national
AGED CARE alliance

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NATIONAL AGED CARE ALLIANCE

POSITION STATEMENT

17 key propositions for Support at Home

About the National Aged Care Alliance

The Alliance is a unique and independent group of over 50 organisations. It is made up of peak national bodies who work within the aged care system. The Alliance's Membership collaborates within and across four key aged care constituencies: consumers, aged care providers, unions, and health professionals.

Further information about the Alliance is available at **naca.asn.au**

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Introduction

The Alliance supports a human right based approach to aged care reforms that respond to older Australians overwhelming desire to age in place. The way aged care services are delivered must support and enhance their human rights as respected and valued members of the community. Older people should receive support and care in the location they choose and, in the setting most appropriate to their circumstances and preferences. Government funding and policy should move away from rationed services to a system of universal access based on assessed needs for older people.

The rescheduling of the implementation of the new Support at Home program, replacing the Commonwealth Home Support Programme, Home Care Packages Program and Short-Term Restorative Care (STRC) Programme, until July 2024 provides an opportunity for the Australian Government and Department of Health and Aged Care to engage with the sector to design and test policy and service delivery solutions.

Reform of community and home support/care services for older Australians and their carers is taking place in a context of an increasing older population and service demand, workforce supply constraints and competing government funding priorities that have been exacerbated because of the global COVID-19 pandemic. The sector is concerned about the robustness of any future community and home support/care program and seeks to ensure that it is responsive to consumer needs, achieves quality outcomes, is sustainable for service delivery organisations, has a qualified, skilled, and supported workforce and has appropriate stewardship arrangements at both local and national levels to deal with service delivery gaps and constraints.

Equity of access should also be a key measure of success for the new community and home support/care program. Consumers, regardless of their location, life circumstances, personal characteristics and living arrangements should be able to receive the same levels of quality service. However, levels of quality service allocation should not be limited to an individualised allocation of resources. Rather, allocations need to be matched to local care ecosystems where service delivery constraint and stewardship arrangements will inform such allocations. Program design needs to allow for alternate care approaches, such as group-based care/support, social-capital solutions, technology solutions, that may be appropriate at some local levels and not others, to fill workforce gaps and respond to unmet needs.

The Alliance recognises that Aboriginal and Torres Strait Islander people require a unique aged care service approach and pathway that is culturally appropriate and includes specific and targeted grant funding for services, infrastructure and training preferably to Aboriginal community-controlled organisations. The Alliance supports the recommendation made by the Royal Commission which provide for unique, flexible and culturally appropriate assessment, care planning and service delivery models, that have been locally co-designed by First Nations people.

The new Support at Home program should be designed with the goal of a single aged care system that is delivered as a continuum of care for older people regardless of the duration and setting in which the care is delivered (i.e., a seamless support between home, community, and, if needed and chosen by the older person, residential care settings). The Alliance recognises the combination of current community and home care programs is a first step towards delivering this longer-term goal. Knowledge, understanding and availability of service types and quantum of services, within a

continuum of care, provides clarity to support service planning and responsiveness benefiting consumers, providers, workers, and health care practitioners.

Care Partnerships (more commonly referred to as Case Management), operating within a continuum of coordinated care, together with the timely application of goods, equipment, and home modifications, supports the realisation of service responsiveness to the needs of older people and results in improved satisfaction and better outcomes for older people with increasing complexity of needs. Prioritising preventative care and early interventions and reablement in response to changing needs and function can improve quality of life and reduce acute and residential care admissions when services are delivered at home in a timely manner.

A key area of consideration in the new program is to ensure its capacity to respond to service delivery constraints (which are sometimes referred to as "thin markets"). The Alliance understand these service delivery constraints to include:

- **regionality** where competition may be low due to the cost-of-service delivery across wide geographical areas and/or the additional cost of delivering business in certain locations,
- servicing small **diverse/disadvantaged populations** in particular areas where competition may be low due to target population size or
- maintaining a **particular service and workforce** where service choice and resources (aka competition) may be low (such as cottage respite care or Geriatricians).

The fragmentation and differing roles of services, with criteria and objectives that are not aligned or complementary across the health, aged care, and human services sector, nor aligned between Commonwealth and State and Territory jurisdictions, makes developing a continuum of care for older people challenging.

The new Support at Home program should recognise and support the important role of family and friend carers as partners in care as a critical success factor for sustainable long-term support at home. Nevertheless, unpaid family and friends providing informal care are not a substitute for the formal paid care workforce. Assessments of need therefore must not determine services for older people based on whether a carer is available to provide support. Inclusion of carers in the assessment pathway and support plan development is essential in this process. This may include the need to identify education and capacity building needs of carers to ensure that supports provided by family and friend carers are safe and responsive to the needs of the older person.

Regulatory alignment across Disability, Aged Care and Veterans Care should be prioritised as part of the extra year agreed to implement the new program. As workforce regulation continues to be developed and rolled out, it must ensure the workforce has opportunities to work across the care sectors. Duplication of regulation processes is a barrier to attraction, retention, efficiency, consistent quality, safety for consumers, and adds to worker and provider costs and discourages the development of workers and growth of services. Importantly with all three sectors experiencing workforce and skills shortages, we must design a system that enables workers to be engaged across the relevant systems seamlessly. Decent wages and conditions, along with appropriate skills and training, are measures that support workforce growth, high-quality care, and workforce mobility across the care sectors.

The success of the Support at Home program should be determined by achieving the outcomes

desired by older people who receive support, and their carers, as reflected in their assessor-developed support plans. Support/care plan development, which must be in partnership with consumers and their carers, should consider the practicality of the plans being implemented, having regard for the needs assessment, and outcomes/goals of the consumer, the availability of services in their area and the quantum of services being approved by the Government assessment. Without a carefully developed support plan, the service experience of the consumer is likely to be poor.

Program design needs to consider the formation and retention of well-paid, high-quality home care jobs that will retain and attract workers to the sector. A significant number of older people assessed as eligible for a home care package receive services at a lower level than that for which they have been assessed as eligible due to long waiting times. This impacts on the workforce, as it means workers are further under pressure and stress to try and ensure these clients have their needs met, without adequate hours being allocated to their care. In addition, it is acknowledged that in some parts of the sector, home care workers are already undertaking some core work, such as travel and writing up client notes following a visit, in their own, unpaid time. These are unsustainable practices and can make entering the sector unattractive.

