why the lack of a minimum mandatory vocational qualification is a problem.

318. At Adelaide Hearing 2, four personal carers from home care services spoke about the impact that a lack of mandatory minimum qualifications and inadequate on the job training had on their effectiveness.[276] For example, Ms Rosemary Dale, a personal carer, expressed a concern that there are not enough workers who hold a Certificate III qualification relevant to aged care, and that this places additional pressure on those who are qualified.[277]

319. At the Perth Hearing, Mr Jason Burton from Alzheimer's WA said that:

> Staff training in aged care remains sporadic with no minimum training requirement and no national applied competency framework. Despite the complexity of providing high quality person centred care to a vulnerable

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271 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 89, CTH.0001.1001.2805 at 2844.

272 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 89, CTH.0001.1001.2805 at 2845.

273 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 89, CTH.0001.1001.2805 at 2844. The proportion of personal care workers in residential aged care who had completed a Certificate IV in Aged Care was 8% in 2003, 20% in 2012 and 23% in 2016.

274 Transcript, Melbourne Hearing 3, Jane Trewin, 14 October 2019 at T5865.37-41.

275 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 89, CTH.0001.1001.2805 at 2902.

276 Transcript, Adelaide Hearing 2, Sally Warren, Rosemary Dale, Heather Jackson, Anna Hansen, 19 March 2019 at T804.25-T832.30.

277 Exhibit 2-29, Adelaide Hearing 2, Statement of Rosemary Dale, WIT.0079.0001 at 0003 [22].

> older person, staff are often lacking in the knowledge and skills that are required to provide care outside of a task focused institutional paradigm.[278]

320. A requirement for an entry level qualification to work in aged care will ensure that personal care workers are equipped with the fundamental skills and knowledge to contribute to the care of people with complex needs. A minimum mandatory qualification provides a baseline on which to build competency frameworks for future generations of personal care workers.

321. The lack of training among the care workforce has also been the subject of evidence by direct experience witnesses. When speaking about carers at the Darwin Hearing, Ms Lisa Backhouse, whose mother was in a residential home, said:

> …they desperately need more training and better qualifications to meet the increasing demands and the complex needs of residents.[279]

322. Several highly credentialed witnesses at the Sydney Hearing expressed support for mandatory and continuing training in dementia to ensure this is as a core knowledge and skill domain for aged care workers.[280] Associate Professor Stephen MacFarlane, Head of Dementia Services at HammondCare, questioned whether staff in residential care facilities are trained, equipped and supported, in any meaningful way, to provide safe or quality care to people living with dementia. He added that:

> Current training is inadequate if the expectation is that such training can adequately equip carers to manage the complex spectrum of dementia care needs within a one size fits all environment.[281]

323. The Aged Care Workforce Strategy Taskforce's report *A Matter of Care, Australia's Aged Care Workforce Strategy* concluded that there are significant gaps in the basic care skills of the workforce, including those relating to hydration and nutrition, oral health, diversity, mental health, medication management, dementia, end of life care, communication, assisted decision making, diversional therapy, person-centred care and client

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278 Exhibit 5-14, Perth Hearing, Statement of Jason Burton, WIT.0214.0001.0001 at 0013 [49].

279 Exhibit 6-20, Darwin and Cairns Hearing, Statement of Lisa Maree Backhouse, WIT.0221.0001.0001 at 0009 [50].

280 Exhibit 3-52, Sydney Hearing, Statement of Associate Professor Lynette Goldberg, WIT.0120.0001 at 0009 [38]; Exhibit 3-49, Sydney Hearing, Statement of Professor Elizabeth Ruby Anne Beattie, WIT.0119.0001 at 0017-0019 [59]-[65]; Exhibit 3-48, Sydney Hearing, Statement of Professor Constance Dimity Pond, WIT.0118.0001 at 0005 [14]-[15]; Exhibit 3-59, Sydney Hearing, Statement of Susan Marie Walton, WIT.0153.0001 at 0010-0011 [40]-[44]; Exhibit 3-57, Sydney Hearing, Statement of Elizabeth [full name known to the Commission], WIT.0152.0001 at 0006 [23]-[26]; Exhibit 3-28, Sydney Hearing, Statement of Kathryn Jill Nobes, WIT.0143.0001 at 0008 [49].

281 Exhibit 3-68, Sydney hearing, Statement of Associate Professor Stephen Robert MacFarlane, WIT.0125.0001.0001 at 0018 [85]-[86].

relationships.[282] The Taskforce concluded that the Aged Services Industry Reference Committee should identify an industry standard to ensure that all care staff are trained and accredited to work with aged care consumers.[283]

324. In a statement to the Royal Commissioners, Ms Melissa Coad from United Voice (a union with many carers as members) said that there should be a mandated minimum qualification to work in aged care that is transferable and recognised across the sector.[284]

325. One option for achieving this is a portable training scheme such as that being considered in the National Disability Insurance Scheme (**NDIS**). The proposal for a Portable Training Scheme in the NDIS works in the following way: disability support workers accumulate entitlements to paid training, for example, fifty hours of work equals one hour of portable training credit.[285] The accumulation of these credits is ongoing and credits are 'fully portable', that is they stay with the disability services worker and are retained by the disability services worker at all times, including when they work for multiple employers or directly for a NDIS participant, which can frequently be the case under the NDIS.

326. It is anticipated that an average worker would accumulate enough credits for a three day training course per year. As such the proposal for a Portable Training Scheme in the NDIS seeks to establish an entitlement to paid training which is vested with the worker. It is the aim of this proposal that it will lead to vocational qualifications that go beyond Certificate IV into advanced qualifications as well as supporting career long training by allowing disability services workers to focus on areas of specialised topics of their choosing.[286]

327. The premise for the Portable Training Scheme model that is being considered in the NDIS has been described as follows:

> In an occupation in which the skills and knowledge of service providers is essential to safe and quality care, it is essential that those providers have the opportunity to continuously upgrade those skills, develop

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282 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 205, ACW.9999.0001.0022 at 0055.

283 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 205, ACW.9999.0001.0022 at 0055.

284 Exhibit 1-52, Adelaide Hearing 1, Statement of Melissa Coad, WIT.0018.0001.0001 at 0009 [54]-[55].

285 Dr Rose Ryan and Dr Jim Stanford, *A Portable Training Entitlement for Disability Support Services Sector*, The Centre for Future Work at the Australia Institute, April 2018, p 50.

286 Dr Rose Ryan and Dr Jim Stanford, *A Portable Training Entitlement for Disability Support Services Sector*, The Centre for Future Work at the Australia Institute, April 2018, pp 50 – 51.

> specialisations, and keep up with new knowledge and leading practices in their field.[287]

328. We submit that the same holds true for the delivery of home care services in the aged care system. Just as in the NDIS, the delivery of quality and safe care in home care in the aged care system is contingent on the home care workforce holding appropriate skills and qualifications in order to perform their duties. Home care workers ought to be supported to develop their skills and qualifications in a workplace that is flexible in its location, employer and broad ranging in the skill level it demands. A portable training scheme, as conceived of for the NDIS by Ryan and Stanford, is premised on the worker having an entitlement to skills and training. It creates the mechanisms in which training and qualifications can be pursued and in the portability of the entitlement to training, it responds to the flexible nature of care work that is delivered in a consumer directed support.

329. Earlier in these submissions, we made reference to the coronial inquest into the death of John Reimers who died in a residential aged care facility. Among the various recommendations made by Coroner Jamieson in the interests of public safety was a recommendation that:

> State and Federal Governments create a legislative mandate requiring Personal Care Assistants to hold a Certificate III in Community and Aged Care as a minimum qualification before they can secure employment in the aged care sector.[288]

330. In response to the request for submissions after Melbourne Hearing 3, the Royal Commissioners received a number of submissions that supported a Certificate III or other qualification to be a minimum requirement for personal care workers to be employed in aged care.[289]

331. At the Sydney Hearing, Professor Brendan Murphy, Chief Medical Officer for the Australian Government provided strong support for a minimum qualification:

> I have – and my committee [Aged Care Clinical Advisory Committee] was of no doubt that there should be a nationally minimum set of standards for training for personal care workers working in aged care and that minimum standard of training should include training in dementia.[290]

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287 Dr Rose Ryan and Dr Jim Stanford, *A Portable Training Entitlement for Disability Support Services Sector*, The Centre for Future Work at the Australia Institute, April 2018, p 62.

288 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 171, Inquest into the death of John Frederick Reimers, 23 August 2019, RCD.9999.0231.0034 at 0075 (rec 5).

289 See Australian Services Union - VIC/TAS, AWF.650.00029.0002; United Worker's Union, AWF.650.00074.0001; Carers NSW/Australia, AWF.650.00065.0001; Quality Aged Care Action Group, AWF.650.00040.0001; Professional Carers Association of Australia, AWF.650.00043.0001; Health Services Union, AWF.650.00053.0002; Australian Lawyer's Alliance, AWF.650.00055; Kathleen Puls, AWF.001.04439.

290 Transcript, Sydney Hearing, Professor Brendan Murphy, 14 May 2019 at T1645.4-8.

332. However, other evidence from a senior officer of the Department of Health questioned the appropriateness of a mandatory qualification for all aged care workers. Charles Wann, First Assistant Secretary, Aged Care Reform and Compliance of the Department of Health told the Royal Commissioners that:

> While it is an aspiration that all aged care workers hold a minimum formal qualification, mandating a minimum qualification may operate as a barrier to entry. A requirement of this nature would have consequences for current recruitment strategies and ongoing employment in the sector, and present Challenges in thin markets such as in rural and remote communities, and for providers who service diverse communities.[291]

333. Finally we note that Associate Professor MacFarlane, Head of Dementia at HammondCare, cautioned against the view that mandatory minimum qualifications for aged care workers are a panacea:

> The demand to improve staff skills and experience must also be balanced with the need to hire on the basis of attitude and character. No amount of training produces kind and compassionate people. A person may hold a Certificate III or IV but that doesn't mean that they like older people, or have a passion for empathizing, caring for and relating to them. You can teach a person to provide good care. You can't teach them to enjoy caring for older people.[292]

334. This emphasis on the need for kind and compassionate people to be employed in aged care was echoed in other evidence.[293]

335. We acknowledge that training alone will not enable a person to provide good care. We need to attract the right people to aged care in the first place and exclude those that are unsuitable. We address that subject in the next part of these submissions. However, Counsel Assisting submits that having sound training opportunities and supported career pathways are also part of making aged care a more attractive place to work. The two go hand in hand.

The Content of the Certificate III

336. Turning to the *content* of the Certificate III and the nature of the qualification, the evidence summarised above is that reform of the VET sector is underway and, in particular, reform of the Certificate III in Individual Support is occurring in response to feedback from the industry that the course 'was not adequately preparing workers for job-ready roles in the sector.'[294]

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291 Exhibit 11-72, Melbourne Hearing 3, Statement of Charles Wann, WIT.0379.0001.0001 at 0021 [96].

292 Exhibit 3-68, Sydney Hearing, Statement of Associate Professor Stephen Robert MacFarlane, WIT.0116.0001 at 0019 [96].

293 Transcript, Adelaide Hearing 1, Barbara Spriggs, 11 February 2019, T40.19-32; T40.24-26; Transcript, Sydney Hearing, Jennifer Lawrence, 14 May 2019, T1585.39-40: 'recruit for kindness and train for excellence'.

294 Transcript, Melbourne Hearing 3, Robert Bonner, 14 October 2019 at T5850.43-45.

337. The content of the Certificate III is currently the subject of intense consideration by the Aged Services Industry Reference Committee. Staff of the Royal Commission will monitor the progress of that work this year and Counsel Assisting will consider further recommendations later in the year about the content of the Certificate III in light of those developments.

338. Based on the evidence received so far, a specific issue being considered further is whether a Certificate IV or Diploma level qualification would be a more appropriate minimum requirement for personal care workers. This may be particularly appropriate where a personal care worker is fulfilling a team leader role, working independently with limited supervision, or providing specialist dementia or palliative care.

Job profiling and job design

339. We turn now to a number of areas that the Royal Commissioners have a keen interest in. They are not the subject of recommendations, but are areas of focus for the work of the Royal Commissioners.

340. They relate to job profiling, job design, career pathways and continuing professional development.

341. In addition to having mandatory minimum qualifications for paid care workers, including personal carers, there needs to be a clearer definition of the job roles of personal carers that reflect the range and nature of their responsibilities.

342. This was highlighted by Mr Clive Spriggs (whose father resided at Oakden) at Adelaide Hearing 1. Mr Spriggs said:

> I think there needs to be more specialisation in aged care… people should specialise in certain areas and care for residents with those specific needs.[295]

343. A need for clearer definitions of the job roles of personal carers that reflect the range and nature of their responsibilities was highlighted in the findings from the Aged Care Workforce Strategy Taskforce, which were informed by a formal Job Evaluation. In particular, the Taskforce found that:

a. there is inconsistency and variable quality in the way jobs are defined and sized across the industry;[296]

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[295] Transcript, Adelaide Hearing 1, Clive Spriggs, 11 February 2019, T44.12-14.

[296] Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 205, ACW.9999.0001.0022 at 0055.

b. there are inconsistent approaches to 'job families'[297], job design, jobs pathways, career development and succession planning in aged care;[298]

c. the value of the personal care worker role is currently underestimated in both home-based and residential settings;[299]

d. the current education and training skills and qualification framework is not aligned with the nature of the work, relationships with consumer and leadership roles now expected in this industry, and the industry's structures;[300]

e. there are new roles emerging based on new models of care and new career pathways that can be opened up.[301] Specialisations or higher skill levels are emerging in dementia care, both for PCWs and in nursing roles;[302] and

f. progression within the personal care worker job family is limited and based largely on external educational qualifications (Certificate III and IV) rather than on a continuum of behavioural and technical competencies acquired and developed on the job.[303]

344. The Aged Care Workforce Strategy Taskforce recommended that, to address these issues, there is a need to define and standardise the industry's job families, designs, grades and definitions. It further proposed that the levels of the personal carer job family be extended to recognise their competencies.[304]

345. Ms Mish Eastman, Executive Director, Pathways & Vocational Education, Swinburne University of Technology, made an important observation on how the role of a Certificate III qualified person needs to be better defined so that its level of complexity and responsibility is consistent with the competencies that can reasonably be delivered via a Certificate III package. She also pointed out that the roles of Certificate III level workers should be designed

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297 A 'job family' is a cluster of jobs that share a specific set of core characteristics such as skills, knowledge, behavioural attributes and accountabilities.

298 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 205, ACW.9999.0001.0022 at 0055.

299 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 205, ACW.9999.0001.0022 at 0056.

300 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 205, ACW.9999.0001.0022 at 0055.

301 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 205, ACW.9999.0001.0022 at 0063.

302 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 205, ACW.9999.0001.0022 at 0057.

303 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 205, ACW.9999.0001.0022 at 0065.

304 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 205, ACW.9999.0001.0022 at 0071.

so that they are working with oversight and guidance from higher qualified workers and health professionals. She said:

> Certificate 3 was never intended nor could it be intended to provide solutions to all of those complex problems. It's to be part of a multidisciplinary team working with Certificate 4 level graduates, with diploma graduates, with degree and masters qualified graduates…the nature of that expanding role and expectations of a Certificate 3-level worker is incongruent with what a Certificate 3-level worker can do.[305]

346. Mr Rob Bonner from the ANMF expressed a similar view:

> … you can keep on adding more and more content into a Certificate 3 level program. So you can add Certificate 3 level knowledge in relation to palliation or dementia or behavioural care. But it doesn't add to the capacity of the worker to assess independently of other people, to have the knowledge and skills to make the decisions about whether or not it's appropriate to medicate or not medicate a client...So that's why we need to build pathways that take people up that knowledge tree and capacity tree as well as broadening skills across the workforce.[306]

347. The importance of clarification around job profiles was raised in the post-Melbourne Hearing 3 submission by the Royal Australian & New Zealand College of Psychiatrists. The College recommended that the aged care industry:

a. clarify the competencies required for different roles in the workforce through the introduction of a national, consistent regulatory framework of skills in aged care;

b. reframe and modernise the qualifications and skills framework for aged care workers; and

c. define clear and rigorous assessment criteria for accreditation and career progression and implement programs which support ongoing career development and progression for all aged care workers.[307]

348. We submit that job design in the aged care industry should be closely informed by the work of the Aged Care Workforce Strategy Taskforce. It identified current and future aged care workforce 'job families', job levels, broad role descriptions and career paths via a Job Evaluation methodology.[308] This work has been done; there is no need for the Royal Commissioners to revisit it.

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305 Transcript, Melbourne Hearing 3, Michelle (Mish) Eastman, 14 October 2019 at T5851.43-5852.2.

306 Transcript, Melbourne Hearing 3, Robert Bonner, 14 October 2019 at T5852.19-27.

307 Submissions of Royal Australian and New Zealand College of Psychiatrists, 6 December 2019, AWF.650.00084.0001 at 0007.

308 Korn Ferry Hay Group, Reimagining the Aged Care Workforce: Report prepared for the Aged Care Workforce Strategy Taskforce, 2017. Current and future state job families

349. We understand that there is further work afoot on job design. The Aged Care Industry Reference Committee is undertaking work to examine the scope of the aged care worker role and the knowledge and skills that an aged care worker needs.[309]

350. The Royal Commissioners will monitor the progress of this work.

Career pathways for personal care workers

351. Related to job roles and job design is the importance of the aged care workforce having clear career pathways that will enable individual workers to develop their skills, to have an enriching career in aged care, and for the sector to retain and build on those workers' continually developing skills and expertise.

352. The need for more clearly defined career pathways and opportunities for employees in aged care was another significant issue identified by the Aged Care Workforce Strategy Taskforce.

353. In summary, the Taskforce found that:

a. organisation structures and role designs do not provide enough career development and progression opportunities;

b. this is exacerbated by limited recognition of additional skills and experience,[310] so that progression is based largely on external educational qualifications rather than on a continuum of behavioural and technical competencies acquired and developed on the job;[311]

c. research and inquiries often identify limited career progression as a principal disincentive to working in aged care;[312] and

d. once personal carers have completed a Certificate III or IV, there is little room for progression regardless of their years of experience. Generally, they end up doing the same job over and over again unless they complete another set of higher educational qualifications to progress to the nursing job family.[313]

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were identified using the Hay's Job Evaluation Methodology. Job families are identified and classified according to how they differ from each other across 3 factors: knowledge, problem solving and accountability.

309 SkillsIQ, Communique from the Aged Services Industry Reference Committee, distributed to registered IRC stakeholders, 20 December 2019.

310 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 205, ACW.9999.0001.0022 at 0056.

311 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 205, ACW.9999.0001.0022 at 0064.

312 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 205, ACW.9999.0001.0022 at 0063.

313 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 205, ACW.9999.0001.0022 at 0065.

354. Witnesses at the Royal Commission's hearings saw career development and progression opportunities as central to improving attraction and retention in the sector. At Adelaide Hearing 1, Mr Ian Yates from COTA, Australia said:

> You need a holistic strategy. As I said, improved staffing levels but better training, better pay, better career structures, making it an attractive place to work.[314]

355. Dr Jennifer Abbey, creator of the Abbey Pain Scale, retired Registered Nurse and Fellow of the Australian College of Nursing, considered that:

> …due to the poor 'image' of aged care, the lack of career pathway and poor remuneration at all levels, it is often difficult to employ people with sufficient skills, empathy and capacity to fill roles.[315]

356. Mr Jason Burton from Alzheimer's WA spoke of the need for training and education continuums to be aligned to career pathways, so that the training and education gateways needed for progression along a particular pathway is clear. He said:

> An education and training framework sits around these competencies to ensure the support worker has access to the development opportunities and support needed to fulfil their role in a person centred way.[316]

357. Other witnesses specifically called for a career pathway that enables employees to specialise in dementia care. For example, Ms Lynda Henderson, an informal carer and advocate for Dementia Australia, said:

> …we badly need to look very closely at career pathways for people working with people with dementia, as most staff in aged care will be doing.[317]

358. There is work underway to address these concerns. The Aged Services Industry Reference Committee has commenced consultation to define the scope of the aged care worker role, and the skills that they need to have.[318] Consultation is occurring on 'job clustering' and ways to make it easier for learners and employees to move from the VET sector through to higher education in order to gain university level qualifications.[319]

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314 Transcript, Adelaide Hearing 1, Ian Yates, 11 February 2019 at T86.20-22.

315 Exhibit 6-58, Darwin and Cairns Hearing, Statement of Dr Jennifer Ann Abbey, WIT.0193.0001.0001 at 0003 [18].

316 Exhibit 5-14, Perth Hearing, Statement of Jason Burton, WIT.0214.0001.0001 at 0004 [18].

317 Transcript, Adelaide Hearing 2, Lynda Henderson, 18 March 2019 at T684.17-20.

318 R Bonner, *Proposed Next Steps – Aged Services Industry Reference Committee in 2020*, SkillsIQ, 2019, https://www.skillsiq.com.au/site/DefaultSite/filesystem/documents/From_the_Aged_Services_Industry_Reference_Committee.pdf, viewed 13 February 2020.

319 R Bonner, *Proposed Next Steps – Aged Services Industry Reference Committee in 2020*, SkillsIQ, 2019,

359. The Royal Commissioners will monitor this work and give careful consideration to mechanisms to develop and support career pathways in aged care, which could range from changes to classifications in awards, and to training opportunities to improved leadership in aged care organisations.

360. We anticipate that reforms around job design and career pathways will need to be progressed in partnership with the Commonwealth government. We will return to the role of the Commonwealth government in Part 6 of these submissions.

Continuing professional development

361. Continuing professional development is an important part of skills and training.

362. Later in these submissions, Counsel Assisting propose a registration scheme for personal care workers. Continuing professional development is part of that proposed scheme.

363. The Royal Commissioners have heard evidence and received a number of submissions about employer-led training that already occurs.

364. In Melbourne Hearing 3, the Royal Commissioners heard evidence about:

a. a scholarship program offered by Benetas which provides employees with financial assistance toward professional learning and development;[320] and

b. a Graduate Nurse Program at Resthaven, which provides structured supported learning for recently registered nurse graduates.[321]

365. The Royal Commissioners have also received a submission from Opal Aged Care about its initiatives in education, training and career development designed to attract, train and retrain its workforce. These include: [322]

a. a 12 month graduate nurse program to attract nurses. This was launched in 2019 and is run in partnership with the Australian College of Nursing. Candidates for the program are selected via assessment centres;

b. a scholarship program run in partnership with the University of Tasmania and Torrens University;

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https://www.skillsiq.com.au/site/DefaultSite/filesystem/documents/From_the_Aged_Services_Industry_Reference_Committee.pdf, viewed 13 February 2020.

320 Exhibit 11-59, Melbourne Hearing 3, Statement of Sandra Hills, WIT.0450.0001.0001 at 0014 [83].

321 Exhibit 11-62, Melbourne Hearing 3, Statement of Richard John Hearn, WIT.0440.0001.0001 at 0017 [97].

322 Submissions of Opal Aged Care, 29 November 2019, AWF.650.00039.0001.

c. a suite of leadership development programs tailored for different workforce segments (nurses, managers and other future leaders);

d. education partnerships to develop course content. For example, Opal Aged Care worked with Western Sydney University to develop post graduate qualifications in aged care and the University of Tasmania to develop a Diploma of Dementia Care. Both are available to all employees free of tuition fees; and

e. delivery of internal dementia care training to employees through Montessori Consulting and Dementia Australia.

366. Many submissions included perspectives on in-house education and training of aged care employees, including examples of how some providers deliver this and ideas on how it could be improved. The consistent view was that providers have a central role to play in the continuing professional development of their staff, and that this can be achieved through a range of modalities.

367. According to Benetas, its own internal training and education is the key means of enabling its workforce, rather than that delivered by registered training organisations. It contends that vocational education and training incentivises high student throughput rather than the delivery of job ready employees who have learned through on the job experience. It added that an advantage of employer led training and education is that employers can pre-screen candidates for motivation and aptitude.[323]

368. Similarly, HammondCare said that formal education should be augmented with on the job experience, buddy mentor shifts and interactive workshops. It added that the purpose of training and education should be on building competency (e.g. through micro-credentials) rather than obtaining formal qualifications.[324]

369. The Royal Commission's staff will consider the best way to encourage ongoing training and professional development of staff, and note that many providers have shown leadership in this regard. As discussed in the next part of these submissions, it is proposed that ongoing professional development should be mandatory for personal care workers as part of their registration requirements.

Higher Education

370. The recommendations discussed above are focused on personal care workers. However, it is also vitally important that health practitioners generally are equipped to provide high quality and safe care to older Australians.

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323 Submissions of Benetas, 6 December 2019, AWF.001.04726.01.

