ROYAL COMMISSION INTO AGED CARE QUALITY AND SAFETY

WORKFORCE SUBMISSIONS

OF THE AUSTRALIAN NURSING AND MIDWIFERY FEDERATION

INTRODUCTION

1. These submissions are provided by the Australian Nursing and Midwifery Federation (ANMF) in response to the Commission's call for written submissions on policy issues relating to:

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

2. In addition to setting out the ANMF's recommended strategies for the policy issues above, the ANMF also seeks in these submissions to correct a number of misconceptions and inaccuracies regarding views, proposals and strategies on selected matters that have been put before the Commission. These matters include the nature of nursing work and the nursing profession; the development, implementation and operation of staffing models and systems; and, the evidence evaluating the effects and impacts of mandated staffing models, including staff to patient/resident ratios.

3. These submissions also explain the relationship between the series of models or tools relating to care provision currently before the Commission, which include the ANMF's evidence based staffing model, the RUCS/AN-ACC funding model and the CMS/NHS Compare 'rating' model, each of which are models designed for specific and different purposes. The submissions explain that the models are not interchangeable; they are not alternatives. Rather, they are three independent systems, which may work together (particularly the ANMF staffing system and the RUCS/AN-ACC model).

4. The primary focus of these submissions is upon the question of mandated staffing and skills mix in residential aged care facilities (RACFs). The ANMF has submitted a substantial body of material to the Royal Commission on the issue. It includes the following:

   (a) Exhibit 1-16 – WIT.0020.0001.0001 – Statement of Annie Butler dated 1 February 2019 in relation to the systemic problems in aged care, safe nursing care, mandated staffing levels and skill mixes and regulation and funding;

   (b) Exhibit 1-19 – ANM.0001.0001.0787 – ANMF National Aged Care Survey 2016 which includes direct responses from participants in the aged care workforce;

   (c) Exhibit 1-20 – ANM.0001.0001.3151 – National Aged Care Staffing and Skills Mix Project Report 2016, which is the basis for the ANMF's mandated staffing and skills mix proposal;

   (d) Exhibit 1-21 – ANM.0001.0001.3308 – Financial and Cost Benefit Implications of the Recommendations of the National Aged Care Staffing and Skills Mix Final Report;

   (e) Exhibit 1-22 – ANM.0001.0001.2102 – Ratios Save Lives Supporting Research dated May 2018, which summarises some of the academic research which shows that better nurse-to-patient ratios save lives;

   (f) Exhibit 11-1 (Tab 6) – RCD.9999.0203.0054 – ANMF National Aged Care Survey 2019 which includes further direct responses from participants in the aged care workforce;

   (g) Exhibit 11-1 (Tab 57) – ANM.0010.0001.0028 – ANMF Victorian Branch Initial Submission to the Australian Government – Caring for Older Australians – Productivity Commission Review of Aged Care;

   (h) Exhibit 11-1 (Tab 96) – ANM.0011.0001.0001 – ANMF Submission: Adelaide Hearings 1: "Ratios", a submission made by the ANMF at the conclusion of Adelaide Hearing 1 on the subject of ratios;

   (i) Exhibit 11-1 (Tabs 98 – 104) – ANM.0011.0001.0033;0037;0041;0045;0058;0059;0060 – Resident Assessment Scoring Tools (RAST), Resident Assessment Scoring Summary (RASS), Residential Aged Care Staffing Calculator (RACSC) and Shift and Skill Mix Calculator (SSMC);

   (j) Exhibit 11-1 (Tab 105) – ANM.0001.0001.3341 – 'Aged Care Ratios Make Economic Sense' dated November 2018 which sets out the ANMF's proposed plan for the implementation of mandated staffing levels and skills mix;

   (k) Exhibit 11-1 (Tab 167) – RCD.9999.0231.0011 – 'ANMF Letter to RC – comments on UoW Report', the ANMF's response to the UoW Report;

(l) Exhibit 11-1 (Tab 174) – RCD.9999.0233.0001 – 'Aged Care Workforce', the ANMF's submission to the Royal Commission on the subject of Workforce before Melbourne Hearing 3;

(m) Exhibit 11-21 – WIT.0430.0001.0001 – Statement of Paul Gilbert dated 26 September 2019 including a brief history of industrial regulation in Victoria, an overview of Victorian aged care bargaining currently, modern awards and the NES, common core conditions, enterprise agreement staffing requirements in Victoria, quarantined funding, ratios in Victoria, workforce regulation and skills and competencies;

(n) Exhibit 11-28 – WIT.0488.0001.0001 – Statement of Robert Bonner dated 2 October 2019 in relation to the process involved in the ANMF's staffing levels and skills mix project, criticisms made to the Royal Commission about the ANMF's staffing model proposals, understanding nursing in the context of aged care, the Resident Assessment Scoring Tool (RAST), the Residential Aged Care Staffing Calculator (RACSC) and training and workforce implications of mandated staffing and skill mix;

(o) Oral evidence of Paul Gilbert (P-5970 – P-6021) on industrial matters;

(p) Oral evidence of Robert Bonner (P-6024 – P-6049) on the subject of staffing.

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

PART 1-1: Context

The nature of nursing work and the nursing profession

5. The internationally agreed definition of nursing from the World Health Organisation and the International Council of Nurses states, *"Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. It includes the promotion of health, the prevention of illness, and the care of ill, disabled and dying people"* (see Bonner Exhibit 11-28 WIT.0488.0001.0001 at 0012 [17]).

6. This definition identifies the unique function of nurses in caring for individuals, sick or well, in assessing their responses to their health status and assisting them in the performance of those activities contributing to health or recovery or to dignified death that they would perform unaided if they had the necessary strength, will, or knowledge and to do this in such a way as to help them gain full or partial independence as rapidly as possible (see Henderson, Virginia (1966), *The Nature of Nursing: A Definition and its Implications for Practice, Research and Education*, Macmillan Publishing, New York).

7. This holistic, person-centred philosophy underpins and forms the core of nursing practice.

8. Both internationally and nationally nurses are prepared and authorised to:

a. engage in the general scope of nursing practice, including the promotion of health, prevention of illness, and care of physically ill, mentally ill, and disabled people of all ages and in all health care and other community settings
b. carry out health care teaching
c. participate fully as a member of the health care team
d. supervise, lead and train nursing and care-workers in the delivery of nursing care
e. be involved in research.

(International Council of Nurses (ICN) (1961) [1960], *Basic Principles of Nursing Care*, ICN, London)

Misconception of nursing in the residential aged care context

9. The evidence before this Royal Commission has disclosed some misconceptions of nursing work and the nursing profession generally, and in particular, of the role of nurses in the residential aged care context. The holistic, person centred approach of nursing practice, as outlined above, and its role in residential aged care has been misunderstood with nursing practice presented as only being required in residential aged care to perform higher-level 'clinical' tasks (Yates Transcript P-89:16–40 and Trigg Transcript P-2806:6-36).

10. This reductionist representation of nursing practice that has been presented (generally by non-nurses) not only demonstrates a misunderstanding of the nature of nursing practice but also trivialises the value of nursing work. This may be attributable to two factors:

    a. First, in the context of the current residential aged care environment nurses are not utilised appropriately (primarily due to cost saving and inadequate staffing levels), which has drastically reduced their capacity to deliver holistic, person-centred nursing care. For example the requirement for documentation completion to be undertaken by registered nurses has resulted in their skills being diverted away from care delivery (Gilbert Exhibit 11-21 WIT.0430.0001.0001 at 0021 [124]).

    b. Second, this reductionist approach to the use of nurses creates the impression that registered nurses are only able to attend to high-level clinical care because, necessarily, they must prioritise the most urgent care needs.

11. The misunderstanding of the breadth and depth of nursing practice as outlined above includes a very common misconception that 'personal care' is not a legitimate element of holistic nursing care but is somehow an entirely separate and distinct part of care provision. In fact, 'personal care' (generally regarded by the nursing profession as 'essential', 'basic' or 'fundamental' nursing care) is the foundational component of all nursing practice irrespective of the setting in which the nursing practice takes place (see Bonner Exhibit 11-28 WIT.0488.0001.0001 at 0015 [28]). Nursing is not confined to medical-related interventions. That is "*one part but by no means the scope of nursing practice. So nursing is a biosocial, psychological, holistic professional practice area and cuts across a whole range of areas that don't fit neatly into what some people would describe as clinical care*" (see Bonner Transcript P-6035:10-13).

12. When the delivery of holistic nursing care is properly supported, it is led by registered nurses and provided by the nursing team of registered nurses (including nurse practitioners), enrolled nurses and, depending on the practice context, care-workers.[1] Decisions to delegate particular aspects of nursing care are made by the registered nurse upon the application of particular criteria (see Bonner Exhibit 11-28 WIT.0488.0001.0001 at 0015 [29]). Which role undertakes, or should undertake, specific elements of nursing care is dependent upon the complexity of the intervention, and the qualifications and skill required to perform the intervention and meet the assessed need, as determined by the registered nurse.

13. The planning and subsequent evaluation of the patient/resident and the outcomes of the care provided, including personal care, is the responsibility of the registered nurse who delegated that care (see Bonner Exhibit 11-28 WIT.0488.0001.0001 at 0015 [28]). The registered nurse is central to delivery of safe, quality care in the residential aged care context (see Butler Exhibit 1-16 WIT.0020.0001.0001 at 0003–0004; Parker Exhibit 1-15 WIT.0017.0001.0001 at 0010–0011; and Bonner Exhibit 11-28 WIT.0488.0001.0001 at 0012 [18]).

14. Safe, quality holistic and person-centred nursing care (which includes personal care) cannot be provided in the residential aged care setting unless there is an objectively adequate number of staff and appropriate skills mix that enables nurses to provide holistic nursing care and to delegate aspects of that care to personal care workers in accordance with their professional responsibilities. Reference to holistic nursing care invites reference to the Commission's Perth Hearings in which the focus was on what is described as "person centred care". The ANMF's submission for the purpose of that hearing (ANM.0004.0001.0001) addressed the issues related to advance care planning, palliative care, the importance of mandated minimum staff levels and skills mix in these contexts, the lack of specific training, poor integration with other aspects of health care, regulatory standards, funding and what is needed to provide best practice person centred care.

15. The evidence of Professor Pollaers provides an example of the common misconception of nursing practice as only engaged in the performance of 'high–level' clinical tasks rather than in the provision of holistic, person-centred care. Speaking of the Taskforce's proposals in respect of workforce planning, he acknowledged the ANMF's work and continued:

> *"So in fact what we did is we looked at the ANMF model for workforce planning and it's a very good model in that it identifies the consumer profiles in, I think, in some ways Professor Eagar's work on case mix is a similar ideal, trying to understand what the kind theoretical case mix is*
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> *...*
>
> *Then they looked at what the clinical interventions were in the AM and the PM. They aggregated those. That then gives you the ratios. So we simply took that model and said what is different in industry? So what's different is that in this industry and looking at the case mix, we suggested that we need to think about holistic care planning. So instead of just clinical*

[1] Care workers can be referred to by a variety of titles, including but not limited to 'assistant in nursing', 'personal care worker' and 'aged care worker'. In Australia, these staff are unregulated in contrast to registered nurses and enrolled nurses. For the purposes of this submission, workers who provide assistance in nursing care within RACFs are referred to as care workers.

needs, it's your clinical needs, your functional health needs, your cognitive health needs, your cultural and linguistic needs and your living well aspirations as the five elements of a care plan." (Pollaers Transcript P-5810-5811)

16. There was some criticism of the ANMF's staffing model because it was confined to nursing care requirements. Of course that was its purpose, and as was explained by Mr Bonner other staffing elements could be bolted on and the model adapted on the basis of an analysis of resident need and interventions required for allied health aspects of care (see Bonner Transcript P-6047:19–39). However, as Professor Willis said, the addition of allied health "wouldn't substitute for the care that's missed at the moment. For example: one of the major cares missed is oral hygiene. You're not going to see a speech pathologist take up that missed care. So you would still need a mandated staffing-level of registered, enrolled – and care workers" (see Willis Transcript P-6047:31). The ANMF submits that the overwhelming priority is the introduction of staffing prescription for the delivery of nursing (including personal) care.

