Aged & Community Care Providers Association
Suite 2, Level 2, 176 Wellington Parade,
East Melbourne, VIC 3002
ABN 19 659 150 786

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Professor Mark Cormack
Independent Review Lead
scopeofpracticereview@health.gov.au

Dear Professor Cormack,

RE: Phase 1 Consultation: Scope of Practice Review – Issues Paper 1

Thank you for the opportunity to comment on Issues Paper 1 for *Unleashing the potential of our health workforce* – Scope of Practice Review. The Aged and Community Care Providers Association (ACCPA) appreciates the extensive consultation on this Review to date.

ACCPA reiterates our support for primary care professionals working in the aged care sector to work at their top of/expanded scope of practice (following advanced training and/or collaborative care agreements) to deliver a range of primary care services to older Australians, where clinically appropriate and safe to do so, and where this is not currently occurring.

This submission has been prepared from an aged care perspective with input from ACCPA members. It addresses each of the interconnected themes identified in Issues Paper 1 - namely legislation and regulation, employer practices and settings, education and training, funding policy, and technology.

Summary of Recommendations

R1: Harmonise the drugs and poisons legislation across states and territories to improve labour mobility of healthcare professionals across the country, and to ensure clarity and consistency with regards to prescribing rights and vaccine administration.

R2: Support general practices to co-locate with residential aged care facilities by providing incentives (such as in the form of rental subsidies) to remove barriers to GP care for residents and to better integrate care with the support/collaboration of general practice primary care nurses and other healthcare practitioners.

R3: (a) Identify and implement measures to address workforce shortages in aged care to ensure Registered and Enrolled Nurses have the necessary support and balance to work to their full scope of practice.

(b) Undertake a study into the impact of legislative requirements for 24/7 RNs and care minutes in aged care and the relationship with nursing staff working to their full scope of practice**.**

R4: Harmonise education and training requirements for the same competency between different professions, to ensure requirements are reasonable and equitable.

R5: Establish a nationally consistent approach in promoting and implementing common interprofessional competencies, to equip health professionals with specific skills common across multiple professions.

R6: Remove restrictions for GPs to prescribe s100 medications so older Australians with complex care needs can access specialised drugs in a timely manner.

R7: Better fund Clinical Pharmacy Services to encourage accredited clinical pharmacists to fully participate in multidisciplinary case conferencing to support resident care.

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R8: Provide financial support/grant funding to transform quality of care delivery by enabling aged care providers to build infrastructure to integrate digital technologies and build the capability of staff in the use of new integrated systems.

R9: Expand access to Healthcare Identifiers (HIs), whilst ensuring any changes to the HI Act maintain the privacy of healthcare recipients and providers, uphold the principles of informed consent, and set clear boundaries around the appropriate use of data.

R10: Clearly define the full scope of practice and develop a framework for which health professionals can expand their scope via advanced training and collaboration with other practitioners.

Legislation and regulation

ACCPA strongly supports the harmonisation of drugs and poisons legislation across states and territories, as well as the harmonisation of protected titles. We are of the view that an appropriately trained and credentialled health professional should be able to perform the same task (such as prescribing) with the same title across Australia.

With many aged care providers operating across multiple states and/or territories, harmonisation of the state and territory legislation will make it easier for healthcare professionals working in the aged care setting to practice across different jurisdictions. The limitations of the existing arrangements are highlighted by the challenges associated with the upcoming introduction of the Aged Care On-site Pharmacist (ACOP) program.

Inconsistencies remain in relation to pharmacist prescribing. Some jurisdictions allow pharmacists to prescribe certain drugs, however in the context of vaccine administration by pharmacists (under the National Immunisation Program Vaccinations in Pharmacy), vaccine regulations in some jurisdictions prevent pharmacists from administering certain vaccines[1]. Aligning legislation would make it easier for accredited clinical pharmacists to move across the country to work to full scope of practice and for aged care providers to deploy ACOP to work at various facilities across jurisdictions to support resident medication review and management.

