Submission from the Decent Work Good Care Research Team

Introduction & Background

1. Following its third Melbourne hearing in October 2019 focused on workforce matters, the Royal Commission sought written submissions on a number of workforce issues in aged care. We address these issues here drawing on some preliminary findings from the Decent Work Good Care research team.
2. The *Decent Work Good Care: International Approaches to Aged Care* project (2017-2020) is an Australian Research Council-funded Discovery project that I lead. Other Chief Investigators include: Prof Donna Baines (Sydney/British Columbia), A/Prof Deb King (Flinders), Prof Ian Cunningham (Strathclyde), Prof Tamara Daly (York). Wendy Taylor is Project Manager and Dr Raelene West is the current research assistant on the project. The Decent Work Good Care (DWGC) project explores the links between decent work and good quality care in aged care systems in Australia, Canada, New Zealand and Scotland. The main objective of this cross-national study is to better understand how national policies, funding and regulation, operationalized through organisational practices and work design, shape both the quality of work and the quality of care. We are also learning and collecting evidence about how the organisation of care relationships in aged care services between care workers and aged care recipients can best promote job quality in the work of aged care and sustainable, good quality aged care services. Our website is here: https://decentworkgoodcare.com, and a very brief overview of our methods is provided here: https://decentworkgoodcare.com/wp-content/uploads/2019/01/Final-DWDC-1-page-project-summary-v5-Jan-2019.pdf.
3. Our empirical research has had two main phases:
    - *Phase I: Regulatory Mapping*: We are seeking to understand the different contexts in which aged care services are provided in each country. We are mapping national, or in the case of Canada, provincial, legislation, policies and regulation influencing the aged care 'market' and the employment of frontline workers in each region and are identifying key similarities and differences between the aged care systems in each of the four countries. This mapping includes:
        - Government/not for profit/private ownership
        - Funding mechanisms
        - Quality/accreditation mechanisms
        - Employment regulation and enforcement
        - Workforce structure and profiles

      As part of this mapping we have been collecting documentation from and/or interviewing representatives from aged care funding/procurement bodies; regulatory agencies, including employment enforcement agencies and care quality accreditation agencies; peak aged care provider organisations; unions and aged care advocacy organisations. We are using this mapping to illuminate the national contexts that are shaping job quality and care quality in aged care and to highlight innovative system-level policies.

    - *Phase II: Organisational case studies*. We have been undertaking in-depth organisational case studies with aged care providers in Australia, New Zealand and Scotland and are drawing on existing case studies undertaken in Canada. The week-long case studies include both residential and home care providers, who have been identified by industry informants in each country as providing good quality employment and good quality aged care services.
    - We use a rapid ethnography (RE) methodology in the case studies. In RE researchers collect data from multiple sources over a relatively short period of time. The data collected includes interviews, participant observations, shadowing of a handful of frontline workers, informal discussions and document reviews. A key feature of this approach is that the research team

includes 'insider' (local) and 'outsider' researchers (from another country) in each case study. Through this approach, we draw links between the 'everyday' life of aged care work, the organisation in which it takes place, and the policy and regulatory context in which the work is undertaken. The value of this RE approach is that the 'outsiders' question and compare many aspects of the work organisation and care based on their knowledge of alternative systems. The 'insiders' provide valuable contextual information that helps the research team understand whether features are unique to an individual organisation or are reflective of the broader policy or regulatory aspects of a country's aged care system.

- The case studies thus help us identify how national policy settings impact on service provision at the organisational level and how providers' organisation of care supports decent working conditions and relationship-based care. The in-depth case studies also allow us to identify innovative or 'promising' practices that support both decent work and good quality care.

4. We are now into the third and final year of the study and have just completed our Scottish organisational case studies. We have started sharing our findings to influence aged care policies and practices through:
   - Conference and other presentations;
   - Providing detailed reports and feedback sessions to case study organisations;
   - Producing promising policy snapshots;
   - Producing promising practice snapshots; and
   - Publishing our newsletter and sharing resources on the www.decentworkgoodcare.com website.

10. In this submission we briefly respond to the workforce issues raised by the Royal Commission drawing on emerging findings from the DWGC project, including in light of other evidence provided to the Royal Commission to date. We focus on the majority frontline aged care workforce in our responses and on issues that may not be addressed in other submissions. We also reference relevant material from the witness statement of Professor Charlesworth to the Royal Commission, including that drawing on the DWGC project, rather than repeating it here (see Witness statement 14/10/19 - RC Exhibit 11-52).