17. Professor Pollaers appears to have particularly misunderstood the nature and value of nursing work, the role of nursing in multidisciplinary teams (health, aged, community and social care teams) and what is meant by 'nurse-led' teams, as well as the staffing model proposed by the ANMF.

18. Professor Pollaers suggests that "*a nurse's role in an aged care environment is distinctly different to primary health care and acute care settings*" (Pollaers Exhibit 11-1 (Tab 166) RCD.9999.0231.0001 at 0008). As has been outlined above, he is incorrect and has drawn this conclusion from observations of how nurses are currently being inappropriately utilised in aged care. This observation demonstrates a lack of understanding by the Professor of both nursing education and nursing practice.

19. The statement provided by Professor Pollaers (Exhibit 11-1 (Tab 166) RCD.9999.0231.0001) continues along this line suggesting that both the ANMF and Professor Eager are focused on 'traditional' job roles for nurses, which perpetuate the "*clinical care model* [that] *marginalises the key role played by personal care workers and functional health specialists*". This is a profound misunderstanding, or misrepresentation, of both nursing generally and the ANMF's position on staffing requirements for residential aged care.

20. Professor Pollaers misrepresents the ANMF's position regarding the role and contribution of the personal care workforce in aged care. In fact, the ANMF regards personal care workers (who are also ANMF members) as a vital component of the aged care workforce. Accordingly, the ANMF's proposed staffing model recommends a significant increase to the personal care workforce in residential aged care to ensure safe and quality care for residents, within an appropriate evidence based skills mix of nurses and personal care workers.

21. Further, in contrast to Professor Pollaers' assertions (Exhibit 11-1 (Tab 166) RCD.9999.0231.0001), nurses are typically best placed to act as care coordinators and liaison within the care team to deliver holistic care planning and a multidisciplinary approach to care. In addition, from a simply pragmatic perspective, when other health and care professionals are absent or not available it is

typically the nurse who must assume their responsibilities (see Professor Beattie Transcript P-1628:32-38). It is in this sense that the ANMF contends for a nurse-led model of care delivery. Proper, quality staffing of all health and associated roles in the care team is vitally important to nurses.

22. It appears that Professor Pollaers may have inappropriately drawn this view from the ANMF's staffing research report (Exhibit 1-20 ANM.0001.0001.3151) which proposes an evidence based staffing methodology for residential aged care for nurses and personal care workers. The research proposes this model as an evidence-based answer to the research question – *what are the evidence based staffing requirements for nurses and personal care workers to meet the needs of residents in residential aged care?*

23. There is no suggestion from the ANMF that this proposal seeks to:

    - exclude the need for allied health or any other staff in residential aged care;
    - reject the need for holistic care planning; or,
    - suggest that other improvements are not needed in residential aged care.

24. Professor Pollaers gave evidence to the Commission that the ANMF had recognised the living well model of care "as opposed to" and "in place of" a nurse-led model of care (see Exhibit 1-64 ACW.9999.0001.0001 at 0020). During the discussions that led to the issue of a joint statement by the ANMF and the Professor in December 2018, calling for action in aged care, the ANMF did not propose as the only solution for aged care, a model of care that was solely focused on nurses.

25. As also stated above, the ANMF supports holistic care delivery and therefore readily accepted Professor Pollaers' additional words for the joint statement: "*Holistic care plans require focus on clinical, functional, and cognitive health along with living well aspirations and cultural needs. The workforce's skills mix and staffing levels also need to reflect the differing needs of all residents at different times. A living well model of care, which enables effective care delivery ... that deliver the holistic care plans required.*"[2]

26. Concerns expressed by the ANMF with regard to the Taskforce's report were not related to its proposal for holistic care planning but to its rejection of mandated minimum staffing levels and skills mix as the core component of safe, sustainable holistic care for the residential aged care sector.

27. The ANMF submits, therefore, that Professor Pollaers' commentary on the ANMF's proposal and policy position should not be accepted.

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[2] *Australia should be a world leader in aged care delivery*, Media Release, 15 December 2018. Available online: http://www.anmf.org.au/media-releases/entry/media_181215.

Staffing in Residential aged care facilities (RACFs) is inadequate

28. The Royal Commission has substantial evidence about the inadequacy of staffing in RACFs. The evidence is consistent and is drawn from a number of perspectives:

    - the direct evidence provided by residents and their families of inadequate care as a result of insufficient staff (e.g. Bernard Cooney Submission Exhibit 5-7 (Tab 67) AWF.001.00519.0001; Holland-Batt Exhibit 8-28 WIT.0330.0001.0001 at 0005 – 0007 [36] – [40]; Daniels Transcript P-6909:37-40; O'Donnell Transcript P-2478; and the indomitable Ms Mitchell Transcript P-1163:12-19 and Transcript P-1167:3-10). ANMF does not in this submission attempt to summarise that evidence. It is overwhelming;

    - the evidence of employees working in RACFs (e.g. Lavina Luboya Exhibit 11-67 WIT.0551.0001.0001 at 0002 and 0004 [16] and [27]–[29]);

    - the results of surveys of staff employed in RACFs (e.g. ANMF Survey Exhibit 11-1 (Tab 6) RCD.9999.0203.0054; Gilbert ANMF Victorian Survey Exhibit 11-21 WIT.0430.0001.0001 at 0027);

    - the acknowledgments from proprietors of the need for more staff (e.g. Mathewson Exhibit 11-19 WIT.0362.0001.0001 at 0010–0011; Midgley Transcript P-4106:17-36);

    - the academic work that has identified shortfalls in care delivered compared to the care needs of residents (Professor Eager Exhibit 11-2 WIT.0459.0001.0001 at 0012 [52]–[53] and see Exhibit 11-1 (Tab 96) ANM.0011.0001.0001 and the references therein);

    - the acknowledgements from RACF operators and the clear evidence arising from the numerous case studies undertaken by the Commission that staffing was inadequate. Again ANMF does not seek to summarise that evidence in this submission. (e.g. Hobart case studies: Wilson Transcript P-7107:1-9; Eastman Transcript P-6951:1-14 and P-6953:11-15; Daniels Transcript P-6909:39-40; Monks Transcript P-6927:26; Sexton Transcript P-6699:3-13. Darwin: Backhouse P-3201:37-45. Mudgee: Deas Transcript P-6388:1-8); and

    - the evidence of various senior health professionals of the need for staffing and skill mix to be addressed (e.g. Dr Boffa Transcript P-2892:8-14; A/Prof Murray Transcript P-3291-3292; Dr Redmond P-2778:31-34 and P-2771:22-42; Dr Morkham P-5210:20-23)

29. The ANMF endorses the submission of Counsel Assisting that in respect of RACFs staffing "the status quo is unacceptable" (Counsel Assisting Transcript P-6295:4). Furthermore, the ANMF notes that Counsel Assisting's observation in Adelaide Hearing 1 that it was "in the hands of the aged care providers" to identify an alternative to the ANMF's model for staffing and skills mix directed to the delivery of safe and appropriate care (Counsel Assisting Transcript P-658:25). They have not done so.

Misinterpretation of the concept of 'ratios'

30. The concept of 'ratios' and the use of the word 'ratios' have been misinterpreted and misconceived in some of the evidence before the Commission (Elderton Transcript P-187:37 – P-188:1-9; Beauchamp Transcript P-338:37-43; Mersiades Transcript P-477:19-38; Sparrow Transcript P-431:1-21). The term 'ratio' simply describes the relative sizes of two or more values. Thus, one to two is a ratio as is one to one hundred. Accordingly, RACFs operate with staffing ratios in their facilities, that is, the number of staff per residents.

31. However, as outlined in the evidence provided to the Commission, current staffing ratios in RACFs are grossly inadequate. This is because present staffing arrangements are not determined by calculating the staffing required to meet the assessed care needs of residents. They are informed by industry comparisons and determined by reference to Commonwealth funding and profit surpluses (see Gilbert Exhibit 11-21 WIT.0430.0001.0001 at 0028 [155]-[156] and Mathewson Transcript 5995:1). Ms Sargent gave candid evidence about the setting of rosters at Pioneer House in the course of the Mudgee Hearing by reference to the budget process, the ACFI and benchmarking (Sargent Transcript P-6377:30-31). As Mr Gilbert said in his oral evidence to the Commission:

> *"...staffing levels are currently set by reference to the StewartBrown report...*
> *The StewartBrown report. It's a chartered – a firm of chartered accountants, I think, who take data from about 900 aged care facilities and then they send that out to their clients and you can compare how much you spend on meals compared to another facility, how much you spend on care compared to another facility ...* [the providers] *use that to decide whether their care is at the right level. If I'm sitting at this comfortable level that's kind of like most other people, that's good enough. And that's the benchmark they're now using to set staffing levels...*
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> *...we're advocating for a case mix-based funding system that is linked to mandated minimum nursing hours per patient day which includes a skill mix of personal care staff and nurses. That will turn into a ratio; it's just the nature of the industry. And ratio is simply X number of staff for X beds. There's already ratios now; they just dreadfully low.*
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> *So if we implement ratios, the benefit of that, of course, is it sets in stone that that money is for care and that care will be delivered and there's no gaming opportunity. The five star system haunts me a little bit. I can see the initial attractiveness of it. But as I said, the employers currently compare with each other what is an acceptable level of care. They could drive that star level down through that comparison process and then we will end up back where we started from..."* (Gilbert Transcript P-6016:22 – P-6017:6)

32. The practical effect of rostering a particular number of staff (which is comprised of a particular skills mix) in a facility that has a particular number of residents is a staffing ratio. For example, rostering five staff on a day shift, four on an evening shift, and two on a night shift, in a facility with 30 beds, produces the following ratios: AM 1:6, PM 1:7.5 and ND 1:15 (see Gilbert Exhibit 11-21 WIT.0430.0001.0001 at 0028 [154]).

33. Ms Hills gave evidence that at Benetas the:

> *"...roster was created based on experience, industry trends, individual organisational trends and service level trends. The staffing profile of the Best Life Model of Care is designed to support the residential environment being a "home first"..."* (Hills Exhibit 11-59 WIT.0450.0001.0001 at 0007)

34. It should be noted that Benetas in Victoria is one of the very few providers that has an enterprise agreement that regulates staffing in some detail (Gilbert Exhibit 11-21 WIT.0430.0001.0001 at 0014 [79]–[92]).

35. Mr Hearn's evidence about rosters at Resthaven facilities was that rosters were fixed by reference to the budget process, data on resident needs and:

> *"Workforce planning references available industry information (e.g. Stewart Brown benchmarking); informal locally shared industry information (e.g. about care management case-loads); internal management, and staff, resident and client feedback."* (Hearn Exhibit 11-62 WIT.0440.0001.0001 at 0008)

His evidence was that Resthaven:

> *"... contributes to the Stewart Brown benchmarking reviews where direct staffing is compared and reviewed on a quarterly basis. Additionally, during the preparation of budgets each year, all site rosters are reviewed, compared and costed to ensure a level of consistency."* (Hearn Exhibit 11-62 WIT.0440.0001.0001 at 0014)

36. In his oral evidence, Mr Mathewson (ACSA) acknowledged the use of the Stewart Brown benchmarking but said that proprietors do not slavishly follow the range of benchmarks provided in the reports (Mathewson Transcript P-6017:45). Proprietors also refer to the character of RACFs as relevant to the question of staffing levels. For example, Mr Mathewson referred to the need for clarity around whether RACFs are "health or a social model of care" as being critical for the workforce profile (Exhibit 11-19 WIT.0362.0001.0001 at 0010 [40]). This question of RACFs either providing a home or providing clinical care has been raised on a few occasions and was answered directly by Professor Eagar: they can do both (Eagar Transcript P-5776:24-27). ANMF adopts Counsel Assisting's submission that the two roles of RACFs are not mutually exclusive in this regard (Counsel Assisting Transcript P-6294:22).

