12 November 2020

Response to Aged Care Royal Commission
Counsel Assisting's Proposed Recommendations

Contact Details

Name	Mrs Jen Coulls, Executive Officer, Australian Council of Deans of Health Sciences
Email Address	secretariat@acdhs.edu.au
Phone:	0407 885 003
Preferred means of contact	email
Postcode of location you are making your response from	5000
I am responding on behalf of	An Organisation

Organisation Details

What is the name of the organisation?	Australian Council of Deans of Health Sciences
What is the nature of the organisation?	Peak Body
What is the organisation's role in Aged Care	As educators of allied health professionals, ACDHS sits at the nexus between health and education. As such, members are well placed to provide insights on the demands our future health workforce will face, and opportunities to improve the efficacy of their practice and the sustainability of the systems they will work in. This includes aged care. Our focus areas are 1. Health workforce education, including leadership and innovation in health professional education; promoting a systems approach to the development of national health and education policy; and promoting excellence in allied health professional education. 2. Health systems and services including promoting the role and contribution of the allied health workforce within the evolving the health, disability and aged care systems; and promoting improvements in health in underserved areas and populations through education and workforce development. 3. Research advocacy, including promoting excellence in research within the health and human service systems; and informing multidisciplinary health workforce planning and promote health workforce research.

PART 3.1 PRINCIPLES OF THE NEW AGED CARE SYSTEM

Recommendation 1: A new Act	**SUPPORT IN PRINCIPLE**

The proposed object of the new Act and the principles do not address the rights of older people as citizens to access all government services, including all elements of the health and social care systems, and to participate fully as citizens in society. This principle supports other recommendations (eg Recommendation 2 – Integrated long-term support and care for older people; Recommendation 75 - Clarification of roles and responsibility for delivery of health to people receiving aged care). Without a strong commitment of this kind, aged care will continue to be seen as an alternative to many health and wellbeing services, particularly those related to physical, social, emotional and intellectual development. The aged care system should not exist in isolation to the broader narratives of health ageing.

The Principles should include the provision of culturally competent and culturally safe care services that respond to the diversity of backgrounds and life experiences, as determined by older people, their families and their communities. This could be done by expanding Principle 1.3(c)(xiii) which uses the language of "special or vulnerable groups" from the current Act.

Recommendation 2: Integrated long-term support and care for older people Act	**SUPPORT IN PRINCIPLE**

ACDHS supports the direction of this recommendation and the need for a joined-up system. The complexities of older age, including physical, psycho-social, financial and relational changes and challenges, are best managed by a team of people from diverse professions using an interprofessional approach. Allied health input is clearly pivotal to this. These approaches can be from in-reach services, teams within aged care or a mixture of approaches.

Further, it is important that understand that interprofessional approaches go beyond communication or simply linking people. We know this has been tried and has failed on multiple occasions example would be hospital avoidance and its link to poor communication between the hospital and community. There is a need for strategies to translate the current evidence about interprofessional approaches both in aged care environments and in intersectoral / integrated care.

PART 3.3 PROGRAM DESIGN

Recommendation 15: Social supports category	**SUPPORT IN PRINCIPLE**

The recommendation references social isolation and loneliness. These are separate concepts that may need different responses. Social isolation can lead to loneliness but people can also be lonely when they are surrounded by others. In addition, the causes or drivers of social isolation and loneliness can include complex matters that require a professional response. Accordingly, this recommendation could be expanded to include greater scope for the range of social supports which may be needed. For example, social work or psychological support services can build a person's capability to engage. Occupational therapists are trained in determining the impact of normal and compromised ageing on participation in meaningful and purposeful activities which in turn impact social and emotional health

Older people can be affected by social isolation and loneliness in any setting, including residential care or in other settings such as group homes. Older people with lifelong disability (for example, intellectual disability) or with chronic or long lasting mental illness are particularly vulnerable. They may not have support through NDIS and are often excluded from mainstream supports, especially if they live in residential settings. The recommendation proposes grant funding as the mechanism for supporting activities and a central role for local government, community organisations and businesses. It appears to limit social support to non-residential care settings. It could be improved by ensuring that people in residential care settings also will be able to access funded supports. This may be achieved by direct funding to residential care.