This is particularly important given that currently there are not enough accredited clinical pharmacists to support the ACOP program (1 pharmacist/250 beds – which means the government will need to credential about another 1500 FTE to adequately support the program[2]). Being able to work across jurisdictions will remove the need for providers to employ an ACOP in each facility, which will lessen the pressure on the clinical pharmacist workforce.

R1: Harmonise the drugs and poisons legislation across states and territories to improve labour mobility of healthcare professionals across the country and to ensure clarity and consistency with regards to prescribing rights and vaccine administration.

Employer practices and settings

In the context of aged care, while General Practitioners (GPs) are the primary medical care providers for older people in the community, when attending to residents in residential aged care facilities (RACFs) they are supported by a multidisciplinary care team. Such teams may include nurses, allied health practitioners, other specialist medical practitioners, pharmacists, and nurse practitioners

[1] PSA States must remove barriers to allow Pharmacists to administer Moderna to adolescents https://www.psa.org.au/states-must-remove-barriers-to-allow-pharmacists-to-administer-moderna-to-adolescents/
[2] Pharmaceutical Society of Australia

(NPs). It is therefore critical that these teams are adequately supported and promoted at the employer level for coordinated and collaborative care to flourish.

To this end, ACCPA recommends that incentives, such as rental subsidies, be provided to encourage general practices to co-locate with RACFs. Not only can a GP see patients in the co-located general practice, which will largely remove the opportunity cost relating to GPs attending a RACF, the arrangement will improve integration of care for residents with the support of general practice primary care nurses. The nurses could also support residents to navigate health services and access care at the right time, in the right place.

R2: Support general practices to co-locate with residential aged care facilities by providing incentives (such as in the form of rental subsidies) to remove barriers to GP care for residents and to better integrate care with the support/collaboration of general practice primary care nurses and other healthcare practitioners.

Registered Nurses (RNs) working in aged care provide nursing care including complex patient assessment, care plan development and evaluation of care. Enrolled Nurses (ENs) provide nursing care as delegated by the RN, including patient assessment, monitoring patient care, maintaining infection prevention and control, wound management, contributing to care planning and administration of prescribed medications.[3,4]

The Royal Commission into Aged Care Quality and Safety identified that staffing levels are critical to the quality of residential care, and recommended at least one Registered Nurse (RN) be on-site at all times at each residential facility. In line with this recommendation, the Government has introduced a new requirement that approved providers must have at least one RN on-site and on duty 24 hours a day, 7 days a week, at each residential facility they operate.

In addition, since 1 October 2023, approved providers have been required to deliver 200 care minutes per resident per day, including 40 minutes from an RN. This will increase to 215 care minutes including 44 minutes of direct care from an RN from 1 October 2024. In a context of significant workforce constraints, these reforms are putting more pressure on aged care providers to meet the new requirements, due to having to employ more RNs and sometimes having to use agency staff which costs more.

If RNs and ENs in aged care had the time and sufficient resourcing to provide more advanced levels of care, such as preventative and restorative care, and to properly manage chronic conditions with their patients, it would help improve the overall health of their patients and reduce the burden on the health system. It is therefore important that nurses working in aged care facilities are supported (including with appropriate levels of funding for the quantum of nurses required and with education and training, as well as by skilled nursing assistants) to work to their full scope of practice to deliver a range of services to support resident care.

R3: (a) Identify and implement measures to address workforce shortages in aged care to ensure Registered and Enrolled Nurses have the necessary support and balance to work to their full scope of practice.

[3] DoHAC https://www.health.gov.au/our-work/care-minutes-registered-nurses-aged-care/care-minutes

[4] NSW Health Careers as an Enrolled Nurse https://www.health.nsw.gov.au/nursing/careers/Pages/enrolled-nurse.aspx#:~:text=As%20an%20EN%2C%20you'll,and%20contributing%20to%20care%20planning .

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(b) Undertake a government-funded study into the impact of legislative requirements for 24/7 RNs and care minutes in aged care and the relationship with nursing staff working to their full scope of practice**.**

Education and training

ACCPA agrees with and supports the need for consistency across professions for education, training and the process for endorsement. We need structures to ensure consistency in training, support for training to be made available, and a structure which enables health professionals to work to the top of their scope and encourages them to work in the settings where they are needed most.