The workforce must be adequately and sustainably resourced, to ensure workers can deliver high-quality, person-centred care, in line with assessed needs, and respond to changes as and when they arise. Addressing attraction and retention levers will assist in easing workforce supply pressures, improving care quality, and build a workforce that is valued and viewed as a desirable profession.

The new program should embed a human rights approach to home care that promotes and supports self-management, provides consumer choice through individualised, flexible services and transparent, publicly available up to date services, cost, and performance information.

The new program should ensure that the aged care workforce must be appropriately trained in identifying, responding to, and reporting incidents of elder abuse in line with the relevant legislative reporting requirements, as all elder abuse should be reported.

The operation environment for the new program should promote direct employer/employee relationship for the delivery of aged care services, while recognising that other indirect arrangements, supported by appropriate regulatory safeguards, will remain a necessary element of the workforce in particular circumstances.

The propositions below outline the Alliance's view on some of the key areas of the current reform discussion and potential direction for a renewed Support at Home program.

Propositions

1. The Alliance supports a defined and phased transition and planning period with key milestones and goals which are clearly and regularly communicated to the aged care sector.

The effectiveness of the implementation of the new Support at Home program will be influenced by how well the transition to a new service approach is planned for and managed. The extra year extension should provide for deeper engagement on transition and implementation.

A defined and phased transition and implementation period should provide opportunities for evaluation of important service design elements. This includes in particular the new assessment processes, the proposed classifications of service delivery, the new agreed funding model and related classification system, and approach to client contributions.

The transition and implementation period should have key benchmarks and milestones and a transparent communication strategy. Communication benchmarks should be *ahead* of policy and service changes being implemented by at least 3 months.

The communication strategy must attempt to avoid confusion between consumers, providers, and the workforce about changes to the service model and approach. Whilst providers will need more technical information, they are also an important source of information for consumers. Alliance members report that there are groups of home care consumers who are fearful and confused by the new Support at Home program because of a lack of comprehensive communications with affected consumers during the design consultations.

Communication, policy, and service reform implementation will need to have a monitoring and review element to assess risks, particularly those that impact on consumers. It is possible that specific consumer population sub-groups may be adversely affected in the change process, and this too should be considered in the monitoring process.

Recording and assessing the perspective, experience and needs of consumers will be an important part of the transition planning and managing process. Where consumer contributions are required, they should always be equitable, fair, and based on the capacity to pay. During the implementation period, some providers and services may exit the industry generating the need for a risk management strategy in some regions and for some service types.

Whilst a new Aged Care Act will provide the legislative base for the new program and frame the basis for home care agreements and support plans, the grandfathering of current service arrangements, support plans and procedures must be considered. Currently, home care consumers are on a range of plans and agreements shaped by previous reform changes. There could be at least five different types of home care agreements related to grandfathered reform changes over the past decade. Types of agreements differ due to starting dates, viability supplement payment arrangements, different subsidy rates and payment arrangements for unspent funds. Consideration of these groups as part of transition should occur early in the communication phases.

2. The Alliance supports the Australian Government moving towards an uncapped community and home support and care system that facilitates service commencement no longer than 30 days from registration.

The Alliance supports moving towards a service system where once an individual's needs are assessed, the identified allocation of home care services should be automatically allocated to that older person. No one should wait more than 30 days for service commencement from registration. The assessment, support plan development, service allocation communication to consumers, and their services being matched and commenced in the context of their local care ecosystems should all occur within 30 days.

Matching and commencement of services will require transparency of information on service

availability to help consumers make informed choices in the context of any demand-supply challenges that exist. However, this should not limit any potential innovative responses to meet demand.

This is consistent with a human rights approach to aged care enabling older people to remain in their own homes and communities living as independently as possible and achieving positive health and wellbeing outcomes.

Despite a range of supply challenges, particularly recruiting and retaining the quantum of skilled, qualified workforce needed, timely access to support should be one of the primary objectives in strengthening the supply of home care services to older Australians.

The Alliance recognises that in the current workforce crisis there will be a transition period to achieve this objective. We urge this transition period to be the shortest possible as it is unacceptable that older people continue to be forced prematurely into residential care (or acute care), and/or to die, whilst waiting for services they are assessed as needing. It is also deeply troubling that the burden falls onto unpaid carers, many of whom are older people themselves, to fill in the gaps while waiting for paid service provision to be allocated.

3. The Alliance supports consumer choice and transparency of information that balances both dignity of risk and provider/worker duty of care. This accounts for consumer supports being delivered by multiple service providers and ensures compliance with Aged Care Standards, general duty of care obligations and state/territory legislation.

Informed user choice empowers consumers to be actively involved in decisions about the services they use, improves outcomes, empowers older people to have greater control over their lives, and enables decision making to meet needs / preferences. It also can generate incentives for providers to be more responsive to consumer needs and drive innovation and efficiencies in service delivery.

However, a multi-service provider operational and regulatory environment does contain risks for consumers, carers and their families, providers, and workers requiring effective regulation, protections, and safeguards. This is particularly the case where people have multiple or complex health and personal issues leaving them at greater risk of harm in the context of service fragmentation and loosely coordinated care that spans multiple providers. Optimal outcomes for the consumer are often best met when providers work effectively together such as jointly across allied health disciplines employed by different providers. System infrastructure and resource investment needs to ensure multi provider environments can be supported. Guidance around information provision and privacy requirements of sharing client information between providers and setting expectations of responsibility on multi providers must be addressed in program design and oversight.

The recent disability care case of neglect of South Australian Anne Marie Smith highlights the importance of this. Systemic requirements include:

- Strong legislative protections in the Aged Care Act including provisions enabling the sharing of information between Commonwealth agencies
- Clear provider duty of care obligations on registered home and community care providers including any minimum service level requirements
- A robust registration, reporting and data collection system

- A developed and funded Commonwealth cross-portfolio approach to identify and respond to consumers at risk
- A clear IT roadmap and standard to improve the interoperability of information between aged care providers and aged care workers including those from different organisations.
- Joined up protocols and data sharing arrangements between Commonwealth agencies and between the Commonwealth and state and territory jurisdictions particularly for at risk consumers.