37. In the Hobart hearing the Commission heard evidence from Ms Webb about the fixing of rosters at BUPA Hobart South. She gave evidence about the development of rosters by plucking numbers out, such as 2.5 hours per resident and relying upon industry benchmarking (Webb Transcript P-7032–7033). Mr Cooper explained that reference to the Stewart Brown reports to develop a roster "gave us a really good guide as to what we could use as an average hours per resident per day" (Cooper Transcript P-7146:10).

38. The Commission also heard from Mr Crane and Ms Williams about staffing at Southern Cross Homes in Tasmania. Mr Crane referred to the Pathway to Break Even rosters as having been "heat tested" against industry benchmarks and the history of staffing at the facility (Crane Transcript P-6795:44-45). Ms Williams gave evidence about the use of QPS Benchmarking reports in connection with staff rosters (Williams Transcript P-6740). Some of those QPS Benchmarking Reports were in evidence (e.g. Exhibit 13-2 (Tab 36) SCT.0011.0003.0002). Importantly, those reports do not specifically address staff numbers or skills mix at facility level.

39. It is submitted that the Commission can readily conclude that the setting of rosters and staffing in the sector is to a significant degree not determined by the properly assessed needs of residents. Mr van Duuren (MiCare Limited) gave evidence of the roster at Avondrust having been a model applied since 2007 for a non-clinically focussed home that had 65 high care residents (van Duuren Transcript P-3522:1-23). Indeed, the references to benchmarking suggest that benchmarking against current industry practice is used as a mechanism to avoid regulatory scrutiny or criticism.

Industrial solutions to staffing are not available

40. The ANMF has sought to fill the regulatory gap around minimum staffing by trying to negotiate with the providers for minimum staffing requirements to be included in enterprise agreements. This has been largely unsuccessful: "*I think we've got three approved providers in Victoria who've got any level of ratio-type staffing arrangement, and otherwise it's just, you'd have to say, been an impossible thing to achieve in bargaining*" (see Gilbert Transcript 5976:14-17 and Gilbert Exhibit 11-21 WIT.0430.0001.0001 at 0012 [68] – 0017 [94]). There are many facilities that do not even have a basic standard of 24/7 Registered Nurse coverage (see Gilbert Exhibit 11-21 WIT.0430.0001.0001 at 0012 [68] – 0013 [72]; 0017 [94]). The current industrial arrangements involve a Modern Award prescribing minimum terms and conditions that exclude staffing prescription and Enterprise Agreements, the terms of which require agreement by the relevant employer.

41. The providers have refused claims for minimum staffing ratios on the basis that it is an "operational matter" (see Field Transcript P-5989:10). The Commonwealth Minister for Aged Care and Senior Australians, Senator the Hon Richard Colbeck, said in a letter dated 20 September 2019, "The Government's view is that aged care providers are best able to determine their workforce needs and staff skill mixes. This is because the relationship between staffing in aged care homes and the quality of the care provided is complex" (see Exhibit 11-1 (Tab 19) RCD.9999.0233.0228).

Adequate staffing: assessment of adequacy left to the providers

42. Notwithstanding the views of the providers, the Commonwealth, the Minister, and the statutory responsibility of providers to maintain an adequate number of appropriately skilled staff (see section 54.1(1)(b) of the *Aged Care Act 1997*), there is no evidence before this Royal Commission that present staffing levels are adequate to ensure that the care needs of residents are adequately met. Mr Bonner's explanation of the difficulty with section 54 was that:

"The provision – in the vernacular – is as long a piece of string. So in whose eyes ... the appropriate number of skilled staff and what are the needs of residents that we're seeking to meet. And that's been an issue that two Productivity Commission inquiries have grappled with over the last two decades – and asked the question about how do we go about quantifying that. There has been no accepted standard in this country at least about what the appropriate answer to that is. So it has always fallen into matters of opinion, matters of conjecture, matters of debate. And when the standards organisations have been going in and assessing that, of course, there's been no real measuring stick that will allow them to determine on any objective measure whether or not the staffing-numbers and mix are appropriate for the needs of the clients." (Bonner Transcript P-6029:1)

43. Professor Willis' evidence was unambiguous in respect of the system meeting the needs of residents:

"MR ROZEN: Dr Willis, anything you'd like to add to that?

DR WILLIS: Only to say that – objectively, that we have done research in which the workers say they cannot do all the work that is required. So it's clear, that it's not met."
(Willis Transcript P-6029:15)

44. This difficulty of assessing appropriate staffing was further illustrated by Ms Wunsch's evidence. She stated that the Aged Care and Quality Commission did not provide its assessors with any guidance on the range of care staff to resident ratios that might be adequate for adequate care or any guidance on the nurse hours per day that might be regarded as reasonable (Wunsch Transcript P-5962 – P-5963).

45. The Aged Care Quality and Safety Commission Standard 7 – Human Resources for RACFs provides as follows:

"7(3)(a) *The **workforce is planned** to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services."* (emphasis added) (Exhibit 11-1 CTH.4016.2000.0010)

There is scant evidence of any planning by providers of their workforce that has as its focus the delivery of safe and quality care.

The absence of industry or Government initiatives for staffing prescription

46. The Royal Commission has heard numerous references to the report of the **Aged Care Workforce Strategy Taskforce** (the Taskforce), A *Matter of Care* (the Report) (Exhibit 11-1 (Tab 205) ACW.9999.0001.0022). The Taskforce was chaired Professor Pollaers who gave evidence to the Commission (Exhibit 11-3 WIT.0361.0001.0001). Providers have generally endorsed the Report's "Strategic Actions". Strategic Action 6 is the proposal most directly related to the question of staffing. This proposal responds to the absence of any systematic workforce model in the industry by suggesting that providers:

- Develop individual holistic care plans for residents;
- Aggregate the care plans into a single intervention plan that determines workload;
- Applies the intervention plan to determine workforce; and
- Establish a committee to periodically assess that care plans are delivered.
  (Exhibit 11-1 (Tab 205) ACW.9999.0001.0080–0081)

47. With due respect to the work of the Taskforce, the strategic action 6 response was, and is, a profoundly inadequate response to the staffing failures in RACFs, as it does not present evidence-based solutions, methodologies or models which would ensure sufficient staffing to meet residents' needs. In fact, it effectively endorses more of the same, that is, no clear direction or guidance to assist providers in staffing to ensure safe, quality care. Further, it demonstrates a misunderstanding and misrepresentation of evidence-based staffing models relevant and applicable to the industry by describing them as "fixed staffing ratios", and a "one size fits all approach" and leaves it to employers to "lead" the process. (Exhibit 11-1 (Tab 205) ACW.9999.0001.0078–0080).

48. The ANMF rejects Counsel Assisting's endorsement of the Taskforce's Report as "broadly on the right track" (Counsel Assisting Transcript P-6299:27) with regard to the Report's proposals on the question of safe staffing levels that would ensure quality care. It manifestly provides no blueprint on that issue.

49. The inadequacy described above has been compounded by the Government's responses to the staffing and workforce issues highlighted in the Report. Noting in particular the Department's advice, seemingly accepted by Government, that a formal response to the industry led Taskforce (which did not included representation from any union or employee organisation):

> *"... 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."* (emphasis added)
> (Exhibit 11-1 (Tab 226) CTH.1000.0003.5207 at 5208 and Beauchamp Transcript P-6266:17)

50. The Commonwealth's position in relation to the Taskforce's workforce strategic action (Action 6) was provided by Mr Wann. It supported the recommendation, while leaving it entirely to industry to progress (Wann Exhibit 11-72 WIT.0379.0001.0001 at 0033).

51. In response to Counsel Assisting's reference to Professor Eagar's findings about the inadequate levels of care and staffing being delivered to residents (Counsel Assisting Transcript P-6288:45), Ms Beauchamp, a senior Commonwealth officer, responded by saying she would like to better understand the rating system canvassed (Beauchamp Transcript P-6284:8-13).

52. The **Aged Care Workforce Industry Council Limited (ACWICL)** has been established arising from the Taskforce's report. Mr McCoy gave evidence to the Commission about the Company (McCoy Exhibit 11-4 WIT.0451.0001.0001 at 0002). This company:

- was established to progress the Taskforce's strategic actions;
- has a membership comprised of 7 or 8 employer related members and 1 union representative; and,
- has no reporting lines to Ministers, Government Departments or to Industry.

53. Mr McCoy's evidence contained no indication of the steps that might be taken by the Company to progress Strategic Action 6 beyond indicating that it was a priority in the 2020 financial year along with three other strategic actions. (Exhibit 11-1 (Tab 45) IRC.0001.0001.0057)

54. The Commission can have no confidence that the Company will be able to agree upon or deliver a staffing strategy for RACFs that is to be led by the industry.

55. The position remains that there is nothing from Government, the Taskforce, the ACWICL or aged care providers that could give the Royal Commission any confidence that the question of staffing numbers and skills mix at a facility level will be addressed by reference to the objectively assessed needs of residents and the delivery of safe and quality care.

56. There is no direction or even understanding evident from the Commonwealth's position as explained to the Royal Commission on how to address the question of ensuring aged care staffing levels and mixes are sufficient to meet residents' needs.

57. Standard 7 of the Aged Care Quality Standards now require providers to demonstrate that their workforces have the right skills mix, are competent and with the right qualifications and trained and equipped to deliver outcomes against the standards. However, the Commonwealth provides no serious and enforceable guidance on how this could and should be achieved. This renders the new standard as barely indistinguishable from the current requirements, thereby almost certainly guaranteeing its ineffectiveness.

58. The Commonwealth, among other stakeholders, appears to be unable, or possibly refuses, to acknowledge that the work that has been completed through the RUCS, the AN-ACC, has not provided a staffing system but rather has produced a new funding model better suited to residential aged care than the current Aged Care Funding Instrument. Guidance on how to ensure safe and sufficient staffing to meet residents' care needs is still required. This is addressed in detail in these submissions in Part 1-2: The Proposal.

59. It is submitted that in the case of providers the Commission should reject any suggestion that the industry itself is either genuinely willing or capable of establishing, introducing and applying staffing arrangements in RACFs that meet the properly assessed needs of residents. It has been demonstrated to the Commission that providers have failed to do so over decades, they have a record of diverting funds directed to improving staffing (Gilbert Exhibit 11-21 WIT.0430.0001.0001 at 0021 [128] ff; Gilbert Transcript P-5997:6 – P-5998).

60. Without clearly prescribed staffing guidelines, underpinned by an evidence base supporting their efficacy in terms of ensuring safe, quality care there is no prospect of the industry achieving an 'appropriate' or 'adequate' minimum staffing and skills mix.

Nurse-to-patient ratios

61. The staffing model of minimum nurse-to-patient ratios, now legislated in both Victoria and Queensland, has been drastically misrepresented in both public commentary and evidence before the Commission (Elderton Transcript P-188:18-33). Nurse-to-patient ratios (frequently just referred to as 'ratios' with very little understanding of they are applied and how they work in practice) are criticised for being 'rigid, inflexible, ineffective, and costly' (Elderton Transcript P-187:37 – P-188:9; Beauchamp Transcript P-338:37-43; Mersiades Transcript P-477:19-38; Sparrow Transcript P-431:1-21).

62. In fact, the evidence in support of nurse-to-patient ratios as a cost effective staffing model, which not only ensures safe, quality care but has been demonstrated to improve the quality of care, is overwhelming. The leading international researcher in the area, Professor Linda Aiken, states that the effectiveness of minimum nurse-to-patient ratios and an appropriate skills mix (implemented in accordance with an evidenced-based framework) is indisputable.[3]

63. Significant evidence in this regard has also been drawn from evaluating the impacts of legislated nurse-to-patient ratios in Australia (see 'Nurse-to-Patient Ratios in Queensland Health Facilities' (University of Pennsylvania, School of Nursing, Center for Health Outcomes and Policy Research) which is attached to this submission and marked **ANM.0015.0003.0001**).