324 Submissions of HammondCare Aged Care, 19 November 2019, AWF.650.00019.0001.

371. This is necessary even for those generalist health practitioners who do not work in aged care. As Ms Rachel Yates, Policy Director, Health and Workforce, Universities Australia, and member of the Aged Services Industry Reference Committee, explained:

> …we know the proportion of older people in the population is increasing. So irrespective of whether a health professional chooses to work specifically in aged care, they will be encountering older people in their practice more and more...[325]

372. Similarly, Dr John Maddison, President of the Australian and New Zealand Society for Geriatric Medicine (**ANZSGM**), and Consultant Geriatrician and Clinical Pharmacologist, explained that:

> the changing profile of health and ageing within Australia presents challenges and opportunities for both undergraduate and postgraduate medical, nursing and allied health training. A paradigm shift is required, where we develop curricula to equip the health professionals of the future with the skills and attitudes they need for their core patient groups of tomorrow and not yesterday.[326]

Background - Higher education system architecture

373. Higher education providers in Australia are regulated by the Tertiary Education Quality and Standard Agency (**TEQSA**). All organisations that offer higher education qualifications in or from Australia must be registered with TEQSA. All higher education providers are regulated against the *Higher Education Standards Framework 2015*.

374. Australian universities have self-accrediting authority from the Tertiary Education Quality and Standard Agency.[327] While this requires Australian universities to ensure the Higher Education Standards Framework is appropriately applied and met in the development, approval, delivery and discontinuance of courses of study, it also provides greater flexibility in the content of curricula. As a result, curricula for professional entry courses in medicine, nursing and allied health are more directly influenced by course accreditation requirements.

The National Registration and Accreditation Scheme Professions

375. For the sixteen health professions covered by the National Registration and Accreditation Scheme (**NRAS**) administered by the Australian Health Practitioner Registration Agency (**AHPRA**), each National Board regulating health practitioners has an accreditation function. Relevantly for aged care,

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325 Transcript, Melbourne Hearing 3, Rachel Yates, 17 October 2019 at T6192.17-21.

326 Exhibit 11-66, Melbourne Hearing 3, Statement of Dr John Maddison, WIT.0484.0001.0001 at 0009 [56].

327 Tertiary Education Quality and Standard Agency, *National Register*, Australian Government, 2017 https://www.teqsa.gov.au/national-register, viewed 19 February 2020.

this includes medicine, nursing, occupational therapy, osteopathy, podiatry, and physiotherapy.

376. This function is performed by an external accreditation entity or a committee established by the National Board. An accreditation authority accredits a program of study and the relevant National Board approves the program of study for the purposes of registration. As such, the National Boards work closely with their accreditation authorities to implement the NRAS.

377. For medicine, accreditation standards for medical schools are developed by the Medical Board of Australia. The Australian Medical Council is responsible for accrediting education providers and their programs of study for the medical profession.[328] The Council assesses university medical schools and their programs of study against the approved Accreditation Standards for Primary Medical Education Providers and their Program of Study and Graduate Outcome Statements.

378. In the case of nursing, the Nursing and Midwifery Board of Australia (**NMBA**) is responsible for the regulation of nurses and midwives.[329] The Australian Nursing and Midwifery Accreditation Council (**ANMAC**) is the accreditation authority responsible for accrediting universities and their programs of study for the nursing and midwifery profession. Standard 3 of ANAMC's Registered Nurse Accreditation Standards 2019 define the key requirements of an accredited program of study to become a Registered Nurse.[330]

379. Similar arrangements are in place for the other NRAS professions.

380. Any amendments in the National Boards' accreditation standards for courses would drive changes in university course curricula.

Self-regulating professions

381. For the self-regulating allied health professions, the university professional entry pathway and any associated course accreditation requirements depends on the profession. In some professions, courses are accredited in line with standards issued by the relevant professional association.

382. For example, to be an Accredited Practising Dietitian (**APD**) you must complete a university-level dietetics program accredited by the Dietitian's

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328 Medical Board of Australia, *Accreditation of medical schools and their programs of study*, 2016, https://www.medicalboard.gov.au/Accreditation/Medical-schools.aspx, viewed 19 February 2020.

329 Australian Health Practitioner Regulation Agency, Nursing and Midwifery Board of Australia, *Accreditation*, 2017, https://www.nursingmidwiferyboard.gov.au/Accreditation.aspx, viewed 19 February 2020.

330 Australian Nursing and Midwifery Accreditation Council, *Registered Nurse Accreditation Standards 2019*, 2019, https://www.anmac.org.au/sites/default/files/documents/registerednurseaccreditationstandards2019.pdf, viewed 19 February 2020.

Association of Australia (**DAA**).[331] Similarly, Speech Pathology Australia accredits the 26 professional-entry training courses for speech pathologists in Australia.[332] As with the NRAS professions, these course accreditation requirements inform university course curricula.

383. For some other allied health professions, such as nutritionists,[333] the relevant professional association does not accredit courses.

384. The complaints handling role performed by AHPRA for the NRAS professions is performed by the relevant state-based health care complaints commission for the self-regulating professions.[334]

Postgraduate qualifications

385. The Royal Commissioners heard at Melbourne Hearing 3 that the primary purpose of undergraduate education programs for doctors, nurses and allied health professionals is to prepare them to meet registration standards (professional-entry), and provide a generalist foundation upon which graduates can undertake post registration specialisation.[335]

386. Ms Amy Lazzaro, a Nurse Practitioner at the Geriatric Rapid Evaluation, Assessment and Treatment Service, Westmead Hospital, noted that residential aged care staff often lack basic clinical skills and knowledge, resulting in inappropriate referrals to her services and to hospitals for clinical assessment and treatment. She noted that skills and confidence relating to wound care and palliative care, in particular, are often poor. [336]

387. Ms Lazzaro attributes this to inadequate education, but also to inadequate staffing, high workloads, inadequate resources and equipment, the appointment of inexperienced or inadequately credentialed staff to managerial or clinical roles and a high turnover of staff. [337] She said that:

> I am even surprised from time to time at the skill levels of specialist staff. For example on occasion I might see a person in a specialised wound

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331 Dietitians Association of Australia, *Accreditation of Dietetics Education Programs*, https://daa.asn.au/becoming-a-dietitian-in-australia/accreditation-of-dietetics-education-programs/, viewed 19 February 2020.

332 Submissions of Speech Pathology Australia, 6 December 2019, AWF.650.00068.0001.

333 The Nutrition Society of Australia Inc., *About Us*, 2020, https://nsa.asn.au/about-us/, viewed 19 February 2020.

334 For example, see Health Care Complaints Commission, *About the Commission*, 2013, https://www.hccc.nsw.gov.au/About-Us/About-the-Commission/default.aspx, viewed 19 February 2020.

335 Exhibit 11-64, Melbourne Hearing 3, Statement of Rachel Yates, WIT.0461.0001.0001 at 0003-0004 [15]; Exhibit 11-65, Melbourne Hearing 3, Statement of Kylie Anne Ward, WIT.0483.0001.0001 at 0004 [16]; Exhibit 11-63, Melbourne Hearing 3, Statement of James Clement Vickers, WIT.0462.0001.0001 at 0002 [11].

336 Exhibit 11-51, Melbourne Hearing 3, Statement of Amy Lazzaro, WIT.0562.0001.0001 at 0005 [27]; 0008 [49]; 0005 [26]-[32]; 0007 [40]-[42].

337 Exhibit 11-51, Melbourne Hearing 3, Statement of Amy Lazzaro, WIT.0562.0001.0001 at 0005 [29]; 0005 [31]; 0006-0007 [38]-[39]; 0005-0006 [32]-[33]; 0006 [36]-[37].

nurse role who is only qualified at an assistant in nursing level, and do not seem to have any specialist skills at all.[338]

388. Adjunct Professor Kylie Ward, the Chief Executive Officer of the Australian College of Nursing gave evidence that, for registered nurses, a three year entry to practice program provides limited opportunity to include specialist content. For this reason, diseases such as dementia are considered specialist and are therefore provided through post graduate studies.[339]

389. Ms Rachel Yates, Policy Director Health and Workforce, Universities Australia, who is a member of the Aged Care IRC, said that universities offer a broad range of post graduate programs to support health professional specialisation. However, Ms Yates explained that specialist courses need to be viable and attract sufficient student enrolments.[340] Courses to support the development of specific workforces cannot be sustained without some form of subsidy or support and many post-graduate qualifications are not offered as Commonwealth Supported Places.

390. Both Ms Yates and Professor James Vickers, University of Tasmania, added that existing health professionals must pay for these courses directly and there may be little to no additional remuneration for a specialist/sub-specialist role. This can be a financial disincentive to gain further specialist qualifications.[341]

391. However, there is an important distinction between postgraduate study to extend scope of practice—such as being endorsed as a Nurse Practitioner—or to specialise in an aged care related field, and approved programs of study for specialist registration as a medical practitioner.

392. The recommendations below are a response to evidence the Royal Commissioners received that raises questions about whether medical practitioners are adequately prepared to provide high quality healthcare to older people in receipt of aged care.

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338 Exhibit 11-51, Melbourne Hearing 3, Statement of Amy Lazzaro, WIT.0562.0001.0001 at 0005 [32].

339 Exhibit 11-65, Melbourne Hearing 3, Statement of Kylie Anne Ward, WIT.0483.0001.0001 at 0005 [20], [22].

340 Exhibit 11-64, Melbourne Hearing 3, Statement of Rachel Yates, WIT.0461.0001.0001 at 0006-0007 [21]-[22]

341 Exhibit 11-63, Melbourne Hearing 3, Statement of James Clement Vickers, WIT.0462.0001.0001 at 0008-0009 [42].

Education and training for medical practitioners

RECOMMENDATION 4

The Medical Deans of Australia, in conjunction with the Australian Medical Council, the Royal Australian College of General Practitioners and the Australia Medical Association, should establish a working group to:

a. Review the skills needed by GPs to enable them to meet the anticipated aged care needs of the Australian Population over the next 30 years.

b. Determine the anticipated need for GPs to deliver geriatric medical services, particularly in the aged care context over the next 30 years.

c. Review the state of geriatric undergraduate medical education with a view to mandating a core subject that enables the medical graduate to adequately meet clinical needs and anticipate demand.

They should have express regard to the ANZSGM Position Statement number 4 – Education and Training in Geriatric Medicine for Medical Students.[342]

RECOMMENDATION 5

Each Australian University Medical School should review its undergraduate medical curriculum with a view towards:

a. making geriatric medicine a core element of the undergraduate medical curriculum.

b. making placement in a geriatric clinical setting a required portion of internship training in advance of registration.

Review of GP skills and training

393. The first of these proposed recommendations is a response to evidence the Royal Commissioners received which questions whether medical practitioners are adequately prepared to provide high quality healthcare to older people.

394. For example, at Adelaide Hearing 1, Professor Constance Dimity Pond, Professor of General Practice at the University of Newcastle, said that

[342] Exhibit 11-1, Melbourne hearing 3, General Tender Bundle, tab 237, RCD.9999.0240.0001.

general practitioners do not have a full understanding of the symptoms and needs of people living with dementia.[343]

395. Similarly, Associate Professor Stephen Robert MacFarlane, Head of Dementia Services at HammondCare Australia, considered that 'the training provided to doctors, nurses and aged care workers in the area of behaviour management is very limited'.[344] He graphically explained the consequences of this for those on the ground in residential aged care facilities on a daily basis:

> The result of knowledge and training deficits is the personal care attendants bear the brunt of any behaviours. They inform the nurse in charge, who then escalates the issue to a doctor who is expected to 'do something.' Often, all that the doctor's training prepares them to do in such a situation is to prescribe psychotropic medication.[345]

396. Professor James Vickers from the Wicking Dementia Research and Education Centre stated that medical curricula are often dense, which makes it difficult to accommodate teaching material related to new and emerging health challenges, such as ageing, aged care and dementia. While dementia is now the second leading cause of death nationally and a major cause of disability, most medical programs don't include content on the major causes of dementia, nor on pharmacological and non-pharmacological approaches to management. He said:

> …when I have my single lecture on dementia – a single lecture on dementia in a five-year program because of a very tight curriculum – the point I make to medical students, unless you choose very specifically your future career options to go into paediatrics or obstetrics and gynaecology, there's a very good chance that every day that you will be working with older frail people with lots of conditions and, into the future, a lot them with dementia.[346]

397. Professor Vickers added that there is a limited will among medical educators to accommodate more course content relating to geriatrics and programs continue to be focused on acute and primary care.[347] However, he said that:

> It may be appropriate for the AMC to consider elderly people with complex needs, and dementia, as part of their established review processes. An engagement with organisations such as Medical Deans

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343 Exhibit 3-48, Sydney Hearing, Statement of Professor Constance Dimity Pond, WIT.0118.0001 at 0017 [71].

344 Exhibit 3-68, Sydney Hearing, Statement of Associate Professor Stephen Robert MacFarlane, WIT.0116.0001 at 0016 [72].

345 Exhibit 3-68, Sydney Hearing, Statement of Associate Professor Stephen Robert MacFarlane, WIT.0116.0001 at 0017 [78]; see also 0018-0019 [85]-[93].

346 Transcript, Melbourne Hearing 3, Professor James Vickers, 14 October 2019 at T6203.40.

347 Exhibit 11-63, Melbourne Hearing 3, Statement of James Clement Vickers, WIT.0462.0001 at 0004-0005 [20]-[25].

> Australia and New Zealand may help stimulate interest and discussion towards a curricular orientation to these emerging areas.[348]

398. Counsel Assisting have this evidence in mind in the formulation of the proposed recommendation.

Assessing projected demand for geriatric health services

RECOMMENDATION 6

The Commonwealth Department of Health should fund and collaborate with the Royal Australian College of Medical Practitioners, the Royal Australian College of Physicians and the Australian Medical Association to conduct an ongoing research program designed to estimate the short, medium and long term demand for geriatric services for older Australians.

400. This recommendation is about a research program to estimate the short, medium and long term demand for geriatric health services for older Australians.

401. At Melbourne Hearing 3, Dr John Maddison, President of the Australian and New Zealand Society for Geriatric Medicine, explained that, under current data limitations, it is difficult to model future demand for geriatricians. He said:

> Modelling workforce demand is similarly difficult - methodology which relies on acute hospital data (reliant on Diagnosis Related Groups) is likely to under-estimate demand. Similarly it is not always possible to specifically identify geriatrician activity with the Medical Benefits Schedule.[349]

402. Dr Maddison also said that modelling efforts have been hampered by a lack of consistency in methods and measures used to estimate demand.[350] He added that while evolving models of care in acute and community medicine are increasing the demand for geriatricians, there is a need to monitor potential workforce risks that may impact on the ability of the geriatrician workforce to meet this demand.[351]

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348 Exhibit 11-63, Melbourne Hearing 3, Statement of James Clement Vickers, WIT.0462.0001 at 0005-0006 [27].

349 Exhibit 11-66, Melbourne Hearing 3, Statement of John Brian Maddison, WIT.0484.0001.0001 at 0006 [40].

350 Exhibit 11-66, Melbourne Hearing 3, Statement of John Brian Maddison, WIT.0484.0001.0001 at 0006 [41].

351 Exhibit 11-66, Melbourne Hearing 3, Statement of John Brian Maddison, WIT.0484.0001.0001 at 0006 [40].

Education and training for registered and enrolled nurses

RECOMMENDATION 7

The Nursing and Midwifery Board of Australia and the Australian Nursing and Midwifery Accreditation Council should incorporate an introductory module/subject on geriatric medicine and gerontology care into the Enrolled Nurse Accreditation Standards and the Registered Nurse Accreditation Standards.

404. At the commencement of these submissions we spoke of the important role played by nurses in our aged care system. We called for there to be more nurses working in clinical roles in aged care. Training for registered nurses and enrolled nurses is also critical.

405. Ms Emma Murphy, a registered nurse working in aged care, said that in her view working in aged care can hinder your career opportunities. She noted how her professional training contributed to this view:

> Personally, going through my training in my degree, it's not focused towards aged care at all. We're trained in a hospital sort of setting so a lot of the clinical placements that we do are conducted in a hospital environment. Aged care isn't very well talked about. I don't think it is identified as a specialty area, and it 100 per cent is a specialty area.[352]

406. The recent Report of the Independent Review of Nursing Education, *Educating the Nurse of the Future*, recommended that the Nursing and Midwifery Board of Australia practice standards should specify the core knowledge, skills, and procedural competence newly registered enrolled nurses and registered nurses require to function in any workplace setting.[353] However, despite being subject to a well-established national registration and accreditation scheme that is designed to prepare nurses to meet registration standards, the evidence the Royal Commissioners received indicates that undergraduate and Diploma level nurse education and training is not adequately preparing nurses to care for older people.

407. For example, at the Cairns Hearing, medical experts and health professionals informed the Royal Commissioners that undergraduate nursing courses do not equip graduates with the skills to work in aged care. Ms Sandy Green, a Nurse Practitioner with extensive aged care experience, said:

> I believe that basic nursing assessment skills are lacking in both nurses and care workers in aged care. Having registered nurses come out of university without the experience, knowledge and skill set for aged care

352 Transcript, Perth Hearing, Emma Murphy, 26 June 2019 at T2531.

353 S Schwartz, *Educating the Nurse of the Future: Report of the Independent Review of Nursing Education*, 2019, p 36.

> is prevalent across all of the aged care facilities to whom I provide services.[354]

408. Amy Lazzaro, Nurse Practitioner and Program Lead at the Geriatric Rapid Evaluation and Treatment Team Hospital Outreach, Westmead Hospital explained that training of nurses in residential aged care facilities was lacking and she was getting called out to facilities to assist with wound care that she considered a basic early part of nurse training.[355]

409. Skill and knowledge gaps in nurses were highlighted by witnesses in wound care,[356] continence,[357] managing incontinence[358] and nutrition.[359] Knowledge and skills relating to dementia and gerontology[360] were also singled out as lacking. Professor Henry Brodaty AO from the University of NSW said:

> In my view, current education is clearly not sufficient for staff caring for people living with dementia…Changes should definitely be made to the curricula for doctors, nurses and personal carers to improve the care provided to people living with dementia in residential aged care. It's often a competition for space in curricula.[361]

410. In submissions made after Melbourne Hearing 3, the Australian Association of Gerontology and the Council of Deans of Nursing and Midwifery advocated for dedicated or embedded content on gerontology in the undergraduate nursing curriculum.[362]

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354 Exhibit 6-55, Darwin and Cairns Hearing, Statement of Sandy Marie Green, WIT.0191.0001.0001 at 0007 [43].

355 Transcript, Melbourne Hearing 3, Amy Lazzaro, 16 October 2019 at T6078.46-6079.6.

356 Transcript, Darwin and Cairns Hearing, Associate Professor Sussman and Hayley Ryan, 11 July 2019 at T3339.15-40.

357 Exhibit 6-24, Darwin and Cairns Hearing, Statement of Professor Michael John Murray as amended, WIT.0273.0001 at 0007 [9].

358 Exhibit 6-25, Darwin and Cairns Hearing, Statement of Joan Ostaszkiewicz, WIT.0222.0001 at 0007-0008 [31]-[34].

359 Exhibit 6-48, Darwin and Cairns Hearing, Statement of Robert Hunt and Sharon Lawrence on behalf of the Dietitians Association of Australia, WIT.0205.0001 at 0016 [80].

360 Exhibit 6-57, Darwin and Cairns Hearing, Statement of Drew Darren Dwyer, WIT.0192.0001.0001 at 0005 [4.A.iii].

361 Exhibit 3-80, Sydney Hearing, Statement of Professor Henry Brodaty, WIT.0116.0001 at 0013 [66]-[67].

362 Submissions of the Australian Association of Gerontology, AWF.650.00016.0001; Submissions of the Council of Deans of Nursing and Midwifery, 13 November 2019, AWF.650.00018.0001.

Scholarships programs

RECOMMENDATION 8

To increase the supply of nurse practitioners, the Australian Government should introduce scholarship programs (with aged care return of service obligations) for nurse practitioner training and advance skill nursing.

411. At the Canberra Hearing, the Counsel Assisting team tested the proposition of expanding the nurse practitioner and registered nursing workforce in aged care through Commonwealth funded bonded scholarship programs and improved access to MBS items. This was proposed to improve aged care residents' access to primary care.

412. The nurse practitioner role was implemented in Australia to improve the flexibility and capability of the nursing workforce and enable new ways of addressing service gaps. This initiative was driven by a clear need to improve access to care for marginalised, underserved and vulnerable populations, including residential aged care.[363]

413. Nurse practitioners have an expanded scope of practice compared with registered nurses, including:

a. autonomy in managing episodes of care;

b. requesting and interpreting diagnostic tests;

c. limited authority to prescribe medications; and

d. an ability to refer patients to other health practitioners.[364]

414. This expanded scope reflects higher tertiary qualifications gained through post graduate studies.

415. A number of evaluations have shown the benefits of nurse practitioners as part of the health workforce. For example:

a. a 2015 report evaluating the role of nurse practitioners in aged care settings by looking at different models of care found that overall, nurse practitioners improved access to primary health care for older people;[365]

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363 Exhibit 14-1, Canberra Hearing, General Tender Bundle, tab 50, RCD.9999.0278.0001 at 0006.

364 Australian Health Practitioner Regulation Agency, Nursing and Midwifery Board of Australia, *Nurse practitioner standards for practice – Effective from 1 January 2014*, March 2018, https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx, viewed 20 February 2020.

365 R Davey, S Clark, J Goss, R Parker, C Hungerford and D Gibson D, *National Evaluation of the Nurse Practitioner — Aged Care Models of Practice Initiative: Summary of Findings, Centre for Research & Action in Public Health*, 2015, pp 11-13, 15.

b. studies have also reported a high cost-benefit when nurse practitioners have been engaged to care for older people at home and residential aged care residents. This was primarily due to a reduction in emergency department admissions and hospitalisations.[366]

416. Despite studies showing that nurse practitioners improve access to primary care for older people resulting in a positive 'cost-benefit' to the health system, the workforce is very small. As at 30 June 2019, there were 1,883 nurses with a nurse practitioner endorsement in Australia, representing only a fraction of the total nursing cohort of 383,509. Nurse practitioners also only make up a small proportion of the direct care workforce in residential aged care (only 0.3% of the residential aged care workforce in 2016, at 386 full time equivalent).[367]

417. At the Canberra Hearing, Ms Nikki Johnston OAM and Mr Peter Jenkin, palliative care nurse practitioners, highlighted through their respective work the benefits of nurse practitioners operating in residential aged care. They explained that these models improve the palliative experience including for people living in residential aged care.[368]

418. The facility managers' panel at the Canberra Hearing was supportive of nurse practitioners working in residential aged care. Mr Thomas Woodage had the most experience with the nurse practitioner workforce and offered the following:

> The benefit for our residents in terms of accessing nurse practitioners is they have more time than the GPs, so they can gather more in-depth personal history than the GPs can. They act a little bit like that coordinator, clinical coordinator of care, especially with increasing comorbidities for our residents. Someone with a kind of finger on the pulse of what's going on and pick up things and alert things, then there's the advantage of increased simple medical care through antibiotics, pain management, prescriptions, things like that that the nurse practitioners can provide. So it provides a more timely, accurate and in-depth service to our residents.[369]

419. While there was in-principle agreement with the proposition by other members of the panel, there was an overarching concern expressed by witnesses about general workforce issues, including recruiting registered nurses, let alone nurse practitioners.[370] This concern points to whether there

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366 KPMG, *Cost-benefit analysis of Nurse Practitioner models of care*, Department of Health, 2018, p 69.

367 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 89, CTH.0001.1001.2805 at 2836.

368 Exhibit 14-23, Canberra Hearing, Statement of Peter Jenkin, WIT.1314.0001.0001; Exhibit 14-22, Canberra Hearing, Statement of Nikki Johnson, WIT.1315.0001.0001.

369 Transcript, Canberra Hearing, Thomas Woodage, 11 December 2019 at T7432.22-30.

370 Transcript, Canberra Hearing, Fiona Lysaught, 11 December 2019 at T7433.40-45; Transcript, Canberra Hearing, Thomas Woodage, 11 December 2019 at T7434.1-5.

are sufficient numbers of nurse practitioners – a more qualified and highly trained workforce – to support the demand in aged care and justify improved access to MBS items.

420. During the Canberra Hearing, Ms Susan Irvine, General Manager of Home Nurse Services, estimated that an additional 600 nurse practitioners nationally would be required to support aged medical care in Australia.[371]

421. In submissions filed after the Canberra Hearing, the Department of Health acknowledged the important role of nurse practitioners operating in residential aged care and supports increasing the availability and supply of nurses, including nurse practitioners and those with advance practice skills, in residential aged care. The Department of Health suggested that nursing staff, particularly those with advance practice skills, working in partnership with general practitioners have a broad scope of practice that would cover numerous functions of nurse practitioners.[372]

422. Counsel Assisting submit that bonded scholarship programs will boost the numbers of nurse practitioners and nurses with advance practice skills operating in residential aged care.