There should be a clear guidance for enacting dignity of risk and duty of care responsibilities of community and home care services. Dignity of risk provides an informed and documented forum to consider the goals and needs of the consumer. Consumers may assume personal risks and responsibilities in the informed support plan choices they make. This guidance is also required to not only consider the consumer needs but also the expectations of the worker/health professional's responsibilities and work health and safety requirements. It facilitates discussion between key stakeholders to moderate an agreed and risk managed approach to care and service delivery. This may consider; the utilisation of unregulated workers to perform a task, the choices of a consumer that are not aligned with the provider's duty of care, or communications and the timeliness of information sharing between service providers and other stakeholders to inform support plan implementation and adjustment when required. The limits of a provider, worker, and health professional's duty of care regarding supporting a client's dignity of risk decisions, needs to be clearly articulated in guidance.

A clear and comprehensive regulatory approach to Work Health and Safety processes and decisions should also be developed. Health care and social assistance workers can experience a high level of work health and safety risk due to the physically and emotionally arduous nature of their work. Home and community care workers can also experience an increased workload due to a lack of available resources, poor supervision and limited or no access to skills development and training.

4. The Alliance supports self-management being a spectrum of decision making and available to consumers as an option. This will include assessments to inform appropriateness and desire of consumers to self-manage. Options of support must be available for those that need assistance to self-manage and protections for whom self-management has been agreed as not suitable.

Self-management should be viewed as part of a spectrum of informed decisions enabling autonomy, self-determination, and dignity through levels of choice and control for consumers within an assessment and support plan.

The right of older people to self-management should be a key principle of service delivery and practice in aged care. It is an integral part of delivering services that put the older person at the centre. This acknowledges the principle that older people and their carers understand their own care and support needs and bring skills and experience to continue to make decisions in their lives.

Self-management gives consumers and carers more control of how the services in their support/care plan are delivered, shared authority to decide on purchases, a way of directly paying for services, products, and activities relevant to their care and a way to choose support workers and other contractors.

When delivered well, self-management reflects a genuine partnership between consumers and providers where consumers are informed and active participants in, and drivers of, informed decision making and where responsibilities, roles and the level of work are clearly identified and communicated. The spectrum of self-management opportunities for consumers should be part of the support plan development and informed by an assessment of the consumer and carer's capacity and desire to self-manage. Roles and responsibilities of consumers and providers can be communicated within the support plan and adjusted relative to consumer decisions about whether care is partly or fully managed by the consumer.

In some circumstances, consumers may choose to self-manage after being assessed as not having the capacity to do so. Options of support must be available for those that need assistance to self-manage and protections for whom self-management has been agreed as not suitable.

Consideration of the regulatory responsibility of providers, in particular care partners, for older people who are choosing to self-manage need further exploration and explanation for consumers, providers, workers, and other interested parties.

Risks in the implementation of self-management can be mitigated through clarifying expectations in the support plan development and implementation using clear processes and evaluative mechanisms. With self-managed goals, consumers will need to understand the greater level of responsibility for their decision making. Clear guidance will be needed about the role of service providers and care partners to provide ongoing information to support self-directed care decisions by consumers. Risks, responsibilities, and liabilities conferred onto the consumer regarding the various employment methods of workers need to be clearly set out and understood by all parties – the worker or health professional, the consumer, and the provider.

The lack of provision and promotion of self-management is partly due to inconsistent or limited understanding of self-management, and how to assess, implement or provide for this service in a considered and funded manner, across the provider sector. There is a distinct need for the government to support upskilling and implementation of quality self-management processes with guidelines, resource material, training, capacity building funding and professional development, in partnership with consumers, to ensure that self-management is part of the Support at Home program. Nationally consistent training and practice improvement programs targeting self-management should also be considered, supporting increased awareness and knowledge transfer in how to address the risk and capacity of some older people and their carers to self-manage.

With self-management being an integral part of the Support at Home program, performance measures should be developed to enable the government to evaluate progress of the implementation of self-managed support plan goals and to inform consumers and providers in their service choices.

5. The Alliance supports funding of community and home support and care services that are not limited to an individualised allocation of resources, but also supports local care ecosystems.

There are currently different assessment processes, eligibility criteria, service provision, funding, and fees across various community and home support/care programs. This can lead to inequitable outcomes for consumers. Nevertheless, multiple providers across different programs have created an

important local / regional infrastructure (or 'care ecosystem') that facilitates a community development approach to supporting older people and their carers. Such an ecosystem must be maintained in any future integrated community and home support/care services program.

Future funding of any community and home support/care program must embed structural support for volunteering, carer supports and venues for community-based service provision (e.g., respite care), and continue to support local ecosystems and communities in diverse ways. Similarly, funding of the future program must better reflect and respond to workforce needs including attracting and training workers. Improved outcomes for consumers and their communities should be demonstrated through government regional stewardship responsibilities.

Providers in the new program should have substantial capacity to be responsive to changes in the complexity of need or circumstances of the consumers they support. Consumers should be able to easily 'flex in and out' of different levels and types of service provision as their needs change and where they might need short-term episodic interventions. This must be able to occur without a need for a reassessment, while also allowing for responsive service provision while awaiting the outcome of a reassessment when required.

The new Support at Home Program should ensure that consumers are clear on what their minimum guaranteed quantum of services over a designated period will be relative to the types of supports specified within their support plan. Allocation of additional flex up services should not be presented as an individual's entitlement.

Ensuring national consistency, service equity, improvements in service quality and performance, and tailored individualised services for older people are an important but challenging program objective. Robust data and evidence, targeted funding, regional stewardship and supporting local innovation will all be important.

Funding must support decent wages and conditions of workers, including enabling workers, unions, and employers to bargain for above award wages and conditions. Funding must be adequate and sustainable, and of a quantum that allows workers to be trained and qualified to meet diverse care needs. Funding invested in the workforce should not come at a cost or trade off to funding available to consumers. There must be stringent transparency and accountability measures for all funding.

The agreed final design of any future program must also explicitly identify what services currently available will be diminished or removed from the future local ecosystems because of the future design. A clear process for transition in such circumstances will be required to mitigate disruption to both consumers and providers.