Recommendation 18: Residential aged care to include allied health care	**SUPPORT**

We strongly support the intent of this recommendation, which recognises allied health care as a core service in residential aged care. Timely access to allied health professionals can significantly reduce premature institutionalisation and extend independent living. In residential settings, allied health professionals can have a significant impact on quality of care and quality of life, including preventing decline; maintaining or improving function (including psychosocial function); pain management; and good end-of-life and palliative care.

However, we are concerned that 18.1(a) is too restrictive. It would be more effective to specify that aged care providers must have appropriate allied health responses according to the needs of the mix of the residents. This recommendation could work interprofessional approaches to care (refer Recommendation 2). In practice, residential providers currently engage allied health providers in different ways, eg employment, contractors, a mix of approaches. Regional, rural and remote services can struggle to employ allied health professionals due to thin markets. The needs to be flexibility, not prescriptive, with respect to implementation, including tele-practice in these RRR areas.

Recommendation 18.1(c)(ii) proposes an activity-based payment. We support this approach, but strongly recommend that there be no cap on the number of services, as this limits the ability of allied health professionals to make a genuine difference. Uncapping supports the diversity of services required and recognises professional judgement. There are other ways to control funding.

Further, eligible interventions should not be prescribed by external regulation or bodies. This has been unhelpful in the current system, for example, the inability to be receive funding with respect to services provided by exercise physiologists; funding for physiotherapy within the ACFRI tool which minimalizes there skill base and ability to make a difference. The system needs to provide flexibility for the older person, the provider and the allied health practitioner to determine the activities appropriate to their needs.

PART 3.4 QUALITY AND SAFETY

Recommendation 25: Priority issues for periodic review of the Aged Care Quality Standards	SUPPORT

We support this recommendation. It could be improved by ensuring that periodic reviews include allied health input, feedback to professions about impact of various allied health on outcomes in aged care sector.

25.1(a) could be expanded to ensure issues identified in the witness statements are addressed, for example, requirements for mandatory training as a broader activity especially in relation to independence, wellbeing and maximising function.

25.1(b) could be modified that delineation between roles and responsibilities must be done without eroding interprofessional approaches which delivers good quality outcomes.

PART 3.6 AGED CARE WORKFORCE

Recommendation 39: Aged care workforce planning	SUPPORT IN PRINCIPLE

We support this recommendation in principle. We strongly recommend that workforce modelling take into account both the need for allied health professionals and the diversity of the allied health workforce. Further, consideration should be given to the broad range of the aged care workforce required such as lifestyles assistants and coordinators and housekeeping staff, all of whom have such a significant impact on the lives of older people. In much of the debate about the makeup of the aged care workforce, there has been a focus on nurses and care workers, without reference to this broader workforce.

As discussed in Recommendation 18, it is essential that the full breadth of allied health professions is taken into consideration, with flexibility "on the ground" to determine the most appropriate mix. As indicated in response to recommendation 18, there are range of ways in which the allied health workforce can be engaged including direct employment model, independent practitioners or tele-practice. Input from allied health representatives would be beneficial in determining how to take account of these practices and other issues, such as workforce shortages and geographic spread.

Recommendation 40: Aged Care Workforce Council	SUPPORT

Recommendations 40.2(a). 40.2(b) and 43 require the Council to make recommendations on skills, capabilities, knowledge and competencies of the aged care workforce and translate these into education and training requirements, with specific reference to certificate-based course. We strongly support these recommendations. With respect to 43, we would like to draw your attention to the work done by the university sector over the past year to develop aged care certificates in consultation with industry. The strong preference of industry is to move away from the task-oriented training to a more values approach, which cover matters such as quality, safety and risk; person-centred care; dignity and enablement; communication; diversity; and interprofessional care which includes care workers as part of the team. This focus is needed if we are to move beyond transactional approaches to care to care which is based on relationships. We also support industry feedback which calls for specialisations – foundation aged care training and education plus

specialisations such as dementia care; lifestyle/psycho-social/spiritual care; rehabilitation and reablement assistance; broader case management skills and so on.

