How Australian residential aged care staffing levels compare with international and national benchmarks
A research study commissioned by the Royal Commission into Aged Care Quality and Safety
Response by Professor John Pollaers OAM

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Date: 20 September 2019

1. This statement made by me accurately sets out the evidence that I am prepared to give to the Royal Commission into Aged Care Quality and Safety. This statement is true and correct to the best of my knowledge and belief.
2. Where direct speech is referred to in this statement, it is provided in words or words to the effect of those, which to the best of my recollection, were used at the time.
3. The views I express in this statement are my own based on my education, training and experience as former Chair of the Aged Care Workforce Strategy Taskforce. They are not intended to represent any views of my employer.
4. Professional background

Currently:

Chancellor of Swinburne University;
Chairman of the Australian Industry and Skills Committee;
Member of Aged Care Sector Committee and former member of the Aged Care Financing Committee;
Chairman of Leef Independent Living Solutions;
Chairman of the Australian Advanced Manufacturing Council;

Prior to this I held roles leading major Australian and International companies including Diageo, Foster’s Group and Pacific Brands.

The focus of my community focus has been in working across Government, Industry and Educational Institutions to bring about major reforms to vocational education and training, higher education, and aged care and including more people with disability in work and training. My business Leef Independent Living Solutions, is an innovative functional health and assistive technology business with 14 Independent Living Centres nationally.

I am an Enterprise Professor of Melbourne University, and Honorary Fellow of the University of Western Sydney, and hold an MBA from INSEAD and Macquarie University, as well as degrees in Electrical Engineering and Computer Science from the University of New South Wales.

5. Thank you for the opportunity to provide feedback on the report titled “How Australian residential aged care staffing levels compare with international and national benchmarks” prepared by the Centre for Health Service Development (CHSD).

My response is provided in four parts:

- Part 1: Those areas that I support in the report
- Part 2: Where the CHSD report can benefit from the context set and forward-looking views around workforce established by the aged care workforce strategy – A Matter of Care
• Part 3: How the Royal Commission is able to consider CHSD’s report with a reframed lens on the following two elements (the application of a holistic care model and the distinctly different role of a nurse in aged care)

• Part 4: The potential flaws in the CHSD report, which suggest that it’s the personal care and functional health components of the workforce that require additional investment, over and above nurses.

I would also make the following overriding qualification about the Centre for Health Service Development (CHSD) report. It is premised around a clinically based, institutionalised government approach to delivering aged care services. There are two key flaws in this approach:

• A focus on clinical care, and when it should have a focus on a living well model of care and Holistic Care Plans (Strategic Action 6. Holistic Care Plans must address - clinical health, functional health, cognitive health, cultural care needs and living well aspirations. This was emphasised during the consultation process during the development of the workforce strategy. By ignoring the need for Holistic Care Planning and associated delivery skills mix, this report ignores the community demand for a living well model of care.

• A focus on traditional job roles (i.e. nursing). Perpetuating the clinical care model marginalises the key role played by personal care workers and functional health specialists play – who remain undervalued members in this traditional view of the workforce.

Part 1:

I support the report’s findings in relation to:

• A move to Case mix based funding\(^1\) and an increase in overall funding. As alluded to in Taskforce Strategic Action 13 and in their report to the Taskforce, Stewart Brown estimated the government funding gap on residential staff levels and staff remuneration to be in the order of $3 billion. This does not include the gap in Home Care Package wait list funding.

• Adjusting skills to reflect the case mix (however the case mix must be based on holistic care planning)

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\(^1\) The concepts put forward is an important precursor to determining current and future funding of the aged care system as defined by the A Matter of Care (Strategic Action 13).
• Improved care through increased staffing levels, although they should be across the wider definition of the workforce\(^2\) and focus on addressing current and future job roles, job families, jobs pathways, career development – to enable the effective delivery of holistic care plans

• That four hours of additional care is necessary and aligned to the qualitative findings of the workforce strategy

• Increased total hours of care, noting the total additional hours defined in the report are in line with the findings of *A Matter of Care*. There is a clear need to increase the number of nurses and minutes they are available each day – however the CHSD report does point to the need for an even greater number of staff and hours to deliver broader Holistic Care needs.

• A rating system to provide consumers, their families and the community with greater transparency and informed choice regarding residential aged care providers\(^3\).