6. The Alliance supports a pricing framework (including supplements or grant programs) for demonstrated thin market populations (including regionality, small diverse / disadvantaged populations and ensuring a particular service/workforce is maintained) to support service access and equity. Prices must be set so that professionals and workers are incentivised to remain within the aged care system and not financially incentivised to transition to other systems where greater financial return for a comparable service is currently available.

There is a range of views within the Alliance about the preferred approach to pricing aged care services. While there is support for a service categorisation approach, the Alliance has no position on

a preferred pricing model. The Alliance notes concerns about the viability impacts of the NDIS approach to set price lists which may be seen as artificially capping prices and in turn affecting sector sustainability.

A robust definition of thin markets supported by strong evidence and data collection should define supplement or grant programs. As outlined above, the Alliance recognises thin markets to include consideration of regionality, small diverse/disadvantaged populations and ensuring a particular service/workforce is maintained.

Targeted, evidence-based funding to improve service access and availability to groups with diverse characteristics including CALD, First Nations, people experiencing homelessness, LGBTIQ+ should be included. This may be through a combination of the provision of specialist services and funding supplements for consumers that are designed and weighted to support the achievement of quality consumer experiences and outcomes that are being achieved.

There are current examples of workers who have been providing caring and professional support to older people leaving the aged care sector to take up better paid positions in other related sectors. At present, some health professionals can receive more income for working with people in the acute health, mental health, or disability sectors. Some personal care workers earn more in disability than aged care. The impact of direct care workers and health professionals moving to other sectors has a broad impact across all areas and adds an additional disproportionate negative impact on "thin market" populations.

The funding model must support, enable, and incentivise aged care workers and health care professionals to remain working in the aged care system. Working in aged care must be attractive enough to retain a multidisciplinary workforce and minimise relocation to better financial remuneration and working conditions in complementary sectors like disability care and support services.

7. The Alliance supports the redesign of the in-home aged care assessment processes to ensure access to early, evidence based reablement and preventative allied health services, rather than waiting for adverse events and/or functional decline to prompt referrals.

Reablement and prevention of functional decline should be key goals of the assessment process, support/care planning and service approach. This is critical to older people developing their most effective support/care plan, maximising both clinical and quality of life outcomes and enabling them to continue to live at home.

The partnership between assessors and allied health professionals can support older people to understand, manage, and address a diverse range of conditions and illnesses including improving nutrition, falls prevention, addressing pain, hearing loss, vision loss and mobility, communication, psychological and behavioural symptoms.

Allied health professionals draw on an evidence-based/informed scope of practice with a strong record of improving health and life outcomes for older people and preventing functional decline.

Reablement is a planned approach to community and home care and support services for older people that aims to help them re- establish daily living skills and community connections through a

goal-oriented program, that may or may not be time-limited, based on individual assessed need.

A reablement-focused assessment model should lead to better outcomes and reduce or delay the need for more complex aged care services.

8. The Alliance supports prioritising the development of a single assessment service from 1 July 2023. There should be a single, nationally consistent, and appropriately skilled assessment workforce, that is independent from service delivery, and comprises of an integrated multidisciplinary team of health professionals, working within a competency framework. Assessors should be able to provide case partner / linkage services within the assessment model.

There should be a single, nationally consistent, and appropriately skilled assessment service, that is independent from providers, and comprises an integrated multidisciplinary team of health professionals. Working within a competency framework will ensure that individuals who have the expertise and knowledge to provide quality, evidence-based assessments are used appropriately across the multidisciplinary team.

It is critical that this commence from 1 July 2023 to establish a key foundation of the new system, remove the current fragmented assessment response, enable regional teams to be recruited, resourced, and well trained in a consistent application of the assessment, to ensure improved assessment outcomes for older people.

Identifying allied health care is a critical part of aged care assessment and access to and provision of individually allocated funding for allied health services an important part of an older person's support/care plan. As part of the multidisciplinary team allied health professionals should be an integral part of the single assessment service.

As experts in the aged care system, assessors should facilitate support/care plan development and advise older people and their carers on the full range of service options, not direct and prescribe the outcome of their support/care planning.

The assessment workforce should have the capacity and capability to identify and scope the care needs of the consumer and match these to appropriate services and levels of care. This includes enabling the participation of specialists in geriatric medicine and geriatricians and nurse practitioners experienced in aged care.

Measures to ensure that cultural safety is embedded in all assessments and assessors are culturally trained and competent are particularly important for consumers with diverse characteristics, for example, Aboriginal and Torres Strait Islander consumers, LGBTIQ+ consumers, and culturally and linguistically diverse (CALD) consumers.

The proposed assessment regime should include the development and strengthening of workforce capacity to appropriately assess consumers' disability and health needs, understanding, and appreciating:

- the impact of terminal and life limiting conditions on the care needs of consumers and the importance of the interconnection with palliative care
- the effects intersectionality can have on consumers

- the appropriate use of language services including translating and interpreting services and the provision of information in alternative formats where required
- other necessary supports to enable meaningful consumer participation in the assessment process

Assessors need resources and effective links with interpreters, including Aslan, and options to support people not able to rely on over the phone communication, i.e., cognitive impairment/ dementia; hearing impairments; speech and communication disability, preferring communication in languages other than English.

Care finders, assessors, care partners and relevant allied health services should work in partnership to encourage older people to access services that align with goals outlined in the older person's support/care plan. This partnership would enable time-limited-service interventions.

9. The single assessment tool and training for and capability of the new assessment workforce should be trialled through a shadow assessment process which adequately captures the diverse needs of older people. The Alliance recognises that service list and price categorisations, along with the single assessment tool, will need to be finalised prior to the full implementation of the single assessment workforce.

The Alliance suggests that an expanded implementation of the new assessment program allows for shadow assessments using the new integrated tool, to sit alongside the current tool in a live environment for a period of at least 3 months.

Such shadow assessment trials need to ensure its applicability with all consumers, particularly those with simple light touch support needs through to complex, episodic, multiple disabilities including cognitive, communication or psychological difficulties. The live environment trial should also consider how 'reassessments' could be included within its period. Triage by a health professional to look beyond the initial screening request should be included in the trials to ensure appropriate assessment staff are allocated to conduct the assessment in a timely manner.