64. In addition, direct evidence was provided to the Commission by Mr Gilbert about the application of ratios in the Victorian public sector including in residential aged care (Gilbert Exhibit 11-21 WIT.0430.0001.0001 at 0029–0032 [152]–[180]). That evidence pointed in particular to the benefits accruing to staff of the certainty of staffing allocation and the impact on attraction of the introduction of ratios. Contrary to the unsupported opinion of Associate Professor MacFarlane to the effect that introducing increased staffing requirements would exacerbate staff shortages (MacFarlane Transcript P-1766:35-37), the Victorian experience and evidence provided by Mr Gilbert is that the regulation of staffing, and thus the regulation of workload, attracted nurses into the workforce. It was estimated that in the first three years following the initial implementation of nurse-to-patient ratios in Victoria, thousands of nurses returned to the workforce.[4]

65. The return of nurses and the increase of new entrant nurses to the workforce in Victoria following the implementation of nurse-to-patient ratios is further demonstrated by the table below – nurse and midwife registrations in Victoria from 1992 – 2010.

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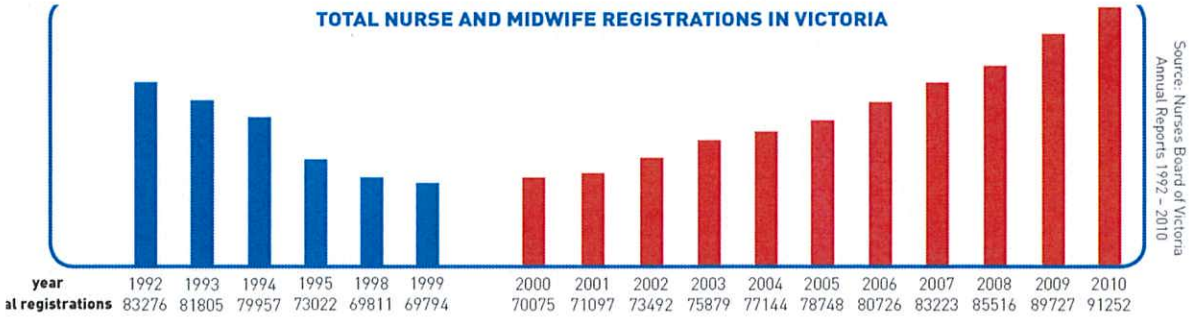
[3] See Aiken LH, Sloane S, Griffiths P, et al. 2017. Nursing skill mix in European hospitals: cross-sectional study of the association with mortality, patient ratings, and quality of care [Internet]. *BMJ Quality and Safety;* 26(7):559-68. Available online: http://dx.doi.org/10.1136/bmjqs-2016-005567;
More nurses means more nurses [Internet]. 2019. *Kai Taiki Nusing New Zealand*; 25(6):12. Available online: https://search.proquest.com/docview/2264566134/fulltext/1E588BFBB7EC4B80PQ/1?accountid=14649.

[4] See *Nurse/midwife:patient ratios: It's a matter of saving lives*, ANMF Victorian Branch, 2014. Available online: http://www.anmfvic.asn.au/~/media/f06f12244fbb4522af619e1d5304d71d.ashx.



year	1992	1993	1994	1995	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
al registrations	83276	81805	79957	73022	69811	69794	70075	71097	73492	75879	77144	78748	80726	83223	85516	89727	91252

66. Ms Peake also gave evidence about the Victorian public sector ratio arrangements (Peake Exhibit 11-29 WIT.0481.001.0001), which provided a powerful demonstration of the positive impact of staffing ratios in the public sector facilities compared to non-public sector facilities on:

- Comparative non-compliance;
- Complaints relating to nurse sensitive indicators;
- Ambulance attendances;
- Residential in reach service usage.

67. It is submitted that the evidence of the Victorian experience of ratios that have been legislated and prescribed industrially over almost two decades overwhelmingly supports the benefits of prescription of RACF staffing, if not the precise form of that prescription.

Mandated Staffing is central

68. In its Interim Report, the Commission observed that workforce issues are relevant to every aspect of its inquiry (page 232). The quality and safety of the care delivered to RACF residents is fundamentally influenced by the number and skills of the staff delivering that care. The ANMF's primary focus is unapologetically on that issue; safe staffing levels and safe workloads are the highest priority issues for ANMF members across the country. Reform in that area will impact on almost every issue raised in the Commission's work including such matters as attraction and attention, the educational preparation of staff and the safety of employees.

69. We turn now to the staffing proposal that is before the Commission.

PART 1-2: The Proposal: Mandated minimum staffing levels and skills mix

70. There are three models or tools related to staffing currently before the Commission:

a. The Australian Nursing and Midwifery Federation (ANMF) Staffing and Skills mix model
b. Australian National-Aged Care Classification-derived funding model (AN-ACC funding model)

c. The United States (US) Nursing Home Compare Five Star Quality Rating System (NHC Rating System)

71. The ANMF submits that only the first model above, the Australian Nursing and Midwifery Federation (ANMF) Staffing and Skills mix model, is an actual staffing model. The other two models represent respectively, a funding model and a rating system – all different. The ANMF's Residential Aged Care Staffing Calculator (RACSC) is an instrument to give effect to the ANMF Staffing and Skills mix model. This tool was the subject of detailed evidence from Mr Bonner (Exhibit 11-28 WIT.0488.0001.0001 at 0017 – 0025 and Exhibit 11-1 Tabs 98 – 104).

72. The ANMF further submits that a mandated minimum staffing level and skills mix of RNs, ENs, and PCWs is required to ensure that RACFs are able to effectively and appropriately meet the care needs of their residents. The ANMF acknowledges and recommends that other actions must also be taken to support and sustain the delivery of safe, quality care in RACFs. This includes but is not limited to improved education, training, and regulation of staff, an improved and fit-for-purpose funding model, and an accessible and understandable system for ensuring that consumers are informed regarding the quality of care and staffing delivered by RACFs. However, safe quality care will not be achieved without mandating evidenced-based minimum staffing levels and skills mix.

73. The Royal Commission has heard important evidence about such matters as staff attraction and retention, the importance of clinical leadership in RACFs, the need for transparent consumer information, and the role and responsibilities of Boards of Management. The ANMF contends that the single most important initiative that could be taken to improve the quality and safety of care in RACFs is to mandate staffing and skills mix. It is submitted that the enthusiastic pursuit of other initiatives whether or not supported by Government and proprietors will be in vain in the absence of staffing prescription. As Mr Gilbert put it, with all his experience, there is a tendency for employers left to their own devices to race to the lowest common denominator (Gilbert Exhibit 11-21 WIT.0430.0001.0001 at 0021 [124]).

74. The next section of this submission addresses the differences and relationships between the three separate models that have been proposed for use by Australian RACFs.

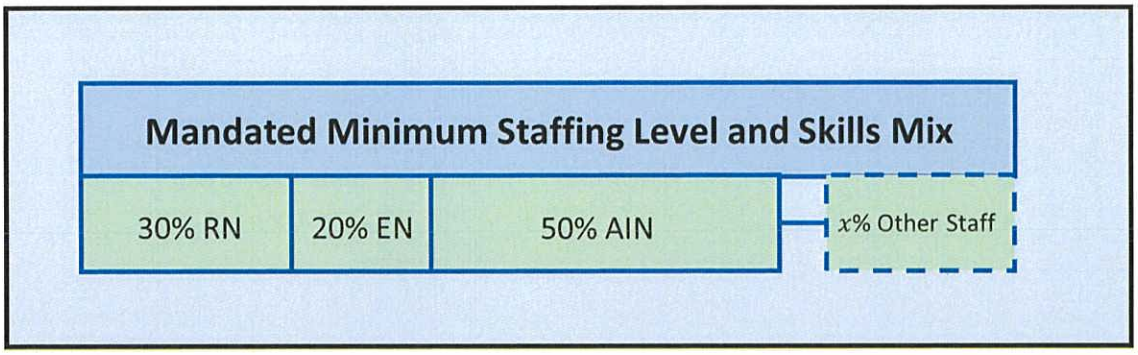
Mandated minimum staffing levels and skills mix

75. To ensure that safe, quality best-practice care is provided to every person in aged care, the right number of the right kind of staff are essential. The ANMF have recommended mandated minimum staffing levels and skills mix to ensure the necessary, best-practice care for people in RACFs based upon individual resident needs. The ANMF submits the prescription should be based on an average of 4.3 hours of care per day with a skills mix of 30% Registered Nurses, 20% Enrolled Nurses and 50% Personal Care Assistants. These mandated requirements should be implemented in accordance with the Plan, "Aged care ratios make economic sense" (Exhibit 11-1 (Tab 105) ANM.0001.0001.3341; Bonner Exhibit 11-21 WIT.0488.0001.0001 at 0025 [64] – [65]).

76. The ANMF commissioned a study to provide an evidence base for a methodology to inform nursing and carer staffing levels and skills mix in RACFs.[5,6] A two-part, mixed-methods study collected and analysed evidence and expert opinion sought to establish recommendations.

77. The study determined that residents should receive an average of 4.3 (four hours and 18 minutes) resident and personal care hours per day (RCHPD) with a minimum staffing and skills mix requirement of 30% registered nurses (RN), 20% enrolled nurses (EN), 50% and personal care workers (PCW) (**See Box 1**).

Box 1: Mandated minimum staffing levels and skills mix



78. One part of the study involved presenting focus groups with six exemplar resident profiles. These profiles were informed by a desktop modelling methodology for staffing from 200 care plans which determined the percentage of nursing and personal care time needed for each resident profile based on the interventions that should be completed over a 24-hour period, and the time taken to complete those interventions inclusive of time for indirect and environmental tasks (see **Table 1**).[7] The profiles illustrate how different residents have different care requirements and that with increasing clinical acuity, personal care needs, and need for assistance with activities of daily living, staff would need to devote longer periods of time to each resident to ensure that high quality, best-practice care is provided safely and appropriately. This was expressed in terms of resident nursing and personal care hours per day (RCHPD). One part of the study was undertaken to develop evidence-based figures based upon the time taken to complete the various tasks required to provide care, while an expert focus group recommended an additional 30 minutes of time per resident to provide additional indirect care for all residents. Each of the exemplar resident profiles are accompanied by a list of care tasks

[5] Exhibit 1-20 ANM.0001.0001.3151.

[6] The ANMF recognises the integral role that other staff play in delivering and supporting safe, quality care for RACF residents. While the ANMF Staffing and Skills mix study focussed solely on the work of RNs, ENs, and PCWs, other direct-care (e.g. allied health, doctors, specialists) and support staff (e.g. domestic services, chefs etc.) are essential and further work is required to underpin evidence-based recommendations regarding the staffing and skills mix of these groups.

[7] While evidence-based, the six resident profiles are also illustrative or 'typical'. The purpose of identifying six discrete resident profiles is not to suggest that every person's individual care requirements and preferences would neatly correspond with the care that the ANMF Staffing and Skills mix study described. Every individual in a RACF has different and unique needs and preferences for care that should underpin and direct the care that they should receive.

that were not calculated into the recommendations for care required per resident per day, so the timings reported are likely to be at the lower end of what residents require each day to be provided with best-practice care.

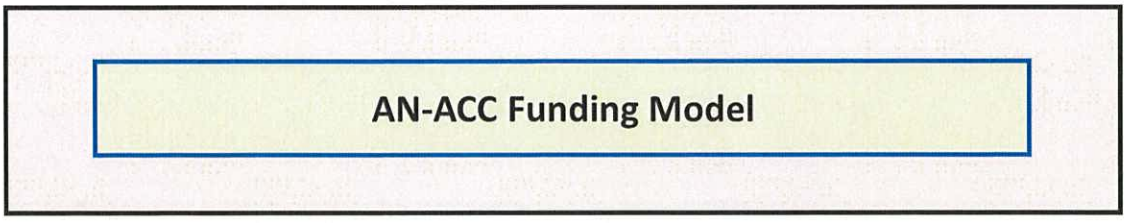
Table 1: ANMF Staffing and Skills Mix study typical resident profiles

Profile	Registered nurse care (mins)	Enrolled nurse care (mins)	Personal care worker care (mins)	Total nursing and personal care minutes per resident/ day	Recommended RCHPD*
1. 'Voula'	45	30	75	150	180 (3 hrs)
2. 'Gwen'	54	36	90	180	210 (3.5 hrs)
3. 'George'	63	42	105	210	240 (4 hrs)
4. 'Walter'	72	48	120	240	270 (4.5 hrs)
5. 'Sarah'	81	54	135	270	300 (5 hrs)
6. 'Norma'	90	60	150	300	360 (6 hrs)^
* Including the extra 30-mins per resident per day for indirect care recommended by the focus group. ^ Norma is recommended to receive an additional 30 mins due to palliative care needs					

Australian National-Aged Care Classification (AN-ACC) funding model

79. The AN-ACC funding model is a proposed model for funding residential aged care in Australia. Australian National-Aged Care Classification Version 1 consists of the AN-ACC assessment, AN-ACC case mix classification, and the AN-ACC funding model (see **Box 2**).[8] A key feature of the AN-ACC approach is that resident assessment for funding is proposed to be undertaken by external assessors and separate from care and staffing planning which are to be undertaken by RACFs internally and based upon individual resident need. The AN-ACC approach was not designed to and does not provide an approach for determining staffing levels or care plans for residents.