In this context, ACCPA supports establishing greater clarity at the system level about expectations and requirements of post-profession entry learning. This may include harmonisation of education and training requirements for the same competency between different professions, to ensure requirements are reasonable and equitable, noting previous education undertaken.

ACCPA also supports establishing a nationally consistent approach in promoting and implementing common interprofessional competencies, to equip health professionals with specific skills common across multiple professions, such as prescribing.

R4: Harmonise education and training requirements for the same competency between different professions, to ensure requirements are reasonable and equitable.

R5: Establish a nationally consistent approach in promoting and implementing common interprofessional competencies, to equip health professionals with specific skills common across multiple professions.

It is important to note, that with the support of community-based aged care services, older Australians are increasingly staying at home for longer, and generally only entering residential aged care when they are frailer with more co-morbidities and complex care needs.[5] The increased prevalence of chronic and co-morbid conditions makes delivering appropriate and timely care more complex and requires multi-disciplinary input from a number of health providers or agencies. Some older people will require highly specialised drugs such as antiviral medications to support ongoing chronic disease management.

However, ACCPA notes that there are restrictions around prescribing certain medications, such as antiviral treatment, due to their classification as s100 'highly specialised drugs'. Currently GPs must undergo additional training to become accredited s100 prescribers to provide quality care within primary care settings. It has been suggested[6] that these additional training requirements should be removed, provided GPs continue to access clinical guidelines and HealthPathways.[7]

R6: Remove restrictions for GPs to prescribe S100 medications so older Australians with complex care needs can access specialised drugs in a timely manner.

Another area of concern is prescribing of antipsychotics for older people in RACFs. In this context, ACCPA notes that the Royal Commission into Aged Care Quality and Safety recommended that only a

[5] Older Australians, Demographic profile - Australian Institute of Health and Welfare (aihw.gov.au)
[6] RACGP https://www1.racgp.org.au/newsgp/clinical/gps-underutilised-for-hepatitis-b-care
[7] About HealthPathways (healthpathwayscommunity.org)

psychiatrist or a geriatrician should be able to initially prescribe antipsychotics as a pharmaceutical benefit for people receiving residential aged care (Recommendation 65). This could potentially lead to deskilling of the GP workforce. In addition, the increasing demand for geriatricians and psychiatrists may exacerbate current issues with access and deny older Australians the appropriate and timely prescription of antipsychotics, especially in rural and remote parts of the country.[8]

Importantly, healthcare professionals must be supported to access ongoing training and education to ensure they are able to work to the full scope of practice, as well as to develop new skills. To this end, ACCPA notes there are increasing opportunities to deliver technology-assisted education and training, including virtual supervision, to increase access.

Funding policy

Multidisciplinary case conferencing can make a difference in health outcomes for older Australians. While the process of multidisciplinary case conferencing has significant potential to improve care and health outcomes, the development of an explicit framework is required to support the effective conduct of these meetings. Key stakeholders need to be engaged to develop a team approach to conducting case conferences which facilitates the active participation of providers, residents, and their carers.

There is high-level evidence that case conferencing can improve medication management outcomes for older people with advanced dementia. Further evidence suggests that case conferencing can improve challenging behaviours of older people with dementia and assist RACF staff competencies in managing these behaviours. Palliative care outcomes for older people with dementia, particularly in the areas of advance care planning, physical symptom management, psychological support, family support and terminal care, may also improve with case conferencing. Qualitative evidence suggests that case conferencing is feasible and useful if barriers are addressed, and facilitators optimised.[9]

Given that up to 30% of hospital admissions for people aged 65+ are attributed to medication related harm, case conferencing for older people should involve the clinical pharmacist that was responsible for medication review. However, while multidisciplinary case conferences are remunerated for medical practitioners under the Medicare Benefits Schedule (MBS) (with reimbursement items for GPs available through Medicare and administrative support noted as enablers for case conferences[10]), clinical pharmacists receive no such compensation for attendance through the Community Pharmacy Agreement.