Methods for determining & implementing minimum staffing levels and appropriate skills mix

11. The Commission has heard and received detailed evidence of a wide variety of views on, and approaches to, determining appropriate minimum staffing levels and skill mix in Australian aged care services. There is no doubt that existing staff levels and the thin skill mix in the Australian system are both highly inadequate, undercutting the quality of services provided to the frail aged and the job quality and dignity of the workers who provide the care.

12. Australian and international evidence points to *time* being critical to *relationship-focused* care quality, an approach to care quality generally accepted as central to good quality care outcomes for service users (Trigg 2019; Armstrong 2015). One of the consequences of the gendered approaches of governments to the funding of aged care is the blindness to the actual *time* needed to provide skilled aged care that meets both the clinical as well as the social and emotional needs of service users. Our own study and others have found that aged care workers need *time* to use the technical and relational skills they have acquired both through experience and training (Banjeree and Armstrong 2015; Armstrong 2013). In the ongoing call for a more skilled workforce that has been echoed in almost every Australian inquiry into aged care, there is little attention paid to the conditions of work that provide for the optimum exercise of skills *currently held*. Those conditions include the quantum as well as the organisation and scheduling of time to care and the system-level incentives and disincentives that structure that time.

13. The DWGC project has focused on services seen as providing relatively good quality care and employment within their national contexts (RC Exhibit 11-52: paras 87-88). We have found that while care quality in these case study sites is generally above national industry norms, in many instances it is also delivered 'on the back of the workers'. That is, it relies on frontline care staff going above and beyond their job descriptions and often the time allocated to their work and /or working in conditions of stressful intensity. This is not sustainable either at the organisational or system levels. Beyond the DWGC project, there is other Australian and international evidence of the 'moral distress' faced by frontline aged care workers who know that having enough time to engage with residents or clients is central to good quality care and who are left feeling personally inadequate and neglectful where they cannot do so (Hussein 2017; Meagher et al 2019).

14. Mandating minimum staffing levels or care hours per service user that exceed current staffing practices, even in currently better quality services, is a crucial starting point. However such minima will not necessarily produce good quality care or the decent employment outcomes that underpin its provision. For example, there is some evidence from the Early Childhood Education and Care sector in Australia that mandated minimum staffing ratios in practice operate as *maximum* staffing ratios with many providers organising their staffing to ensure that minimum ratios are not exceeded (Fenech et al 2012). Further, one of our concerns about some of the North American-based models and Australian analysis is that they are overwhelmingly focused on clinical needs rather than also specifically taking into account the time required to meet the social and emotional support needs of service users (see Eagar et al 2019; Harrington et al 2016; Blackman et al 2019). In our view *any mandated staffing or care hour per service user ratios need to be based on sufficient time to meet both clinical needs of clients and residents* and *the exercise of relational and technical skills in meeting the social and emotional well-being needs of clients and residents*. Mandated minimum ratios need at the very least to recognise and provide for time *beyond* the allocation of specific number of staff per shift. Mandated minimum ratios need to be accompanied by funding models that take a number of factors into account:

    - They need to provide for the 'irregular irregularities' that characterise aged care service provision across the day and across the week, which take time and skill to manage when they occur. The changing needs of individual service users on a day to day basis or sudden but not infrequent events involving a number of residents, such as a gastroenteritis outbreak, mean that unless minimum staffing or hours of care per client/resident ratios have some 'fat' built in beyond the number of staff rostered on, the shifting time demands on staff to provide good quality relationship-focused care will not be able to be accommodated. Our experience to date also suggests that time to meet the inevitable transitions in aged care such as end of life care are rarely formally factored into staffing rosters or schedules. While some services are able to access some additional support from external or community based palliative care services at such times, ensuring that the necessary additional time required of staff remains ad hoc.
    - There needs to be time factored into minimum staffing/care hours per service user ratios for regular handovers and for staff leave. Minimum ratios need to also recognise and provide for time for the ongoing requirements for the development of staff, including supervision, and additional training.
    - Experience in other countries suggests that there is frequent evasion of minimum staffing standards both in terms of ratios and also skill mix in residential aged care (Laxer et al 2016). Thus there will need to be oversight and enforcement of compliance with any minimum ratios put in place. This means that there needs to be resourcing of auditing and compliance with real consequences for services that are found to not meet or to inadequately met these

ratios. Borrowing from the occupational health and safety and industrial relations enforcement regimes, such action could result in 'provisional notices of improvement' or 'enforceable undertakings' to immediately remedy any inadequate staffing/care hour ratios and put in place proactive steps to ensure that adequate staffing/care hour ratios are re-established and maintained over the long term. Services that fail to comply with these intermediate steps in the enforcement pyramid should not be allowed to continue to access public funds to provide aged care services.