423. Having said that, we note that the Department of Health indicated in its written response to the Canberra Hearing that their current nursing scholarship program – *Nursing and Allied Health Scholarship and Support Scheme* – is winding down due to high drop-out rates and low uptake due to the length of training and accreditation processes.[373]

424. We also note the concerns raised by Dr Bartone of the Australian Medical Association. Dr Bartone said nurse practitioners operate within a defined scope of practice and work under supervision or delegation of a medical practitioner.[374] He added that, while nurse practitioners work well in acute clinical environments where medical specialists are present, their limited scope – without medical support – is not well-suited to the breadth of complex conditions and care observed in residential aged care.[375]

425. Ms Johnston rejected the claim that nurse practitioners must work under the supervision or delegation of a medical practitioner.

> I want to make it clear, that nurse practitioners do not need to be supervised by doctors. So nurse practitioners – if we are working in the private system and want to access MBS and PBS, we need to have a

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371 Transcript, Canberra Hearing, Susan Irvine, 9 December 2019 at T7243.25.

372 Submissions of the Commonwealth Department of Health, Canberra Hearing post-hearing submissions, RCD.0012.0058.0001 at 0013-0014

373 Submissions of the Commonwealth Department of Health, Canberra Hearing post-hearing submissions, RCD.0012.0058.0001 at 0013-0014.

374 Transcript, Canberra Hearing, Dr Anthony Bartone, 9 December 2019 at T7275.39-41.

375 Transcript, Canberra Hearing, Dr Anthony Bartone, 9 December 2019 at T7275.41-7276.6

> collaborative arrangement. It's not supervision. If we're working in the public system, we don't have to have that.[376]

426. Ms Johnston's claim is supported by the nurse practitioner standards of practice, which do not contain a requirement to work under supervision or delegation of a medical practitioner.[377]

427. We submit that there is a strong case to support the nurse practitioner model, alongside the medical workforce, to improve access to quality primary care in residential aged care. Nurse practitioners are particularly beneficial in areas with poor or intermittent access to General Practitioners.

428. Mr Joshua Cohen, Palliative Care Nurse Practitioner, Calvary Health Care Kogarah, described the scope for nurse practitioners to work effectively in aged care as follows:

> The scope of the nurse practitioner is so suited to the aged care environment where they can assess, they can diagnosis, they can do appropriate diagnostics to lead to that, and then implement the actual medications, prescribing or de-prescribing. That is gold in that space. As is…other roles coming from within aged care organisations: clinical nurse consultations in the particular speciality that are familiar with how the organisations works, with the care plans that they use, more so than [a nurse practitioner coming in from] an outside organisation.[378]

429. Mr Cohen considered that the effect on the industry, to feel as though there was an interest in the clinical care of residents, cannot be under estimated.[379]

430. Ms Sandy Green explained that, despite their advanced clinical expertise, nurse practitioners are not appropriately utilised in aged care:

> A nurse practitioner is a registered nurse (or 'RN')…that has the experience and expertise to diagnosis and manage most common conditions and many chronic and acute illnesses. Nurse practitioners are authorised to perform physical examinations, order and interpret diagnostic tests, provide counselling and education, and write prescriptions for some medications.[380]
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> I find myself on an almost daily basis having to educate staff in aged care facilities, as well as the residents and their families, on the role of a nurse

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376 Transcript, Canberra Hearing, Nikki Johnston, 11 December 2019 at T7468.1-6

377 Australian Health Practitioner Regulation Agency, Nursing and Midwifery Board of Australia, *Nurse practitioner standards for practice*, 2017, https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards/nurse-practitioner-standards-of-practice.aspx, viewed 18 February 2020

378 Transcript, Perth Hearing, Joshua Cohen, 27 June 2019 at T2922.36-42.

379 Transcript, Perth Hearing, Joshua Cohen, 27 June 2019 at T2722.43-44.

380 Exhibit 6-55, Darwin and Cairns Hearing, Statement of Sandy Marie Green, WIT.0191.0001.0001 at 0002 [9].

> practitioner. People are generally not familiar with my scope of practice and are unsure if I can treat residents' care needs.[381]

Other Issues

431. There are a number of other areas of importance about which we have not made specific submissions or recommendations today, but which are being considered by staff at the Royal Commission. It is worth noting at least some of them.

Placements

432. A number of witnesses referred to the importance of placements with aged care providers as part of any training program.

433. For example, Rachel Yates, Policy Director, Health and Workforce, Universities Australia, noted the 'immediate benefits' of having placements in aged care, and said:

> They are very well documented through [the Training Centre in Subacute Care] and also through Wicking and through some of the case studies that we've provided from our individual universities…It teaches them how to care because often when you are working with older people and the frail elderly, it's more than just clinical skill.[382]

434. Professor James Vickers told the Royal Commissioners that this was not a new issue:

> 10 years or so ago, … the Wicking centre, in collaboration with the school of nursing and the school of medicine, decided we needed to provide high-quality placements to a range of health-professional students in the residential-aged care sector, and that was really borne out of research that we had conducted that showed that many of these health-professional students have a negative view of aged care and that might be because they've had an unsupported placement in residential aged care or, probably, more so that they've had very little experience of that domain in their regular curriculum.[383]

435. The Royal Commissioners have also heard about some of the challenges associated with placements in aged care, including in particular the need for placements to be supported by clinical supervision, which is a challenge with the existing demands on registered nurses.[384]

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381 Exhibit 6-55, Darwin and Cairns Hearing, Statement of Sandy Marie Green, WIT.0191.0001.0001 at 0002 [11].

382 Transcript, Melbourne Hearing 3, Rachel Yates, 17 October 2019 at T6192.14-24.

383 Transcript, Melbourne Hearing 3, Professor James Vickers, 17 October 2019 at T6189.27-34.

384 Transcript, Melbourne Hearing 3, Adjunct Professor Kylie Ward, 17 October 2019 at T6188.24-43.

436. In a submission made to the Royal Commissioners after Melbourne Hearing 3, the Council of Deans of Nursing and Midwifery proposed that undergraduate placements in aged care should be undertaken in facilities with good accreditation histories and with staff to ensure adequate supervision.[385]

Incentives to enter geriatric medicine

437. Dr John Maddison, Geriatrician and Clinical Pharmacologist at SA Health and President Elect of the Australian and New Zealand Society for Geriatric Medicine explained that 'in terms of political, public and professional interest, geriatrics is something of a Cinderella amongst the consulting physician and procedural specialties. It is not fashionable, or glamorous.'[386]

438. Despite this, there has been a 39 per cent increase in the number of geriatricians from 2013 to 2017. This compares to a 20 per cent increase in the number of cardiologists over the same period.[387] It is estimated that Australia needs around 1000 full time geriatricians.[388] Current estimates are that there are around 874 registered geriatric medicine specialists in the country.[389]

439. Dr Maddison attributes the growth in the number of geriatricians to two factors. The first is that some jurisdictions are making an investment in specialist geriatric medicine training. The second factor is the introduction of Medicare Benefits Schedule items for geriatric services which makes it financially viable to practice primarily as a geriatrician.[390]

440. Dr Maddison said that as the public hospital system is unlikely to create new positions for geriatricians at the same rate as it has over the last decade, much of the new geriatrician workforce will be available to undertake significant activity in the private aged care sector.[391]

441. Dr Maddison stated that the introduction of dedicated geriatric Medicare Benefits Schedule item numbers was an important validation of the Comprehensive Geriatric Assessment. However, the proposed abolition of geriatric specific item numbers will likely reduce access to these

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385 Submissions of the Council of Deans of Nursing and Midwifery, 13 November 2019, AWF.650.00018.0001.

386 Exhibit 11-66, Melbourne Hearing 3, Statement of Brian John Maddison, WIT.0484.0001.0001 at 0014 [90].

387 Exhibit 11-66, Melbourne Hearing 3, Statement of Brian John Maddison, WIT.0484.0001.0001 at 0006 [38].

388 Exhibit 11-66, Melbourne Hearing 3, Statement of Brian John Maddison, WIT.0484.0001.0001 at [41]. Dr Maddison described this figure as 'conservative'.

389 Exhibit 11-66, Melbourne Hearing 3, Statement of Brian John Maddison, WIT.0484.0001.0001 at 0005 [35].

390 Transcript, Melbourne Hearing 3, Dr Maddison, 17 October 2019, at T6211.9-40.

391 Exhibit 11-66, Melbourne Hearing 3, Statement of Brian John Maddison, WIT.0484.0001.0001 at 0014 [89].

assessments in the private sector,[392] may remove an incentive for geriatricians to provide comprehensive services and may discourage physicians from specialising in geriatrics.[393]

Conclusion

442. There is a great deal to be done to ensure that all parts of the aged care workforce are adequately educated and trained to ensure that they can provide the high quality care that is needed by our elderly citizens. The recommendations that we propose and the ongoing work of the Royal Commissioners in this care should make a substantial contribution to this outcome.

443. In the next part of our submissions we direct our attention to the benefits of a registration scheme for personal care workers.

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392 Exhibit 11-66, Melbourne Hearing 3, Statement of Brian John Maddison, WIT.0484.0001.0001 at 0014 [91]; 0015 [100].

393 Exhibit 11-66, Melbourne Hearing 3, Statement of Brian John Maddison, WIT.0484.0001.0001 at 0018 [106].

PART 4 Regulation of personal care workers

Establishment of a registration scheme

RECOMMENDATION 9

A registration scheme for personal care workers should be established, with the following key features:

- mandatory minimum qualifications
- scope to require that qualifications be obtained from certain approved training providers
- ongoing training and continuing professional development requirements
- minimum levels of English language proficiency
- criminal history screening requirements
- a Code of Conduct and power for the registering body to investigate complaints into breaches of the Code of Conduct.

444. As noted earlier, the Royal Commissioners are asked to make recommendations to ensure that aged care is both of high quality and safe. There are clear examples in the evidence of instances in which conditions in aged care facilities have been unsafe due to the conduct of those charged with the care of residents. In some cases, where such conduct has been drawn to the attention of the providers of the aged care services where it has occurred, their response has been unsatisfactory and even callous.[394]

445. Perhaps the most compelling and confronting example of this was that of the late Mr Clarence Hausler who lived in a Japara aged care facility in Adelaide. The Royal Commissioners viewed video recordings secretly recorded by Mr Hausler's daughter Noleen which showed the late Mr Hausler being violently assaulted in his room by one of his carers on more than one occasion.[395] Mr Hausler's assailant was identified as personal care worker, Corey Lucas.[396]

446. Mr Hausler's daughter complained to the police and Mr Lucas was ultimately charged with, and convicted of, assault.[397] He was sentenced to a brief period of imprisonment. As will be seen below, this means that Mr Lucas is not allowed to become a 'staff member' of an approved provider of aged care

394 Royal Commission into Aged Care Quality and Safety, *Interim Report,* Vol 2 at pp 205-207.

395 Exhibit 5-8, Perth hearing, Mitcham General Tender Bundle, tab 26, NOL.0001.0002.001 and tab 28, NOL.0001.0002.0004.

396 For detailed findings about this case, see Royal Commission into Aged Care Quality and Safety, *Interim Report,* Vol 2, pp 192-207.

397 Exhibit 5-8, Perth Hearing, Mitcham General Tender Bundle, tab 215, SMA.0001.0001.0004.

services.[398] Had the police not pursued the case (as often happens in such circumstances), there would be no such prohibition.

447. Sadly, the case of Mr Hausler is not isolated, based on the evidence before the Royal Commissioners. In the Royal Commission's Darwin Hearing, Ms Lisa Backhouse gave evidence about her mother being assaulted twice by her carers in a residential aged care facility.[399] Ms Sarah Holland-Batt, who gave evidence in Brisbane, described being informed by a whistleblower registered nurse that a care worker had 'deliberately and repeatedly abused' Ms Holland-Batt's helpless father.[400]

448. There was also the case of 'UA' in Melbourne Hearing 3.[401] In that case study which also involved Japara, the management of the Bayview aged care facility substantiated through an internal investigation several occasions on which a carer, who was given the pseudonym UA, had engaged in violent and abusive conduct towards several residents of the facility over more than 12 months. His employment was ultimately terminated after he was given several warnings by his employer. However, in contrast to the case involving the carer Corey Lucas, no charges were laid by the police against UA. There is therefore no prohibition under existing law that would stop UA continuing to work in the aged care sector.

449. The Royal Commissioners heard evidence from care recipients and their representatives, including those involved in these cases, that more rigorous screening and monitoring of aged care workers is needed to ensure the safety, health and well-being of care recipients. For example, Ms Backhouse said that:

> I have proceeded with pressing an assault charge against the carer. Not because I'm vindictive but because I don't want her to work again in the aged care sector and this is my only choice. There is no regulation for care workers in Australia. No national register to guard against this type of behaviour, not even a blue card or equivalent. Without any way to check employment history and dismissals, this carer can walk into another centre tomorrow with no record of this event to follow her. Nurses and other health professionals are regulated under the Australian Health Practitioners Regulation Agency (AHPRA) but this does not currently extend to carers.[402]

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398 See s 48 of the *Accountability Principles 2014* discussed below.

399 Transcript, Lisa Backhouse, Darwin and Cairns Hearing, 11 July 2019, T3198.21-3200.36.

400 Exhibit 8-28, Brisbane hearing, Statement of Sarah Holland Batt, WIT.0330.0001.0001 at 0007-0008 [44]-[53].

401 Transcript, Melbourne Hearing 3, 17 October 2019, T6104-6151.

402 Exhibit 6-20, Darwin and Cairns Hearing, Statement of Lisa Backhouse, WIT.0221.0001.0001 at 0005 [29].

450. Ms Holland-Batt explained that she was ultimately informed by the provider that the carer who had abused her father was dismissed from her employment. However, she added:

> It was unclear from his phrasing whether she had been fired or moved to another - facility.
>
> I do not know whether this carer continues to work in a different facility. The thought haunts me. I think there should be some sort of register that keeps track of any substantiated complaints so that abusive carers do not have access to vulnerable persons in the future.[403]

451. In our submission, the evidence received by the Royal Commissioners during the course of Melbourne Hearing 3 has clearly identified that there are significant gaps in the existing regulatory regime. In part, that is the result of limits in the Commonwealth law and the States and Territories having different regulatory regimes or different approaches to the application of those schemes. These problems are exacerbated by ineffective communication between the Aged Care Quality and Safety Commission and State and Territory regulatory bodies.

452. On any view, we submit that the present position is quite inadequate and is in need of urgent and fundamental reform. As with many of the issues the Royal Commissioners have examined, these deficiencies have been identified previously by other inquiries and recommendations have been made to address them.[404]

453. This part of our submissions commences with an examination of the current Commonwealth law before examining the law in the States and Territories.

Current situation: Commonwealth Law

454. The *Aged Care Act 1997* (Cth) is primarily concerned with the regulation of aged care *providers*. Staff members and volunteers are only lightly regulated.

455. The Act provides that the responsibilities of approved providers in relation to 'accountability for the aged care provided by the approved provider through an aged care service' include the responsibilities specified in the 'Accountability Principles' (paragraph 63-1(1)(m) of the Act). Part 6 of the *Accountability Principles 2014* deals with approved providers' responsibilities in relation to staff members and volunteers.

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403 Exhibit 8-40, Brisbane Hearing, Statement of Sarah Holland-Batt, WIT.0330.0001.0001 at 0012 [79]-[80].

404 See Senate Community Affairs References Committee, *Future of Australia's aged care sector workforce* (2017) pages 109-10 (recommendation 19). See also Australian Law Reform Commission, *Elder Abuse – A National Legal Response* (2017) pages 132-4. The ALRC recommended that unregistered aged care workers who provide direct care should be subject to the planned National Code of Conduct for Health Care Workers. It noted that it received submissions in support of industry specific registration, that its recommendation did not preclude this and that the issue "extend beyond responses to elder abuse" (at para 4.147).

456. We have set out Part 6 in full:

> **47 Purpose of this Part**
>
> For paragraph 63-1(1)(m) of the Act, this Part specifies the responsibilities of an approved provider to ensure:
>
> (a) that each person who is a *staff member*[405] of the approved provider, or a volunteer for the approved provider, has been issued with a police certificate and, if necessary, has made a statutory declaration stating that the person has not been convicted of certain offences; and
>
> (b) that persons with certain criminal convictions do not provide aged care.
>
> **48 Requirements in relation to new staff members and volunteers**
>
> An approved provider must not allow a person to become a staff member of the approved provider, or a volunteer for the approved provider, unless the approved provider is satisfied that:
>
> (a) subject to section 49, there is for the person a police certificate that is dated not more than 3 years before the day on which the person would first become a staff member or volunteer; and
>
> (b) the police certificate does not record that the person has been:
>
> (i) convicted of murder or sexual assault; or
>
> (ii) convicted of, and sentenced to imprisonment for, any other form of assault; and
>
> (c) if the person has been, at any time after turning 16, a citizen or permanent resident of a country other than Australia—the person has made a statutory declaration stating that the person has never been:
>
> (i) convicted of murder or sexual assault; or
>
> (ii) convicted of, and sentenced to imprisonment for, any other form of assault.
>
> **49 Arrangements for new staff members or volunteers who do not yet have police certificates**
>
> Despite paragraph 48(a), an approved provider may allow a person to become a staff member of the approved provider, or a volunteer for the approved provider, if:
>
> (a) a police certificate has not been issued for the person; and
>
> (b) the care or other service to be provided by the person is essential; and
>
> (c) an application for a police certificate for the person has been made before the day on which the person would first become a staff member or volunteer; and

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405 Section 4 of the Principles provides that: A staff member of an approved provider, means a person who:

(a) is at least 16 years old; and
(b) is employed, hired, retained or contracted by the approved provider (whether directly or through an employment or recruitment agency) to provide care or other services under the control of the approved provider; and
(c) has, or is reasonably likely to have, access to care recipients.

(d) until the police certificate is issued, the person will be subject to appropriate supervision during periods when the person has access to care recipients; and

(e) the person makes a statutory declaration stating that the person has never been:

(i) convicted of murder or sexual assault; or

(ii) convicted of, and sentenced to imprisonment for, any other form of assault.

50 Continuing responsibilities of approved providers

(1) An approved provider must ensure that, except for any period during which a person did not have a police certificate as permitted by section 49:

(a) there is a police certificate for each person who is a staff member of the approved provider or a volunteer for the approved provider; and

(b) the certificate is not more than 3 years old; and

(c) the certificate does not record that the person has been:

(i) convicted of murder or sexual assault; or

(ii) convicted of, and sentenced to imprisonment for, any other form of assault.

(2) An approved provider must ensure that each person who is a staff member of the approved provider, or a volunteer for the approved provider, is not allowed to continue as a staff member or volunteer unless the approved provider is satisfied that a police certificate issued for the person, or a statutory declaration made by the person, does not record that the person has been:

(a) convicted of murder or sexual assault; or

(b) convicted of, and sentenced to imprisonment for, any other form of assault.

(3) An approved provider must take reasonable measures to require each person who is a staff member of the approved provider, or a volunteer for the approved provider, to notify the approved provider if the staff member or volunteer is:

(a) convicted of murder or sexual assault; or

(b) convicted of, and sentenced to imprisonment for, any other form of assault.

(4) An approved provider must ensure that a staff member of the approved provider, or a volunteer for the approved provider, is not allowed to continue as a staff member or volunteer if the approved provider is satisfied on reasonable grounds that the staff member or volunteer has been:

(a) convicted of murder or sexual assault; or

(b) convicted of, and sentenced to imprisonment for, any other form of assault.

51 Spent convictions

> Nothing in this Part affects the operation of Part VIIC of the *Crimes Act 1914* (which includes provisions that, in certain circumstances, relieve persons from the requirement to disclose spent convictions and require persons aware of such convictions to disregard them).

457. In summary, an approved provider has a responsibility to ensure:

- that each person who is a staff member of the approved provider, or a volunteer, has been issued with a police certificate and, if necessary, has made a statutory declaration stating that the person has not been convicted of certain offences; and
- that persons with certain criminal convictions do not provide aged care.

458. Section 48 of the Accountability Principles specifies that the approved provider must be satisfied that the police certificate is not more than three years old and that it does not record that the person has been:

a. convicted of murder or sexual assault; or

b. convicted of, and sentenced to imprisonment for, any other form of assault.

459. We submit that the existing Commonwealth law is a very limited measure to ensure that those people who are unsuitable for aged care work are excluded from working in the sector. Before we outline what we submit ought to replace it, we need to examine the relevant State and Territory health complaints regimes as they supplement the Commonwealth provisions albeit in a patchwork and unsatisfactory manner.

Current situation: State and Territory Law

460. Aged care workers who are not registered health practitioners are not regulated by the Commonwealth. The Department of Health and the Aged Care Quality and Safety Commission (**ACQSC**) have powers to regulate approved providers but do not currently have power to regulate individual aged care workers.[406]

461. The Australian Health Practitioner Regulation Agency (**AHPRA**) and National Boards regulate nurses, medical practitioners and some allied health professionals who operate in aged care, so that, for example, a nurse who provides substandard care in an aged care setting may be the subject of a complaint to AHPRA.

462. However, there is no agency dedicated to the regulation or registration of personal care workers.

463. As the Australian Medical Association observed in its submission to the Royal Commissioners, 'personal care attendants spend proportionately more time caring for older people than any other staff type'. This makes them 'a

[406] Transcript, Shona Reid, Melbourne Hearing 3, 18 October 2019, T6241.17-20.

crucial component to the aged care workforce and a crucial component in influencing safety and quality issues'.[407]

464. The evidence before the Royal Commissioners is that, to the extent that there is regulation of the conduct of personal care workers, it is patchy and inconsistent at best and entirely ineffective at worst.

National Code of Conduct

465. In April 2015, through the Council of Australian Governments (**COAG**), health ministers agreed to the terms of the first National Code of Conduct for health care workers. The National Code of Conduct sets standards of conduct and practice for all unregistered health care workers.

466. It is a matter for each State and Territory to determine how the National Code of Conduct is implemented and progressed. As at September 2019, the National Code of Conduct had not yet been implemented in Western Australia, Tasmania, the Northern Territory or the Australian Capital Territory, although work was underway to progress implementation in those jurisdictions.[408]

467. The Royal Commissioners obtained statements from the health complaints officer in each jurisdiction, which outline the extent to which their office regulates unregistered aged care workers and deals with complaints about aged care.[409]

468. There is significant variation between States and Territories concerning the jurisdiction of their respective complaints officers to regulate aged care workers as set out in the following table.

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407 Australian Medical Association submission dated September 2019, AMA.9999.0001.0001 at 0013.

408 See for example, Western Australia: Exhibit 11-37, Statement of Sarah Jane Cowie, WIT.0392.0001.0001 at 0010 [39].

409 Exhibit 11-32, Melbourne Hearing 3, Statement of Karen Toohey, Health Services Commissioner in the ACT Human Rights Commission, WIT.0386.0001.0001. Exhibit 11-33, Melbourne Hearing 3, Statement of Stephen Dunham, Commissioner, Health and Community Services Complaints Commission, Northern Territory, WIT.0387.0001.0001. Exhibit 11-34, Melbourne Hearing 3, Statement of Richard Connock, Tasmanian Health Complaints Commissioner, WIT.0388.0001.0001: Exhibit 11-35, Melbourne Hearing 3, Statement of Dr Grant Davies, Commissioner of the Office of the Health and Community Services Commission, South Australia, WIT.0390.0001.0001. Exhibit 11-36, Melbourne Hearing 3, Statement of Susan Dawson, Commissioner, NSW Health Care Complaints Commission, WIT.0391.0001.0001. Exhibit 11-37, Melbourne Hearing 3, Statement of Sarah Cowie, Director of the Health and Disability Services Complaints Office, Western Australia, WIT.0392.0001.0001. Exhibit 11-68, Melbourne Hearing 3, Statement of Karen Cusack, Health Complaints Commissioner, Victoria, WIT.0389.0001.0001. Exhibit 11-69, Melbourne Hearing 3, Statement of Andrew Brown, Health Ombudsman of Queensland, WIT.0385.0001.0001.