Shadow Assessments that have reviewed the assessment outcome, and the publication of data demonstrating the validity of the assessment tool, will increase confidence among consumers and providers in the new assessment process and the outcomes it will generate. It will be particularly important to demonstrate that the support plan, as the outcome of the assessment, is able to be individually tailored to a consumer's needs and preferences.

Assessments of need must not determine services for older people based on whether a carer is available to provide support. Genuine and practical inclusion of carers in the assessment pathway and support plan development is essential.

Multidisciplinary health professionals including specialists in the assessment and support planning process should respond to the changing circumstances and needs of consumers.

As part of developing a single assessment workforce, new and strong pathways between assessment teams and the health system for discharge planning and health professionals including geriatricians must be considered given their current collaboration and integration within ACAT.

The shadow assessment must demonstrate how the single assessment tool, a service list approach

and a pricing model will work in practice.

The fact that some services for an individual's need may need to be delivered at a different cost point to another individual's need for the same type of service must be considered in any future pricing approach. For example, The delivery of some services can be provided in a bundled approach. In addition, a single item in the a service list may have require different various levels of skills, qualifications, scope of practice of workers to provide the service required by the individual consumer. In turn these different levels of requirements have different costs of service delivery. For example, assisting with monitoring an older person's skin integrity may be able to be delivered by a suitably trained personal care worker, under the direction of a Registered Nurse. Alternatively, it may require the services of an experienced Registered Nurse. It is unlikely that the assessor will have the necessary skills to determine which level of qualification is needed, as a clinical assessment will be needed to determine this.

10. The Alliance agrees with a support plan approach based on a standardised assessment of need, used to inform an individually tailored support plan co-designed and agreed to by the consumer and assessor. Review of support plans requested by care partners or consumers must be timely and seamless without the need for a full reassessment.

Support plans should draw on the broad range of health and human services available including those outside of aged care, family and friends providing informal care, and other social and community services to meet the most appropriate need of the consumer. Any support plan must have the flexibility of including relevant supports beyond those included within any service classification approach.

The single assessment tool will be critical in determining consumer needs and identifying services for support plans. It is important the assessment tool and accompanying process identifies episodic or ongoing health and wellbeing needs in partnership with consumers. As independent experts in the aged care system, assessors should commence facilitating support plan development and advise older people and their carers on the range of service options available.

The Alliance recognises support planning is a distinct function that, in practice, today sits in the care management functions of a service provider. Delays between assessment determinations and accessing support, as well as inaccuracies in assessment determinations often require further refinement of assessor generated support plans during the commencement of care partnership services.

The Alliance recognises that consumers may have varied preferences about how they access care partnership services with account for self, shared and fully managed support plan goals. Care partnership services may be offered as either independent of providers or as an extension of a provider's direct service provision. Transparency of consumer experiences and outcomes in support plan implementation will be an important metric in determining the impacts of these varied approaches to care management

The timing between assessment and support plan development, and resources being allocated / services commenced, will provide indication of how reliable and valid an assessor generated support plan is. The longer the period, the less useful it is. Government will need to carefully consider the balance of demand driven assessments and service supply in various care delivery services to ensure

support plan development can be matched with timely service/support solutions.

Requirements for reviews and/or reassessment will need to be considered where support plan development and flexibility provisions are unable to facilitate service responsiveness. Mechanisms for review of support plans need to be considered where changed by, or specialised needs are identified by, health professionals. Clear guidance is needed on circumstances where reassessment is necessary and assessment workforce planning needs to account for reassessment demand to ensure timely access to these services.

The development of service types and the capacity of services to be provided to meet needs will be a key aspect to support planning. Unfortunately, current workforce constraints are likely to limit access to some services for consumers and carers. Consumers and carers, along with care management and direct service providers will need sufficient flexibility to adjust support plans to match service solutions accessible in their local care ecosystems.

Additionally, stringent prioritisation and allocation of services may be required where flexibility provisions appear inadequate in responding to workforce and care delivery constraints.

The support planning process may need to prioritise services relative to the evidence on benefit to the consumer and subject to agreement and consent by the consumer. Considerations in prioritisation should include services offering the optimum quality of life benefits and approaches to mitigating risk.

The primary aim of assessment is to accurately identify consumer needs to inform and partner with consumers to develop support plans. Assessors must also have up to date information about the service availability within the local care ecosystem to ensure they do not set unrealistic expectations with consumers as part of the support plan development. Consumers must be informed at the point of assessment about potential issues related to the implementation of support plans co-designed with consumers.

The assessment and care partnership workforce should have the capacity and capability to identify and scope the health and social care needs of the consumer and match these to appropriate services and levels of care. This includes enabling engagement with geriatricians, nurse practitioners and allied health professionals experienced in aged care.

Analysis or interpretation of support planning metrics should incorporate an understanding of workforce shortages and service capability.

11. The Alliance supports care partnerships as a valued core function, that facilitates the implementation of, and in some circumstances initiates the reviews of, support plans.

Care partners work alongside older people and their carers to support and inform them to make support plan decisions and to access health, community, social assistance, and aged care services as they are needed. Care partners should be a suitably qualified professional with the expertise and knowledge to provide quality, evidenced based assessment and care planning, as a part of a multidisciplinary team. Care partnership services may be offered as either independent of providers or as an extension of a provider's direct service provision.

Care partners should be involved to the extent that older people want to have them engaged. This

could span the spectrum of fully managed care through shared management arrangements through to the highest form of self-managed care where a consumer may only need to be contacted from time to time. The level of care partnership support provided could vary over time in response to any decline and/or request from the older person and both program and funding design needs to accommodate the varied care partnership support needs and cost for delivering these services. Clear guidance on duty of care and dignity of risk regarding the role of care partners in these different levels of support must be provided by Government and the regulator.

Care partnership should be defined as a valued service and not an administration charge. The administrative rostering process that has been defined under the current Quality of Care principles as part of care management should be incorporated into the cost of delivering services. Pricing of services should reflect this inclusion. Every consumer will need an allocation of care partnership support and funding as part of their support plan. It may be necessary to price care partnership in ways that allow variation in care partnership expertise, aligned to consumer needs.