- Transparency is crucial to the effective implementation of minimum staffing/care ratios in aged care. Average actual (rather than planned) staff and skill mix ratios should be published at least on an annual basis by service providers on their own websites and also provided to both current and prospective service users and their families. They should also be published on an accessible public-facing website by the government agency responsible for care quality standards and further, be linked to detailed quality standards on staffing.
- As the majority purchaser of publicly funded aged care services, the Federal government is in a unique position to put in place mechanisms to both ensure contract compliance with the delivery of actual minimum staffing/hours of care ratios (see for example Xerri et al 2019) and encourage above minimum staffing/hours of care ratios. Such mechanisms should also include access to additional funding for piloting staffing models to both test and evaluate innovative approaches to staff/care ratios to inform ongoing reform in the aged care sector. For example, based on a recent study by Prof Pat Armstrong and her colleagues in Ontario, Canada (Armstrong et al 2019), the City of Toronto has just adopted a recommendation to pilot a new emotion-centred approach to care. New staffing ratios will be put in place in its 10 City-run nursing homes to ensure an increase from 3.6 to 4 hours care per resident per day. The City has also agreed, based on the Armstrong et al 2019 study, to hire more full-time staff to promote continuity and take steps to accommodate diversity.

15. The focus on minimum staffing/ care hour ratios in Australia and internationally is almost exclusively focused on residential aged care. While challenging, it is vital that mandated staffing/ care hour ratios also be developed in the home care sector. The consumer directed care model in home care has led to care being task-focused and rationed (Meagher et al 2019), the anthesis of the goal of relationship-focused care (Trigg 2019). Adequate time needs to be factored into home care visits (and the packages that provide for them) to enable the flourishing of the relationship aspects of home care workers' interactions with clients and the time necessary to provide personal care ensuring dignity for clients. Minimum care hours per client in home care services also need to account for the actual time taken to travel between clients. While we have found that good providers try to protect and buffer their workers from many of the time rigidities of the aged care system, they cannot always do so entirely. One case study example in Australia is where an employer provides paid, although unfunded, travel time to home care workers for between client travel. However, because this time is unfunded it can be squeezed and cut back when there are service delivery pressures. We have also found internationally, even where travel time is formally recognised as 'work', that home care workers may not be fully or even partially compensated for this travel time. This is due mainly to system-level settings, such as the inadequate level of funding put in place for the recognition of between client travel by home care workers as paid time in New Zealand, and the unfunded legal obligation in the UK (including Scotland) to pay home care workers the minimum wage for between client travel, an obligation which has been effectively unenforced by HM Revenue and Customs.

16. An adequate staff skill mix is clearly central to minimum staffing or hours of care ratios. Our experience in the DWGC project suggests services rely overwhelmingly on frontline personal care assistants or home care workers in the provision of direct care. In Australia there has been

a steady loss over time of both registered nurses and enrolled nurses from the aged care system (Meagher et al 2019). This has also occurred in Scotland and New Zealand and today the frontline aged care workforce provides most of the direct care. While almost non-existent in poorer quality services, we also saw a distinct lack of any substantive 'skill mix' in many aged care services we have visited in Australia, New Zealand and Scotland. In most of the residential services a registered nurse would be available but only very rarely involved in any hands-on day to day care. For different reasons and responding to different system pressures we found many residential services prefer to upskill frontline care staff via short courses to administer medicine (including class A drugs in Scotland) and to provide specialist dementia care rather than employing nurse-qualified staff or indeed directly employing allied health staff.

17. One noteworthy exception to the more typical distance of RNs from direct care identified in the DWGC project was in an Australian residential facility where the nurse-in-charge was involved both at meal times in assisting residents to eat, in quiet one-on-one recreational activities and in regular conversations with residents. However this reflected the individual practice of this particular RN rather than being formally part of the rostering arrangements. We also found a more planned approach in two NZ home care services, where workers were closely supported by nursing-qualified staff in the regular review of care plans and also in responding to specific client concerns raised by workers. In two Australian residential services we visited there is some use of enrolled nurses above the industry norm. It was notable in one of these services that enrolled nurses worked alongside and interchangeably with personal care workers. One Australian home care service we visited provided regular feedback to regular home care workers on clients and also involved more experienced workers in care planning, paying a small wage premium for the time they spent in care plan reviews. Our case studies are, however, exceptions.