Summary of Health complaints officers' statements – jurisdiction to review complaints

State / Territory	Whether jurisdiction exists for aged care workers	Whether complaints are referred to the ACQSC or reviewed	Number of complaints about aged care
ACT	No jurisdiction[410]	N/A	33 (0 in relation to unregistered workers)[411]
NT	Yes[412]	Complaints are **reviewed**[413]	9[414]
Tas	Yes[415]	Complaints are **referred** to the ACQSC[416]	44 (all complaints are referred; no data held on categories for out-of-scope)[417]
SA	Yes[418]	Certain complaints are **reviewed**, others are **referred** to the ACQSC[419]	64 (24 In relation to unregistered workers)[420]

410 Exhibit 11-32, Melbourne Hearing 3, Statement of Karen Toohey, WIT.0386.0001.0001 at 0002.

411 Exhibit 11-32, Melbourne Hearing 3, Statement of Karen Toohey, WIT.0386.0001.0001 at 0002.

412 Exhibit 11-33, Melbourne Hearing 3, Statement of Stephen Dunham, WIT.0387.0001.0001 at 0001 [1].

413 Exhibit 11-33, Melbourne Hearing 3, Statement of Stephen Dunham, WIT.0387.0001.0001 at 0001 [2].

414 Exhibit 11-33, Melbourne Hearing 3, Statement of Stephen Dunham, WIT.0387.0001.0001 at 0001 [2].

415 Exhibit 11-34, Melbourne Hearing 3, Statement of Richard Connock, WIT.0388.0001.0001 at 0001 [3]-[4].

416 Exhibit 11-34, Melbourne Hearing 3, Statement of Richard Connock, WIT.0388.0001.0001 at 0001-0002 [6]-[7].

417 Exhibit 11-34, Melbourne Hearing 3, Statement of Richard Connock, WIT.0388.0001.0001 at 0001 [6] and 0002 [8].

418 Exhibit 11-35, Melbourne Hearing 3, Statement of Dr Grant Davies, WIT.0390.0001.0001 at 0003 [20].

419 Exhibit 11-35, Melbourne Hearing 3, Statement of Dr Grant Davies, WIT.0390.0001.0001 at 0006 [29].

420 Exhibit 11-35, Melbourne Hearing 3, Statement of Dr Grant Davies, WIT.0390.0001.0001 at 0006 [27] and 0007 [45].

NSW	Yes, subject to 'therapeutic/ treatment aspect' to service[421]	Complaints are **reviewed**[422]	892 (59 in relation to unregistered workers)[423]
WA	Likely, yes[424]	Certain complaints are **reviewed,** others are **referred** to the ACQSC[425]	217 (2 confirmed relate to unregistered workers, but 181 of 217 complaints are missing details)[426]
Vic	Likely, yes[427]	No power to formally refer to the ACQSC. *Complainants* are **referred**.[428]	96[429]
Qld	Yes, subject to providing or supporting a 'health service'[430]	Complaints are **reviewed** (systems and processes are referred to ACQSC)[431]	856 (90 in relation to unregistered workers)[432]

421 Exhibit 11-36, Melbourne Hearing 3, Statement of Susan Dawson, WIT.0391.0001.0001 at 0004 [15].

422 Exhibit 11-36, Melbourne Hearing 3, Statement of Susan Dawson, WIT.0391.0001.0001 at 0004-0006 [16]-[18].

423 Exhibit 11-36, Melbourne Hearing 3, Statement of Susan Dawson, WIT.0391.0001.0001 at 0006 [18.d)].

424 Exhibit 11-37, Melbourne Hearing 3, Statement of Sarah Cowie, WIT.0392.0001.0001 at 0005 [18].

425 Exhibit 11-37, Melbourne Hearing 3, Statement of Sarah Cowie, WIT.0392.0001.0001 at 0004-0005 [15]-[17].

426 Exhibit 11-37, Melbourne Hearing 3, Statement of Sarah Cowie, WIT.0392.0001.0001 at 0005 [20]-[25]. Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 35, HDS.0001.0001.0006

427 Exhibit 11-68, Melbourne Hearing 3, Statement of Karen Cusack, WIT.0389.0001.0001 at 0002-0003 [3].

428 Exhibit 11-68, Melbourne Hearing 3, Statement of Karen Cusack, WIT.0389.0001.0001 at 0004 [9]-[10]. Transcript, Karen Cusack, Melbourne Hearing 3, 18 October 2019 at T6233.26-33.

429 Exhibit 11-68, Melbourne Hearing 3, Statement of Karen Cusack, WIT.0389.0001.0001 at 0003 [7].

430 Exhibit 11-69, Melbourne Hearing 3, Statement of Andrew Brown, WIT.0385.0001.0001 at 0002 [10]-[12].

431 Exhibit 11-69, Melbourne Hearing 3, Statement of Andrew Brown, WIT.0385.0001.0001 at 0006 [24].

432 Exhibit 11-69, Melbourne Hearing 3, Statement of Andrew Brown, WIT.0385.0001.0001 at 0004 [20].

469. In each State or Territory that has implemented the National Code of Conduct, the extent to which an aged care worker is subject to regulation by the health regulator in that jurisdiction depends on whether they are providing a 'health service', as defined in the relevant State or Territory law. The scope of the definition of a 'health service' varies significantly between jurisdictions.

470. For example, in Queensland, the definition is broad and encompasses 'a service that is, or purports to be, a service for maintaining, improving, restoring or managing people's health and wellbeing', as well as a 'support service' to such a service.[433] According to the Queensland Health Ombudsman, although a person providing in-home care to an elderly person that consists only of house cleaning, shopping, cooking and transportation is unlikely to be characterised as providing a 'health service', if that person is also providing assistance with showering or toileting, they would likely to be subject to the jurisdiction of the Queensland Health Ombudsman. Similarly, services such as transportation or catering may come within the Queensland Health Ombudsman's jurisdiction, as 'support services', if provided by a health service (such as a residential aged care facility).[434]

471. By contrast, the definition of 'health service' in s 7 of the *Health Care Complaints Act 1993* (NSW) identifies various services, such as 'medical, hospital, nursing and midwifery services' and 'optical dispensing, dietitian, massage therapy, naturopathy, acupuncture, speech therapy, audiology and audiometry services'. According to the NSW Health Care Complaints Commissioner, whether or not a personal care worker was providing a 'health service' requires consideration of whether 'there was a therapeutic/treatment aspect to the care provided', so that non-therapeutic support (such as assistance with dressing or cleaning) would be unlikely to constitute provision of a 'health service'.[435]

472. The various State and Territory health regulators were asked in advance of Melbourne Hearing 3 about their regulatory activities in relation to personal care workers in aged care between 1 July 2014 and 30 June 2019. In that period, only the New South Wales, South Australian and Queensland health complaints officers had exercised their powers to issue prohibition orders restricting the ability of aged care workers to work in a 'health service'. The NSW Health Care Complaints Commissioner had issued two prohibition orders against personal care workers, one against a person for posing as a registered nurse and one against an Assistant-in-Nursing.[436] The SA Health and Community Services Commissioner had issued only one prohibition

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433 *Health Ombudsman Act 2013* (Qld), s 7(1).

434 Exhibit 11-69, Melbourne Hearing 3, Statement of Andrew Brown, WIT.0385.0001.0001 at 0002 [11]-[12].

435 Exhibit 11-36, Melbourne Hearing 3, Statement of Susan Dawson, 6 September 2019, WIT.0391.0001.0001 at [15].

436 Exhibit 11-36, Melbourne Hearing 3, Statement of Susan Dawson, WIT.0391.0001.0001 at 0008 [23].

order.[437] By contrast, the Health Ombudsman of Queensland had taken immediate registration action against seven registered practitioners and made 16 interim prohibition orders, including 12 against unregistered practitioners in an aged care setting.[438]

473. We summarise below what a panel of health complaints officers told the Royal Commissioners about how they address complaints against personal care attendants in aged care. The evidence highlights the fragmented nature of the current regulatory framework for unregistered aged care workers.

474. The Victorian Health Complaints Commissioner and the Health Ombudsman of Queensland gave evidence in a panel together with Shona Reid, Executive Director, Performance, Education and Policy, Complaints Resolution Group of the Aged Care Quality and Safety Commission.

475. Ms Karen Cusack, the Victorian Health Complaints Commissioner gave evidence that complaints received by her office are initially assessed to determine whether they fell within the *Health Complaints Act 2016* (Vic), and if so, whether there is another agency established to deal with the complaint. In such a case 'as a general rule' her office will not deal with the complaint.[439] She told us that in the case of aged care, there is a dedicated agency and her practice is to provide information to the complainant about the existence and role of the ACQSC.[440] Consistently with that practice, of the 67 complaints regarding the provision of a health service in the aged care context received by the office of the Victorian Health Complaints Commissioner since its establishment on 1 February 2017, all but one of them have been closed with information provided to the complainant about the role of the ACQSC and without any further involvement by the Victorian Health Complaints Commissioner.[441]

476. Ms Cusack said that the *Health Complaints Act 2016* (Vic) establishes express referral processes by reference to the *Disability Act 2006* (Vic), *Mental Health Act 2014* (Vic) and AHPRA among others.[442] However, Ms Cusack considered that confidentiality provisions in the Victorian Act prevented her office from referring a complaint to the ACQSC.[443] The ACQSC confirmed that no complaints were referred to it from the Victorian Health Complaints Commissioner between July 2014 and June 2019. By

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437 Exhibit 11-35, Melbourne Hearing 3, Statement of Dr Grant Davies, WIT.0390.0001.0001 at 0008 [46].

438 Exhibit 11-69, Melbourne Hearing 3, Statement of Andrew Brown, WIT.0385.0001.0001 at 0006-0008 [30]-[36].

439 Transcript, Melbourne Hearing 3, Karen Cusack, 18 October 2019 at T6230.30-35.

440 Transcript, Melbourne Hearing 3, Karen Cusack, 18 October 2019 at T6233.01-03.

441 Transcript, Melbourne Hearing 3, Karen Cusack, 18 October 2019 at T6232.39–6233.04.

442 Transcript, Melbourne Hearing 3, Karen Cusack, 18 October 2019 at T6233.09-15.

443 Transcript, Melbourne Hearing 3, Karen Cusack, 18 October 2019 at T6233.26-33.

contrast 25 complaints were referred to it by the Queensland Health Ombudsman.[444]

477. The Queensland Health Ombudsman, Mr Brown, told the Royal Commissioners that his office was the single point of contact in the first instance for any complaints about registered health practitioners or unregistered health practitioners who provided 'health services'. The Health Ombudsman's office makes an initial assessment of whether the complaint is 'frivolous, vexatious, lacking in substance or trivial'. Less serious complaints about registered practitioners that are not frivolous are referred to AHPRA.[445] The Health Ombudsman's office retains and will deal with complaints involving more serious allegations about registered health practitioners, being complaints about conduct that might constitute professional misconduct or otherwise might result in the suspension or cancellation of the practitioner's registration. Complaints about unregistered health practitioners who are providing a 'health service' are also dealt with by the Health Ombudsman's office.

478. The Queensland Health Ombudsman has the power to impose an interim prohibition order on an unregistered health practitioner, including to prohibit the practitioner from providing a health service or imposing conditions on their practice.[446] The power to impose an interim prohibition order turns on whether the Health Ombudsman reasonably believes that 'because of the practitioner's health, conduct or performance, the practitioner poses a serious risk to persons and it is necessary to issue the order to protect public health or safety' or 'issuing the order is otherwise in the public interest.'[447] A final prohibition order against an unregistered health practitioner may be made by the Queensland Civil and Administrative Tribunal.

479. The National Code of Conduct for Health Care Workers (Queensland) was published by the Department of Health and is a prescribed 'conduct document' for the purposes of the *Health Ombudsman Act 2013* (Qld). The Health Ombudsman may have regard to the National Code of Conduct when making a decision under the *Health Ombudsman Act 2013* (Qld).[448]

480. The Queensland Health Ombudsman explained that his office had arrangements with the police, including a funded position within the Queensland Police information service, by which it obtained information about health services and investigated matters within his jurisdiction on his

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444 Exhibit 11-70, Melbourne Hearing 3, Statement of Shona Reid, WIT.0528.0001.0001 at 0030.

445 Transcript, Melbourne Hearing 3, Andrew Brown, 18 October 2019 at T6234.06-09.

446 Exhibit 11-69, Melbourne Hearing 3, Statement of Andrew Brown, WIT.0385.0001.0001 at 0006 [30].

447 Exhibit 11-69, Melbourne Hearing 3, Statement of Andrew Brown, WIT.0385.0001.0001 at 0006-0007 [30]-[31].

448 Exhibit 11-69, Melbourne Hearing 3, Statement of Andrew Brown, WIT.0385.0001.0001 at 0008 [37]-[38].

'own motion'.[449] The Victorian Health Complaints Commissioner's arrangements with the police are limited to reports from police which had mostly concerned massage services.[450]

Information sharing by the ACQSC

481. A significant number of complaints received by the ACQSC concern individual workers and are outside of its jurisdiction. Ms Reid told the Royal Commissioners that in one financial year, her office received over 300 complaints involving allegations of conduct by an individual working in an aged care facility.[451] What does it do with those complaints?

482. In her statement to the Royal Commissioners, Ms Reid outlined the arrangements between the ACQSC and various State and Territory health complaints officers.[452] Prior to the establishment of the ACQSC, the former Aged Care Complaints Commission (**ACCC**) had negotiated a Memorandum of Understanding (**MOU**) with each health complaints body. Since its establishment, the ACQSC has been pursuing new MOUs with the State and Territory health complaints officers. At the time of Ms Reid's evidence however, an MOU had been signed only with NSW.[453] The ACQSC continued to engage with other health complaints bodies in accordance with the arrangements put in place by the ACCC.[454]

483. The ACQSC's ability to share information with the health complaints officers is constrained by s 62 of the *Aged Care Quality and Safety Commission Act 2018* (Cth). In the case of unregistered aged care workers, information may be provided by the ACQSC only if the Commissioner forms the belief 'on reasonable grounds that the disclosure is necessary to prevent or lessen a serious risk to the safety, health or well-being of an aged care consumer'.[455] Ms Reid said that, between July 2014 and June 2019, only three complaints had been referred to a state or territory health complaints entity.[456] This is despite the ACQSC receiving as many as 300 complaints about individuals in at least one financial year.[457]

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449 Transcript, Melbourne Hearing 3, Andrew Brown, 18 October 2019 at T6236.25-33.

450 Transcript, Melbourne Hearing 3, Karen Cusack, 18 October 2019 at T6237.17-30.

451 Transcript, Melbourne Hearing 3, Shona Reid, 18 October 2019, T6242.7-14.

452 Exhibit 11-70, Melbourne Hearing 3, Statement of Shona Reid, WIT.0528.0001.0001.

453 Exhibit 11-70, Melbourne Hearing 3, Statement of Shona Reid, WIT.0528.0001.0001 at 0006 [21]-[23], 0007 [29] and 0008 [32]; and Transcript, Shona Reid, Melbourne Hearing 3, 18 October 2019 at T6242.30-31.

454 Exhibit 11-70, Melbourne Hearing 3, Statement of Shona Reid, WIT.0528.0001.0001 at 0008 [32].

455 *Aged Care Quality and Safety Commission Act 2018* (Cth), s 61(1)(e); see also Exhibit 11-70, Melbourne Hearing 3, Statement of Shona Reid, WIT.0528.0001.0001 at 0012 [39].

456 Exhibit 11-70, Melbourne Hearing 3, Statement of Shona Reid, WIT.0528.0001.0001 at 0028.

457 Transcript, Melbourne Hearing 3, Shona Reid, 18 October 2019, T6242.7-14.

484. At Melbourne Hearing 3, Counsel Assisting referred this panel to the evidence of Sarah Holland-Batt, given at the Brisbane hearing,[458] and the evidence in relation to UA and Japara Bayview, received earlier during Melbourne Hearing 3.[459]

485. Ms Holland-Batt had given evidence that a whistleblower had raised concerns about the appalling conduct towards her father by an employee of the residential aged care facility in Queensland where Ms Holland-Batt's father resided.[460] Ms Holland-Batt complained to the former ACCC about the allegations. The ACCC considered the allegations insofar as they related to the approved provider of the facility, but told Ms Holland-Batt that it did not have the power to investigate conduct by individual workers.[461]

486. In some welcome plain speaking, Ms Holland-Batt had this to say about what she was told by the representative of the former ACCC:

> I thought this sounded like a bunch of malarkey. How could this body be responsible for complaints about the aged care industry, but have no power to protect the vulnerable people receiving care in that setting?[462]

487. That is a very good question. Counsel Assisting submit that it points to a gap in the current regulation of the aged care sector. That gap exposes care recipients to acts of violence by care workers even when those workers have been dismissed from their previous employment. In Ms Holland-Batt's case, the abusive carer was dismissed but, in the absence of a criminal conviction for assault, and a sentence of imprisonment, is free to continue working in the sector, which Ms Holland-Batt says haunts her.[463]

488. The Victorian Health Complaints Commissioner told the Royal Commissioners that, if Ms Holland-Batt's complaint had concerned conduct at an aged care facility in Victoria, her office would not deal with the complaint but would assist the complainant to contact the ACQSC.[464] Ms Cusack said that, although she was aware that the ACQSC did not have power to make orders in relation to an individual aged care worker, 'If the person is employed within the aged care facility, then … we would see the responsibility being with the oversight body for the Quality and Safety

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458 Transcript, Brisbane Hearing, Sarah Holland-Batt, 7 August 2019 at T4562-4576.

459 Transcript, Melbourne Hearing 3, Japara Bayview case study, 17 October 2019 at T6105-6151.

460 Exhibit 8-40, Brisbane Hearing, Statement of Sarah Holland-Batt, WIT.0330.0001.0001 at 0007-0008 [44]-[53].

461 Exhibit 8-40, Brisbane Hearing, Statement of Sarah Holland-Batt, WIT.0330.0001.0001 at 0011 [69] and [74].

462 Exhibit 8-40, Brisbane Hearing, Statement of Sarah Holland-Batt, WIT.0330.0001.0001 at 0011 [74].

463 Exhibit 8-28, Brisbane Hearing, Statement of Sarah Holland-Batt, WIT.0330.0001.0001 at 0012 [79]-[80].

464 Transcript, Melbourne Hearing 3, Karen Cusack, 18 October 2019 at T6237.43-6238.17.

Standards in aged care.'[465] This is of course in contrast to the position of the ACQSC's predecessor the ACCC, which told Ms Holland-Batt that it could *not* deal with those parts of her complaint that concerned the individual worker's conduct. It is no surprise that Ms Holland-Batt found the complaints process so bewildering. It need not be so.

489. By contrast to the approach of the Victorian Health Complaints Commissioner, the Queensland Health Ombudsman told us that shortly after his office became aware of Ms Holland-Batt's evidence to the Royal Commissioners, it reached out to Ms Holland-Batt. Ms Holland-Batt has now made a complaint to his office which is being investigated.[466] Mr Brown considered the aged care worker concerned was 'clearly within our jurisdiction'.[467]

490. When taken to the evidence of the allegations of physical assault of a resident by UA, the employee at the Japara Bayview residential aged care facility in Victoria to which we have previously referred, Ms Cusack said that her office would not deal with such a complaint and would instead inform the complainant about the function of the ACQSC.[468] By contrast, Mr Brown said that the Queensland Health Ombudsman would consider the complaint as falling within his jurisdiction if it occurred in Queensland. Further, he said that if the allegations could be proved, having regard to the course of conduct indicated by the evidence, he considered that the 'serious risk threshold' would likely be met which would lead to consideration being given to issuing a prohibition order against UA.[469]

491. Ms Shona Reid of the ACQSC accepted that in Victoria there was a gap in the regulation of unregistered aged care workers who were providing a health service, given the view taken by the Victorian Health Complaints Commissioner that the ACQSC was the preferred agency to deal with such complaints, and the ACQSC's lack of powers in relation to individual workers.[470] Ms Reid said in such circumstances, the ACQSC would need to rely on the service provider taking action against its employee.[471] Surprisingly, Ms Reid said that she had only become aware in the lead up to the Royal Commission's hearing that the Victorian Health Complaints Commissioner took the view that complaints about the conduct of an individual in an aged care setting were matters that should be dealt with by the ACQSC.[472]

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465 Transcript, Melbourne Hearing 3, Karen Cusack, 18 October 2019 at T6238.37-39.

466 Transcript, Melbourne Hearing 3, Andrew Brown, 18 October 2019 at T6238.45-6239.07.

467 Transcript, Melbourne Hearing 3, Andrew Brown, 18 October 2019 at T6239.25.

468 Transcript, Melbourne Hearing 3, Karen Cusack, 18 October 2019 at T6240.12-21.

469 Transcript, Melbourne Hearing 3, Andrew Brown, 18 October 2019 at T6240.25-30.

470 Transcript, Melbourne Hearing 3, Shona Reid, 18 October 2019 at T6243.11-30.

471 Transcript, Melbourne Hearing 3, Shona Reid, 18 October 2019 at T6243.28-30.

472 Transcript, Melbourne Hearing 3, Shona Reid, 18 October 2019 at T6243.03-09.

492. When asked whether the ACQSC considered on every occasion whether it should exercise its referral powers to share information about the conduct of an individual with other agencies, Ms Reid said that 'more often we would advise the complainant to go to the appropriate body for unregistered worker conduct and we would provide them with the information, phone numbers and describe the National Code of Conduct to the complainant'.[473] Ms Reid accepted that, in those circumstances, there was a risk that a complainant might not follow up with the State-based complaints entity.[474] She said that if the complainant sounded reluctant, or said they could not do that:

> we would think about getting an advocate to help them do so and we can refer them to an advocate to do so and we would do a warm transfer to an advocate or we would consider doing it ourselves depending on the risk, how high the risk is.[475]

493. Ms Reid was also asked about evidence received by the Royal Commissioners in the course of the Menarock case study.[476] That case study provided further examples of inappropriate conduct by care workers directed at residents in an aged care facility in Victoria. Ms Reid said that the ACQSC had not referred the allegations about the conduct of any employee at a Menarock facility to the Victorian Health Complaints Commissioner.[477] She accepted that the allegations appeared at least to suggest a breach of the National Code of Conduct, in particular the obligation on a general health service provider to provide health services in a safe and ethical manner.[478] Ms Reid said that it was open to the ACQSC to refer the allegations to the Victorian Health Complaints Commissioner, but that was not done.[479] When asked by Counsel Assisting why the ACQSC had not referred the complaint to the Victorian Health Complaints Commissioner, Ms Reid told the Royal Commissioners that there was a need for the ACQSC to review its guidance material and information, and to clarify the differences around the country to make it clearer for complaints officers what they can and should do in such cases.[480]

494. In her second statement to the Royal Commissioners, in the course of addressing the ACQSC's response to Ms Holland-Batt's complaint, Ms Reid said that the ACQSC was:

> strengthening the instructions for complaints officers to make it clearer that in similar circumstances, a referral to the relevant state-based body

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473 Transcript, Melbourne Hearing 3, Shona Reid, 18 October 2019 at T6243.44-6244.09.

474 Transcript, Melbourne Hearing 3, Shona Reid, 18 October 2019 at T6244.11-14.

475 Transcript, Melbourne Hearing 3, Shona Reid, 18 October 2019 at T6244.15-18.

476 Transcript, Melbourne Hearing 3, Menarock case study, 15 October 2019 at T5877-5965.

477 Transcript, Melbourne Hearing 3, Shona Reid, 18 October 2019 at T6245.36-39.

478 Transcript, Melbourne Hearing 3, Shona Reid, 18 October 2019 at T6245.41-46.

479 Transcript, Melbourne Hearing 3, Shona Reid, 18 October 2019 at T6246.08-09.

480 Transcript, Melbourne Hearing 3, Shona Reid, 18 October 2019 at T6246.01-18.

(where the National Code of Conduct has been adopted) and/or police service by either the provided or ACQSC should be considered.[481]

495. Ms Cusack considered it was critical that the different regulatory schemes and regulators work together and understand one another's roles and responsibilities because 'fragmentation can potentially lead to people slipping through the cracks and that's what we want to avoid at all costs'.[482] It appears to Counsel Assisting that, on the evidence, this is far from a theoretical risk. It is likely that there are many other cases similar to those we have discussed that have not been brought to the Royal Commissioners' attention.

496. Mr Brown said that, when you looked at the regulatory system as a whole, it was complicated, in the sense of being fragmented.[483] In a fragmented environment, Mr Brown said it was essential that the various players understood the limits of each other's jurisdiction, and that there was good information-sharing between agencies.[484] We submit that, on the evidence, it is far from clear that this is presently occurring.

497. Mr Brown also thought it was important that the general public, service providers and employees have access to information that explains the fragmented system.[485] Once again, this does not appear to be the case. Mr Brown said that such a system could work, and expressed the view that more recently in Queensland in what he described as the 'aged care space', 'it works fairly well because we have a fairly close working relationship with the ACQSC. We speak to them quite regularly both at officer level and at more senior levels and we think we have a good understanding of each other's jurisdiction.'[486] While this may well be the case in Queensland, we submit that it is quite unsatisfactory that residents of other States and Territories do not enjoy the benefits of such co-operation.