Recommendation 43: Review of certificate-based courses for aged care	**SUPPORT**

We reiterate our comments against Recommendation 40 - We would like to draw your attention to the work done by the university sector over the past year to develop aged care certificates in consultation with industry. The strong preference of industry is to move away from the task-oriented training to a more values approach, which cover matters such as quality, safety and risk; person-centred care; dignity and enablement; communication; diversity and cultural safety; and interprofessional care which includes care workers as part of the team. This focus is needed if we are to move beyond transactional approaches to care to care which is based on relationships. We also support industry feedback which calls for specialisations – foundation aged care training and education plus specialisations such as dementia care; lifestyle/psycho-social/spiritual care; rehabilitation and reablement assistance; case management; care coordination; and so on. This approach also supports the creation of workforce pathways, through linkages to graduate study.

Recommendation 45: Review of health professions' undergraduate curricula	**SUPPORT**

We strongly recommend that the undergraduate curricula across all professions should include a focus on broader narrative of health ageing, including health promotion and disease prevention over the life course. It is critical that the curricula explicitly address ageism and disablism,

We also strongly support placements which provide students with lived experience, opportunity to problem solve complex and multifaceted health problems using evidence, reflective practice and clinical reasoning, engage with multiple stakeholders including the client, work in MDT, all of which support students to be work ready. Refer to our comments against Recommendation 46 about the Teaching and Research Aged Care Service (TRACS) model for a more information on practices that have demonstrated success.

Placements in aged care and disability or in environments which support older people need to be given an equivalent status to placements in paediatric or acute settings. Currently, this is not the case, which is a reflection of ageist attitudes in the education sectors and the community more broadly.

Recommendation 46: Funding for teaching aged care programs	**SUPPORT**

We strongly support Teaching and Research Aged Care Service (TRACS) models, which have been recognised for their ability to support research translation and build future workforce capability.

The key features of TRACS are:

- Research and/or teaching partnerships between aged care providers and research and/or teaching organisations.

- Provide a focus for evidence-gathering and best practice models of aged care. Research is co-designed and this can include all levels of an aged care workforce and consumers, as well as students.
- These centres act as a hub, with spokes leading to aged care providers- usually at local or regional level, but with capacity for national level.

PART 3.9 RESEARCH, INNOVATION AND TECHNOLOGY

Recommendation 55: Dedicated Research Council	**SUPPORT IN PRINCIPLE**

We strongly support the need for an independent, dedicated aged care research focus. However the research council, as described in the recommendations, has limitations. For example, it does not include Counsel's own aim "**to encourage co-designed, applied and non-clinical ageing and aged care research**" (pg 259). The current wording, which focuses on aged care and ageing related health conditions, is more likely to lead to more medically focused research. There are other avenues for this research. Aged care needs research which impacts directly on and is translatable into practice.

Numerous Royal Commission witnesses identified the need for a different approach to research in the aged care space to that which is traditionally used, through NHMRC and ARC processes, for example. While recognising the value of these processes, we support the strong arguments put to the Royal Commission that aged care research needs to be focused on translation into practice. It should also impact on policy and curriculum for education and training at all levels.

An example is the Centre for Growth and Translational Research (CGTR), currently in development. Counsel notes it has taken a long time to develop and should be replaced by the Council. We have an alternative view. The time delays in commissioning the CGTR are indicative of the bureaucratic processes which get in the way of rapid, innovative and translatable research. The new CGTR not only has the potential to take on the role describe in Recommendation 55 but also to promote and conduct research in partnership with older people and aged care. It will shift the balance from the current focus of mainstream research from research publications and hopes that the findings will find their way into practice to research that has translation and implementation in its modelling from conception to completion.

This recommendation, by changing tack again, will not progress the research agenda. It will stall and set back the existing process, which aims to achieve what is intended in this recommendation plus much, much more.