**Part 2:**

Whilst I was pleased to see *A Matter of Care* referenced, I am not sure its findings were appropriately considered. The workforce strategy emphasises a holistic approach to addressing national aged care workforce issues and solutions, and the following aspects of the workforce strategy are highly relevant to CHSD’s report:

• **Strategic action 3**: Reframing the qualification and skills framework—addressing current and future competencies

This strategic action is about reframing the qualifications and skills framework in order to focus on addressing new and emerging roles and job families. This recognises that consumers rely on a knowledgeable and skilled workforce to meet their evolving care needs, and that they value the *relationships* with the people they see daily in a variety of settings.

If the analysis, as presented in CHSD’s report, is based on current “Clinical” thinking then we will continue to undervalue the roles Personal Care Workers (PCWs) and functional health specialists such as Occupational Therapists, Physiotherapists,

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\(^2\) *A Matter of Care* takes a wider definition of ‘the workforce’ to ensure it included all of the touchpoints’ for consumers in their ageing journey—from 65 years of age until end of life and from 50 years of age for Aboriginal and Torres Strait Islander people, and for the homeless and other prematurely ageing populations.

\(^3\) This transparency is important given the removal of the high and low care classification in Australia.
Speech Therapists, Meal Occasion and Nutrition Specialists, Diversional Therapists etc, and other staff essential to a living well model.

The workforce strategy’s analysis of the current state of current workforce architecture highlighted the value of the PCW role is underestimated; and that PCW roles have a much bigger impact in residential facilities. Further, PCWs form the majority of the aged care workforce and are the eyes and ears of the entire aged care system. And they spend the maximum amount of time with consumers and work with them daily in the closest proximity.

- **Strategic action 4: Defining new career pathways, including how the workforce is accredited**
  
  This strategic action aims at supporting an agile workforce by re-thinking and opening jobs pathways and career options. Specifically, it looks at defining new career pathways including accreditation.

  It recognises the role of nurses, who are skilled practitioners, leaders that support teams, an integral part of delivering holistic care, and who play key roles in terms of system governance and counselling complementary workforces.

  The workforce strategy identified that existing structures and job roles within aged care organisations do not currently allow for realistic career progression. Specifically, several pathways could be opened up:

  - Extended levels within the PCW job family
  - Recognising the role of nurses – skilled practitioners, leadership, holistic care, evidence-based competencies and working in teams
  - Defining new and emerging roles that support the consumer experience, such care coordination or care team leaders

- **Strategic action 6: Establishing a new industry approach to workforce planning, including skills mix modelling**

  The workforce strategy identified that aged care does not have a standard approach, across the sector, to workforce planning. This strategic action adopts a holistic approach to workforce planning that focuses on a person’s clinical health, functional health, cognitive health, cultural care needs and living well aspirations.
My personal observations are that the conversation around workforce planning has become more developed in recognising the need to move from a nurse model of care to a living well model of care. Unfortunately, this is not reflected in the CHSD report, which continues to focus on a clinical care model delivered by nurses.

Accordingly, the workforce strategy emphasises that workforce planning needs to address current consumer expectations and the living well model. And moving from clinical care plans to holistic care plans, recognises management and the Board’s role to deliver that care. This shift recognises the skills mix required and associated funding necessary to deliver that level of care.
It is also essential that we plan and provide this skill mix in the AM, PM, Night time and Weekends and move away from a mindset of night shift, over time and skeleton staffing as implied in the CHSD’s report.

I believe for CHSD’s report to be actioned, they would need to work in close consultation with the Aged Care Workforce Industry Council, who are the leadership group responsible for ensuring implementation of the workforce strategy.

**Part 3:**

Noting the above, I would strongly encourage the Royal Commission to consider CHSD’s report with a reframed lens on the following two elements. Looking at these two elements in the manner described below will better enable the Commission to address workforce in a more inclusive and collaborative way, so as to ensure all staffing levels (notably nurses, PCWs and allied health professionals and those providing critical support roles) can be addressed in a manner that reflects a consumer’s total care needs:

- Firstly, if you apply a holistic care model, the narrative shifts from being nurses or other staff to nurses and personal care workers.

  The workforce strategy reinforces that a holistic approach enables differentiated service offerings, improved consumer understanding of what to expect, together with greater transparency to the consumer and their families.

  Applying a holistic care model places a greater emphasis on emerging roles such as dementia care and diversional therapists. It also requires functional health roles to be better understood as part of the total workforce skills mix.