498. Ms Reid said that, for a national body like the ACQSC, the process of referring complaints to state or territory entities was difficult as a result of having different laws around the country.[487] From her perspective, harmonised laws in the States and Territories would 'be very nice'.[488] She considered there would be value in a national oversight body or shared register for state based health complaints officers to share information.[489]

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481 Exhibit 11-70, Melbourne Hearing 3, Statement of Shona Reid, WIT.0528.0001.0001 at 0018 [56].

482 Transcript, Melbourne Hearing 3, Karen Cusack, 18 October 2019 at T6250.08-16.

483 Transcript, Melbourne Hearing 3, Andrew Brown, 18 October 2019 at T6248.44-6249.04.

484 Transcript, Melbourne Hearing 3, Andrew Brown, 18 October 2019 at T6249.04-07.

485 Transcript, Melbourne Hearing 3, Andrew Brown, 18 October 2019 at T6249.06-13.

486 Transcript, Melbourne Hearing 3, Andrew Brown, 18 October 2019 at T6249.09-13.

487 Transcript, Melbourne Hearing 3, Shona Reid, 18 October 2019 at T6250.20-23.

488 Transcript, Melbourne Hearing 3, Shona Reid, 18 October 2019 at T6250.20-28.

489 Transcript, Melbourne Hearing 3, Shona Reid, 18 October 2019 at T6247.45-46.

499. Mr Brown considered that there were 'pros and cons' with both national and fragmented systems. However, he thought that there were some national systems which 'are just going to be too big and too cumbersome to work properly'.[490]

A national register for personal care workers

500. Ms Reid considered that the aged care system would be improved by 'some sort of unregistered carer' national register, which would assist service providers to be able to 'screen people that they employ to ensure that they are getting good quality staff'.[491]

501. During Melbourne Hearing 3, witnesses were also asked to comment on the desirability of such a national registration scheme.

502. Mr Darren Mathewson of ACSA considered the purpose of a registration scheme should be to 'provide adequate screening to protect residents/clients in aged care whilst also providing information on the criminal and work history, work readiness, training, skills and qualifications of individual workers'.[492] He told the Royal Commissioners that ACSA would support the establishment of such a scheme and would work collaboratively with whatever agency was responsible for administering it.[493] He noted that ACSA's members would consider it a benefit and thought that government and industry had a role to pay where a low-paid workforce may lack the capacity to cover the costs of the scheme themselves.[494] Mr Mathewson warned that higher regulation may deter much-needed workers from entering the workforce.[495]

503. Mr Paul Gilbert, on behalf of the Victorian Branch of the ANMF, considered that there should be a mandated minimum qualification of a relevant Australian Qualifications Framework Certificate III for any worker delivering nursing care approved by the Australian Nursing and Midwifery Accreditation Council.[496] He told the Royal Commissioners that the Victorian Branch of the ANMF thought registration through AHPRA for the aged care workforce would 'inject much needed public confidence, while at the same time enhancing the professionalism of the occupation'.[497] He considered AHPRA

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490 Transcript, Melbourne Hearing 3, Andrew Brown, 18 October 2019 at T6249.43-46.

491 Transcript, Melbourne Hearing 3, Shona Reid, 18 October 2019 at T6247.38-40.

492 Exhibit 11-19, Melbourne Hearing 3, Statement of Darren Mathewson, WIT.0362.0001.0001 at 0008 [22].

493 Exhibit 11-19, Melbourne Hearing 3, Statement of Darren Mathewson, WIT.0362.0001.0001 at 0010 [35].

494 Transcript, Melbourne Hearing 3, Darren Mathewson, 16 October 2019 at T6010.11-14.

495 Exhibit 11-19, Melbourne Hearing 3, Statement of Darren Mathewson, WIT.0362.0001.0001 at 0009 [30].

496 Exhibit 11-21, Melbourne Hearing 3, Statement of Paul Gilbert, WIT.0430.0001.0001 at 0032 [181].

497 Exhibit 11-21, Melbourne Hearing 3, Statement of Paul Gilbert, WIT.0430.0001.0001 at 0033 [186].

had the expertise and systems to register aged care workers.[498] Registration with AHPRA, he said, may avoid unnecessary duplication in the event nurses would be required to register both with AHPRA and a new scheme and could be used with the NDIS.[499] He argued the Commonwealth should fund AHPRA and the National Boards' expansion of registration to aged care workers.[500]

504. Ms Clare Tunney, Industrial Officer with the union United Voice,[501] 'absolutely agreed that there is a need' for regulation and registration of aged care workers.[502] However, she considered that regulation by AHPRA was not the right model and thought the NDIS model of more rigorous police checks and reporting was the correct approach. Ms Tunney said that aged care workers should not be doing nursing work and should not be subject to the APHRA model's extensive criteria.[503] She said it would be unreasonable to create cost barriers for low-paid workers to enter the workforce.[504] However, Mr Gilbert expressed the view that AHPRA could have a role to play where personal care workers are performing nursing care under the supervision of a nurse.[505] Ms Tunney stated that associated costs should be covered otherwise than by the worker themselves.[506]

505. Ms Alcock of the Health Workers' Union (**HWU**) did not consider that a registration scheme should be established. She said the HWU's view was that placing the cost and onus of obtaining and maintaining registration on the low-paid worker would operate as a barrier to entry to the workforce.[507] Ms Alcock expressed the view that a worker exclusion scheme was sufficient.[508] She noted that schemes such as the Victorian Working with Children Check involved continuous police checks.[509] She considered the Working with Children Check could be expanded to include elderly people.[510]

506. Counsel Assisting note that a statutory registration scheme for all unregistered health practitioners, including personal care assistants and

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498 Exhibit 11-21, Melbourne Hearing 3, Statement of Paul Gilbert, WIT.0430.0001.0001 at 0035 [202].

499 Exhibit 11-21, Melbourne Hearing 3, Statement of Paul Gilbert, WIT.0430.0001.0001 at 0035 [200].

500 Exhibit 11-21, Melbourne Hearing 3, Statement of Paul Gilbert, WIT.0430.0001.0001 at 0038 [215].

501 On 11 November 2019, United Voice merged with the National Union of Workers to form the United Workers Union.

502 Transcript, Melbourne Hearing 3, Clare Tunney, 16 October 2019 at T6007.21-22.

503 Transcript, Melbourne Hearing 3, Clare Tunney, 16 October 2019 at T6007.31-6008.2.

504 Exhibit 11-22, Melbourne Hearing 3, Statement of Clare Tunney, WIT.0577.0001.0001 at 0010 [41].

505 Transcript, Melbourne Hearing 3, Paul Gilbert, 16 October 2019 at T6010.32-6011.11.

506 Transcript, Melbourne Hearing 3, Clare Tunney,16 October 2019 at T6008.01-02.

507 Exhibit 11-20, Melbourne Hearing 3, Statement of Lisa Alcock, WIT.0463.0001.0001 at 0016 [78].

508 Exhibit 11-20, Melbourne Hearing 3, Statement of Lisa Alcock, WIT.0463.0001.0001 at 0016 [79].

509 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T6008.13-26.

510 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T6009.10-16.

assistants in nursing, was considered by the Australian Health Ministers Advisory Council in 2013,[511] but was rejected in favour of the National Code of Conduct discussed above.[512]

507. As noted above, the National Code of Conduct is a 'negative licensing' regime that does not vet individuals seeking entry but sets national standards against which a health care worker's conduct can be measured in the event of a complaint or a serious adverse event. In certain circumstances, a prohibition order can be issued if an individual fails to abide by the standards set out in the code.[513] Because it has been left up to each State and Territory to determine how the National Code is implemented, Australia has the confusing system revealed by the evidence and described above.

508. The option of a statutory registration scheme was rejected by COAG largely because of the estimated cost. However, the costs of various regulatory options were estimated on the basis of regulating 33 health occupations[514] rather than individual occupational categories. Therefore, the cost of implementing a statutory registration scheme solely for personal care workers would need to be recalculated. Against the costs of establishing such a scheme must be weighed the costs of inaction many of which have been revealed in the evidence.

A Serious Incident Response Scheme

509. We note that the Commonwealth Department of Health is considering a registration scheme as part of its 'Serious Incident Response Scheme'. The Royal Commissioners heard evidence about this at its Brisbane Hearing.[515]

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511 Australian Health Ministers' Advisory Council, Final report *Options for regulation of unregistered health practitioners*, April 2013.

512 COAG Health Council, Final report *A National Code of Conduct for health care workers*, April 2015.

513 Generally, breach of the National Code of Conduct alone is not sufficient for the making of an interim order; the relevant health complaints body must also be satisfied that the making of the order is necessary to avoid a serious risk to the health, safety or welfare of the public: see for example ss 90 and 91 of the *Health Complaints Act 2016* (Vic). In some jurisdictions that have enacted the National Code of Conduct such as Queensland, the test for the making of a prohibition order is prescribed by the relevant legislation, however the National Code of Conduct is a prescribed document that the health complaints entity may have regard to in determining the standard of services that should be provided by health service providers.

514 Costs were estimated on the basis of regulating all of the following occupations: ambulance services/paramedics, optical dispensers, dieticians, massage therapists, shiatsu, naturopaths, western herbal medicine, speech therapists and pathologists, audiologists, audiometrists, dental technicians, personal care assistants/assistants in nursing, anaesthetic technicians, social workers, reiki practitioners, arts therapy, exercise scientists and physiologists, sonographers, reflexology, infant massage instructors, cardiac scientists, medical laboratory scientists, emergency medical technicians, homeopaths, orthotists/prosthetists, orthoptics, hypnotherapy, medical photographers or illustrators, counselling and psychotherapy, music therapists, respiratory scientists, sleep technologists, pharmacy assistants.

515 Transcript, Brisbane Hearing, Amy Laffan,8 August 2019 from T4636.

510. The Secretary of the Department of Health, Ms Beauchamp explained to Melbourne Hearing 3 that the Department had done 'much work' on the Serious Incident Response Scheme, which was about ensuring that the Department had 'good information on who is affected by reportable assaults'.[516]

511. She told the Royal Commissioners that the Serious Incident Response Scheme and the idea of a screening or registration scheme were related. Ms Beauchamp said that a screening register or registration scheme would ensure that the Department was able to 'track workers through the aged care system'.[517] She said in October 2019 that the Department was 'looking to have something in place over the next 12 months, assuming that we can get legislation through Parliament and a range of other things done'.[518]

512. We note that the Serious Incident Response Scheme was originally proposed in October 2017 by Ms Kate Carnell AO and Professor Ron Paterson in their *Review of National Aged Care Quality Regulatory Processes* (**Carnell/Paterson Review**).[519] At Melbourne Hearing 3, which took place two years after the Carnell/Paterson Review, Senior Counsel Assisting suggested to Ms Beauchamp that there had been no sense of urgency on the part of the government in relation to establishing that scheme. Ms Beauchamp responded that the Department was working as hard as it possibly could 'to look at what occurs in other jurisdictions, other countries, and making sure that we are well-aligned with other workforces that do provide support for our most vulnerable' including the NDIS.[520] In January 2020, the Australian Government released the *Report on the Outcome of Public Consultation on the Serious Incident Response Scheme*, with 'next steps' noted as:

> Feedback from this consultation is being considered in detail by the department in consultation with key stakeholders to develop the final version of the SIRS model.[521]

513. Given that it is now two and a half years since the Carnell/Paterson Review and in light of all of the evidence that the Royal Commissioners have heard, Counsel Assisting submit that the Commonwealth should act quickly to establish both a Serious Incident Response Scheme and a national registration scheme for unregistered personal care workers.

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516 Transcript, Melbourne Hearing 3, Glenys Beauchamp, 18 October 2019 at T6281.29-31.

517 Transcript, Melbourne Hearing 3, Glenys Beauchamp, 18 October 2019 at T6281.31-35.

518 Transcript, Melbourne Hearing 3, Glenys Beauchamp, 18 October 2019 at T6282.01-04.

519 Exhibit 1-25, Adelaide Hearing 1, Kate Carnell and Ron Paterson, Review of National Aged Care Quality Regulatory Processes, October 2019, RCD.9999.0011.1833.

520 Transcript, Melbourne Hearing 3, Glenys Beauchamp, 18 October 2019 at T6282.29-36.

521 https://www.health.gov.au/sites/default/files/documents/2020/02/report-on-the-outcome-of-public-consultation-on-the-serious-incident-response-scheme-report-on-the-outcome-of-public-consultation-on-the-serious-incident-response-scheme-for-commonwealth-funded-residential-aged-care.pdf (accessed 20 February 2020).

What should the pre-conditions for registration be?

514. Clearly the detail of any registration scheme is very important. While we have proposed some features of the scheme in the proposed recommendation relating to registration, and we set out below some of the rationale for those features, there is further work to be done. The work of the Royal Commissioners in this regard is ongoing. As with all aspects of the Royal Commissioners' work, submissions from members of the public are welcome to inform that work.

Minimum skills

515. In Part 3 of these submissions we proposed a recommendation that all personal care workers have at least attained a relevant Certificate III prior to being able to perform aged care work. This should also be a requirement of registration.

Ongoing professional development

516. Counsel Assisting submit that, in addition, there should be a requirement that personal care workers participate in a specified number of hours of recognised professional development each year as a condition of maintaining their registration. The importance of continuing professional development across a range of areas is discussed in Part 3 of these submissions.

Proficiency in English

517. One of the requirements which we submit should be imposed on a personal care worker before they can be registered is proficiency in English. For each of the AHRPA registered health professions, English language proficiency is a requirement, although the particular standards vary between the professions.[522]

518. A theme in the evidence has been care recipients and family members informing the Royal Commissioners that they found it hard to understand what care workers were saying to them, especially over the telephone. For example, in the Sydney Hearing, a witness given the pseudonym 'DI' spoke of a telephone conversation with a care worker about whether DI's mother should be sent from the aged care facility to hospital. DI said that the care worker's 'English wasn't great, so it was very difficult to have an informed conversation with her'.[523]

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522 Australian Health Practitioner Regulation Agency, 'English Language Skills', https://www.ahpra.gov.au/Registration/Registration-Standards/English-language-skills.aspx, (accessed 20 February 2020).

523 Transcript, Sydney hearing, DI, 13 May 2019 at 14.80.11-27; see also at T1481.39-1482.8; Exhibit 3-35, Sydney hearing, Statement of DI, WIT.0101.0001.0001 at 0007 [42] and Exhibit 3-36, Sydney hearing, Statement of DJ, WIT.0190.0001.0001 at 0003 [21].

519. Similarly, at the Darwin Hearing, Ms Jo-Anne Lovegrove, was discussing her father's experience in an aged care facility in the Northern Territory, when she said:

> There appears to be quite a lot of staff that English is a second language [sic], and I see that my dad struggles to understand what they're trying to communicate to him and this can make him very aggravated. He has trouble hearing and it just creates such aggression and confusion for him.[524]

520. Clearly, an appropriate level of proficiency in spoken English is fundamental to being able to form the care worker/care recipient relationship that the evidence before the Royal Commissioners demonstrates is essential to high quality care.

521. At the same time, we have received evidence about the importance of diversity in aged care and the value of having a diverse workforce. We have received evidence about the value of care recipients being able to communicate in their own language. In Melbourne Hearing 2, Mr Angeli gave evidence about his mother's experience in care and said:

> Greek speakers would be awesome. All Greek speaking workers would be great, just so she can engage and have a conversation with people and understand when I guess things aren't the norm that what's going on, so she can have a say in her own treatment, in her own, I guess, her own life.[525]

522. In Adelaide Hearing 2, Ms Mary Patetsos gave evidence that referred to the increase in the proportion of overseas-born workers in aged and disability care.[526]

523. With this in mind, we need to give careful consideration to transitioning to requirements around English language and find an approach that supports quality and safe care, while also recognising the diversity of the workforce and the need to build the capability of that workforce.

Criminal history screening

524. We submit that it is also appropriate that there be a requirement for a personal care worker to have criminal history screening and background checks undertaken. This should require more than the police check that is currently required. It may extend to checking of information on a range of

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524 Transcript, Darwin and Cairns Hearing, Jo-Anne Mayse Lovegrove, 12 July 2019, T3357.22-25. See also Transcript, Mudgee hearing, Susan Margaret Hood, 5 November 2019, T6499.44 – 6500.4; Transcript, Hobart hearing, Diane Daniels, T6909.40-45 and 6910.32-36; Exhibit 13-21, Statement of Diane Daniels, Hobart hearing, WIT.0583.0001.0001 at 0009 [54] and 0010 [58].

525 Transcript, Melbourne Hearing 2, Angelos Angeli, 7 October 2019, T5276.11-15.

526 Exhibit 2-37, Adelaide Hearing 2, Statement of Mary Patetsos, WIT.0084.0001.0001 at 0011 [76].

relevant databases, such as the NDIS Worker Screening database, AHPRA and Health Complaints Commissioners.

525. It would also enable checking of an internal register of complaints and breaches of the code of conduct (see below).

Good Character

526. We submit that it is also appropriate that there be a requirement for a personal care worker to be of good character to be able to be registered. This should require more than the absence of a narrow range of criminal convictions as is presently the case. At the least, there should be no substantiated instances of misbehaviour such as that allegedly engaged in by 'UA' in the case study examined in Melbourne Hearing 3.[527] Counsel Assisting acknowledge that giving statutory effect to such a requirement will present challenges. However, there are similar requirements for care workers working as part of the National Disability Insurance Scheme which provide useful models. [528]

Compliance with a Code of Conduct

527. We submit that there should be a Code of Conduct for personal care workers, in the same way that there is for each of the AHPRA registered health professions and unregistered health workers. Complaints about non-compliance with the Code of Conduct should be the subject of investigation by the registering body and, if substantiated, have potential consequences, including suspension or restriction of registration. Consideration would need to be given to the interaction between this investigation function and the proposed Serious Incident Reporting Scheme.

528. This is similar to the approach that has been adopted in Victoria with its new Disability Worker Registration Scheme. It is also, of course, very similar to the AHPRA model.

What is the mechanism for any registration scheme?

529. As noted above, witnesses before the Royal Commissioners have expressed differing views as to the preferred mechanism to administer a registration scheme for personal care workers. Work on the preferable mechanism for any registration scheme is ongoing. Counsel Assisting's tentative view is that a National Board under AHPRA is not the correct body as personal care workers are not part of a health profession as that term is generally understood.

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527 Transcript, Melbourne Hearing 3, Japara Bayview case study, 17 October 2019 at T6105-6151.

528 For example, the Disability Worker Registration Scheme in Victoria.

Implementation and transition

530. This is a large proposed reform. There are a number of implications of implementing a registration scheme for personal care workers in aged care not the least of which is the overlap with other relevant workforces such as disability.

531. During Melbourne Hearing 3, Lisa Alcock raised concerns about a registration scheme placing 'the onus on the employee to meet safety screen mechanisms' and placing 'a barrier to entry'. Ms Alcock noted the 'cost and burden' on workers 'who are already in a particularly low-paid industry'.[529] Paul Gilbert noted the need for 'transitional arrangements for people's qualifications'.[530]

532. There would need to be work undertaken to transition to a registration scheme. Consideration may need to be given to staged transition. The existing aged care workforce would need support and time to transition to full registration.

533. There is a separate body of work being performed by the Royal Commissioners on transition to the new aged care system and Counsel Assisting will be in a position to make further submissions about these questions later in the year.

534. In addition, the costs of implementation also need to be considered and, of course, the question of who bears those costs. The Royal Commissioners are aware of the need to minimise the financial burden to the workforce and the need to avoid a registration scheme having negative consequences in terms of workforce supply.

529 Transcript, Melbourne Hearing 3, Lisa Alcock 16 October 2019 at T6008.13-17.

530 Transcript, Melbourne Hearing 3, Paul Gilbert, 16 October 2019, T6011 at T6011.10.

Part 5 Terms and conditions of employment

535. A consistent theme in the evidence before the Royal Commissioners has been that aged care workers are insufficiently remunerated for the work they perform and endure poor working conditions. We submit that these deficiencies need to be addressed so that:

a. this important work is appropriately rewarded; and

b. the sector becomes a more attractive one in which to work to improve both attraction of new employees and retention of existing ones.

Remuneration

536. In 2011, a Full Bench of what was then Fair Work Australia (**FWA**), concluded that 'a very significant proportion of the employees in the aged care sector are low-paid in that they are paid at or around the award rate of pay and at the lower award classification levels'.[531] The case before FWA was an application for a 'low paid authorisation' under the *Fair Work Act 2009* (Cth) by two unions representing over 60,000 aged care employees employed by over 300 aged care employers. We examine the case later in these submissions.

537. Trade union representatives are well placed to make observations about the terms and conditions of employment of their members. The Royal Commissioners received extensive evidence from representatives of relevant trade unions in the aged care sector.[532]

538. For example, Mr Paul Gilbert, Assistant Branch Secretary of the Australian Nurses and Midwifery Federation said:

> … the comment I hear when I go and have meetings is, 'I could get paid more working on the checkout at Aldi,' and it's technically true. And so they see themselves as – 'Why is my life treated as being – my – what I dedicate myself to being seen as of less worth than that position?'. And that's, interestingly, what they tend to compare themselves to, because they see those jobs advertised with an hourly rate of 24, 25 and 26 dollars.[533]

539. Ms Lisa Alcock, Industrial Officer with the HWU recounted two stories. The first was of a woman whose partner worked in an aluminium smelter in a role that required no specific education or training, and was paid $100,000 a year. By comparison, she had a TAFE qualification and was paid $21 an hour, which worked out to be about $40,000 a year 'at best with penalty rates and

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531 *United Voice and AWU, Queensland* (2011) 207 IR 251 at [19].

532 See for example, Exhibit 11-24, Melbourne Hearing 3, Statement of Carolyn Smith, WIT.0487.0001.0001 at 0002-.0003 [14]-[19]; Exhibit 11-21, Melbourne Hearing 3, Statement of Paul Gilbert, WIT.0430.0001.0001 at [44]-67; and Exhibit 11-22, Statement of Clare Tunney, WIT.0577.0001.0001 at [7]-[37].

533 Transcript, Melbourne Hearing 3, Paul Gilbert, 16 October 2019 at T5978.25-30.

loading'.[534] The other was of a woman who had to pay a man $150 an hour to clean her gutters, when she was only paid $21 an hour to clean a person.[535]

540. Ms Carolyn Smith, Secretary of the United Workers' Union[536] explained that, from her experience:

> Aged care workers are some of the lowest paid workers in Australia. This is significant problem for the industry and is recognised by providers and workers as an obstacle to genuine reform. The 2018 A Matter of Care Report found that direct care staff were paid significantly below the market median and were undervalued by at least 15%.
>
> Residential Care Workers are covered by the Aged Care Modern Award which provides minimum rates for a full time aged care worker ranging from $20.73 to $25.18 over seven steps. This is a relatively flat classification structure with the difference between the lowest and highest rates of pay being $169 per week, for a full time worker. As an hourly rate this is less than $5 per hour. This amount in no way reflects the increase in skills, experience and even qualifications gained by aged care workers over time.
>
> United Voice is party to more than 180 current and expired agreements in the aged care sector across Australia. Under our agreements the classification approximated with Aged Care Worker Level 1 under the award starts at $20.90 to $24.53 and Level 5 between $23.59 to $27.89. The majority of agreement-reliant Level 1 workers sit between $21.09 p/h and $22.49 p/h, with the $24.53 rate anomalous. The majority of agreement-reliant Level 5 workers sit between $23.59 to $24.92, with the rate of $27.89 being anomalous.[537]

541. Professor Sara Charlesworth has been researching the terms and conditions of care workers for a number of years.[538] Her view is that the low remuneration reflected the gendered nature of the work, because:

> it is assumed to be the work that women are born to do naturally and, as such, with paid care work being seen as equivalent to unpaid care work it's therefore viewed as something that a lot of women are capable of doing, and so that it's not particularly skilled work.[539]

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534 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T5979.44-5980.5.

535 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T5979.36-40.