18. The recommended staff mix of RNs, ENs and personal care workers set out in both Eagar et al (2019) and by Blackman et al (2019) seems appropriate as a starting point to ensure a broad range of skills is available in residential care settings. However having a better staff mix in and of itself does not ensure that the necessary skill set is available to provide high quality direct care to residents and clients. Research on skill mix suggests that not only are a range of skills needed in aged care services but that working *in collaboration* with other more qualified and experienced staff enhances overall service quality and job quality (Laxer et al 2016). Thus any skill mix provisions need to be modelled on a more inclusive approach where there a mix of staff with different skill sets to undertake care and where registered nurses are also directly involved in hands on care.

19. The Nordic countries provide a sharp contrast to Australian skill mix norms. In a Norwegian care home Professor Daly and I visited in December 2019 with other colleagues as part of the 'Age Friendly Communities within Communities' project (Exhibit 11-52: para 89), there were two registered nurses and two licenced practitioner nurses (equivalent to enrolled nurses) on a day shift team for an average of 10 residents per team. Our experience is consistent with a 2012 study which found that although Norway had no mandated care standards, that staffing levels and skills mix were about the levels recommended by experts (Harrington et al 2012). The level of staffing we found in the Norwegian care home can be contrasted with one Australian residential facility we visited where the relatively good direct care staffing (excluding kitchen staff) in the more demanding 20 person dementia unit included 2.5 FTE care workers and an enrolled nurse on the day shift with the oversight of a registered nurse, who was also responsible for the rest of the facility.

20. Finally, providing for an effective and enhanced skill mix needs to ensure that decent compensation is attached to gaining additional skills and that training is provided on paid time.

Registration scheme for non-clinical staff in aged care

21. Two jurisdictions covered in our DWGC study, Ontario in Canada and Scotland have recently put in place mandatory registration schemes that cover frontline aged care workers. Both are linked with minimum qualification standards. Both have experienced some implementation issues.

    - In Ontario a registration scheme was initially put in place in 2012 for home care workers. The Personal Services Worker (PSW) Registry provided as an important first step towards the professionalisation of this group of workers and the development of a common educational standard for PSW programs (Kelly and Bourgeault 2016). However, the Registry was shut down by the government in 2016 as it was found to have failed to determine either the number of PSWs working in Ontario or the level of their training. In 2017 the Ontario government introduced a new mandatory PSW Registry covering PSWs working both in home care and in residential aged care, which is expected to be fully implemented by December 2019 and fully operational in 2020 (see https://www.psw-on.ca/). According to the government the purpose of the registry is 'to verify training and education credentials of PSWs, to provide oversight and accountability and to ensure that all PSWs follow the same code of conduct'. Registrants are required to have completed a recognised PSW program (typically 600-700 hours of training over 8 months); to have undergone a Police Record Check and agreed to the Registry's policies and procedures, including the Registry's Code of Ethics. The Code of Ethics sets out, among other things, that PSWs must practice within the parameters defined by the Code, their verified education/training, terms of employment, and the roles and responsibilities of personal support workers. Importantly, PSWs are expected to maintain ongoing competence in their current area of practice and must continuously improve their competence to respond to evolving and emerging health care needs (https://www.psw-on.ca/assets/documents/policies/code-of-ethics.pdf). The Registry will also provide a complaint mechanism, although the precise standing of this mechanism is unclear as it will not change a registered PSW's listing on the Registry 'unless the Registry receives a relevant finding or recommendation from a third party or registered employer' (https://www.psw-on.ca/complaints.html). To date, most home care employer bodies and unions have supported the PSW Registry. The Service Employees International Union (SEIU), for example, sees the new Registry as 'a positive step towards more fully recognizing PSWs as not only caring, but respected and essential healthcare professionals' (https://markets.businessinsider.com/news/stocks/seiu-healthcare-celebrates-ontarios-renewed-commitment-to-establish-a-mandatory-psw-registry-583342).
    - In Scotland, the Scottish Social Services Council (SSSC) operates a registration scheme which now covers frontline care workers both in nursing homes and in home care services as well as professional social service workers. This is a far more comprehensive registration scheme than that in Ontario and is seen by the SSSC as a mechanism to professionalise this workforce (see: https://www.sssc.uk.com/registration/). The introduction of registration for social care workers has been phased in but workers coming into new roles are required to register within six months of starting. Existing social care workers are now required to register with the SSSC and to re-register every five years. Once mandatory registration is in place, employers can be prosecuted if they employ an unregistered worker. Registration fees vary according to the role undertaken with a current registration fee of £25.00 for frontline workers (Hayes et al 2019: 42). As in Ontario, registrants are required to follow a Code of Practice. Alleged breaches of the SSSC Code may be subject to a 'fitness to practice' investigation. If an investigation finds that the registrant's fitness to practice is impaired,