In a new Support at Home program, a care partner should be a key advocate for older people linking them to a range of services within and outside the aged care system. The care partner function could also include identifying and reporting risks for consumers about dignity of risk and duty of care. A trusted relationship between care partner and consumer is important, enabling older people to raise concerns they may be reluctant to address regarding support plan implementation and to act as an independent advocate.

Care partnership should include reviewing the consumer's service agreement and support plan, ensuring care and services are aligned with other supports, liaising with the consumer and the consumer's representatives, ensuring that care and services are culturally appropriate, and identifying and addressing risks to the consumer's safety.

Care partnership will require information from frontline workers to be alerted to evolving issues facing their clients. A clear IT roadmap must be developed to improve the interoperability of information between organisations and individuals providing the ability for data driven flags to alert care managers to consider the changing needs of consumers and associated outcomes. Consideration of privacy requirements will be necessary to ensure the new Aged Care Act permits the facilitation of information exchange, with consent of the consumer, between organisations and individuals who are key stakeholders in support plan implementation linked to the provision of support for individual consumers.

12. The Alliance supports an enhanced service list approach responsive to consumer needs and preferences; worker skills, training, scope of practice; provider obligations; support for carers and volunteers; and facilitating consumer flexibility to appropriately variable needs. The service list approach should be considered agnostic to whatever pricing model is decided.

The development of an enhanced service classification approach to the design of the new Support at Home program is important for clarity for both consumers and providers. The Alliance supports the use of an enhanced version of a service list approach, but notes this should not be confused with support from across the Alliance regarding any particular pricing model.

A consistent list of services will allow the needs of consumers to be assessed and matched with a

quantum of service hours or occasions of service against service types. It will remove the need for customers to 'price shop' from aged care providers and shift the price negotiation to between providers and Government.

In the development of any service classification approach, the Government should consult on:

- How services should be grouped, taking into consideration, location (e.g., consumer's home or a community venue), worker scope of practice, WHS obligations, and skills, training of individual workers and consumer directed choices for services to be delivered.
- How a service list/classification approach will enable consumers to reallocate their services on any given day for any service delivered by the same organisation allocated to provide the services, by a comparably qualified and skilled person, and at a comparable price point, (e.g., a funded hour of domestic assistance delivered by the same provider by a comparable client may on a particular day become a social support funded hour).
- How a service classification approach will facilitate innovation and flexibility. The Alliance proposes that any service category approach requires a miscellaneous category that assessors can allocate funds for specific purposes agreed to by the independent assessor and the consumer. For example, paying for a commercial passenger vehicle service rather than a community transport trip. Data analysis of the miscellaneous supports category should inform future evolution of service classification. Clear guidance on how the items in the miscellaneous category are linked to client need should be documented in the support plan.

A service classification approach must consider how it will accommodate different levels of qualification, supervision and multi-disciplinary teams within its approach to classification (and separately pricing approaches). For example, some personal care services could include supporting client self-administration of medication or monitoring skin integrity under the direction of a Registered Nurse (in accordance with some state/territory obligations and with clear workforce health and safety policies and procedures), while other types of personal care services may not require direct supervision of a Registered Nurse. Consideration of how similar services requiring different obligations are implemented must form part of the service classification design.

Allocation of the quantum of services by the assessment for individual clients, must include providing for flexible and innovative solutions. This includes allocating to their service provider additional hours of service to allow for the variable and episodic needs of consumers. The calculation of additional hours will be dependent on the final funding design and may start with a flat percentage that overtime is made variable based on consumer profile data.

13. The Alliance supports a more effective and equitable Goods, Equipment and Assistive Technology (GEAT), and Home Modifications program. These programs enable older people to maintain their functional independence for as long as possible in the various home settings in which older people live. The Alliance encourages the unique and distinct characteristics of the GEAT versus the Home Modifications programs be retained. The Alliance recommends the programs be expanded from 1 July 2023, before the full Support at Home program is implemented.

Goods, equipment, and assistive technologies help older people maintain independence and minimise safety risk (to the older person, their family, friends, carers, and care workers) without the

need for expensive ongoing services and contribute to reducing the risk of unnecessary hospitalisations.

The need for a national GEAT scheme in home and community care with increased resources, consistent eligibility, and widespread availability is long overdue. The Alliance supports the continued expansion of the GEAT services available, recognising the challenges of implementing the GEAT program on its original timeframe of 1 July 2023.

A GEAT and home modifications program should include a strong educative, information and awareness function, developing an independent source of trusted information that enables consumers to understand and locate relevant GEAT products and services.

Funding for GEAT must be bundled with funding for allied health professionals to allow for specialist assessment and prescription, customisation (where needed), implementation support, training, and reviews. A bundled approach is required to ensure appropriate implementation of aids, equipment, and home modifications. Funding levels for GEAT / Home Modifications will need to be finalised following specialist assessment to determine prescribed recommendations.

The continued expansion and further development of the GEAT/Home modifications program will need to be aware of the program's interaction with relevant state and territory laws, along with similar programs regulated in disability, health, and veteran affairs.

The GEAT and Home Modifications program should be regularly evaluated to assess its capacity to provide consumer outcomes including improving consumer quality of life and potential cost benefits for the delivery of community and home support/care services. Evaluation of innovative solutions to supplement the workforce with GEAT will be important to inform future policy solutions. Alliance members appreciate the co-design of the new program with older people, providers and professionals working in this area. We note however that the approach to date has not directly included relevant peak bodies and would encourage consultation mechanisms in the next round directly with relevant peak bodies.

14. The Alliance supports the Government's announcement to build a positive worker registration scheme not later than 1 July 2024, as part of the new Aged Care Act, and earlier if possible.

The Alliance welcomes the opportunity to engage with the Australian Government about the design of a positive worker registration scheme. A positive registration scheme is one that moves beyond just screening requirements and punitive measures. It is important that the registration scheme captures all types of workers, irrespective of their engagement/employment method and is not cost prohibitive compared to the current cost of police checks/working with vulnerable people and children checks.

Despite comprising most of the workforce, Personal Care Workers (PCWs) and other essential support roles are not subject to formal quality oversight by way of a regulation scheme. Registration is the formal means by which care work can be recognised as skilled practitioners. It is an opportunity to improve job readiness and minimum education qualifications, practising standards, for workers to access formal qualifications and ongoing training, enhance career pathways, safeguard the safety and wellbeing of workers and care recipients, and assure the community of the quality of aged care

services. Together, these benefits of registration will improve attraction and retention of workers to aged care.