536 Formerly United Voice.

537 Exhibit 11-24, Melbourne Hearing 3, Statement of Carolyn Smith, WIT.0487.0001.0001 at 0002-.0003 [17]-[19].

538 Exhibit 11-52, Melbourne Hearing 3, Statement of Professor Sara Charlesworth, WIT.0381.0001.0001 at [9]-[13.]

539 Transcript, Melbourne Hearing 3, Professor Sara Charlesworth, 16 October 2019 at T6085.36-44.

542. The low rate of remuneration directly affects both attraction and retention of aged care workers. In evidence that reflected much of what the Royal Commissioners heard from care workers themselves. Ms Alcock told us:

> workers in this industry enter it because they care deeply about providing high quality care to residents. I think it's probably true to say they don't enter the industry to earn incredible amounts of money; they know they're not going to come out with $100,000 a year. But we're not going to be able to retain workers unless we increase their rates of pay, and we make the industry safer. We're just not going to be able to retain workers, and we're not going to be able to generate and attract the next generation of high quality workers either. I think from the HWUs perspective we need to increase funding and that funding needs to be directly linked to wage increases and increases in staffing as we've discussed today.[540]

543. This evidence is broadly supported by home care worker Ms Janice Hilton, who warned:

> Our pay doesn't keep up with the cost of living so we're attracting the wrong sort of people into the positions now.[541]

544. A number of aged care providers also referred to the need to increase remuneration for aged care work alongside other changes to meet the future needs of the sector. Nicolas Mersiades, Director of Aged Care at Catholic Health Australia expressed the view that:

> much greater attention will be required to workforce training and development, including opportunities for continuous staff development, and to terms and conditions of employment and remuneration if the aged care sector is to be equipped to attract and retain the almost three-fold increase in the formal aged care workforce (to 980,000) that the Productivity Commission estimates will be required by 2050.[542]

545. Evidence from both approved providers and their representatives was that providers would love to pay their staff higher wages, but that they are constrained by the amount of funding provided by the Commonwealth government.[543] This is a reason providers give to unions for being unable to increase wages.[544] The implication from that statement appears to be that, if

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540 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T6017.18-27.

541 Transcript, Melbourne Hearing 3, Janice Hilton, 17 October 2019 at T6158.16-17.

542 Exhibit 1-50, Adelaide Hearing 1, Statement of Nicholas George Mersiades, WIT.0011.0001.0001 at 0013 [59].

543 Exhibit 11-23, Melbourne Hearing 3, Statement of Jenna Field, WIT.0363.0001.0001 at 0005 [24]; Transcript, Melbourne Hearing 3, Darren Mathewson, 16 October 2019 at T5996.28-30. See also Exhibit 11-62, Melbourne Hearing 3, Statement of Richard Hearn, WIT.0440.0001.0001 at .0006 [25].

544 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T5975.9-13.

the Commonwealth were to increase funding, approved providers would pass on at least part of that increase to workers.

546. However, the evidence of Mr Gilbert of the ANMF was that there have been three times, in his 24 years' industrial experience, where 'the Commonwealth Government has increased taxpayer subsidies to aged care to improve wages, and not once did that deliver a dollar in improved wages'.[545] There is evidence of two such occasions when this has occurred.

547. The first was in 2002/3. The federal budget allocated $211 million over 4 years for increased subsidies to:

> allow providers of aged care to attract and retain more aged care nurses by offering them pay rates closer to those of nurses in the public hospital sector.[546]

548. The second was more recently, in the 2012/13 federal budget. The sum of $1.2 billion was provided over 5 years to address workforce pressures in aged care.[547] This was delivered by way of a 'workforce compact' in an attempt to improve wages for aged care workers in order to retain existing workers and encourage new workers.

549. There is no evidence that either initiative resulted in improved wages in the sector.

550. This evidence suggests that merely increasing the level of subsidies paid to providers without more is unlikely to translate into higher levels of remuneration for the workforce.

551. Mr Wann of the Department of Health admitted that the Department of Health 'does not have full visibility of the remuneration and working conditions applicable to the hundreds of thousands of aged care workers across the country at any one point in time'. He was of the view that 'issues relating to remuneration and working conditions are matters for providers as employers'.[548]

552. In our submission, while that is strictly correct, Mr Wann's statement seriously discounts the important role of the Commonwealth government as funder of the aged care system. As Mr Mersiades put it:

> The role of government in relation to the aged care workforce in many respects is the same as for other sectors of the economy. That is, pulling its economy-wide levers to secure a strong economy and funding and

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545 Transcript, Melbourne Hearing 3, Paul Gilbert, 16 October 2019 at T5997.7-10; Exhibit 11-21, Melbourne Hearing 3, Statement of Paul Gilbert, WIT.0430.0001.0001 at 0007 [32].

546 Transcript, Melbourne Hearing 3, Paul Gilbert, 16 October 2019 at T5998.5-8.

547 Transcript, Melbourne Hearing 3, Paul Gilbert, 16 October 2019 at T5997.15-20.

548 Exhibit 11-72, Melbourne Hearing 3, Statement of Charles Wann, WIT.0379.0001.0001 at 0022 [100].

> regulating the higher education and vocational education and training (VET) sectors.
>
> The significant difference that distinguishes the aged care sector from most other sectors of the economy is that the government is also the primary funder and regulator, and therefore directly and significantly influences the viability of employers through its regulation of care prices and revenues.
>
> How the government performs its funding and regulatory role therefore influences the aged care sector's capacity to compete in the labour market, to create attractive work places, and to foster a positive image of aged care as a career for potential employees.[549]

553. When asked what role the Commonwealth has in improving the conditions and the remuneration of aged care workers in Australia, Professor Charlesworth said:

> It has a huge potential role but in fact over the years, because there have been inadequate rises … there has been inadequate accounting for normal rises to wages, particularly through the national minimum wage case, which is the main way that wage rises are received if they're frontline care workforce, and by not paying indexation some years, by paying part of indexation, by not paying CPI wage increases, providers don't have the money to be able to pay better.[550]

Industrial mechanisms to increase wages

554. Apart from the gendered nature of care work, another key factor in the systemically low remuneration of the sector is the limitations inherent in the modern industrial system. Evidence about this was received from Professor Charlesworth (from an academic perspective), Darren Mathewson from Aged and Community Services Australia, and Jenna Field from LASA (from an approved provider perspective) and Clare Tunney, Lisa Alcock and Paul Gilbert (from an employee perspective).

555. The two main industrial mechanisms these various witnesses spoke of were industrial awards and enterprise agreements. The Australian industrial relations system under the *Fair Work Act 2009* (Cth) provides for a guaranteed safety net of minimum terms and conditions of employment primarily through modern awards.[551] Terms and conditions that exceed those minimum requirements are to be bargained for through enterprise-level collective bargaining.

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549 Exhibit 1-50, Adelaide Hearing 1, Statement of Nicholas George Mersiades, WIT.0011.0001.0001 at 0013 [60]-[62].

550 Transcript, Melbourne Hearing 3, Professor Sara Charlesworth, 16 October 2019 at T6086.13-19.

551 *Fair Work Act 2009* (Cth), s 3(b); 5(4).

Awards

556. There was evidence that the 'modern awards' which cover aged care workers are not presently adequate.[552] The *Social, Community, Home Care and Disability Services Award 2010* (relevantly) covers home care workers,[553] and the *Aged Care Award 2010* covers aged care workers in residential aged care facilities.[554] In addition, the *Nurses Award 2010* covers nurses.[555]

557. As a safety net, modern awards set the minimum pay rates for workers covered by the relevant award. In the case of personal care workers working in a residential environment, that rate is only $2.09 an hour more than National Minimum Wage.[556] For personal care workers working in a home care setting, that rate is only $1.49 an hour more than the minimum wage.[557] In circumstances where it is extremely difficult to negotiate wage increases through an enterprise agreement (see below), the award rates operate in practice as the default rates of pay, rather than as part of a minimum safety net.

558. The process for reviewing modern awards was described by Professor Charlesworth as a 'long, tortuous process',[558] which has only resulted in 'piecemeal improvement' since 'award modernisation' commenced in 2009/2010.[559] Professor Charlesworth said that:

> at the moment, and this is both employers and unions, are spending an enormous amount of resources in this modern award process and it's just inching forward and, as I said, over the time since the modern awards came in, 2010, there have been some very small improvements in conditions but they are not improvements over and above that had existed prior to award modernisation, certainly in some awards.[560]

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552 See, e.g., Ex 11-24, Melbourne Hearing 3, Statement of Carolyn Smith, WIT.0487.0001.0001 at 0002-.0003 [17]-[19].

553 Exhibit 11-52, Melbourne Hearing 3, Statement of Professor Sara Charlesworth, WIT.0381.0001.0001 at 0006 [21].

554 Exhibit 11-52, Melbourne Hearing 3, Statement of Professor Sara Charlesworth, WIT.0381.0001.0001 at 0008[27].

555 Exhibit 11-23, Melbourne Hearing 3, Statement of Jenna Field, WIT.0363.0001.0001 at 0003[16].

556 Exhibit 11-52, Melbourne Hearing 3, Statement of Professor Sara Charlesworth, WIT.0381.0001.0001 at 0008 [28].

557 Exhibit 11-52, Melbourne Hearing 3, Statement of Professor Sara Charlesworth, WIT.0381.0001.0001 at 0008 [28].

558 Transcript, Melbourne Hearing 3, Professor Sara Charlesworth, 16 October 2019 at T6086.43.

559 Exhibit 11-52, Melbourne Hearing 3, Statement of Professor Sara Charlesworth, WIT.0381.0001.0001 at 0007 [25]-[26].

560 Transcript, Melbourne Hearing 3, Professor Sara Charlesworth, 16 October 2019 at T6087.39-44.

559. The other issue identified by Professor Charlesworth was the job classification structure in the awards. Professor Charlesworth described them as 'very meagre',[561] and went on to say that:

> For home care workers they're required to have basic oral communication skills [in the Award]. That seems absolutely ridiculous; they need highly developed communication skills. They need to be able to talk to somebody, maybe a new client, the first time they meet them who is very anxious about having someone in their home. They need to have the communication skills to be able to put someone at their ease, to work out fairly quickly how somebody likes to be spoken to ... The way that the skills are described in a very rudimentary way in both awards really fails to acknowledge the complexity of the work that is being done, the judgment and the deep knowledge that people have to have about working with – if you just think of just straight body, intimate body work with a variety of older people who have not just different needs as individuals, but have different needs on different days at different times of the day.[562]

560. As will be seen later in these submissions, in one significant case before the Fair Work Commission significant amendments were made to the *Social, Community, Home Care and Disability Services Award 2010*. These amendments delivered significant pay rises to care workers.

Enterprise Agreements

561. There was evidence of the many reasons why the enterprise bargaining system is not working to increase wages in aged care. These included:

- the Commonwealth provides the majority of the funding, and approved providers are unable to afford wage increases within the funding framework;[563]
- a decentralised workforce which makes organising and collective discussion very difficult;[564]
- employees have a reluctance to take industrial action, as it may cause a risk to the health and safety of the residents or clients for whom they care;[565] and

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561 Transcript, Melbourne Hearing 3, Professor Sara Charlesworth, 16 October 2019 at T6087.38-39.

562 Transcript, Melbourne Hearing 3, Professor Sara Charlesworth, 16 October 2019 at T6091.12-27.

563 Transcript, Melbourne Hearing 3, Darren Mathewson, 16 October 2019 at T5984.39-47; T6003.4-7.

564 Transcript, Melbourne Hearing 3, Professor Sara Charlesworth, 16 October 2019 at T6087.16-19; Transcript, Melbourne Hearing 3, Clare Tunney, 16 October 2019 at T5990.39-42.

565 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T5991.29-34.

- workers who are already low paid may not be able to afford the income reduction that results from taking industrial action.[566]

562. As Clare Tunney of United Voice explained:

> We have not found enterprise bargaining to be an effective means to increase the pay and conditions of the majority of workers in the aged care sector. Today, not only are we struggling to maintain existing terms and conditions with many providers, but we are also seeing the erosion of these conditions.[567]

563. Professor Charlesworth agreed, stating that 'enterprise bargaining is not practical … particularly in home care. … In home care, it's almost impossible'.[568] She explained that this is in part due to the nature of home work: workers communicate via a smart phone and there is very little opportunity for unions to organise.

564. The Aged Care Workforce Strategy Taskforce report observed that wages in aged care are significantly lower than comparable wages in the acute health sector. Estimates of the differential vary between 10% and 15% on the evidence.[569] What is so concerning about this evidence is that, based on the responsibilities nurses have in aged care settings where they are required to work often without the support that would be present in a hospital and they are dealing with the very challenging clinical needs of the residents, one might expect them to be paid more than their hospital counterparts and not less.

565. We submit that these differentials must be addressed to ensure that workers with aptitude, skills and training are attracted to and remain within the aged care sector. The sector must become an employer of choice. However, addressing the wages gap is far from easy as you heard this morning from Professor Harrington and Dr Ravenswood.

566. These factors that are specific to the aged care sector need to be seen against a broader background of what is a sustained period of historically low wage growth. The authors of a recent book about the subject note that in recent years, 'private sector Wage Price Index growth has been especially weak, languishing below 2% (on a year-over-year basis) since 2016'.[570]

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566 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T5991.21-27.

567 Exhibit 11-22, Melbourne Hearing 3, Statement of Clare Tunney, WIT.0577.0001.0001 at 0007 [25].

568 Transcript, Melbourne Hearing 3, Professor Sara Charlesworth, 16 October 2019 at T6087.16-21.

569 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 205, ACW.9999.0001.0022 at .0121

570 J. Stanford, 'Charting Wage Stagnation in Australia' in A. Stewart et al (2018), *The Wages Crisis in Australia* (University of Adelaide), p 23.

Other mechanisms for improving remuneration levels

Equal Remuneration Order

567. In the cases in recent years in which substantial pay rises have been obtained by care workers, active engagement by the government has been vital. One concerned an Australian application for an equal remuneration order and the second was a similar application in New Zealand.

SACS case

568. The first case involved Social and Community Service (**SACS**) workers in Australia. In 2010, five unions led by the Australian Services Union applied to Fair Work Australia (**FWA**)[571] for an equal remuneration order under Part 2-7 of the *Fair Work Act 2009* (Cth). The SACS case, as it is known, was ultimately successful and delivered a significant number of employees employed under the SCHADS Award pay increases of between 19% and 41% in Modern Award pay rates phased in over eight years.[572]

569. The employees concerned performed care work in the community service sector. FWA noted that 'more than 80% of the employees in the industry are female'.[573] There was extensive evidence before FWA that 'the funding structures, the size and geographical spread of workplaces and enterprises and the industrially passive nature of the industry made access to enterprise bargaining difficult'.[574] The evidence before the Royal Commissioners is that the aged care sector shares all of these features.

570. FWA summarised the ASU's case as follows:

> the SACS industry is female dominated, …the work in the industry is undervalued and that there is a causal relationship between those two things – the undervaluation arises because it is a female dominated industry.[575]

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571 Fair Work Australia was subsequently renamed the Fair Work Commission.

572 *ASU v Australian Business Industrial (Re Equal Remuneration Case)* (2012) 207 IR 446. For a detailed discussion of the case, see Cortis, N and Meagher, G (2012) 'Recognition at Last: Care Work and the Equal Remuneration Case' 54(3) *Journal of Industrial Relations* 377; for a broader discussion of equal remuneration under the *Fair Work Act 2009* (Cth), see Smith, M and Stewart, A, 'A New Dawn for Pay Equity? Developing an Equal Remuneration Principle under the Fair Work Act; (2009-10) 23 *Australian Journal of Labour Law* 152.

573 *ASU v Australian Business Industrial (Re Equal Remuneration Case)* (2012) 208 IR 446 at [31]. For more detail about the industry, see [167]-[169]; [225].

574 *ASU v Australian Business Industrial (Re Equal Remuneration Case)* (2012) 208 IR 446 at [170]-[174].

575 *ASU v Australian Business Industrial (Re Equal Remuneration Case)* (2012) 208 IR 446 at [30].

571. This was the case that was ultimately accepted by FWA.[576] FWA was 'in no doubt that gender has an important influence' in the gap between pay in the social, community and disability service industry and that in State and local government employment'. This was based on the evidence that the work was caring work. Smith and Stewart summarise the reasoning in the SACS case as follows:

> much of the work is caring work; that such a characterisation can contribute to, that devaluation of work; that work in the sector was indeed undervalued; and given that caring work has a female characterisation, that the undervaluation was gender-based.[577]

572. The Royal Commissioners have heard evidence about the female characterisation of aged care work, in particular, home care work, in Melbourne Hearing 3 from Professor Charlesworth, who described:

> the gendered norms that underpin the devaluation of care work are premised on an ideology of domesticity that positions the care women do, both in home and as paid work, as natural and therefore unskilled.[578]

573. Professor Charlesworth gave evidence that home care workers feel that society does not value their role and that often do not feel valued by their employers.[579]

574. In the SACS case, the Commonwealth submitted that:

> the remuneration of employees in the SACS industry has been undervalued and that a gender-neutral rate of remuneration that reflects the value of work performed, but which excludes other factors such as labour market attraction or retention rates and productivity should be fixed.[580]

575. FWA noted that there was:

> considerable evidence in this matter and widespread acceptance by the parties that a major reason for the actual wage rates in the SACS industry is the level of funding provided by governments.[581]

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576 *ASU v Australian Business Industrial (Re Equal Remuneration Case)* (2012) 208 IR 446 at [245]-[290].

577 Smith, M and Stewart A 'Shall I compare thee to a fitter and turner? The role of comparators in pay equity regulation' (2017) 30 *Australian Journal of Labour Law* 113 at 129; see also Cortis, N and Meagher, G (2012) 'Recognition at Last: Care Work and the Equal Remuneration Case' 54(3) *Journal of Industrial Relations* 377.

578 Exhibit 11-52, Melbourne Hearing 3, Statement of Sara Charlesworth, WIT.0381.0002.0001 [15].

579 Transcript, Melbourne hearing 3, Sara Charlesworth, 16 October 2019, T6085 29-44.

580 *ASU v Australian Business Industrial (Re Equal Remuneration Case)* (2012) 208 IR 446 at [123].

581 *ASU v Australian Business Industrial (Re Equal Remuneration Case)* (2012) 208 IR 446 at [270].

576. In the second part of the SACS case,[582] FWA received a joint submission from the applicant unions and the Commonwealth government. FWA noted an announcement by the Prime Minister in November 2011 that 'the Australian government would provide over $2 billion during the six-year implementation period'.[583] The ultimate cost was approximately $3 billion.[584]

577. The Commonwealth and the unions jointly proposed an outcome which was largely accepted by the FWA. FWA made orders accordingly.

578. Commentators have noted that 'the success of the [SACS] case was widely seen to have hinged on securing federal government engagement from the outset'.[585]

579. However, in a subsequent case seeking a similar order for early childhood workers, the Fair Work Commission significantly changed the law by requiring evidence of an appropriate comparator before deciding if any pay differential was gender-related.[586] According to Creighton and Stewart, the FWC's new interpretation 'plainly created significant impediments to the success of industry-wide claims of the type advanced in this case'.[587]

The New Zealand Pay Settlement

580. In June 2017 a settlement was reached in New Zealand between government bodies, employer representatives, employee representatives which led to a pay rise for aged and disability residential care and home and community services workers of between 15% and 50%, depending on a worker's qualifications and experience.[588] There was also some additional funding for training. The settlement followed a pay equity claim which had been made by an aged care worker, Kristine Bartlett, on the basis of what she alleged was the systemic devaluation of the work she performed because it was mainly performed by women.

581. Following on from the settlement, the *Care and Support Workers (Pay Equity Settlement) Act 2017* (NZ) (**the NZ Act**) was introduced to implement

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582 *ASU v Australian Business Industrial (Re Equal Remuneration Case)* (2012) 208 IR 446.

583 *ASU v Australian Business Industrial (Re Equal Remuneration Case)* (2012) 208 IR 446 at [14].

584 *Social and Community Services Pay Equity Special Account Act 2012* (Cth); Smith, M and Stewart A 'Shall I compare thee to a fitter and turner? The role of comparators in pay equity regulation' (2017) 30 *Australian Journal of Labour Law* 113 at 129.

585 MacDonald, F et al (2018), 'Access to Collective Bargaining for Low-Paid Workers' in McCrystal S et al (eds), *Collective Bargaining under the Fair Work Act* (Federation Press, 2018), at 223.

586 *Equal Remuneration Decision 2015* [2015] FWCFB 8200 – see generally Smith M and Stewart A, 'Shall I compare thee to a fitter and turner? The role of comparators in pay equity regulation' (2017) 30 *Australian Journal of Labour Law* 113.

587 Stewart A et al (2016), *Creighton and Stewart's Labour Law* (6th ed) at [15.44].

588 See *Terranova Homes and Care v Service and Food Workers Union and Kristine Bartlett*, CA631/2013 [2014] NZCA 516.

changes to funding, wages and training for care and support workers in residential aged care, home and community care, and disability support.

582. In her evidence to the Royal Commissioners, Dr Ravenswood highlights that whilst there is limited evidence of how the implementation of the NZ Act impacted on the quality of care provided to clients:

> Where [the NZ Act] was implemented as intended with higher wages, no reduction in weekly hours (unless chosen by the healthcare assistant), and guaranteed training opportunities [the NZ Act] had a significant positive impact on the workforce. Healthcare assistants' wages increased to a level where some spoke of being able to afford basic items such as reading glasses, could work fewer hours (some worked long weekly hours to make enough money) and spend more time with family, some could save up for holidays (Douglas and Ravenswood, 2019).

583. Dr Ravenswood considers the decision by the government to intervene in the settlement and the legislative changes which followed, 'marked a change' to the otherwise 'distant approach' the New Zealand government has had on domestic supply chains and it is an example of how government can become involved in employment matters.

584. However, there were unintended consequences of the NZ Act. These included an increased workload and work intensification by residential aged care providers as staff numbers are reduced, a reduction in training and education compared to what had been offered previously (and the offering of online courses instead of on the job or face to face training) and the recruitment of new employees who were on the lowest tier of wages prescribed. Workers were also indirectly restricted from changing employer as the wage level they receive is based on their level of experience with their current employer.[589]

585. We submit that there is much that Australia can learn from the New Zealand experience. Plainly, increases in wages and allocating funding to training will not be enough. We must look to our existing mechanisms to the extent that they are able prioritise labour standards. Where they are unable to do so, we ought to consider what is needed. Further, we must reconceptualise the role of government in regulating employment standards in aged care. And, as Dr Ravenswood has told us, we must include the voice of the worker and the older person in any changes we make.[590]

Low Paid Bargaining under the Fair Work Act 2009 (Cth)

586. A third case concerned the Australian aged care industry directly. It involved an application under Division 9 of Part 2-4 of the *Fair Work Act 2009* (Cth) by

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589 Exhibit 15-2, Adelaide Hearing 3, Statement of Katherine Ravenswood, RCD.0011.0043.0008.

590 Exhibit 15-2, Adelaide Hearing 3, Statement of Katherine Ravenswood, RCD.0011.0043.0010.

unions representing aged care workers in Queensland for a 'low wage bargaining order'.[591]

587. When it was introduced in 2010, the 'low paid bargaining stream' in Division 9 of Part 2-4 of the *Fair Work Act 2009* (Cth) was hailed by some commentators as part of the 're-regulation of collective bargaining'.[592] A leading labour law text observes that 'the low-paid stream certainly represents an important departure from the overwhelming focus on promoting bargaining at the *enterprise* level under the FW Act…'.[593]

588. Of particular importance in this regard, is s 246(3) of the *Fair Work Act 2009* (Cth) which empowered Fair Work Australia to direct a third party that is not an employer to attend a conference if satisfied that:

> the person exercises such a degree of control over the terms and conditions of the employees …that the participation of the person in bargaining is necessary for the agreement to be made.

589. As noted above, FWA accepted that aged care workers were 'low-paid employees' which was a threshold question. The FWA concluded that the phrase is 'intended to be a reference to employees who are paid at around the award rate of pay and who are paid at the lower award classification levels'.[594] One of the matters to which FWA was required to consider in determining the application was 'the extent to which the terms and conditions of employment of the employees who will be covered by the agreement is controlled, directed or influenced by a person other than the employer, or employers, who will be covered by the agreement' (s 243(3)(d)). The FWA concluded that:

> there is no doubt that funding plays a pervasive role in workplace relations in the sector. The level of funding is a significant consideration when employers make decisions in relation to wages and conditions to be afforded to their employees. The Australian government plays the dominant role in the provision of funds.[595]

590. Although FWA ultimately granted the authorization, it excluded many employers on the basis that they were already covered by agreements under the Act. Creighton and Stewart observe that 'the stringent tests for accessing the unique scheme of multi-employer bargaining …mean that its use … has been quite limited'.[596] MacDonald et al (2018) concluded that 'realising the

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591 See *United Voice v AWU, Qld* (2011) 207 IR 251. For a general discussion of Div 9 of Part 2-4 of the *Fair Work Act 2009,* see Stewart A et al (2016), *Creighton and Stewart's Labour Law* (6th ed) at [25.56]-[25.65].

592 R Cooper and B Ellem, 'Fair Work and the Re-regulation of Collective Bargaining', *Australian Journal of Labour Law,* 2009, Vol 22, 284, 299-304.

593 Stewart A et al (2016), *Creighton and Stewart's Labour Law* (6th ed) at [25.65].

594 *United Voice and AWU, Queensland* (2011) 207 IR 251 at [17].

595 *United Voice and AWU, Queensland* (2011) 207 IR 251 at [33].