s/he may be liable to a fitness to practice hearing and to sanctions such as conditions being placed on their registration or being removed from the register. Both employers and unions expressed some concerns about the 'fitness to practice' hearings. In some cases these hearings were seen as lacking procedural fairness or were more focused on the alleged deficits of the individual worker rather than on the systems of work or work conditions in which neglect or poor care may be rooted.

- A non-mandatory disability support worker registration scheme has been recently developed in Victoria that will also have a complaints and investigation function (see: https://www.vdwc.vic.gov.au/). In the establishment of the scheme, many of the same issues raised in considering the mechanics of a registration scheme for frontline workers in the aged care sector have been canvassed. These include, for example, how a registration scheme should run, worker costs, inclusion/exclusion criteria, mapping of skills/qualifications, frequency of review, how information is to be obtained and stored, and who has access to information. Currently there is consultation on a proposed Code of Conduct and on regulations for unregistered workers and registration standards for registered workers. While a mandatory scheme was initially proposed and supported by sector unions, some disability advocacy groups and employer peaks have argued the scheme should remain voluntary.

22. Based on our understanding of the registration systems and debates about them in Ontario and Scotland and on our case studies and discussions with stakeholders, unions and aged care providers, including in New Zealand and Australia where there are no registration scheme, we would support a mandatory registration scheme for frontline aged care workers. We believe that this would be a positive step in better recognising and professionalising this often taken-for-granted workforce and also in helping to ensure better care quality and accountability. However to meet these goals, any such scheme for frontline aged care workers should have the following characteristics:

    - Mandatory registration for frontline care workers and also of employers in receipt of public aged care funding;
    - Be run by a government body, initially at state level, and substantially resourced by the Commonwealth;
    - Representation of frontline care workers and/or their unions on the Registry, along with employer groups, to ensure workers' views and expertise is represented;
    - Mandatory minimum qualifications to work in aged care be at least equivalent to a Certificate 111 level;
    - Nationally consistent professional standards for practice, such as in the Scottish Code of Practice, that also address expectations of employers, such as around regular supervision;
    - A robust complaint system for service users, their families and workers to report concerns about the quality of care provided by workers and/or employers which do not meet the designated professional standards of practice;
    - As in Scotland, registration should be tied to requirements for ongoing professional development by workers and obligations on employers to assist their workers meet these requirements including through the provision of training on paid time; and
    - Tax-deductable worker registration fees should be kept as low as possible.

Options to resolve low remuneration and poor working conditions

23. In a statement before the Royal Commission (see Witness statement 14/10/19 - RC Exhibit 11-52) a number of options to address low remuneration and poor working conditions , including those drawing on the DWGC project, were set out. It bears repeating, however, that any such options are:

'entirely dependent on federal government commitment and action, given its role as effectively almost the sole purchaser and as lead employer in an aged care supply chain of contracted out services. At a systemic level to provide adequate funding to allow for meaningful wage increases, the federal government will need invest in the aged care sector… financing high quality care services and the workforce to deliver these services is costly and Australian governments will need to increase expenditure on care infrastructure to provide strong social care services... Recent international research estimates that if Australia spent an additional 2% of GDP on care infrastructure (including all care services, not only long term care) we would be able to deliver a decent and sustainable care system that provides the high-quality services people need alongside decent working conditions for those working in these services. However if additional funding for wages and improved conditions, including increased staffing numbers in aged care were to be provided, it would be vital that funding be tied to that purpose.' (Exhibit 11-52: para 47)

24. Enterprise bargaining in Australia has not provided an effective option for addressing low remuneration and poor working conditions in aged care or in any other low-paid feminised sector, nor has the low-paid bargaining stream provision for multi-employer bargaining been effective (Exhibit 11.52: paras 39-46).