Registration will also enable labour mobility across like-professions by establishing industry-wide standards and having mechanisms in place for employers to access and verify appropriately skilled and qualified workers. For aged care, the greatest labour mobility opportunity is with the disability and veteran sectors. Future work to mutually align with State and Territory working with vulnerable people / children checks should also be considered. The administration of a registration scheme requires a well-resourced and experienced statutory authority.

The scheme should develop a clear registration approach including mutual recognition of registrations administered by other regulators such as AHPRA and the NDIS Quality and Safety Commission. More information sharing between regulators should be provided. Over time a single care registration scheme should be developed to reduce the burden and cost to aged care providers and the aged care workforce.

Support at Home program design needs to ensure a funding model enables providers to enact any initial and ongoing education and professional development responsibilities.

The Alliance recognises that any ongoing professional development and supervision elements of a scheme will need to accommodate the non-static nature of workers and workplaces i.e., people's homes rather than a residential setting. Supervision and effective reporting mechanisms (where required/applicable) are important aspects of a well-functioning registration system and professionalisation of the care workforce. Workers and providers must be resourced to ensure they receive training in incident reporting and can fulfil supervision and ongoing support functions.

The Alliance recognises that in the first instance for practical reasons, a registration scheme is likely to apply to PCWs only. The Alliance suggests Government should consult on the design of a positive registration scheme for care workers which may include the following elements:

- Is free or otherwise cost-proportionate to the wages of these workers.
- Publishes a register that includes information for each worker.
- Has a minimum mandatory qualification of Certificate III
- Includes a criminal history screening outcome.
- Has an accreditation element where care specialisation skills and additional qualifications are recognised and can be used positively to enhance career and employer mobility.
- Has Recognised Prior Learning provisions and provisional arrangements for existing workers to attain qualifications while continuing their work. Entry and transitional implementation arrangements, such as time-limited 'provisional registration' and 'qualified registration' can be mechanisms to ensure that registration does not become a barrier to enter or remain in the sector.
- Has established registration standards and standards for practice for care workers, their employers, and consumers to understand their role function.
- Has continued professional development requirements, including appropriate practical training and supervision tailored where applicable to meet the specific needs of home and

community care.

- Has cross-sector mobility with the disability and like care sectors, including building on the shared Code of Conduct.
- Is administered by a well-resourced authority that has the capacity, experience and supporting framework to ensure the scheme is not just based on worker screening and punitive responses.
- Adequately and sustainably funded, including resourcing of the relevant statutory authority/regulator.
- Adequately resourced statutory authority/regulator to provide timely investigations of issues of risks by registered aged care workers.
- Affords PCWs nationally to share a professional identity.
- Has stringent regulations to ensure that regardless of how a worker is engaged registration is required, including for the on-demand workforce.
- Is well-managed by a statutory authority with adequate resources to administer the scheme and work closely with relevant stakeholders.

The design and implementation of a positive registration scheme will build on recently passed legislation enabling a Code of Conduct, banning orders and requisite procedural fairness.

The registrar or regulator needs to be adequately resourced to provide timely investigations of issues of risks by registered aged care workers.

15. The Alliance supports reforms to encourage a direct employer/employee relationship for the delivery of aged care services, while recognising that brokerage and subcontracting may remain a necessary element of workforce supply in particular circumstances. Appropriate regulatory safeguards must be extended to indirect models of engagement to address specific risks. Within the Alliance, it is not universally accepted that an "on demand" workforce is appropriate in the care sector.

Opportunities for direct employment (either full time, part time or casual) should be supported in the design of aged care reforms. This reflects the evidence that quality jobs, which provide workers with good wages and conditions including job security, are linked to quality care.

The safety and quality of care for workers and consumers must never be compromised by the model of employment/engagement. This includes market stewardship decisions related to the level of competition and the rate of independent pricing.

The Alliance recognises that there will be circumstances where alternative direct employment arrangements are necessary. These include opportunities for providers to fill unforeseen short-term staffing gaps; increased flexibility for workers to choose and schedule their working arrangements and place of work; and improved choice for consumers to find workers that best suit their unique needs. It is also acknowledged that older Australians highly value continuity of care and that care provided by the same workers enables better care and improves wellbeing. Continuity of care is best ensured with a highly valued, well-paid, directly employed workforce, with high levels of retention.

In the context of workforce shortages, it is acknowledged that the use of workers through brokered and subcontracted arrangements (including through an agency) may be necessary. During the current workforce crisis, a range of workforce solutions will be needed as the aged care workforce builds. Other means of boosting the workforce when there are shortages must also be utilised by providers, such as offering additional hours to existing casual and part-time employees.

There is not a universally accepted position amongst Alliance members as to whether an "on demand" workforce (sometimes referred to as the platform or app economy, or the sharing economy) is appropriate in the care sector. Members of the Alliance identify risks and increased responsibilities of the consumer, harm to the amounts earned by workers, impacts on competition with other providers, as well as benefits and flexibility provided to consumers and workers who understand and prefer this mode of engagement.

When directly engaged by the consumer (without government subsidies or funded through an approved provider) the consumer adopts the role of 'employer' and may be liable for such things as ensuring the worker's safety while in their home. Consumers who engage on demand workers must be made aware of the responsibilities they assume. This includes obligations to ensure the worker is entitled to work in aged care on the worker register and that the consumer is ensuring a 'safe' work environment in their home. Information and training for consumers to understand their responsibilities is required. Subsequent training for assessors and care partners who may need to explain these responsibilities to consumers will also be required.

The Alliance recognises that the use of the on-demand workforce, is a distinct form of indirect engagement where there may not be a traditional employment relationship between the provider and worker. In these circumstances, the individual worker assumes employment-related responsibilities (e.g., liability for injury to self or consumer; workers' compensation insurance; training and development costs; payment of the superannuation guarantee). The costs associated with the above responsibilities must be taken out of the hourly rate charged to determine the final amount earned by on-demand workers.

Best practice training for on demand workers should be available. Such training should include information about contributing to superannuation; establishing and maintaining insurance (including workers compensation and professional indemnity); how to calculate wages at the appropriate level (at or above the relevant award wage), including costs of covering leave, tax, and superannuation; the financial risk they assume for making a profit or loss for each contract; and responsibilities for ongoing professional development and training.