596 Stewart A et al (2016), *Creighton and Stewart's Labour Law* (6th ed) at [25.65].

potential of the low-paid bargaining provisions in the FW Act has proven elusive'.[597]

591. On 18 February 2020, staff of the Royal Commission held an informal workshop with a number of Australia's leading labour law academics. The participants were:

- Professor Andrew Stewart, Adelaide University;
- Professor Meg Smith, Queensland University of Technology;
- Professor Fiona McDonald, RMIT University;
- Senior Lecturer Tess Hardy, University of Melbourne; and
- Professor Paula McDonald, Queensland University of Technology.

592. They were asked to assume that it is desirable for the levels of remuneration, classification structures, levels of training and career paths of aged care workers to be improved. They were asked about the best available mechanism under the current law to achieve these outcomes. The advice from this group was that, for the reasons discussed above, neither the low wage bargaining steam nor equal remuneration orders were likely to be fruitful. They considered that it may be possible to amend the three awards applying to aged care workers to effect such improvements. However, they advised that history suggests that, without strong federal government commitment and a co-operative approach that involves the employers, unions and care recipients, success will be elusive.

593. We will return to the issue of the important leadership role of the Commonwealth government in Part 6 of these submissions.

Employment conditions generally

594. Mr Gilbert said that:

> With the right incentives (decent minimum standards, professional recognition, low or no fees, and career paths) people will want to work in aged care and, over time, seek out the education opportunities required.[598]

595. Ms Tunney explained that her union's members:

> report that they are provided with fewer types of training, and that training is occurring less frequently. Furthermore, some training that used to be conducted face-to-face is now being provided online. Often, workers are required to complete online training outside of work hours.[599]

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597 MacDonald, F et al, (2018), 'Access to Collective Bargaining for Low-Paid Workers' in McCrystal, S et al (eds), *Collective Bargaining under the Fair Work Act,* at 217.

598 Exhibit 11-21, Melbourne Hearing 3, Statement of Paul Gilbert, WIT.0430.0001.0001 at 0038 [213].

599 Exhibit 11-22, Melbourne Hearing 3, Statement of Clare Tunney, WIT.0577.0001.0001 at 0006 [24a].

596. During Melbourne Hearing 3, Ms Tunney said:

> We consistently hear that they're concerned about low pay, the erosion of existing conditions, that they don't have adequate training, they don't have manageable workloads, that there aren't enough staff on the floor and that they have significant concerns about job security.[600]

Travel time

597. An important issue that was raised by a number of witnesses was payment for travel time for home care workers. There is no provision for paid travel time between clients in the *Social, Community, Home Care and Disability Services Award 2010*, and consequently, as the vast majority of home care workers are not covered by an enterprise agreement, they do not receive it.[601]

598. Ms Alcock told the Royal Commissioners that:

> There are women right now, sitting in their cars, waiting to go into someone's home and not being paid for that time. And that isn't their time. So they're not paid for kilometres travelled. They're not paid to travel between homes. That's not their time, and they're not paid for any of that work.[602]

599. Home care worker, Ms Hilton gave evidence of her personal experience, which was that although she was paid some allowance towards travel time, that did not always reflect the reality:

> The travel time between clients' homes isn't right. They might have me down for ten minutes, but it will take me twenty minutes to get there. I don't get paid for the wear and tear on my car.[603]

600. Professor Charlesworth described her experience of researching payment for travel time for home care workers in Australia and internationally.[604] Her evidence was that the issue of travel time went directly to the question of whether personal care work was valued:

> I think the whole issue of travel time is absolutely – it's very revealing about the lack of value we accord home care workers' work. It's hard to think of any other job where you are required to travel from client to client and you are not paid for your travel time. You are recompensed for your

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600 Transcript, Melbourne Hearing 3, Clare Tunney, 16 October 2019 at T5976.28-31.

601 Exhibit 11-20, Melbourne Hearing 3, Statement of Lisa Alcock, WIT.0463.0001.0001 at 0006 [33].

602 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T5999.47-6000.4.

603 Transcript, Melbourne Hearing 3, Janice Hilton, 17 October 2019 at T6156.17-19.

604 Transcript, Melbourne Hearing 3, Professor Sara Charlesworth, 16 October 2019 at T6089.12-38.

> mileage when you travel, when you use your own car, which home care workers do but you are not paid for your travel time.[605]

Split shifts

601. A related issue for home care workers which was raised in the evidence was that of the split shift arrangements available under the *Social, Community, Home Care and Disability Services Award 2010*. The consequence of this provision is that workers are only paid for the time they are tending to clients, not for wait times in between.[606] Ms Alcock described the situation as follows:

> For a part-time employee – because in my experience those workers are not engaged as casuals, they are engaged as part-time employees, there is no minimum period of engagement. So they can be engaged on the split shift provisions for, say, 30 minutes or an hour at a time over, say, 12 hours, and they're not paid for the time between people – between those shifts.[607]

Low hour contracts

602. Many aged care employees work on low hour part time contracts that can be increased by their employer,[608] leading to reduced certainty and security of hours but providing what Ms Alcock described as 'maximum flexibility for the employer to change the way they roster that flexibility into the workplace'.[609] Ms Hilton gave evidence of the effect that this arrangement has on her life:

> I'm on a 30-hour contract fortnightly, which can be up to 39 hours fortnightly. If I ask – if I get asked to do extra shifts, I do them, if I can. I have foster children, one with a disability. So I need to spend time with them as well. Rosters are changing regularly, which makes it difficult to try and have some work-life balance and plan ahead for events.[610]

Daily risk of assault

603. The Royal Commissioners heard evidence of the daily risk that aged care workers face, of assault by the very people they are there to care for. Ms Kathryn Nobes is a care worker who has worked in aged care since 2015. Her evidence to the Sydney hearings was that she and her co-workers were exposed to regular assaults by the people living with dementia that they look after. She explained that the working conditions that she and her colleagues endure impact on the quality of care they are able to provide. Ms Nobes

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605 Transcript, Melbourne Hearing 3, Professor Sara Charlesworth, 16 October 2019 at T6089.12-17.

606 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T6005.26-30.

607 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T6005.31-36.

608 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T5981.40-43.

609 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T5982.1-3.

610 Transcript, Melbourne Hearing 3, Janice Hilton, 17 October 2019 at T6155.32-36.

called for more training about dementia for care workers in part to address this risk.[611]

604. Ms Alcock described the situation as:

> I think we have a culture at the moment which accepts that in aged care and social community – that if you work in this industry, you should be prepared to be assaulted and sexually assaulted on a weekly basis.[612]

605. Ms Tunney agreed, and drew particular attention to the situation faced by home care workers:

> Yes, we repeatedly hear from aged care workers and particularly home care workers that they regularly experience assaults. The home care workers are particularly vulnerable because they're in private residences, they are exposed to difficult situations both with the clients that they care for but also the families of clients, and also they have, as Ms Alcock has outlined, they don't have any control over the actual work spaces that they work in and the sorts of hazards that they are exposed to also like heat – excessive heat and cigarette smoke, those sorts of things.[613]

606. Counsel Assisting note that research about the NDIS workforce reveals similar concerns. For example, a September 2019 report which examined the impact of the NDIS delivery model on working conditions concluded that disability support workers are 'experiencing increased levels of violence at work'.[614] The authors noted that:

> The frequency of violence from clients, the general absence of reliable reporting systems, and the inadequacy of training, support and back-up for [disability support workers] are all exacerbated by the fragmented model of service delivery inherent to the NDIS's marketised model.[615]

607. Mr Gilbert of the ANMF described assaults in aged care as 'very common'. His evidence was that:

> There are a couple of aspects to it. I think sometimes you [can] be assaulted … because you happen to be down doing up somebody's shoe laces and it's a matter of convenience. … I've been assaulted – in my history – in that same circumstance. On other occasions, it's a consequence of being rushed. People are rushing people to comply with their timelines and that's creating a situation where someone who has already got issues around their mental competence is getting frustrated

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611 Exhibit 3-28, Sydney Hearing, Statement of Kathryn Nobes, WIT.0143.0001.0001 at .0004 [22b].

612 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T6001.15-18.

613 Transcript, Melbourne Hearing 3, Clare Tunney, 16 October 2019 at T6006.36-42.

614 Prof D. Baines et al (2019), *Precarity and Job Instability on the Frontlines of NDIS Support Work,* (The Centre for Future Work), pp 6 and 26-28.

615 Prof d. Baines et al (2019), *Precarity and Job Instability on the Frontlines of NDIS Support Work,* (The Centre for Future Work), p 27.

> and angry at being forced down a path and that's a consequence of being rushed. People are getting six minutes to get a resident out of bed, washed, in a chair, in a lounge room. It's just madness.[616]

608. Ms Alcock highlighted the seriousness of the problem, stating that:

> I'm convinced that we will potentially have a death in residential aged care unless we address occupational health and safety seriously.[617]

609. The 2016 Aged Care Workforce Census surveyed participants about occupational health and safety in aged care.[618] Around a quarter of respondents 'raised OHS concerns' ranging from manual handling concerns and overwork caused by staff shortages.[619]

610. Similarly, in its 2017 report entitled 'Future of Australia's aged care sector workforce', the Senate's Community Affairs Reference Committee was:

> concerned at the evidence presented to it in relation to poor working conditions and threats to workers' health and safety, which the Committee has heard are impacted by issues including insufficient staffing levels and the need for existing staff to cover staff shortages. These issues in turn impact on quality of care, and contribute to the poor reputation of the industry. [620]

611. The Committee concluded that:

> poor working conditions [are] an urgent matter given the impacts on the need to grow and sustain the aged care workforce and on the ability of staff to deliver a standard of care expected by the community.[621]

Physical work

612. Ms Janice Hilton described doing 'six hours of cleaning without a break' and described her work in aged care as 'physically demanding, especially in a heatwave'.[622]

613. Ms Lavina Laboya, an aged care worker, told the Royal Commissioners that she had been warned by more experienced workers that she should leave the profession if she wanted to avoid back problems:

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616 Transcript, Melbourne Hearing 3, Paul Gilbert, 16 October 2019 at T6012.1-9.

617 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T6017.35-37.

618 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 89, CTH.0001.1001.2805 at 2969.

619 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 89, CTH.0001.1001.2805 at 2970-2971.

620 Senate Community Affairs Reference Committee, *Future of Australia's aged care sector workforce,* 2017, p 49. The evidence is summarised at paras 3.23 – 3.29.

621 Senate Community Affairs Reference Committee, *Future of Australia's aged care sector workforce*, 2017, p 49.

622 Transcript, Melbourne Hearing 3, Janice Hilton, 17 October 2019 at T6153.34-35.

> My back and my shoulder are always sore and I worry that if I injury my back while I am young, I won't be able to get a job after that. A lot of the people I work with are much older than me and they tell me to get out and save my back. If there were more staff and better equipment I might stay in aged care but management refuse to acknowledge that there is a problem.[623]

614. Ms Laboya also described the pressures of working in an under resourced environment, both in terms of staff and equipment:

> During the morning shift at both facilities there isn't enough time to spend with each resident, and other staff and I spent each around 10 to 15 minutes with the residents and we're constantly rushing.[624]
>
> …
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> The other issues that affect the staff at both facilities I work is the lack of equipment. We don't have enough equipment or the equipment is faulty. We put tags on the equipment to advise that it's faulty, but it may not be fixed. For example, at the first facility, we only with one hoist that can raise all the residents. We have to run back and forth with the one weight hoist across the facility.[625]

615. Ms Alcock of the HWU gave an example of how rostering can result in unsafe work practices. She presented a scenario where a worker is working at night where there are fewer staff rostered. A resident needs to visit the bathroom but needs a two-person lift to safely get out of bed. A personal care worker is alerted to the needs of the resident, but for whatever reason cannot find the other rostered personal care worker on the night shift. If the worker does not help the resident they may get out of bed and fall and hurt themselves. The worker is directed not to assist the resident unless they have 2 workers to assist with the lift. If the worker assists the resident by themselves, the worker risks being disciplined by her employer. [626]

616. It is clear that each of these occupational health and safety issues is exacerbated by a lack of staff. As the evidence before the Royal Commissioners demonstrates, workplace safety concerns are one of the many reasons that the aged care sector is not presently seen as an employer of choice.

Conclusion

617. It is broadly recognised that poor terms and conditions of employment, exacerbated by low staffing levels and poor training opportunities and career paths are a disincentive for people to want to work in aged care. They also

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623 Transcript, Melbourne Hearing 3, Lavina Laboya, 18 October 2019 at T6224.40-47.

624 Transcript, Melbourne Hearing 3, Lavina Laboya, 18 October 2019 at T6222.26-28.

625 Transcript, Melbourne Hearing 3, Lavina Laboya, 18 October 2019 at T6224.3-8.

626 Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T6014.21-33.

are part of the reason why sector has difficulty retaining its existing staff. Most workers are on minimum award rates.

618. The issues are complex with statutory mechanisms such as the low paid bargaining scheme appearing to hold much promise but failing in practice to deliver. Staff of the Royal Commission will continue to examine these issues. However, based on the work to date, two things are abundantly clear. First, for there to be any significant improvement in the terms and conditions of employment of aged care workers, there must be a co-operative approach by all relevant parties – employers, unions, care recipients and the Commonwealth government. Secondly, the equal pay cases in Australia and New Zealand show that where there is such an approach and the government provides real and tangible leadership, change can be effected that improves the lives of aged care workers.

619. In the final part of our submissions, we address questions of leadership more generally.

PART 6 Leadership of the aged care workforce

620. In Professor Harrington's research, mentioned earlier, about the importance of minimum staffing levels in nursing homes, Professor Harrington notes that addressing staffing levels alone was insufficient to have a real impact on quality of care. It was also vital, in her view to ensure that the workforce is well led. This is consistent with the evidence received from good providers by the Royal Commissioners as recorded in the Interim Report.

621. We submit that leadership in relation to workforce reform is important at every level – we need good leadership from providers, strong leadership across the industry and, crucially, leadership by government. We will address each in turn.

Leadership at the provider level

622. At the approved provider level, the evidence demonstrates that good leadership, governance and management practices within organisations are crucial to supporting, engaging, building and retaining the aged care workforce.

623. In Melbourne Hearing 3, Ms Sandra Hills, Chief Executive Officer of Benetas gave evidence that the difference between an approved provider organisation that was struggling, providing substandard care and was poorly staffed, and an approved provider organisation that was well-managed and providing a terrific service was culture, 'right from the very top, the board of directors, right through to the executive'.[627]

624. There is evidence about the terrible outcomes that happen when strong and healthy leadership is missing from an aged care workplace.

625. During Melbourne Hearing 2, Dr Duncan McKellar, Head of Unit for Older Persons' Mental Health Services in the Northern Adelaide Local Health Network, identified poor workplace culture as one of the principal causes of the events that led to the closure of the Oakden Older Persons Mental Health Service. He emphasised that it was 'critical to understand' that it was a 'cultural failing' of the 'organisation and… the people that worked within it' and that was 'at the core of what went wrong'.[628] Dr McKellar said that organisational support is important as commitment is required 'from the CEO level right through to the…grass roots delivery of care'.[629]

626. Following the Hobart Hearing, Bupa Aged Care Australia accepted that there were deficiencies in its governance, leadership and culture during the relevant period, which impacted upon the quality and safety of care at Bupa South Hobart. Bupa Aged Care Australia accepted that 'there were times

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627 Transcript, Melbourne Hearing 3, Sandra Hills, 17 October 2019 at T6166.17-18.

628 Transcript, Melbourne Hearing 2, Dr Duncan McKellar, 8 October 2019 at T5466.39-T5467.4.

629 Transcript, Melbourne Hearing 2, Dr Duncan McKellar, 8 October 2019 at T5480.35-38

when the culture at [Bupa South Hobart] was such that residents, their families and staff members did not feel encouraged or supported to provide complaints or comments.'[630] Bupa Aged Care Australia acknowledged that this failure is itself an instance of substandard care, as well as a contributing factor to other instances of substandard care at Bupa South Hobart.[631] Bupa Aged Care Australia accepted that the culture within Bupa South Hobart also 'contributed to the manner that comments and complaints were handled by the General Manager and the leadership team.'[632]

627. During the Perth Hearing, Dr Lisa Trigg described the importance of instilling good leadership to enable staff to build relationships with residents:

628. So you imagine those sorts of places where you don't have the time to make relationships, you're just in a massive negative spiral. Because if you're not making the relationships, you're not providing good care. You don't know what good care looks like because you don't know the person. You leave, there's less staff. It gets worse. And without instilling good leadership and good practice you will never get out of that spiral. You know, it will always be about, you know, rationing incontinence pads and trying to find agency staff, and not being able to keep them.[633]

629. The Royal Commissioners have also heard about strong and innovative leadership, and about its positive outcomes, including staff retention and person-centred care, when staff are working under such leadership.

630. In Perth, Mr Chris Mamarelis, Chief Executive Officer of Whiddon, explained the importance of his focus and leadership as CEO in setting the tone and culture of the organisation. He said it is important for him to empower his staff and give them licence to start thinking in a person-centred care way—he said it is important to let the team members know 'this approach is okay'.[634] Mr Mamarelis told the Royal Commissioners that Whiddon's relationship-based care model applies to all of its employees, including the care workers, the registered nurses, the people in the kitchen, and acknowledges that everyone has a role to play in ensuring that it feels like a home, and that residents find themselves in a friendly and supportive environment.[635]

631. At the same hearing, Mr Brian Lipmann, Chief Executive Officer of Wintringham, described the culture of respect and admiration he has for staff at Wintringham. He said:

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630 Submissions of Bupa Aged Care Pty Ltd: Bupa South Hobart Case Study, 18 December 2019, RCD.0012.0050.0001 at 0020 [50].

631 Submissions of Bupa Aged Care Pty Ltd: Bupa South Hobart Case Study, 18 December 2019, RCD.0012.0050.0001 at 0021 [50].

632 Submissions of Bupa Aged Care Pty Ltd: Bupa South Hobart Case Study, 18 December 2019, RCD.0012.0050.0001 at 0026 [63].

633 Transcript, Perth Hearing, Dr Lisa Trigg, 28 June 2019, at T.2805.31.

634 Transcript, Perth Hearing, Chris Mamarelis, 25 June 2019, T.2431.33.

635 Transcript, Perth Hearing, Chris Mamarelis, 25 June 2019, T.2438.18.

> I tell them that they are special people doing special work and they will go home and they will feel they've done something that very few people ever will. Our guys are rejected by the aged care industry which is a disgrace, it's nothing short of a disgrace…So for these staff to be doing that in such often difficult circumstances fills me with great pride. I – I am enormously proud of my staff, they are really very special people. That's not just idle comment..New staff do not have to work in isolation with little or no support in situations that can be intimidating. Staff are supported, respected, and admired. They in turn train new workers. [636]

632. Staff at Wintringham are regularly reminded that they are special people doing special work, which is valued and appreciated by the clients, their management and the organisation's executive. This helps to instil a culture that after nearly 30 years is as strong as it was when the company was formed.[637]

633. Mr Lippman said that a by-product of the culture they have built at Wintringham is 'spectacular' staff loyalty. He said:

> I read in the papers about aged care providers struggling to keep staff or get them. I have a five year reward. It's signed by the president and myself and a cash grant. I've done 380 of them and it's only for 26 years.
>
> …
>
> I've got 152 staff members have been with us for 10 years, 47 longer than 15 and every year those people who have been with me more than 20 years, and we're only 26 years old, I take them to Parliament for lunch. Last year I took 17 people. I mean, this level of staff loyalty, it's so easy just to gloss over, I mean, it's spectacular.[638]

634. Recent research in the early childhood sector evidences that strong leadership and good employee engagement promotes job satisfaction and staff retention even if remuneration levels are low.[639]

635. In submissions to the Royal Commissioners made in response to the call for submissions after Melbourne Hearing 3, Opal Aged Care outlined its approach to leadership of its workforce.[640] Opal Aged Care said it focuses on 'culture by design, not by default'.[641]

636. To fulfil its stated purpose of 'Bringing joy to those Opal cares for', Opal Aged Care says it is committed to a 'deliberate culture that grows future leaders

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636 Transcript, Perth Hearing, Brian Lipmann, 25 June 2019, T2466.12.

637 Exhibit 5-19, Perth Hearing, Statement of Bryan David Lipmann, WIT.1135.0001.001 at 0007 [53].

638 Transcript, Perth Hearing, Bryan Lipmann, 25 June 2019, T2465.45-T2466.10

639 P McDonald, K Thorpe and S Irvine, 'Low pay but still we stay: Retention in early childhood education and care', *Journal of Industrial Relations*, 2018, 60, pp 647-668.

640 Submissions of Opal Aged Care, AWF.650.00030.0002 at 0001.

641 Submissions of Opal Aged Care, AWF.650.00030.0002 at 0003.

who are capable and confident to lead'.[642] Part of this has involved investment in and mapping of career pathways to attract and retain the workforce.[643] This has, Opal Aged Care says, involved development of programs across all areas of Opal Aged Care through:

a. a structured 12-month graduate nurse program;

b. a scholarship program providing financial assistance for Opal team members towards recognised formal qualifications;

c. leadership programs;

d. strategic partnerships in education which include internships and course development; and

e. appointment of key roles including a Head of Dementia Care and a National Clinical Training Manager, as well as regional quality advisors.[644]

637. Counsel Assisting are in no position to evaluate this submission. However, we consider that it reveals some very interesting ideas. This sort of forward thinking leadership needs to be fostered and encouraged.

638. In his witness statement, Professor Pollaers described the aged care industry as a 'fragmented industry in adolescence'.[645] He expanded on that characterisation in his oral evidence:

> So the adolescence is really represented by, I think, three factors: it's that lack of consolidated position; the fragmented way in which government engages it and, you know, the very, very many reports, you know, I think that haven't led to a decision is an example of the way in which this industry has not been big enough to resist that kind of oppression. It has been quite an oppressed set of circumstances. And then, finally, I think the way in which the industry is structured, we often do in Australia talk about small to medium enterprise.

639. Now, internationally, a small to medium enterprise is between 20 and 50 million dollars of revenue. In this industry it's between – we are seeing one to five million, you know, with employees of up to 20. So unless we start to talk about it as a microindustry that needs to have policy settings to help it to build over time, then I think we are going to face continued issues. So that's another reason why I call it adolescent is that it's an industry that hasn't really found a way of properly representing itself. [646]

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642 Submissions of Opal Aged Care, AWF.650.00030.0002 at 0003.

643 Submissions of Opal Aged Care, AWF.650.00039.0002 at 0003 and 0011-0012.

644 Submissions of Opal Aged Care, AWF.650.00039.0002 at 0003-0007.

645 Exhibit 11-3, Melbourne Hearing 3, Statement of Professor John Pollaers, WIT.0361.0001.0001 at 0011.

646 Transcript, Melbourne Hearing 3, Professor John Pollaers, 14 October 2019 at T5801.20-35.

640. Professor Pollaers was asked whether he thought that the people leading the aged care industry could actually understand the importance of engagement and enablement of staff, in ensuring staff retention. In responding, Professor Pollaers reiterated his concern about the need for the industry to develop its own capacity:

> I think, Commissioner, that the – I think we have got to keep going back and reminding ourselves that many of these are very small companies that have grown over time and haven't necessarily developed those skillsets. So when we do start to think about the transition of this industry, it's not just about skilling people as they come in or personal care workers or nurses, there is a leadership growth requirement right across the board that needs to reflect the size – the small business, all the way through, if we're going to get the kind of shift that we need.'[647]

641. A panel of Chief Executive Officers of leading approved providers gave evidence in Melbourne Hearing 3. The Royal Commissioners heard from:

- Richard Hearn, Chief Executive Officer, Resthaven is a not-for-profit provider of aged care which supports around 10,000 people in the community, and 1,290 in residential aged care.[648]
- Sandra Hills, Chief Executive Officer, Anglican Aged Care Services t/a Benetas (**Benetas**), a not-for-profit provider, with approximately 1,069 residential care places.[649]
- Jason Howie, Chief Executive Officer, KinCare Health Services Pty Ltd, a for-profit specialist in-home care provider, serving aged care, health and disability customers, but not residential aged care.[650]
- Kerri Rivett, Chief Executive Officer, Shepparton Retirement Villages, a not-for-profit community based service in regional Victoria consisting of 301 residential care beds and 272 independent living units.[651]

642. Senior Counsel Assisting asked the panel how, in their respective views change can be embedded in the aged care industry.

643. Mr Howie suggested utilising existing, 'well-established change management frameworks you would expect organisations and professional leadership

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647 Transcript, Melbourne Hearing 3, Professor John Pollaers, 14 October 2019 at T5809.7-18.