25. In our view there need to be decent minimum wages attached to detailed skill classifications and working time standards that cover all frontline aged care workers in residential care and home care. As below the Commonwealth would need to directly intervene to achieve these outcomes. Ultimately, while such conditions should be extended to all workers whether or not they were designated as 'employees' under the *Fair Work Act 2009,* as a first step the current residential care and home care sector awards should be comprehensively restructured. This restructuring would need to include four key steps to enhance not only job quality but the continuity and quality of relationship-focused care for service users:

    - One: Fully articulate the knowledge and skills currently required and used in frontline aged care work and assess its work value at different skill levels;
    - Two: Develop a stepped wage and classification structure for frontline care workers that reflects the range of skills and knowledge used and required that clearly differentiates between levels of skills and responsibilities and the wage for each level;
    - Three: Improve key working conditions in sector awards. Priority areas include:
        - Payment for between client travel;
        - Specification of minimum engagements for casuals and permanent part time workers;
        - Regular schedules with continuous hours on days worked (no broken shifts);
        - Overtime for permanent part time staff over their guaranteed minimum hours;
        - Payment of an availability allowance where workers are required to be available outside their scheduled hours; and
        - Fairer conditions and payment for shift cancellation in home care.
    - Four: Additional funding to cover the implementation of improved remuneration and working conditions be tied to the full extension of these conditions to each aged care provider's workers.

26. In designing options for addressing low remuneration and poor working conditions in aged care, it would be useful to draw on the architecture of the recent NZ pay equity settlement as well as the lessons of its initial evaluation. The settlement covered not only wages tied to both training qualifications and career progression but also better working time arrangements (see Exhibit 11-52: paras 51-54). Two of the key lessons of the NZ experience to date are that the government failure to provide the *full* funding required in the implementation of the substantial reforms it put in place as well as inadequate communication of the changes to workers and

providers, have limited the realisation of the potential impact of these reforms both on care quality and worker job quality (Douglas and Ravenswood 2019; Ryall forthcoming).

27. Models that still currently exist in Victorian Local Government (see for example the City of Greater Dandenong's Home Care Enterprise Agreement 2015 - still in operation at: https://www.fwc.gov.au/documents/documents/agreements/fwa/ae417703.pdf), and that did exist until 2016 in the NSW Home Care Service (see Charlesworth 2017) also provide important starting points for reconfiguring remuneration and skill classifications as well as working time conditions for frontline aged care workers. While limited to home care work, what distinguishes these two models is the attention to the nature of the *actual* work performed and the skills, knowledge and autonomy required to perform it. These models not only provide for wages and conditions that sit significantly above the relevant award but also provide for at least partially 'unpacked' skill descriptions and linked wage classifications that provide for some meaningful career progression.

Raising the overall skill, knowledge and competencies of all care staff (existing and new entrants)

28. There are frequent calls in Australia to increase the skills of aged care staff. There is no doubt with the increasing age and frailty of service users that additional competencies are required by frontline workers both now and in the future. However, such calls also assume that most current staff do not have sufficient skill, knowledge and competencies to provide good quality relationship-focused care. We have not found that to be the case in the Australian case study sites we have visited. Several of the unremarked issues in the call for increased skills are:

    - The lack of *sufficient time* for the practice of *existing* skills in frontline aged care work, as noted above. The allocation of adequate time to care is crucial to the *optimum* use of existing and acquired skills, knowledge and competencies. Unless workers have the *time* to use and practice their skills, the impact of any additional investment in skill development will be limited;
    - A lack of recognition of the complex skills and competencies currently required and used, including in award skill classifications (see RC Exhibit 11-52: para 16);
    - The inadequate provision for, and of, additional training opportunities at work; and
    - The acquisition of additional skills and competencies is untied to meaningful increases in remuneration and a career path.

29. In the DWGC project we have found that the level of formal qualifications held by most frontline workers varied considerably from country to country (see also Laxer et al 2016). We also found that a relatively higher proportion of frontline aged care workers in the Australian organisations we visited held formal aged care qualifications than their counterparts in New Zealand and Scotland, with opportunities provided for further training and qualifications.

    - In Australia in 2016, only 13% of personal care workers did not have any post school qualification. Over 67% of personal care workers held a Certificate III in Aged Care, 12% a Certificate III in Home & Community Care and over 23% held a Certificate IV qualification in aged care. Only 14 % of home care workers did not have any post school qualification. Over 51% of home care workers held a Certificate III in Aged Care, 27% a Certificate III in Home & Community Care and over 12% held a Certificate IV qualification in aged care (Mavromaras et al 2017: 22, 81).
    - To date there is no publicly available representative data on qualifications currently held by frontline care workers in New Zealand following the 2017 pay equity settlement, which linked the attaining of higher level qualifications to additional pay levels. However it is

intended that as many workers as possible will attain a NZQA certificate 4 level qualification, comparable with the Australian Certificate IV. In Scotland, the current qualification level of the frontline workforce is relatively low. While more than 60% of frontline workers in care homes and in home care services who are registered with the SSSC now hold some certification, the vast majority of certificates are at the SVQ2 level (SSSC 2019). The SVQ2 certificate is a relatively basic qualification focused on the recognition of acquired on-the-job skills after a period of working in social care than the acquisition of core knowledge and competencies though vocational education.