  Therefore, as an industry, there is a need to transition to a higher standard. This is essential if the industry is to move ahead of community expectations and be able to begin a much more nuanced and sophisticated discussion around staffing levels that reflect a providers’ aggregated care planning (and intervention) requirements, rather than using a ‘one size fits all’ approach.

  Lastly, the report makes mention of “greater reliance on lower skilled personal care workers” (page 4). It is critical that we do not put down any part of the aged care workforce, particularly PCWs. They need to be recognised as differently skilled employees for different tasks and they represent a growing part of the workforce.
• Secondly, a nurse’s role in an aged care environment is distinctly different to primary health care and acute care settings. The role had been redefined in more advanced residential providers from a 100% Clinical focus to 40% Clinical Health, 40% Functional Health and 20% Cognitive Health. These can be very rewarding roles if properly defined and supported.

Overall staffing in Aged care settings need to be considered in the context of a holistic care plan, which if included in the CHSD analysis may fundamentally reset the allocation of care minutes and skills mix. Intuitively it may be along the lines of this example for a mid to late stage person living with Dementia (illustrative only):

• 20% of effort attributed to clinical health needs (performed by nurses)
• 20% of effort attributed to functional health needs (performed by allied health)
• 20% of effort attributed to cognitive needs such as dementia (performed by Lifestyle Coordinators, Dementia Specialists and PCWs)
• 40% of effort attributed to living well aspirations and cultural needs (performed by Lifestyle Coordinators and PCWs).

Part 4:
However, I was disappointed to find a major flaw in the report:

• The report talks about staffing levels (highlighted in the key findings and discussion & conclusion), which implies consideration of the total workforce required to care for the people in residential care and home care. However, the report fails to highlight that the application of the CMS methodology to the Australian data (discussed on page 19) excludes allied health, lifestyle personnel, administration officers and staff employed in quality and education roles. Therefore, the report in effect is limited to nursing levels, and fails to recognise the roles vital to deliver a holistic care model.
• Table 7 (page 22) details RN and total time required to achieve 3 to 5-star ratings. Notwithstanding the above, most of the additional staff time required is not for nurses, but for ‘other staff’. Application of Strategic Action 6 reinforces that the ‘other staff’ would in fact be referring the skills of a wider workforce (i.e. PCWs and functional health) essential to delivering holistic care.
• Examining Table 7 further, you can see that to move from 1-star and 2-star facilities (to 3-stars) requires in absolute terms (minutes) significantly more time for the total workforce, reinforcing that it is those 'other staff' that bring the majority of the required care time (effort)

Currently, the tenor of the report does not reflect this and gives the reader a distinctly different impression, particularly when reading the key findings. This is reinforced by the following observations:

• The report states “There are two broad approaches to determining staffing requirements: (1) mandated minimum levels and (2) specification of ‘appropriate’ (not minimum) levels”. As the workforce strategy highlights, there is a third approach – underpinned by Strategic Action 6 around workforce planning

• The report takes a clinical focus as the only care need for consumers. As such the tenor of the report is set around clinical care and nurse staffing levels. There has been an ongoing debate about staffing (nurse) ratios of nurses to personal care workers in residential care, linking staffing ratios to the quality of care outcomes for consumers. The workforce strategy highlights two key failings of this report:

  o Consumers have a holistic set of care needs, of which clinical is one part. A consumer’s functional, cognitive, cultural and living well aspirations are all equally important. Therefore, the report continues to focus on an outdated model based around institutional care
  o By taking a wider definition of the workforce, nurses account for around 20% of the total current workforce. The report does adequately address the remaining 80%, notably the sizeable cohort of PCWs, who work with nurses to deliver quality care outcomes.
In summary, the CHSD's report makes some positive findings that I support. However, it is limited by its focus on a clinically based, institutionalised government approach to delivering aged care. Perpetuating the clinical care model marginalises the key role played by personal care workers and functional health specialists play – who remain undervalued members in this traditional view of the workforce.

By contrast the workforce strategy (A Matter of Care) looks at the provision of holistic care through a living well model of care. In so doing focuses on the new and emerging workforce needs and recognises that the workforce comprises key roles including PCWs and functional health specialists. It also helps define the distinctly different role of nurses in aged care settings.

Signed: ______________________
Date: 8 October 2019

Witness: Diana Louise Pollaers
Date: 8 October 2019