Box 2: AN-ACC funding Model.



80. The AN-ACC assessment approach, case mix classification, and funding model was developed from the Resource Utilisation and Classification Study (RUCS) conducted by the Australian Health

[8] The AN-ACC System is designed to determine the cost of *care* specifically. Other costs of aged care such as capital accommodation and other 'hotel' services were beyond the scope of the study, as was care for non-permanent residents (e.g. respite care).

Services Research Institute (AHSRI) and commissioned by the Commonwealth Department of Health.[9]

81. The RUCS was a national study into needs, costs, and classification of residential aged care. The RUCS:

    a. Identified the clinical and need characteristics of aged care residents that influence the cost of care (cost drivers).
    b. Identified the proportion of care costs that are shared across residents (shared costs) and the proportion that are related to individual needs (individual costs).
    c. Developed a 13-category case mix classification based on identified cost drivers that can underpin a funding model that recognises both shared and individual costs.
    d. Developed a new funding assessment that efficiently allows for each resident to be assigned to one of 13 payment classes based on their needs.
    e. Tested the feasibility of implementing the recommended classification and funding model across the Australian residential aged care sector.

82. Importantly, the authors of RUCS highlight that 'price' was beyond the scope of their study and note that payers (i.e. Government and consumers) must be involved in decision making regarding the actual monetary figures paid to RACFs to provide care to residents. In terms of price, the RUCS utilises terms such as 'relative value unit' (RVU) to explain a measure of resource consumption (staff time or dollars) where an RVU of 1.2 refers to a cost being 20% above the national average of 1.0. The value of 1.0 RVU is the price to be determined by the payers, but its monetary value is unknown. The authors suggest that a group such as the Department of Health or the Independent Hospital Pricing Authority could undertake yearly studies to inform a 'National Efficient Price' (NEP) which involves an explicit relationship between the cost and price of care where price equals 'efficient cost' plus a reasonable return on investment. This approach is already implemented in the national hospital funding model.

83. It is extremely important that a suitable NEP be determined and regularly reviewed and updated if necessary. If the NEP is too low, then insufficient funding would be provided to RACFs to enable them to deliver the necessary care to residents. Providers may cut costs through reducing staffing and the use of resources for clinical and personal care which in turn puts residents at risk. Likewise, if the NEP is too high, RACFs could unfairly receive surplus funding that may not be used for the provision of care to residents. The ANMF recommends that RACFs should be held publicly accountable for the use of funds provided to them for the care of residents and sees no reason why providers should not be required to publish transparent information so that those who pay (i.e. the government and consumers) are able to easily see how funds provided specifically for resident care via the AN-ACC has been spent.

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[9] Eagar K. et al. 2019. Resource Utilisation and Classification Study – RUCS Overview and Reports [Internet]. Australian Government Department of Health. Available online: https://agedcare.health.gov.au/reform/resource-utilisation-and-classification-study-rucs-overview-and-reports

84. Within the AN-ACC there is a proposed once-off 'adjustment payment' for each new resident entering a facility for the first time, a fixed price per day for the costs of the 'shared care' that all residents receive which may vary by location and other factors, and a variable price per day for the costs of 'individualised care' for each resident based on their AN-ACC case mix class. The ANMF recommends that aged care providers be held publicly accountable for the transparent use of funding for each of these payments.

85. The ANMF has provided substantial feedback on the proposed AN-ACC approach during the public consultation, and is generally supportive of the approach as an improvement on the current Aged Care Funding Instrument (ACFI) and a promising funding model for residential aged care in Australia. Importantly, the ANMF highlights that the AN-ACC has been developed based upon data that has been collected through the RUCS of the care provided to residents to develop a funding model for that care, rather than to underpin the provision of care that residents *should* receive.

86. The AN-ACC is being trialled in RACFs across Australia for 10,000 residents with the outcome of that trial expected to conclude in April 2020 (Beauchamp Transcript P-6284:20 – P-6285).

Nursing Home Compare Five Star Quality Rating System (NHC Rating System)

87. In the US, the Centers for Medicare and Medicaid Services (CMS) NHC Rating System provides consumers with an online five-star rating system for Medicare- and Medicaid-certified RACFs across the country (see Box 3).[10]

Box 3: The five-star NHC Rating System.

88. The purpose of the NHC Rating System is to inform consumers regarding how well specific RACFs perform in terms of:

    a. health and fire safety inspections
    b. staffing including RNs and other staff
    c. care for their residents

[10] Nursing Home Compare. 2019. Design for Nursing Home Compare Five-Star Quality Rating System: Technical Users' Guide October 2019 [Internet]. United States Government Centers for Medicare & Medicaid Services. Available online: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/usersguide.pdf

d. preventing abuse
e. maintaining compliance to protect resident health and safety

89. The NHC Rating System was not designed to and does not provide an approach for determining staffing levels, care plans for residents, nor a funding model for paying for the costs of care. It is not a staffing model. There still needs to be an agreed community benchmark that all of the providers reach.

90. The NHC Rating System is "not used for allocation or future rostering of staff. It's used for retrospective guidance in terms of what measures of quality have been achieved from the system considering those staffing-inputs." The ANMF's Residential Aged Care Staffing Calculator (RACSC), on the other hand, "is about helping people understand over time what they should be putting in the rosters this week, next week and the month after by constant refreshing of the resident profile over time." (Bonner Transcript P-6046:18)

91. The 'star-rating' approach is used by NHC to provide consumers with information derived from the CMS health inspection database, a national database of resident clinical data known as the Minimum Data Set (MDS), and Medicare claims data in an accessible format (see **Table 2**). While the ANMF acknowledges the importance of monitoring and reporting each of the above factors to consumers, this submission is specifically focused upon the staffing-related element of the NHC rating system.

Table 2: ANMF Staffing and Skills Mix study typical resident profiles mapped onto NHC Rating System.[11]

RN Rating and Minutes		Total nurse staffing 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	★★	★★★	★★★	★★★	★★★★
4	44 - 63	★★★	★★★^	★★★★^	★★★★^	★★★★^
5	≥ 63*	★★★	★★★★	★★★★	★★★★★	★★★★★

Table Legend

- Values provided by CHSD Report, interpreted as >63 / >264 to maintain mutual exclusivity. Where Resident Profile 3 requires 63 minutes of RN staffing per day, different interpretations of ≥ 63 / ≥ 264 rate Resident Profile 3 significantly differently.

[11] Table adapted from the UoW Report (originally adapted from the CMS Technical Users' Guide April 2019) along with ANMF Staffing and Skills Mix study typical resident profiles.

^ Resident Profile 3 is only allocated this star rating where RN time is maximised within the category (i.e. 63 minutes), if not maximising RN time in this scenario (i.e. <63 minutes) then ^ indicates star ratings that would not be appropriate for Resident Profile 3.

▨ Cross-hatched cells indicate where an ANMF resident profile staffing requirement is exceeded either by additional RN minutes or additional total staff minutes.

– – Broken-outline cells indicate a rating required to deliver minimum best-quality care (inclusive of the additional recommended 30-minutes of care) as determined by the ANMF Staffing and Skills Mix study.

92. The overall staffing rating is based on two measures; RN hours per resident per day (due to the widely recognised importance of specifically RN-delivered care for better resident outcomes), and; 'total staffing' hours per resident per day including RN, Licensed Practical Nurses (LPN)/Licensed Vocational Nurses (LVN), and Certified Nursing Aides (CNS) time. Other staff (e.g. allied health, doctors, diversion therapists) are not included. This information is submitted quarterly and is auditable. Both direct care hours and other staff time (e.g. administrative duties) are collected, so the times do not reflect the actual direct care time that staff deliver to residents.

93. The CMS adjusts the reported staffing ratios for the needs of a RACF's residents using the Resource Utilization Group (RUG-IV) case mix system. The Staff Time Resource Intensity Verification (STRIVE) study is then utilised to provide the average number of RN, LPN, and CNS minutes associated with each RUG-IV case mix group. These ratings are then combined to assign an overall staffing rating. For RN staffing and total staffing, a 1- to 5-star rating is assigned according to thresholds established for each rating category. A RACF may be assigned a 1-star rating if they do not have an RN onsite every day, do not submit staffing data, or where RACF data cannot be verified.

94. The thresholds or cut-off points between star ratings for both RNs and 'total staffing' are periodically updated in consideration of the clinical evidence for the relationship between staffing and quality of care. 'Total staffing' scores are also rounded towards the RN staffing rating due to the importance of RN-delivered care.

95. It should be noted at the outset that the NHC Rating System did not build its staffing profiles based on an assessment of needs, but rather on analysis of supply against outcomes. It observes "the inadequacy that is already there rather than working from what is required and then building the hours from a zero base. So that's the difference of our approach" (Bonner Transcript P-6041:26). Harrington and colleagues have argued that the staffing levels in many US facilities are dangerously low and that enforcement of the existing standards is weak despite State-based

minimum staffing standards that are higher than the federal minimum.[12] That review also states that higher State-standards than the federal standards have been demonstrated to have significant positive effects on staffing levels and quality outcomes.

96. One possible outcome of adopting a rating system for RACFs is to drive increased market competition between residential aged care providers.[13] On one hand, providers may compete in order to attain higher staffing ratings and thus greater consumer confidence and custom.[14] On the other, if the rating system does not truly represent or relate to the delivery of safe, quality care (i.e. the NHC rating system does not report actual care received by residents and the brackets between ratings are not based upon actual care required), consumers will still not be adequately informed of the real-world care being provided in RACFs.[15] Furthermore the significance of market competition and consumer choice is heavily constrained by the lack of availability in the real world of choice particularly in regional and remote communities. As reported in a recent study by Ryskina and colleagues, improvements in RACF star ratings after the release of the NHC Rating System were not accompanied by improvements in potentially preventable hospitalisations—a broader measure of outcomes for post-acute care patients.[16]

97. Further, according to the NHC rating system, there are multiple avenues to achieve higher ratings (i.e. increasing RN employment hours and/or increasing total staff hours). Indeed, while there are five overall star ratings (one to five stars) there are in-fact 25 possible ratings (see **Table 2** above). This may result in residents not getting the kind of care they need from the right kind of staff as, for example, there are six possible four-star combinations each with different RN and total staff time brackets.

98. Another potential problem that has been noted in the US is inequitable market differentiation; providers located in higher income areas tend to be more likely to have higher star-ratings and residents from more vulnerable populations are more likely to access lower-rated RACFs.[17] This could mean that providers that can attract greater funding from prospective residents and their families will be able to afford to sustain higher-ranked RACFs relative to RACFs in other areas

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[12] Harrington C, Schnelle J, McGregor M, Simmons S. 2016. The need for higher minimum staffing standards in US Nursing Homes [Internet]. *Health Services Insights*. 9:13-19. Available online: https://doi.org/10.4137/HSI.S38994

[13] Perraillon MC, Konetzka RT, He D, Werner RM. 2019. Consumer response to composite ratings of nursing home quality [Internet]. *American Journal of Health Economics.* 5(2):165-190. Available online: https://doi.org/10.1162/ajhe_a_00115

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[17] Konetzka RT, Grabowski DC, Perraillon MC, Werner RM. 2015. Nursing home 5-star rating system exacerbates disparities in quality, by payer source [Internet]. *Health Affairs.* 34(5):819-27. Available online: https://doi.org/10.1377/hlthaff.2014.1084

that may not be able to achieve better staff rankings due to their more vulnerable consumers' inability to pay.