30. In several of our DWGC case study sites we found that employers encouraged and in some cases subsidised the gaining of additional qualifications by workers. This experience is very far from the Australian norm. The lack of importance placed by providers on their workers gaining the formal skills required is surprising given the increasingly complex and varied competencies across technical and non-technical domains required of frontline aged care workers. Even in some Australian age care providers seen to provide good quality care, there has been been a shift away from on-the job training to e-learning to complement formal qualifications, leading to some worker concern about the quality of e-learning modules as well and/or not being undertaking relevant training in paid time. There have been various criticisms of the quality of some Australian vocational education providers Certificate-level training noted by the Royal Commission. However with the PSW Registry in Ontario, the oversight of mandatory qualifications via a registration system (see above) could be used as one mechanism to ensure the quality and consistency of approved courses for registration.

Ensuring service providers develop a culture of strong governance and workforce leadership

31. This issue is directly linked to the final issue canvassed by the Royal Commission. Ensuring service providers develop a culture of strong governance and workforce leadership can only occur *systemically* where the Commonwealth plays an effective and proactive stewardship role in the provision of formal aged care services. While the Australian DWGC case study organisations had effective governance structures, these structures have been developed over a long time within the context of a clear mission, a not-for-profit ethos and a consistent set of values. These case studies represent Australian exceptions in terms of strong organisational governance. However, there were some clear differences between them in terms of workforce leadership, especially at individual sites of larger organisations. Compared, for example, to the DWGC case study organisations in New Zealand, management at some sites tended to operate more hierarchically and be less consultative with their frontline workers.

32. Safework Australia defines workplace leadership as being present at all ‘all levels of an organisation: from the board and senior executives, through middle level managers such as site managers, to front-line supervisors’. Among leadership characteristics relevant to the aged care sector are commitment to:

- role clarity, worker involvement and workgroup cohesion;
- consultation and clear two-way communication;
- compliance with procedures;
- organisational learning;
- appropriate training;
- organisational justice and an environment of dignity and respect;
- supervisor support; and
- a positive leadership and management style (Safework Australia 2019).

33. Supporting aged care providers develop both a positive culture of workplace leadership and effective governance structures needs strong modelling by and support from the Federal government including through establishing and monitoring clear contract compliance conditions. The quality of workplace leadership with effective voice for workers as well as service users also needs to be included in any Australian assessable care quality standard. While more detailed than the previous inadequate standard that dealt with issues of workforce leadership, it remains entirely unclear how rigorous the assessment of the current quality standard, Standard 7: Human Resources, will be, the extent to which workers will be consulted and whether worker involvement in the organisation of care will be considered at all.

34. One useful example to consider to encourage improvement in and assess the quality of workforce leadership in aged care providers is the quality assessment process in Scotland, where workers are interviewed as part of the annual quality assessment. These audits are unannounced. The Scottish Care Inspectorate audits and assesses the performance of aged care providers against five broad quality domains. These domains draw on the Scottish Health and Care Standards, built on five principles of: dignity and respect, compassion, inclusion, responsive care and support and wellbeing. Inspectors assess individual providers' performance within each domain using both ratings and qualitative assessments of a set of quality indicators (Scottish Care Inspectorate 2018). The two domains most relevant here are those relating to the quality of leadership and the staff team. As part of achieving good quality ratings in these domains, there is an expectation providers will be able to demonstrate they have ongoing formal and informal consultation with workers throughout the year. Workers are interviewed in the auditing process and the nature and level of the involvement of, and consultation with, workers is assessed as evidence of service quality in the same way as is the nature and level of engagement with service users and their families. Further, even where providers are rated highly in one of more domains the Care Inspectors will frequently make suggestions for further improvements. Our interaction with Scottish aged care providers suggests that these suggestions are taken very seriously. This may be because the full Care Inspectorate reports with their current and historical quality ratings are publicly available on the Care Inspectorate website as well as on provider websites.