648 Exhibit 11-62, Melbourne Hearing 3, Statement of Richard Hearn, WIT.0440.0001.0001 at 0001 [4], [6].

649 Exhibit 11-59, Melbourne Hearing 3, Statement of Sandra Hills, AIT.0450.0001.0001 at 0001 [4].

650 Exhibit 11-60, Melbourne Hearing 3, Statement of Jason Howie, WIT.0383.0001.0001 at 0003 [12], [14].

651 Exhibit 11-61, Melbourne Hearing 3, Statement of Kerri Rivett, WIT.0441.0001.0001 at 0001 [4].

teams to be accessing'. His view was that the fundamental importance of leadership, starting with the board and governance structures.[652]

644. Ms Rivett said that it was necessary to use 'clear and simple messages' and 'engage with the coalface', to ensure their buy-in to the proposed change.[653] She noted the importance of open disclosure and listening and hearing the truth 'warts and all' about what is actually happening.[654]

645. Ms Hills, who is also a member of the Aged Care Industry Workforce Council,[655] referred the Royal Commissioners to recommendations from the Australia's Aged Care Workforce Strategy Taskforce Report, in particular the voluntary code of practice and the Aged Care Centre for Growth and Translational Research[656]. She said that, if implemented, those initiatives would provide an opportunity to look at new business models by going outside the sector and seeing what's happening internationally, nationally and in other sectors.[657]

646. Ms Hills gave evidence about what she said was the 'huge commitment' in the aged care industry, but cautioned that:

> perhaps there are some – well, there are some providers that shouldn't be in the industry and perhaps will choose one way or the other to move on because hopefully your recommendations will be such that it will be very clear that this is the way going forward and if you are not on the boat, there's the sea.[658]

647. We agree that there is huge commitment in parts of the aged care sector. The challenge is how to harness that commitment and ensure that it is not wasted at this crucial juncture. That leads us to what we submit is the vital role of the Commonwealth government.

648. The Royal Commissioners are undertaking work examining the governance of aged care services, and recommendations will be made in relation to provider governance and leadership at a later time. In the meantime, it is clearly vital that all approved providers develop or build on strong and healthy leadership practices at all levels within their organisations. It should not take recommendations from the Royal Commissioners for this to occur.

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652 Transcript, Melbourne Hearing 3, Jason Howie, 17 October 2019 at T6181.37-41.

653 Transcript, Melbourne Hearing 3, Kerri Rivett, 17 October 2019 at T6182.28-32.

654 Transcript, Melbourne Hearing 3, Kerri Rivett, 17 October 2019 at T6182.35-37.

655 Exhibit 11-59, Melbourne Hearing 3, Statement of Sandra Hills, AIT.0450.0001.0001 at 0001 [6].

656 Transcript, Melbourne Hearing 3, Sandra Hills, 17 October 2019 at T6183.1 and T6182.39-41.

657 Transcript, Melbourne Hearing 3, Sandra Hills, 17 October 2019 at T6183.1-6.

658 Transcript, Melbourne Hearing 3, Sandra Hills, 17 October 2019 at T6184.6-10.

Industry leadership and the role of the Commonwealth

649. The Commonwealth government sets the regulatory framework, implements that framework and establishes the policy settings for the aged care sector. It also provides the overwhelming majority of the funding for what is a major part of the Australian workforce. It has an important role in workforce planning.

650. We submit that the Royal Commissioners should make the following recommendation.

Workforce planning

RECOMMENDATION 10

The Commonwealth should lead workforce planning for the aged care sector, and should identify an agency or body that has overall responsibility for aged care workforce planning, with key actions being:

a. long-term workforce modelling on the supply and demand of health professionals and care workers (however described), to inform the development of workforce strategies for aged care

b. overall management of the training pipeline for health professionals and care workers, in partnership with the States and Territories, universities, Registered Training Organisations, National Boards, professional associations, specialist colleges and other key stakeholders

c. driving improvements in labour productivity across the health professions and care workforce (however described)

d. ensuring an appropriate distribution of the health professional and care workforce to meet the needs of population across the aged care sector, particularly in rural and regional Australia, and

e. facilitating the migration of health professionals and care workers to Australia to address identified health, aged care and disability workforce needs.

651. In Melbourne Hearing 3, Ms Hills said that government was not currently providing sufficient leadership on aged care workforce development and planning.[659]

652. Mr Jason Howie noted that the government has a role in workforce planning in terms of sharing data and information with industry that will support industry to meet demand. He said:

[659] Transcript, Melbourne Hearing 3, Sandra Hills, 17 October 2019 at T6178.18-23.

> We would welcome a detailed report from government that forecasts workforce supply…Ensuring that there is sufficient training funding available and that we have a community wide strategy in place to reskill workers from other industries is also a government responsibility.
>
> It would be helpful for providers to have increased transparency from government regarding matters such as waitlist times and volumes for home care services in order to anticipate and plan for the demand for services by matching supply. The Australian government collects and holds comprehensive data which could be shared with providers.[660]

653. When asked about the role of the Commonwealth in terms of taking leadership on aged care and the workforce, the former secretary of the Department of Health, Ms Beauchamp described the various Commonwealth agencies that have a role in this regard. She said:

> when we are talking about leadership of the workforce and the Commonwealth's role, there are a number of agencies involved in workforce matters and do, indeed, play a leadership role. For example, the Department of Education around higher education, particularly for the professional streams in health, when you're talking of nurses, physios, doctors and the like. There's also the Department of Employment and Small Business – Family and Small Business, that do take a role in establishing vocational education and training system, and skills for job-seekers, and matching up available jobs with job-seekers, and do actually take a leadership role in ensuring that vocational education and training system and the competencies that go with that meet the needs of industry, and there has been, as we have heard this week, the set-up of the committee under the Department of Employment. There's also the Department of Immigration that provides workforce, fills workforce gaps and shortages through the skilled migration program for us and we work closely with the Department of Home Affairs as well on that. And, of course, us in the Department of Health have a very big role to play to ensure we've got the skills and competency and attitude of workers to support the needs of clients in care, whether it's residential aged care facilities, home care or other elderly people accessing the system. So there's a lot of areas of the Commonwealth that do take a leadership role.[661]

654. Ms Beauchamp went on to describe the Secretaries Social Policy Committee, which seeks to bring those various agencies together, and examines matters impacting across health, disability, social services and employment, including in relation to the workforce.[662]

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660 Exhibit 11-60, Melbourne Hearing 3, Statement of Jason Andrew Howie, WIT.0383.0001.0001 at 0038 [113-114].

661 Transcript, Melbourne Hearing 3, Glenys Beauchamp, 18 October 2019 at T6260.27-48.

662 Transcript, Melbourne Hearing 3, Glenys Beauchamp, 18 October 2019 at T6261.6-10.

655. In his statement, Mr Charles Wann explained that the Secretaries Social Policy Committee was established in January 2019 as a cross portfolio approach to workforce planning and strategy.[663] Mr Wann explained that the Secretaries Social Policy Committee facilitates the cross portfolio approach to workforce planning and strategy, given the Department of Health and Department of Social Services share a similar profile of workforces delivering services and support for consumers across the aged care and disability sectors.[664]

656. Mr Wann gave evidence about two government programs that support aged care workforce capacity: the Boosting the Local Care Workforce Program and skilled migration program managed by the Department of Home Affairs.[665] The Department of Health conducts four health workforce strategies relating to the following areas; rural health, the Aboriginal and Torres Strait Islander health, medical workforce and mental health workforces.[666] The Department of Health also monitors supply and demand of medical, nursing and midwifery and palliative care workforces.[667]

657. Ms Beauchamp was asked whether she had confidence that the Department of Health has in place the workforce-planning mechanisms and settings to ensure that it is going to be able to achieve the significant increase in staff numbers required to meet demand. She replied:

> I think we need more information in terms of the workforce planning, and I think we need to do, as a Commonwealth, across all of those other Agencies I mentioned earlier, a much better effort around workforce planning, particularly if we're looking at getting – 'a million workers', I think I've said previously in my statement – by 2050, and I think that is a challenge for us all in attracting and retaining good-quality staff to the industry.[668]

658. There was evidence in Melbourne Hearing 3 that high levels of turnover and churn at the senior executive level in the Department of Health are a feature of the Commonwealth's workforce.[669] There appears to us be a lack of

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663 Exhibit 11-72, Melbourne Hearing 3, Statement of Charles Wann, WIT.0379.0001.0001 at 0013 [67].

664 Exhibit 11-72, Melbourne Hearing 3, Statement of Charles Wann, WIT.0379.0001.0001 at 0013 [67]; 0014 [71].

665 Exhibit 11-72, Melbourne Hearing 3, Statement of Charles Wann, WIT.0379.0001.0001 at 0014 [72]-[73].

666 Exhibit 11-72, Melbourne Hearing 3, Statement of Charles Wann, WIT.0379.0001.0001 at 0015-0016 [76].

667 Exhibit 11-72, Melbourne Hearing 3, Statement of Charles Wann, WIT.0379.0001.0001 at 0013 [72]-[73]; 0016-0017 [77].

668 Transcript, Melbourne Hearing 3, Glenys Beauchamp, 18 October 2019 at T-6287.34-39.

669 See Exhibit 11-71, Melbourne Hearing 3, Statement of Glenys Beauchamp, WIT.0379.0002.0001 at 0002[9]; 0002 [14]-[15]; 0003 [18]-[20]; 0004 [21]; 0005 [26] [9]-[38].

leadership and expertise about aged care within the Department of Health. Professor Pollaers considers that the Department of Health:

> is not a department that is resourced well enough, that has sufficient experience and/or weight within the current government department that it sits. Quite often the secretary, the deputy secretaries have other portfolios and not the focus.[670]

659. Professor Pollaers also said that, based on his nearly two years of dealing with the government, that 'in many ways the industry is undergoing a level of oppression'.[671] He explained that his sense was:

> that the way that government has positioned itself over the last few years is that, to the extent that this can be an industry issue and they can leave industry to deal with union, and then use the fragmentation as a reason to say, 'Well, without one voice we don't know what you're asking', has been, you know, a reasonably successful approach, and if not a strategic approach then a real shame because the answers to many of these questions have been on the table for quite some time.[672]

660. Professor Pollaers has devoted a considerable amount of energy, enthusiasm and expertise to the task he was given by the government. He has no axe to grind; unlike many from whom the Royal Commissioners have heard he has no vested interest; nor does he represent others with a vested interest. He is clearly frustrated by a lack of progress. We submit that his evidence should be given considerable weight by the Royal Commissioners.

661. That evidence paints a concerning picture of a government that does not see itself as a leader but is at best a facilitator. In its 2017 report entitled 'Future of Australia's aged care sector workforce', the Senate Community Affairs References Committee noted that:

> The Department of Health (department) views the Australian government's role in the development of a workforce strategy as more of a 'facilitator', rather than a leader. The department explained that the Australian government's position on a national aged care workforce strategy is that it will support the sector in developing a strategy, but that it is ultimately the sector's responsibility:
>
> > Aged care employers are responsible, like any other employer, for assuring that their workforce needs are aligned with their business strategy, as an essential component of organizational governance.[673]

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670 Transcript, Melbourne Hearing 3, Professor John Pollaers, 14 October 2019 at T5813.12-15.

671 Transcript, Melbourne Hearing 3, Professor John Pollaers, 14 October 2019 at T5813.11.

672 Transcript, Melbourne Hearing 3, Professor John Pollaers, 14 October 2019 at T5813.25-31.

673 Senate Community Affairs Reference Committee, *Future of Australia's aged care sector workforce,* 2017, p 21.

662. ‘Facilitator’ is of course one of those modern expressions that is of indeterminate meaning. It says very little about the true role of the Commonwealth.

663. It is pleasing to see that, with the advent of this Royal Commission, the government’s position on this fundamental question of its role has apparently changed. Challenged by Senior Counsel Assisting to describe the Commonwealth’s aged care workforce role, Ms Glenys Beauchamp, former Secretary of the Department of Health emphasised that:

> We do absolutely have a leadership role in terms of workforce matters in the aged care system…not just the Department; it's across the Commonwealth more broadly.[674]

664. As recommended by the Aged Care Workforce Strategy Taskforce in Strategic Action 10 of the report, *A Matter of Care*, there is a need to build the Commonwealth’s own aged care workforce given the pivotal role it plays in the administration of ‘My Aged Care’, the various regulatory functions performed by the Department of Health and the Aged Care Quality and Safety Commission and other related roles.[675] The report includes the following:

> The taskforce considers that the Australian government must continue to invest in these workforces, which have clear training and competency development needs and where people with the right aptitudes need to be recruited.
>
> The taskforce considers that secondments and exchanges support this approach and recommends that agencies develop formal secondment programs with the aged care industry. These placements should provide for movement both ways—government employment to private sector and private sector to government.
>
> Additionally, the taskforce considers that a thorough review is needed of induction resources and processes for government workforces so that they gain the required understanding needed of the industry, the impact of changing consumer demand and their roles in the continuum of care and consumer journeys.[676]

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674 Transcript, Melbourne Hearing 3, Glenys Beauchamp, 18 October 2019 at T6260.15-17.

675 Transcript, Melbourne Hearing 3, Professor John Pollaers, 14 October 2019, at T5812.23-38.

676 Exhibit 1-4, Adelaide Hearing 1, A Matter of Care – Australia’s Aged Care Workforce Strategy, UVH.0001.0007.0001 at 0086.

The Aged Care Workforce Industry Council

RECOMMENDATION 11

The Australian Government should work in partnership with the Aged Care Workforce Industry Council, and provide the financial and practical support necessary to implement the Aged Care Workforce Strategy Taskforce Report recommendations.

665. At Adelaide Workshop 1, held on 10 and 11 February 2020, Ms Sandra Hills said:

> strong leadership is absolutely needed in the sector and I think people need to speak out more, perhaps be a bit more, you know, a bit more risky about what they're doing and what they want to do ... it's up to the sector. We have to lead.[677]

666. As described in detail earlier in these submissions, there have been many reviews of aged care in recent years. A number of those key reviews (in particular, the 2017 Tune Review) did not focus on workforce issues because the then Minister for Health and Aged Care, Ken Wyatt AM, had established the Aged Care Workforce Strategy Taskforce to develop an aged care industry workforce strategy. The strategy was to include implementable actions to address issues identified through the course of the Taskforce's work and also those reviews that had preceded it.[678]

667. Professor John Pollaers was appointed independent chair of the Taskforce on 14 September 2017.[679] The Taskforce delivered its report *A Matter of Care, Australia's Aged Care Workforce Strategy* in June 2018.[680]

668. In his evidence to the Royal Commissioners, Professor Pollaers summarised the scope and purpose of the Taskforce as:

> attempting to deal with a substantial number of open issues resulting from very many previous reports that had touched upon workforce but hadn't actually addressed it. So the intention was to make sure that we looked at the current structure of the workforce, the changing nature of consumer expectations, and then the various models and responses to the issues that arose.

669. The Taskforce recommended 14 strategic actions:

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677 Transcript, Adelaide Workshop 1, Sandra Hills, 11 February 2020 at T7827.19-22.

678 Exhibit 11-3, Melbourne Hearing 3, Statement of John Pollaers, WIT.0361.0001.0001 at 0011.

679 Exhibit 11-3, Melbourne Hearing 3, Statement of John Pollaers, WIT.0361.0001.0001 at 0004.

680 Exhibit 1-4, Adelaide Hearing 1, Statement of John McCallum, WIT.0004.0001.0001 at UVH.0001.0007.0001.

669.1. Creation of a social change campaign to reframe caring and promote the workforce

669.2. Voluntary industry code of conduct

669.3. Reframing the qualification and skills framework – addressing current and future competencies and skills requirements

669.4. Defining new career pathways including accreditation

669.5. Developing cultures of feedback and continuous improvement

669.6. Establishing a new standard approach to workforce planning and skills mix modelling

669.7. Implementing new attraction and retention strategies for the workforce

669.8. Developing a revised workforce relations framework to better reflect the changing nature of work

669.9. Strengthening the interface between age care and primary / acute care

669.10. Improved training and recruitment practices for the Australian Government age care workforce

669.11. Establishing a remote accord

669.12. Establishing an Aged Care Centred for Growth and Translational Research

669.13. Current and future funding considerations, including staff remuneration

669.14. Transitioning the existing workforce to new standards.

670. Counsel Assisting are of the view that these strategic actions are broadly heading in the right direction and we support their implementation.

671. Strategic Action 14 of the Taskforce Report recommended the establishment of an 'Aged Services Industry Council' to 'lead execution of the strategic actions in a coordinated and systematic manner'.[681] The body that was ultimately established is called the Aged Care Workforce Industry Council. Its initial membership included:

- Ian Hardy AM, Independent (Interim) Chair
- Kevin McCoy, Australian Unity (Deputy Chair)
- Melissa Coad, United Voice
- Graham Dangerfield, Baptcare
- Sandra Hills OAM, Benetas

[681] Exhibit 11-4, Melbourne Hearing 3, Statement of Kevin McCoy, WIT.0451.0001.0001 at 0002[9]-[10].

- Ross Johnston, Regis (Guild Chair)
- David Maher, Catholic Healthcare
- John McCallum, National Seniors Australia
- Lucy O'Flaherty, Glenview
- Graeme Prior, Hall and Prior
- Cathy Thomas, BlueCare (Part of Uniting Care Australia)
- Ian Thorley, Estia Health

672. At Melbourne Hearing 3, there was evidence from the Deputy Chair of the Council, Kevin McCoy, as well as from representatives of the Commonwealth government.

673. That evidence painted a picture of an Industry Council tasked with leading, but without funding and with minimal support from the federal government.

674. Mr Kevin McCoy, Acting Chair of the Aged Care Workforce Industry Council Limited and Chief Executive Officer, Australian Unity, gave evidence at Melbourne Hearing 3 that, as at the time of making his statement:

a. the Government's funding commitment to the Industry Council of $2.6 million was yet to result in a direct funding agreement, other than the funding of Miles Morgan for secretariat services until 30 June 2020[682]

b. otherwise the Industry Council was acting with no funding, and it did not have any insight into when funding was expected[683]

c. in the short-term the Industry Council was self-funding its operations[684]

d. the Industry Council sought engagement with the Department of Health since its formal establishment in May 2019[685]

e. the Department of Health participated in a phone dial-in with the Council in September 2019[686]

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682 Exhibit 11-4, Melbourne Hearing 3, Statement of Kevin McCoy, WIT.0451.0001.0001 at 0010-0011 [65], [70].

683 Exhibit 11-4, Melbourne Hearing 3, Statement of Kevin McCoy, WIT.0451.0001.0001 at 0011 [68].

684 Exhibit 11-4, Melbourne Hearing 3, Statement of Kevin McCoy, WIT.0451.0001.0001 at 0011-0012 [77].

685 Exhibit 11-4, Melbourne Hearing 3, Statement of Kevin McCoy, WIT.0451.0001.0001 at 0007 [47].

686 Exhibit 11-4, Melbourne Hearing 3, Statement of Kevin McCoy, WIT.0451.0001.0001 at 0007 [48].

f. the Industry Council hopes to develop a more meaningful and collaborative dialogue with the Department of Health in the future.[687]

675. Mr McCoy gave evidence that without 'strong government support' the work of the Industry Council will not be possible.[688] This view was supported by Industry Council member Ms Sandra Hills of Benetas.[689]

Government Response to the Aged Care Workforce Strategy Taskforce report

676. Five of the fourteen strategic actions in the Aged Care Workforce Strategy Taskforce report are directed at the Australian Government.[690] They are:

- Strategic action 1 – a social change campaign to raise the profile of the aged care sector;[691]
- Strategic action 9 – strengthening the interface between the aged care and health sectors;[692]
- Strategic action 10 – improved recruitment and training of the government's own aged care workforce; [693]
- Strategic action 12 – establishing an aged care centre for growth and translational research;[694] and
- Strategic action 13 – current and future funding, including staff remuneration.[695]

677. The report was delivered to the government in June 2018. Professor Pollaers' evidence in October 2019 was that the government was yet to establish its position with respect to those practical and necessary strategic actions that were its responsibility.[696] He told the Royal Commissioners that

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687 Exhibit 11-4, Melbourne Hearing 3, Statement of Kevin McCoy, WIT.0451.0001.0001 at 0007 [48].

688 Transcript, Melbourne Hearing 3, Kevin McCoy, 14 October 2019 at T5833.19-25.

689 Transcript, Melbourne Hearing 3, Sandra Hills, 17 October 2019 at T6178.10-23.

690 Exhibit 11-3, Melbourne Hearing 3, Statement of Professor John Pollaers, WIT.0361.0001.0001 at 0013.

691 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 205, ACW.9999.0001.0022 at 0047-0048.

692 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 205, ACW.9999.0001.0022 at 0097-0102.

693 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 205, ACW.9999.0001.0022 at 0103-0108.

694 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 205, ACW.9999.0001.0022 at 0113-0116.

695 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 205, ACW.9999.0001.0022 at 0117-0124.

696 Exhibit 11-3, Melbourne Hearing 3, Statement of Professor John Pollaers, WIT.0361.0001.0001 at 0013-0014 [u].

> there has been no detailed response [from the Commonwealth] at all to each of those recommendations but for a pre-election commitment to fund the Aged Care Centre for Growth and Translational Research … Which I haven't seen any progress on. But with all others, I wrote to the Minister asking for a point-by-point response to those and did not receive a response. I think they're important because strategic action 1 is a co-commitment, if you like, between industry and government. It's one that needs to be done together but essentially what we were focusing on is in – the philosophy of the taskforce was let's see how far industry can go on its own, and then what's left is the work of government. So we made sure that not everything was, if the government doesn't do it, we can't do it. And industry have been stepping up in this timeframe, they have responded in the main. But on these areas we haven't had a sufficient – or a response at all from government.[697]

678. Perhaps not surprisingly, Professor Pollaers considered that this was 'profoundly disappointing'.[698] He clarified that he had received an email from the Department of Health in response to his request to the Minister, but that he did not consider that response was sufficient, and so he had asked for a 'step-by-step' response.[699] Professor Pollaer's view was that the Department, in its response to him, had not 'done justice to the brief they were given'.[700]

679. Ms Beauchamp was asked by Counsel Assisting about this. Her evidence to the Royal Commissioners was that 'the government has come out in broad support of the recommendations of the taskforce'.[701] She also said that:

> the Department doesn't embrace things publicly when there have been reports made to government. Our role is to support implementation and delivery, and it wasn't our place, to embrace it or not.[702]

680. The Commonwealth provided the Royal Commissioners with a briefing note dated 26 October 2018 prepared by officers of the Department of Health for the Ministers of Aged Care and Health respectively.[703] It was entitled '*Issue: Government Response to the Aged Care Workforce Strategy'*. The advice to the Ministers from the Department was that:

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697 Transcript, Melbourne Hearing 3, Professor John Pollaers, 14 October 2019 at T5812.23-38.

698 Transcript, Melbourne Hearing 3, Professor John Pollaers, 14 October 2019 at T5813.5-8.

699 Transcript, Melbourne Hearing 3, Professor John Pollaers, 14 October 2019 at T5812.44-46; Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 244, CTH.1000.0003.5922.

700 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 244, CTH.1000.0003.5922 at 5923.

701 Transcript, Melbourne Hearing 3, Glenys Beauchamp, 18 October 2019 at T6269.11-12.

702 Transcript, Melbourne Hearing 3, Glenys Beauchamp, 18 October 2019 at T6269.19-21.

703 Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 226, CTH.1000.0003.5207.

> Release of a formal response to the strategy would carry several risks for government.[704]

681. The authors of the briefing note, who are senior officers in the Department of Health, explained to the Ministers that one of the risks to government would be that releasing a response would:

> Invite renewed criticism of the absence of similar responses to other aged care review reports, including the Legislated Review of Aged Care and the Review of National Aged Care Quality Regulatory Processes.'
>
> …
>
> A further risk for government is that a formal Government response will invite public statements by key stakeholder groups, drawing renewed attention to sensitive matters such as staff ratios, aged care funding, access to health services for older Australians and service quality.'[705]

682. As was put to Ms Beauchamp in the hearing, this is not leadership.[706] It rather suggests an approach at the highest levels of the aged care bureaucracy that is timid, risk-averse and more worried about political risk than making a contribution to the vital issue of aged care reform. It is an approach that we submit must change if the government is to fulfil the true role of a leader that is so necessary to assist the aged care sector to become an employer of choice.

683. These submissions will be published on the Royal Commission's website. The Royal Commissioners welcomes submissions in reply by Friday 13 March 2020.

Counsel Assisting the Royal Commission into Aged Care Quality and Safety

21 February 2020

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[704] Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 226, CTH.1000.0003.5207 at 5208.

[705] Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 226, CTH.1000.0003.5207 at 5208.

[706] Transcript, Melbourne Hearing 3, Glenys Beauchamp, 18 October 2019 at T6269.40-43.