99. The ANMF has provided substantial feedback on the University of Wollongong's (UoW) report *'How Australian residential staffing levels compare with international and national benchmarks'* where the same research group from AHSRI have outlined several international examples of RACF staffing with a considerable focus on the NHC Rating System. The ANMF's commentary on the UoW Report (Exhibit 11-1 (Tab 167) RCD.9999.0231.0011) directed particular attention to the fact that the UoW report failed to recommend changes that would fully address current staffing inadequacies. Instead, the report concluded that the NHC Rating System would be the most appropriate system available on which to build an Australian system to ensure reporting on quality of care and to build a contemporary Australian aged care staffing model. This conclusion is of particular concern because, as is outlined below, the NHC Rating System does not provide a sound basis for a staffing model.

100. In relation to the NHC Rating System, the ANMF submits that while a rating system (which could operate in a similar fashion to the NHC Rating System) would be an appropriate approach for informing consumers regarding RACF staffing, the NHC Rating System should not be adopted whole-scale in Australia due to noted deficiencies. As we have outlined in our response, according to the NHC Rating System, staffing that would receive a star-rating of less than five stars would not provide safe, quality care for residents. The ANMF disagrees with Professor Eagar that a RACF with a three star rating has an "acceptable" level of staffing. Rostering staff at a three star level would mean that (at least) the most needy half of the resident profile would receive inadequate care (Bonner Transcript P-6046:37-44). The skills mix derived from the NHC Rating System is grossly inadequate (Bonner Transcript P-6047:9).

101. Based upon the evidence underpinning the ANMF's recommendation of mandated minimum staffing levels and skills mix, a rating system in Australia should transparently inform consumers how well a facility is performing in relation to the provision of the best-practice care that residents deserve and require where anything less than what would achieve a 5-star rating according to the NHC Rating System would be deemed inadequate.

102. In the appendix to these submissions (marked **ANM.0015.0002.0001**), each of the ANMF staffing model, the AN-ACC funding system and the NHC rating system have been brought together to demonstrate how each has been designed and performs different functions. A potential relationship between the three models is also considered.

How do minimum staffing levels and skills mix ensure safe, quality care?

103. Based on the ANMF Staffing and Skills mix study and wider evidence including the effectiveness of particularly RN-delivered care, the ANMF argues that without mandated minimum staffing levels and skills mix, safe, quality care cannot be ensured. In short, mandated minimum staffing levels and skills mix helps to guarantee the right number of the right people

present to successfully deliver person-centred, best-practice care plans to all residents regardless of their level of need.

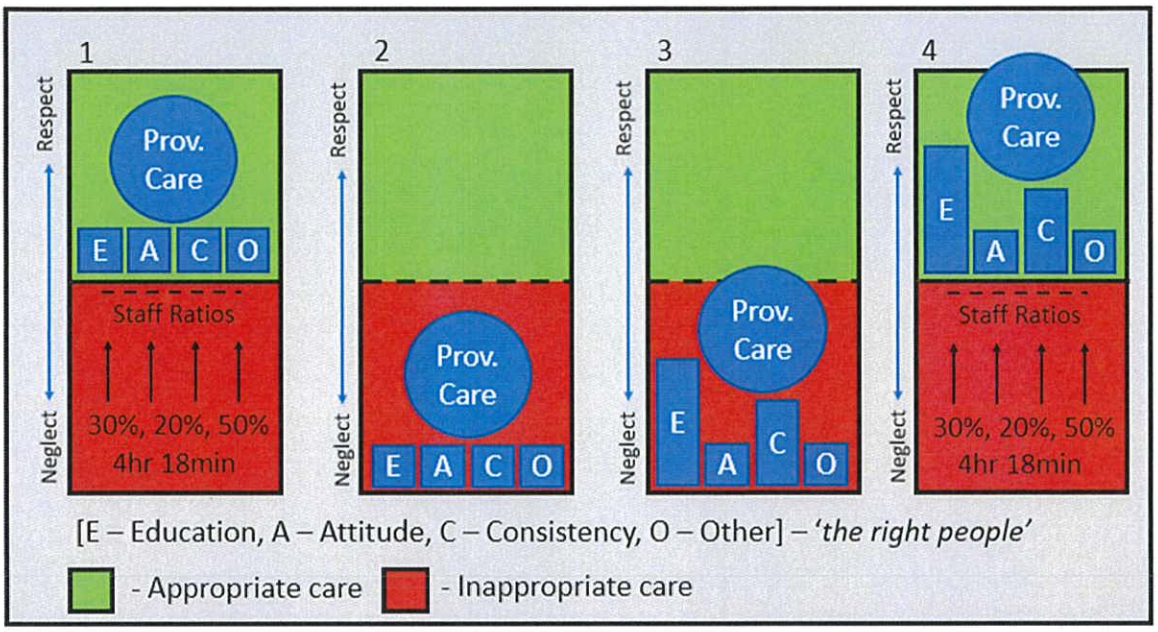

Figure 1: Mandated minimum staffing levels and skills mix (*'the right number'*) ensures safe, quality care.

104. **Figure 1** above illustrates how mandated minimum staffing levels and skills mix ensures the provision of safe, quality care by setting a 'baseline' to ensure that there are always the right number of the right kinds of staff to provide the care that residents need. It is important to highlight too, that mandated minimum staffing levels and skills mix *alone* cannot be successful in ensuring best-practice care, but that without these, best practice care cannot be guaranteed and other approaches may not be effective.

105. As well as mandated minimum staffing levels and skills mix, other factors are integral, these include but are not limited to;

i) **Education** - appropriately qualified, trained, and educated staff to provide clinical and personal care;
ii) **Attitude** - staff with the right attitude and personal conviction to provide compassionate, empathetic care;
iii) **Consistency** - care that is provided by a consistent group of staff who are able to work together effectively and build personal relationships and rapport with residents and their families,[18] and;

[18] While temporary and agency staff may be required on occasion, it is important that residents and their families are able to build genuine relationships with familiar staff. The flexibility of mandated ratios must therefore also be built on ensuring that a provider has an adequately sized workforce to draw upon and not simply rely on temporary staff when residents' care needs change.

iv) **Other** - factors such as involvement of families and loved ones, RACF health and safety standards, quality diets and nutrition, sufficient and transparently utilised funding, a sector that is respected and attractive to work in etc.

106. The ANMF argues that all these factors and more must receive considerable attention and improvement, but without mandated minimum staff levels and skills mix, only modest improvements in the overall quality and safety of the care provided to residents may be realised. Without *at least* the right number of the right staff to provide care, each of the other factors, even combined cannot be expected to guarantee best-practice care.

107. In **Figure 2** below, several alternative examples are provided to illustrate that while different factors can be improved, it is mandated minimum staffing levels and skills mix that ensures that best-practice care is possible.

108. Further, **Figure 2** also illustrates how implementation of a rating system would not ensure safe, quality care as a rating system is designed to convey information to the public not underpin staffing and care planning or delivery. Safe, quality care can only be achieved through the implementation of mandated staffing levels and skills mix.

109. In the top row where mandated minimum staffing levels and skills mix has been implemented, the right number of the right staff are guaranteed. Each of these facilities could achieve five-star care if five-star care meant that every resident would receive the required RCHPD (on average 4.3 RCHPD) from a mandated staffing level and skills mix of nurses and carers, plus all care required from other staff (e.g. allied health and doctors etc), and that care plans and staffing flexes as residents' needs change. The other factors that influence the safety and quality of care would also operate in an additive and complementary fashion, enhancing the overall effectiveness and appropriateness of care and ensuring *respect*.

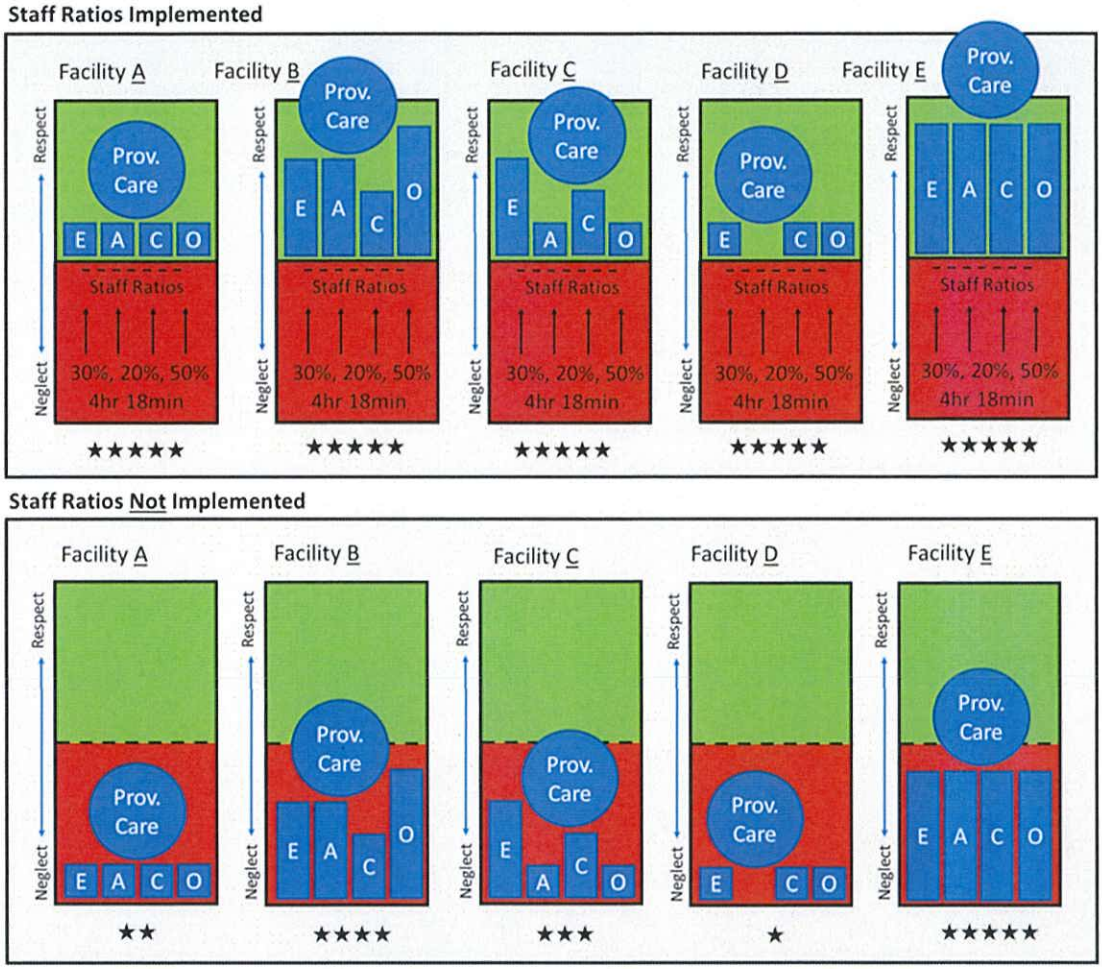

Figure 2: Providing safe, quality care - ratios ensure the right number of the right kind of staff, without ratios, this is challenging.

110. In the bottom row of **Figure 2**, facilities are illustrated where mandated minimum staffing levels and skills mix has not been implemented. Here, residents fall through the cracks when a rating system is implemented without the support of the right number of the right kinds of staff are not assured. This is where residents experience *neglect* – which is sadly the current situation for many people in Australian RACFs.

111. In this bottom row, even with the 'right people' with adequate education, attitudes, consistency of care, and all the other factors necessary to provide safe, quality care (i.e. 'Facility E'), there is simply no way of ensuring even a baseline of the right number of the right kind of staff to provide the care that residents require. A workforce, regardless of their expertise, training, experience, and attitude cannot deliver appropriate care if they do not have the time or co-worker support to physically meet the needs of residents.