Institutional changes needed to ensure the Commonwealth fills its role as system steward

35. In the foreword to its 2019 Interim Report, the Royal Commission rejected the assumption that the aged care sector was an effective consumer-driven 'market'. It stated that while the aged care sector 'prides itself in being an "industry" and it behaves like one, [this] masks the fact that 80% of its funding comes directly from Government coffers.' And further that: 'Australian taxpayers have every right to expect that a sector so heavily funded by them should be open and fully accountable to the public and seen as a "service" to them. As a service, aged care is an integral part of our social support system and, as such, it must aim to be the best service that an inventive, clever and compassionate country can provide. It should be delivering aged care services of an exemplary standard, in ways that are responsive to older people's care needs and aimed at delivering the best possible quality of life to them in their later years.'

36. If the Australian aged care system is to deliver responsive, high quality and sustainable services, this cannot be achieved through the distanced and minimal government involvement we have seen to date. Substantial institutional and policy changes are required to ensure the Commonwealth fills its role as system steward, exercises effective leadership in workforce planning, development and remuneration. The Commonwealth needs to be fully accountable for relationship-focused quality outcomes at both the individual service and system levels. A radical shift from the gendered undervaluing of the work of frontline care and the ageist

mindset towards service users that have characterised Australian aged care funding models, quality assessment, aged care wages and conditions and skill recognition is needed. There also needs to be a shift from the currently very limited Commonwealth consultation with the aged care sector, which has been distinguished by consulting only with a few lead employers and provider lobby groups. Government needs to lead Australian aged care sector reform in designing a decent aged care system and ensuring a sustainable, resilient and responsive aged care system through ongoing involvement in collaborative consultation with service users, unions and providers. This would be a huge and important endeavour as it means *active* government financial investment and involvement in shaping the conditions of high quality service provision, supported and enabled through ensuring decent work and on-going high quality training and supervision. It also requires a significant shift in policy to recognising that providing good quality relationship- focused care can only be delivered through decent remuneration and working conditions and crucially, ensuring the time to provide good quality relationship-focused care. Finally, in taking up a proactive stewardship role in the aged care system, the Commonwealth would need to commit to continuous quality review and improvement of the various elements of this system.

37. While beyond our capacity to canvass all the institutional changes required to ensure the Commonwealth takes on the full ownership of its role as proactive system steward, we note several much needed areas of government action highlighted above:

- An urgent and comprehensive review undertaken by the Commonwealth in consultation with unions and employer peak bodies of the current skill and remuneration structures and working time arrangements to ensure future structures and arrangements properly reflect the full value of work undertaken by frontline care workers and provide the basis for them to undertake this work in conditions of human dignity. There must also be a clear commitment by the Commonwealth to invest in the full implementation costs of restructured remuneration and working conditions;
- The establishment of minimum care ratios for both residential and home care services that provide adequate time for workers to meet not only the clinical but also the social and emotional well-being needs of service users. Increased ratios for specific groups of service users such as those with dementia or complex care needs would need to be established over these minima;
- The establishment of robust and transparent contract compliance processes with all service providers in receipt of government funding. This will require significant investment including in: provider education, clear and detailed contract criteria, active monitoring and auditing together with an enforcement pyramid of clear escalating sanctions, such as, for example, when there are failure to meet mandated staff or care ratios;
- Increased transparency, inclusivity and proactivity of the auditing structures and processes to ensure that good quality relationship-focused care is the norm in all publicly-funded aged care services. These reforms should include criteria for direct engagement with both workers and service users and a requirement that service providers publish the results of quality audits on their websites;
- In its role as the main provider of funds for formal aged care services the Commonwealth must establish far closer and responsive ties with service providers. While complex in a federation as large and diverse as Australia, this may mean providing for more local-level engagement, including through the states and indeed local government. For example we have found practical benefits of the Alliancing model of provider and government partnership operated in a number of New Zealand District Health Boards. These benefits include, encouraging collaboration rather than competition between providers, sharing the

number of service users and service users with complex needs across providers operating in a local area; and putting in place more innovative models of care. See https://decentworkgoodcare.com/wp-content/uploads/2019/10/Promising-Policy-2-Alliance-Contracts-FINAL-8-Oct-2019.pdf.

- Governments in many countries encourage and resource innovation in aged care. As a proactive system steward, the Commonwealth should encourage service providers to pilot innovations in the organisation of care in both residential and home care services in collaboration with workers and service users. It should fund the robust evaluation of such pilots to ensure that, where useful, these innovations can be shared with other service providers and inform the ongoing review of government aged care policy and regulation more widely.

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