PART 3.13 BETTER ACCESS TO HEALTH CARE

Recommendation 62: A new primary care model to improve access	**SUPPORT IN PRINCIPLE**

While acknowledging that this recommendation is seen as an introductory step (as set out in 62.2(c)), with a view to growing and enhancing the model over time, we suggest that there are initial

criteria that should be included. Specifically, Counsel has already highlighted the critical importance of allied health involvement in aged care services (eg recommendation 18). Thus, it will be important that accredited aged care practices can demonstrate their willingness and capability to work closely with allied health professionals. Potential evidence to demonstrate this commitment would be an affiliation with allied health professional practices or associations or a commitment to interprofessional approaches. This could be added to 62.2(b).

Recommendation 64: Access to specialists and other health practitioners through Multidisciplinary Outreach Services.	**SUPPORT**

We support this recommendation, particularly as it ensure allied health practitioners are seen as crucial members of the team. It supports the intent of recommendation 2 and could be seen as an implementation strategy for achieving integrated care.

We note that, throughout the recommendations, Counsel is promoting the involvement of older people, their families and aged care providers (including their allied health staff or providers) in the development of solutions, using co-design approaches. This will be critically important in the implementation of this recommendation to ensure that the models developed are not simply replicating hospital and medical models of care into the aged care environment. There are many examples of in-reach models have not worked because aged care was not involved as an equal partner from the beginning of the design process.

Recommendation 67: Short-term changes to the Medicare Benefits Schedule to improve access to medical and allied health services	**SUPPORT**

A specific option to consider would be for allied health professionals to claim against MBS for services eg self-initiated as with optometry, but with restrictions against number and type of services (to be realistic), with guidance as to remuneration from other schedules (eg TAC).

A general principle for this recommendation, regardless of the payment method, is that allied health professionals must receive commensurate remuneration as compared with their counterparts who work in other parts of the system. This is critical not only to facilitate professionalism but also in relation to workforce attraction and retention

Recommendation 75: Clarification of roles and responsibility for delivery of health to people receiving aged care.	**SUPPORT IN PRINCIPLE**

The merits of this recommendation are that it should provide more clarity and avoid people falling through gaps. However, we are concerned that a hard boundary between responsibilities impacts on the rights of older people to access services of their choice. For example, how are boundaries around dental care to be determined? If an older person prefers to see their own dental hygienist but this is deemed to be an aged care responsibility, how is this managed? We refer to our comments in Recommendation 1, regarding adding a principle that support older peoples' rights to access health service. This principle would support decision-making about roles and responsibilities and also protect older people living in residential aged care from being denied access to services of their choice.

Other concerns arise with respect to funding of these arrangements and who will be involved in decision-making. This recommendation also needs to be implemented in conjunction with Recommendation 76.

Recommendation 76: Improved access to State and Territory health services by people receiving aged care	**SUPPORT**

We support this recommendation which aims to protect the rights of older people to access allied health services. However, as indicated in response to Recommendation 75, "hard boundaries" about which agency is responsible for what have the potential to undermine access and choice in access to health care services. There needs to be flexibility to allow the provision of services to be provided by the practitioners and in the locations which best suit the needs and preferences of older people.-

PART 3.15 FUNDING IN THE NEW AGED CARE SYSTEM

Recommendation 84: immediate funding for education and training to improve the quality of care.	**SUPPORT**

We refer to our comments related to recommendation 46, where we discussed alternatives to the current Certificate III and IV offerings. We support funding for additional training targeted towards the direct care workforce. We suggest that the recommendation be expanded to include more innovative approaches which facilitate knowledge transfer rather than typical deliveries. Some of the innovation might relate to delivery and how that might be provided in a way which is flexible and timely. For example rather than training everyone in palliative care, training might be provided in an individualised way when they are actually providing palliative care. Different ways of delivery encourage interactive and interesting learning experiences.

Universities, for example, have developed considerable expertise and curricula in delivering education and training in different and flexible ways, including on-line delivery and simulations. For example, courses developed with COVID funding demonstrate that the university sector can develop and deliver well on VET type courses which also provide a pathway to future stud and careers. They are able to give students a broader exposure to opportunities in aged care and event to professions they had not previously considered to be relevant to aged care They can open students' minds to seeing aged care as a career as they can move through the system. By doing this, aged care at all levels becomes more attractive for attraction and retention. This recommendation could build on this investment by Government and the university sector as an additional option.