PART 2: Who should be covered by a registration scheme for non-clinical staff and, how such a scheme might be implemented, administered and funded

Personal care workers should be covered by a registration scheme

112. To ensure that people receive safe, quality care, regardless of the place they receive care or the care delivery model, minimum standards must be in place. In particular, the vulnerability of the people who are cared for in the aged care sector and the inherent potential for harm in delivering their care demand appropriate regulation.

113. However, as the evidence before the Commission has made clear, while nurses, doctors and some allied health workers are regulated health professionals with clear minimum standards in place, personal care workers (PCWs) (however-titled) currently do not have effective regulatory requirements in place. They are not required to work in accordance with any professional standards and there is no effective process for managing complaints against them. PCWs do not have a minimum education requirement to work in the sector, do not have to maintain regular professional development or need to have professional indemnity insurance.

114. In addition, as there is no national registering or licensing scheme in place for PCWs, consumers, families or employers cannot check to ensure the PCW is appropriate to be looking after them or their loved one, or working for them. This is compounded where PCWs are working independently, such as in the home care environment. Currently, if a care worker is found to be unsafe in the care they provide and is dismissed from their employment, they can move onto another employer with a minimal checking process occurring or, on many occasions, without any process at all.

115. This presents a significant and real risk of harm to the public. As has been presented to the Commission, several incidents detrimental to the aged care resident have already occurred due to poor and inadequate staffing levels and skills mix.

116. A suitable registration scheme for PCWs, who are responsible for direct care of elderly people, must be developed and implemented to reduce and manage this risk.

How a registration scheme for PCWs should be implemented, administered and funded

117. The key purpose of registration of health professionals is to protect the safety of the public, that is, the safety of those in their care wherever the health professional practises and works. The key purpose of any registration scheme for personal care workers (PCWs) should be the same, to protect the safety of the public, in this case, the safety of older Australians receiving care from PCWs wherever that occurs across the aged care system.

118. Benefits of a registration scheme for PCWs would include certainty of the suitability of the worker for the care recipient, their family and the employer, increased credibility for recognition of the PCW's work and role, increased potential for improved career progression, and facilitation of workforce planning.

119. The features of a registration scheme must include as a minimum:

- Oversight by an appropriate, independent national regulatory body
- Minimum education standards provided by accredited training/education organisations

- Minimum communication standards, including English language skills
- Processes for criminal/police history check (and working with vulnerable people check)
- A notifications scheme that manages complaints and concerns and records any conditions, suspensions or cancellations of registration that is available to the public and to employers
- Support through codes of conduct, ethics and standards commensurate with the expectations of the public and the role
- Requirements for continuing education and training commensurate with the role
- A fee structure that reflects the nature of the employee covered by the scheme.

120. The ANMF submits that the most effective mechanism for a registration scheme for personal care workers, which achieves the above, would be via:

The establishment of a separate register for personal care workers on the Nursing and Midwifery Board of Australia (NMBA) within the existing national health practitioner regulation scheme and under the auspices of AHPRA.

121. The benefits to this option include:

- The legislative framework and administrative arrangements for a national registration scheme are already in place, making it a cost effective option;
- Registration would be linked to the quality and standard of training required to be undertaken to enter the workforce via accreditation requirements under the scheme;
- The scheme has existing mechanisms for notification and management of complaints and concerns, and for administering and maintaining a public register;
- The scheme has existing administrative structures to enable the functions listed above;
- The scheme has consistent core standards across all registered professions but allows for individual professional customisation of the standards related to the nature of the role.

122. Establishment of a register for personal care workers would need to develop standards that reflect the scope of the work required of the role (however titled) and the education and training level assessed as required to perform the role. For example, the education standard required for registration should be set at certificate rather than diploma or degree level. English language skills requirements should not operate to unreasonably exclude workers from CALD backgrounds.

123. If a registration scheme is established for personal care workers there will also need to be a sufficient transition time to gain qualifications and/or assess and recognise prior learning and experience, and educate the workforce about the requirements and expectations of registration.

Fees for registration must be set at a level commensurate with salary ranges for this part of the workforce and at a level that does not impose a barrier to registration.

124. The evidence of Mr Gilbert to the Commission on this question was, it is submitted, compelling. In that evidence he referred to the need for a registration scheme as proposed above (Gilbert Exhibit 11-21 WIT.0430.0001.0001 at 0032-0036). The ANMF's earlier submission to the Commission on regulation referred to by Mr Gilbert canvassed regulation options and proposals (ANM.0006.0001.0001 referred to at Exhibit 11-21 WIT.0430.0001.0001 at 0036).

PART 3: Options to resolve low remuneration and poor working conditions, including how the remuneration and working conditions of aged care workers can be aligned with their counterparts in the health and disability sectors

125. The provision of safe and quality care cannot be separated from the people who deliver that care. It is therefore essential to address a range of areas - from entry to the sector through to maintaining a career that is satisfying, appropriately rewarded, secure and comparable to working in the public health sector.

126. The ANMF points out that there are many broader industrial relations reforms that could occur that would, for example, make bargaining in aged care more effective. We do not seek to address the detail of broader industrial reforms in this submission, on the basis that these impact many industries and nursing and care work performed across all sectors. The need for improvement in wages and conditions in aged care is urgent and must be progressed in a targeted industry based manner.

127. The question posed by the Royal Commission asks how aged care workers can be aligned with their counterparts in the health and disability sectors. The ANMF considers the appropriate alignment is with public sector health as in each state and territory public sector enterprise agreements set employment standards. Many of the issues in aged care employment, such as low wages, insecure work and a fragmented workforce are also to be found in the disability sector. The ANMF considers that improvements in aged care that align it with the health sector will also benefit disability workers.

128. Options to resolve low remuneration and poor working conditions must be viewed as components of overall solutions to improve the aged care sector. To improve wages and conditions the primary requirement is to have funding and staffing models in place that ensure:

- Mandated minimum staffing levels and skills mix that meet care needs
- The size and composition of the workforce is appropriate to meet demand both now and into the future and funding meets workforce demand
- There are sufficient funds available to meet the required standard of pay and conditions set by reference to public health sector standards
- The funding is provided with a sufficient level of accountability that ensures money granted for wages and conditions for direct care workers is used for that purpose
- The funding is transparent at both Government and provider levels

Wages

129. Wages in aged care have consistently remained below comparable wages in the public and acute health sectors.[19]

130. To attract and retain staff in aged care it is essential wages match those of nurses and care workers in the public sector health system. This will address the entrenched disparity between aged care and other parts of the health system that results in workers in aged care being regarded as 'second class' and as not performing work that is as valued as other work.

131. For example, nationally and on average, the rates of pay for a Registered Nurse (RN) level 1 sitting at the top of the aged care classification structure earns 15% less in aged care compared to public sector wages. Mr Gilbert gave evidence that, in Victoria, a grade 5 nurse in a public RACF earns 19% more than that same nurse doing that same job in a private RACF.[20] To reach parity with the public sector, aged care wages would have to be increased substantially with amounts varying based on location of work, job classification and relevant public sector rates.

132. Award rates under the *Nurses Award 2010* are also low. For an RN at the top of level, the average difference between rates of pay in the public sector and the award rate is 50% and between the aged care sector and the award rate, 29%. The difference for an Assistant in Nursing (AIN) at both the entry level and top level between the public sector and award rates is 19% and between aged care and award rates around 6%.

133. This disparity supports the proposition that award rates are too low and that the base rate of pay should be increased. For the lowest paid workers in aged care an increase to the base rate of pay under the award would have an impact, however, it is evident this would potentially still leave many workers well behind public sector rates.

134. For the majority of aged care workers, in particular RNs and Enrolled Nurses (ENs), greater impact would be achieved if wages were brought into alignment with public sector rates. This would improve both attraction and retention to the aged care sector.

135. Any increase to base wages in aged care, whether by enterprise bargaining, award reform or industry agreement, must not be at the cost of staffing levels and skills mix. As expressed by Mr Gilbert "our membership understands - is that if they get a high wage increase, then their hours will be reduced"[21].

136. The government must commit to a substantial reform package that achieves both increases in wages, increases in staffing levels and skills mix and secure, attractive working conditions. The base rate of pay must be improved in order to improve attraction and retention to the sector.

Conditions

137. In order to improve wages and conditions across providers and state and territory jurisdictions, there would be considerable benefit to establishing minimum standards for wages and conditions. In essence a nurse or care worker doing the same job should receive the same wages and conditions regardless of location and sector. This is of course premised on raising wages and conditions for all workers via a mechanism of agreed and enforceable conditions.

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[19] Exhibit 11-1 (Tab 174) RCD.9999.0233.0001 at 0025-0026

[20] Gilbert Transcript P-5978:47 and P-6005:7

[21] Gilbert Transcript P-5985

138. Many working conditions are linked to salary, such as shift penalties, overtime payments, the calculation of payment for leave, long service leave and superannuation. If an agreed base rate of salary were established, then salary related conditions would also be raised. This would avoid bargaining at the enterprise level being used to reduce conditions in exchange for offering modest salary increases.

139. In areas with low levels of bargaining, such as in home and community care, agreed minimum wages and conditions would provide an employment basis for workers who are usually excluded from bargaining.

140. The ANMF submits that core conditions should be applicable to all aged care workers regardless of employment status or work site. Baseline conditions that ensure work is properly remunerated and not subject to trade-off is essential for attraction and retention of the aged care workforce. Minimum conditions should address key factors that influence attraction and retention in the aged care workforce including:

- Wages that are comparable to the relevant state or territory public sector rates
- Minimum staffing levels and skills mix
- Provision for transition into the workforce that provides adequate time for training, supervision and mentoring
- Provision for ongoing training and skills development
- Conditions that address workload
- Conditions that support secure work
- Dispute resolution capacity that gives the Fair Work Commission power to deal with and resolve disputes at the request of one of the parties
- Preservation of superior pre-modern award conditions on a state and territory basis

141. Development of minimum conditions must be done with the input of all relevant stakeholders with unions being key stakeholders. The possibility of achieving minimum wages and conditions through industry bargaining is discussed below.

Secure work

142. The Royal Commission has heard evidence about the negative effects of high staff turnover, and the excessive use of casual staff on the quality of care in residential and home care.

143. Care standards for aged care recipients, particularly those with dementia, are improved with consistent and familiar staff. The benefits of consistent and familiar staff include the opportunity to develop relationships, to understand recipients care needs and personal stories, to reduce the risk of medication errors and to be more attuned to changes in health.

144. In addition to the negative impact on quality of care, insecure work has a significant impact on workers in aged care. Job satisfaction, income, skills and knowledge and career opportunities are all decreased with insecure work.

145. The issue of underemployment of part-time workers or offering minimum hours contracts places part-time employees in a particularly vulnerable position. The fear of losing shifts impacts on both the quality of work and the ability to participate and speak up in the workplace. Ongoing part-time employees are utilised by providers as de facto casual or 'on demand' workers.

146. Casual workers, despite doing regular work, may opt to remain casual due to the low base rate of pay making the 25% casual loading necessary to earn a viable wage.

147. ANMF submits providers should be encouraged to maximise the potential of the existing part-time workforce. Workers who wish to increase hours should be offered contracts that reflect the work done, rather than offer a minimum number of hours on the basis of providing employer flexibility. The benefits include offering secure and reliable work and maximising the experience of the existing workforce which will also improve quality of care.

148. Improved base rates of pay would reduce the reliance on casual loadings to make the work viable for low paid employees.

149. Workers engaged under temporary visa arrangements should be encouraged to apply for and be granted permanent status. These workers are particularly vulnerable to exploitation due to their insecure status.

150. Enterprise agreements should promote secure work by encouraging part-time work that reflects the level of regular work actually performed and discourages low contract hours by ensuring additional hours are paid as overtime.

151. Provision of secure work that meets the needs of both workers and care recipients is core to improving attraction and retention in the aged care sector.

Methods to improve wages and conditions

152. There are a range of industrial means to improve wages and conditions. The primary method under current arrangements is through enterprise bargaining, however, it should be noted there are a number of shortcomings in relying on bargaining outcomes to improve wages and conditions across the sector.[22,23]

153. Award reform provides a method of improving wages and conditions, but again this has many shortcomings, including being time consuming, costly and not aged care specific.