Aged care workers in the on-demand workforce performing relevant care roles must be captured by the aged care worker registration scheme. As part of any registration scheme, an aged care worker in the on-demand workforce must confirm they understand the obligations required. Approved providers who source workers through the on-demand workforce, and particularly where they are funded through government subsidies, must ensure worker compliance with registration obligations.

There will need to be clear guidance on what is expected in a multi-provider environment that provides for levels of responsibilities when drawing on brokerage, sub-contracting, and on demand workforce arrangements.

Inclusive supports for carers and maintaining volunteers as part of the care ecosystem must also be included in any future design.

16. That the Support at Home program takes into consideration the diversity of consumers and incorporates the Aged Care Diversity Framework principles and recommendations in the program.

The Alliance recognises that the Royal Commission did not have the time to systematically address recommendations for all people from diverse backgrounds. More needs to be done to create an inclusive aged care system. The new human rights based Aged Care Act must ensure the cultural, linguistic, spiritual, and other needs and preferences of older people from diverse backgrounds are embedded into everyday practice of aged care service delivery.

For all older Australians to feel included and respected, it is essential that diversity, equity, and inclusion are at the heart of the aged care system. The current aged care policy landscape reflects this approach. However, future revisions of the Aged Care Quality Standards must better include specific consideration of diversity. Quality Assessors must consider the inclusive practices of aged care providers.

The Aged Care Diversity Framework recognises that to have quality care in our aged care system, we must respect the dignity and human rights of every person and tailor care to meet an individual's diverse needs.

Design of the new Support at Home program should identify and address perceived or actual barriers that prevent people from getting the care they need and support older people and carers to take an active role in improving aged care.

Action plans have been developed for First Nations people, people from Culturally and Linguistically Diverse (CALD) backgrounds and Lesbian, Gay, Bisexual, Transgender, gender diverse and Intersex (LGBTIQ+) people. A further plan is being developed for older people who are homeless or at risk of homelessness.

The Specialisation Verification Framework provides a verification of aged care providers who state they deliver services to specific diverse populations to have this as part of their Aged Care profile. Such an approach should form part of any criteria for targeted funding to meet the needs of diverse groups.

17. The Alliance supports the implementation of an annual report and analysis in all regions from 1 July 2023. The analysis should consider regional demand, supply availability, workforce needs and availability (including allied health planning), and population/consumer outcomes.

To understand the full scope of demand for community and home care, annual regional demand reports and analysis should be created and published. Data to inform these reports should be initially drawn for existing data reporting arrangements. Over time a clear IT roadmap to improve the interoperability of information across providers, and governments may improve this reporting function.

The Alliance supports expanding the current eight regional stewardship trials to all locations to expand the availability of and access to regional data, undertake in-depth analysis and build local awareness of and solutions to identified needs in specific regions. Regional reports will include an

understanding of current waiting lists by service type, regional assessment timeframes, service access challenges and solutions and future projected needs in the forward 12 and 36 months.

Regional stewardship strengthens the governance of aged care by creating a local network comprising Department of Health staff and aged care stakeholders, targeting responsive improvements in local aged care consumer experience and outcomes, and ensuring that national planning and policy development is informed by an understanding of local issues, requirements, and achievements for delivering and locally tailored solutions to local needs.

The functions of the regional local network include analysing local needs, supporting workforce planning, building the capacity and capability of providers, monitoring the effectiveness of the new care finders and single assessment workforces, and supporting best practice and innovation. The introduction of regional networks also supports improved on the ground coordination of services and should be a cornerstone of the Government's monitoring of the effectiveness of the new Support at Home program.

Improved data collection and reporting particularly for regional, rural, and remote services, will be useful for workforce planning and skills matching. Workforce planning should be based on improved research and data; genuine, sector wide consultations into which all stakeholders are proactively engaged; and regular and improved financial, regulatory, and quality reporting. Intersecting Departments and programs, such as the soon to be established Jobs and Skills Australia Authority, the Department of Home Affairs and any relevant visa and migration pathways, must be responsive and complimentary to aged care workforce and skills planning.

NACA


ACCPA
Aged & Community Care Providers Association


Allied Health Professions Australia


Anglicare Australia
in every Community


independence matters
Association of Independent Retirees


apna
Supporting nurses in primary health care


audiology australia


ASCN
AUSTRALASIAN SERVICES CARE NETWORK


AAG
Australian Association of Gerontology


AASW
Australian Association of Social Workers


Australian College of Nursing


acia
leading quality in community support


ACTA
Australian Community Transport Association


ADA
AUSTRALIAN DENTAL ASSOCIATION


ahha
australian healthcare & hospitals association


Australian Nursing & Midwifery Federation


AUSTRALIAN PHYSIOTHERAPY ASSOCIATION


APS
Australian Psychological Society
Believe in Change


BAPTIST CARE AUSTRALIA


Carers Australia


COTA
For older Australians


Dementia Australia


Dietitians Australia


Diversional & Recreation Therapy AUSTRALIA


EAAA
Elder Abuse Action Australia


ESSA
EXERCISE & SPORTS SCIENCE AUSTRALIA


FECCA


HSU NATIONAL


Home Modifications Australia


LEGACY


LUTHERAN CHURCH OF AUSTRALIA
MINISTRY WITH THE AGEING


Macular Disease Foundation AUSTRALIA
Our focus is your vision


Meaningful Ageing AUSTRALIA


LGBTIQ+ HEALTH AUSTRALIA


NATSIAACC


Occupational Therapy Australia


OPAN
Older Persons Advocacy Network


PalliativeCare AUSTRALIA


The Pharmacy Guild of Australia


PICAC alliance
Partners in Culturally Appropriate Care


PURAC
LEADERSHIP
PUBLIC SECTOR RESIDENTIAL AGED CARE

PROPERTY COUNCIL of Australia
Retirement Living COUNCIL

RETURNED & SERVICES LEAGUE AUSTRALIA

rsb
The Royal Society for the Blind

Speech Pathology Australia

UNITED WORKERS UNION

UnitingCare Australia

Vision Australia
Blindness. Low Vision. Opportunity.