154. Industry agreement and consensus on improving wages and conditions could be effective but would require significant buy-in from government, providers, unions and aged care bodies to be truly successful. Funding commitment and accountability would be the first principles to address.

Industry or sub-industry level collective bargaining

155. The ANMF considers that industry or sub-industry bargaining could improve wages and conditions if the relevant state or territory public health sector agreement is used as the standard. If base salary rates are set against the relevant state or territory public sector jurisdiction this would avert the risk of industry level bargaining being a vehicle for lowest common denominator outcomes. Conditions that are linked to salary could also be subject to industry level enterprise agreements and again, if the base rate is established at an appropriate level, salary related conditions would not be eroded.

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[22] Exhibit 11-1 (Tab 174) RCD.9999.0233.0001 at 0029-0032; Gilbert Exhibit 11-21 WIT.0430.0001.0001 at 0009-0020 [44]-[120]

[23] Charlesworth Transcript P-6086

156. For any industry level bargaining to be effective it must be enforceable. Enterprise agreements registered at the Fair Work Commission can be enforced.

157. Industry or sub-industry level bargaining would need to be supported by Government and providers. The Fair Work Commission could play a role in assisting parties to identify suitable workplaces for bargaining, conciliation and where agreement cannot be reached arbitration. There would be merit in providing for minimum wages and conditions to be negotiated for self-employed and contract workers who would not otherwise be capable of entering negotiations for an enterprise agreement, such as in the home and community sector.

158. Enterprise bargaining at the provider level could be encouraged via funding incentives to mirror industry enterprise agreements. The scope for workplace specific agreements could operate in conjunction with industry level bargaining.

159. Improved bargaining outcomes, whether achieved at the local or industry level, would be a significant factor in improving wages and conditions and hence attraction and retention of the aged care workforce.

Transparency and accountability in funding

160. The ANMF submits that both the Government and providers must be required to be transparent and accountable in relation to direct care funding. This requires Government to provide a breakdown of components of funding that identifies funds intended for direct care wages and conditions.

161. Providers must be required to have a level of accountability for the government funding received. Funding intended for wage costs must be demonstrated to have been used for that purpose and a failure to account for the use of tax-payer funds must have consequences. For example, any funds allocated to direct care not spent should be returned to government or deducted from the next round of funding.

162. Transparency and accountability in funding would improve bargaining outcomes as the level of funding available for wages and conditions would be clear to the bargaining parties. The Commission heard Mr Gilbert's evidence about the failure of providers to pass on funding following questioning by the Commissioners (Gilbert Transcript P-5997:7 – P-5998:12). He also provided evidence about quarantining funding for direct care providers and the consequences of not doing so (Gilbert Exhibit 11-27 WIT.0430.0001.0001 at 0021-0026 [128]-[142]).

Conclusion

163. Any industrial based improvements must be designed to make aged care an attractive sector to work in and offer a career that retains staff and builds on skills, training and experience. The sector requires both depth and growth.

164. It is essential that wages and conditions improve and move towards matching those available in the public and acute health sectors. It must be acknowledged that wage and condition cost increases need to be funded and that the funding provided is transparent and accountable. Most importantly any increase in wages should not be at the expense of staffing levels and conversely any staffing level increase must not be at the expense of wages and conditions. Provision of mandated minimum staffing levels and skills mix will ensure both that

appropriate safe and quality care is provided and that funding cannot be eroded or diverted away from the provision of direct care.

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

165. The ANMF refers to its aged care workforce submission[24] in relation to educational preparation and training pathways for the aged care workforce and to its submission to the current Independent Review of Nursing Education – 'Educating the Nurse of the Future',[25] which provides a detailed overview and analysis of the education of registered and enrolled nurses, and nurse practitioners.

166. In relation to raising the overall skill, knowledge and competencies of care workers, the ANMF submits the following should be implemented or addressed:

(i) There should be a regulated minimum education requirement for care workers. A Certificate III in Individual Support provides baseline training which is suitable for the role of care worker.

(ii) The quality of delivery of the Certificate III qualification is variable and needs to be reviewed and regulated. There are many instances of the program not meeting the requirements for the role of a care worker due to poor delivery. Certificate III trained care workers do not always have the skills necessary for entry to the aged care sector due to poor quality or non-aged care specific training. There should be a national accreditation scheme for qualifications leading to working in aged care for care workers.

(iii) Training for care workers, supported by an accreditation scheme, must provide programs that prepare care workers for aged care work. Recognition of program units identified as desirable in aged care should be made core units rather than elective, for example dementia care, palliative care, diversity training and how to recognise and report elder abuse and issues of concern.

(iv) Care workers must be subject to a registration scheme as proposed above.

(v) Regulation through registration of care workers will provide greater opportunity for care workers to articulate into nursing and other health professional qualifications as well as into higher level certificate qualifications and relevant training packages

(vi) Care workers should have clearly identified competencies and vocational pathways that lead to certificate III qualifications and thereafter higher level certificates and the opportunity to move to a Graduate Diploma (EN) and Bachelor Degree (RN).

Transition to the workforce and ongoing professional development

167. All direct care workers in aged care should be supported during training via work placements. Registered Training Organisations should develop relationships with providers that ensure quality placements. Once in employment, providers should be required to offer

[24] Exhibit 11-1 (Tab 174) RCD.9999.0233.0001 at 0017-0019
[25] Exhibit 11-1 (Tab 176) RCD.9999.0233.0059

continuing professional development to ensure currency of knowledge and ongoing development, relevant to care and worker needs.

168. Workplace training and development would be enhanced with the following:

(i) Workforce development should be required across the sector with options including a training levy of 1.5% of payroll to be allocated to training and professional development activity of the workforce (excluding executive staff) which if unallocated/expended would be used to support industry wide training initiatives.

(ii) Mandatory induction for all staff

(iii) Nurse Practitioners should be key providers of CPD with the capacity to empower RNs to improve clinical practice. This would be likely to have a 'knock on' effect for all residential care staff.

(iv) Ongoing CPD would address concerns about de-skilling in the aged care sector

(v) Scholarships could be used as an incentive to attract suitable applicants into the aged care workforce.

(vi) Localised on-site education, closer links to primary health and clinical supervision will assist in raising skills and knowledge

(vii) Data collected through reporting mechanisms should be analysed to identify targeted training and development needs

(viii) Annual performance and development reviews linked with CPD and professional development actions

(ix) Obtaining additional, relevant aged care related qualifications should be recognised in classification and salary structures

(x) Developing an educational culture of continuous improvement

169. In order for work placements, transition to the workforce and ongoing professional development to be successful and meaningful for the participants, staffing levels and skills mix must be appropriate. Resources must be dedicated to ensure staff have reasonable workloads, can work within the scope of their training and practice and are appropriately supported in delegation, supervision and mentoring. There must be time and funding allowed for all direct care workers both to access training and development and to offer training and development support where required.

PART 5: How to ensure service providers develop a culture of strong governance and workforce leadership

170. The evidence before the Royal Commission paints a picture that suggests that it is not uncommon for providers to operate on the basis of assuming there will be little scrutiny of their governance practices. This was illustrated very clearly with the failure and closure of Earle Haven in Queensland. The report *Inquiry into Events at Earle Haven*[26] makes 23 recommendations

[26] Exhibit 13-1 (Tab 4) RCD.9999.0266.0003

focused on improving governance of RACF providers and ensuring there is appropriate government and regulatory body oversight of RACF operations. The ANMF supports the implementation of these recommendations.

171. Aged care providers must have expertise in governance, clinical governance and workforce management at the Board level.

172. Clinical governance should be embedded in all levels of management, including at Board level. Nurses with clinical governance skills should be promoted and supported into management roles to ensure there is appropriate clinical oversight and that problems are identified from a clinical perspective and acted upon.

173. Boards and all providers should have clinical governance structures in place with direct reporting accountability. Both corporate and clinical governance could be enhanced with compulsory features of workforce support such as:

- reportable workforce climate surveys across the sector delivered by an independent agency
- transparent work consultative processes locally involving workers and their unions

174. Standards for accreditation should include demonstrating Board capacity and ongoing development. The accreditation process must become more robust with respect to management practices and driving cultural change. Regulatory frameworks which emphasise development of strong governance processes are also needed.

175. It must be acknowledged that for the aged care industry it will require time and resources to build Board and management capacity. Data collection and analysis is necessary to identify problems and tailor training and where necessary regulatory oversight to ensure overall management capacity is developed.

176. The Government needs to support the work of the Aged Services Industry Reference Committee in its role as a peak body for workforce planning. Data collection and analysis must inform workforce planning.

177. A strong leadership culture that supports good governance practice must be developed and implemented. Good governance and leadership must move from a 'tick a box' approach to periodical accreditation processes to ongoing continual improvement. This will require change, which creates a culture that is open to reporting and acting on issues of concern, continual review and improvement to corporate, clinical and care practices and clear lines of accountability.

178. Cultural change will not be achieved without a secure, well-trained and well-remunerated workforce with appropriate staffing levels and skills mix. It is submitted that attention to addressing shortcomings in RACFs governance and leadership should not become a vehicle to divert attention from the pressing and immediate need for mandated staffing and skills mix.

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

179. More than 95% of residential aged care facilities are operated by either not for profit (55%) or for profit (41%) providers. The role of state, territory or local government in the operation of

aged care facilities is therefore minimal.[27] It is a predominately privatised industry, with over 40% being present in the industry for the purpose of making profit. In this environment it is essential to have independent regulatory oversight of the sector that is robust and highly capable of performing its regulatory functions. The industry cannot be relied upon to self-regulate.

180. As a system steward, the Commonwealth must:

- Have explicit accountabilities around public reporting of data, funding and aged care outcomes.
- Prioritise workforce mapping, planning and how to meet future workforce demand, including collecting and maintaining data to inform workforce demand and supply
- Ensure funding mechanisms are geared to deliver sufficient funds for workforce composition (adequate numbers and skills mix) that are comparable across industry sectors for work of equal and comparable value
- Resource and support functions of the regulatory bodies with oversight of the aged care sector – in particular the Aged Care Quality and Safety Commission
- Commit to implementing the recommendations of the Royal Commission in consultation with key stakeholders

181. The Commonwealth must provide leadership that sets expectations and provides incentives for industry to improve workforce planning, development and remuneration. Improvement must be measured against care outcomes.

Government co-operation

182. The Commonwealth as the primary funder of the sector has significant capacity to influence industrial efforts to improve remuneration and workforce composition. Too often, unions seek to improve wages and conditions in poorly paid sectors via applications under provisions of the *Fair Work Act 2009* only to be defeated by technical arguments and highly adversarial responses. Where there is merit to claims for equal remuneration, work value, low paid bargaining and award review, the Commonwealth should exert appropriate influence to avoid protracted proceedings and commit to funding outcomes.

183. The ANMF submits that the Government should adopt a policy of working to achieve industrial outcomes that minimises cost and time for applicants (unions) and that addresses the merits of applications with a minimum level of adversarial approach.

CONCLUSION

184. As is becoming increasing clear from the evidence before the Commission, the aged care sector is one requiring significant and whole-scale reform, particularly with regard to workforce matters. Older Australians, those who cared for us as we grew, are entitled to affordable, accessible and high-quality aged care services delivered by a professionally trained, accredited and dedicated workforce. They do not deserve the current, chronic understaffing that leads to unnecessary pain and suffering.

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[27] Australian Government, Department of Health, 2018-19 Report on the Operation of the *Aged Care Act 1997,* 45

185. Caring for elderly people, especially those with behavioral and psychological symptoms of dementia and other disabling health conditions, is a stressful occupation requiring the right people with the right knowledge and skills to develop and implement holistic care plans customised to individual needs.

186. Multidisciplinary teams of general practitioners, geriatricians, palliative care specialists, nurse practitioners, dietitians, speech pathologists and allied health workers providing clinical guidance, which enables registered nurses to deliver effective care with dedicated, qualified care-workers, will result in safe and best practice care for our elderly.

187. But 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.

188. Staffing ratios need not stifle innovation. Instead, they can lay the foundation on which better quality standards can be built. And while mandated staffing ratios alone are not the only indicator of high quality aged care services, it is certain that high quality care cannot be achieved without them.