There is an expectation that the time spent on a case conference be 'absorbed' into the $28 - $113 fee allocated for a medication review. As these discussions can vary between 15-60 minutes in length, the funding allocated to a pharmacist for participation is wholly inadequate, resulting in a reluctance among clinical pharmacists to fully participate in case conferences unless absolutely necessary. In this context, ACCPA is strongly of the view that accredited clinical pharmacists should be better funded.

R7: Better fund Clinical Pharmacy Services to encourage accredited clinical pharmacists to fully participate in multidisciplinary case conferencing to support resident care.

[8] RACGP https://www1.racgp.org.au/newsgp/clinical/fears-aged-care-antipsychotics-proposal-could-impe
[9] palliAGED (2017) Case conferencing https://www.palliaged.com.au/tabid/4460/Default.aspx
[10] Phillips et al (2013) Does case conferencing for people with advanced dementia …. Improves care outcomes https://pubmed.ncbi.nlm.nih.gov/23200128/

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Technology

One of the barriers to timely healthcare (such as GP care) for residents of RACFs is the lack of interoperability between systems used by RACFs and healthcare providers, resulting in the generation of multiple records and time-consuming information management processes.

Having an integrated online client record system that facilitates shared clinical care information exchange between the information management systems of a resident's usual GP/healthcare providers and their RACF will enable continuity of care and lead to improved health outcomes for residents.

However, system upgrades to support interoperability can be costly. In light of the financial constraints experienced by many providers in the current environment, ACCPA recommends that the Australian Government provides financial support/grant funding to enable aged care providers to build the infrastructure needed to integrate digital technologies, as well as to train staff in the use of new integrated systems.

To this end, ACCPA 2024-25 Pre-Budget Submission recommended "Support quality of care for older Australians through innovation and technology transformation:

a) Invest $990 million over 3 years (2024/25 to 2026/27) to establish access to a multi-year grant that will encourage, support and enable, technology transformation of aged care providers to enhance quality of care, create efficiencies and support sector-led continuous improvement. This will support:
    - Improved infrastructure and systems;
    - Improve digital maturity and workforce capability; and
    - Standardised data collection with translation of research and data insights to enhance quality of care.

b) Sector capacity and capability - $15 million over 3 years directed to:
    - supporting aged care provider uptake of innovation and digital transformation opportunities;
    - encouraging scalability and continuous improvement through the translation of research to practice;
    - supporting digital education;
    - supporting sector led data collection, analysis, benchmarking and innovation living lab networks;
    - incentivising collaboration and shared insights; and
    - monitoring outcomes generated from the innovation uplift and impact on quality of care."

Additionally, increased use of the healthcare identifiers (HIs) will be key to supporting a connected care. ACCPA supports expanded use of the HIs as long as any expanded access to them will be tightly regulated with privacy protections for both patients and providers. It is also critical that any changes to the HI Act will maintain the privacy of healthcare recipients and providers, uphold the principles of informed consent, and set clear boundaries around the appropriate use of data.

R8: Provide financial support/grant funding to transform quality of care delivery by enabling aged care providers to build infrastructure to integrate digital technologies and build the capability of staff in the use of new integrated systems.

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R9: Expand access to Healthcare Identifiers (HIs), whilst ensuring any changes to the HI Act maintain the privacy of healthcare recipients and providers, uphold the principles of informed consent, and set clear boundaries around the appropriate use of data.

Additional comments

In terms of risks, ensuring patient/resident safety is a key concern for ACCPA. We therefore recommend that this review not only clearly defines the full scope of practice, but also develops a framework or pathway (that demonstrates positive results including patient safety and outcomes) for which health professionals can expand their scope of practice via advanced training and collaboration with other practitioners.

Importantly, implementation of any of the recommendations from this review to support health professionals working to their full/expanded scope of practice must deliver better health and care outcomes for the Australian people, who will benefit from increased access to the full range of skills of their health professionals and improved collaboration between those health professionals.

Furthermore, expanding scope of practice should not be about task substitution, but rather a way for health professionals to complement/augment services provided by other practitioners within a multidisciplinary team (where clinically appropriate), so as not to fragment care.

R10: Clearly define the full scope of practice and develop a framework for which health professionals can expand their scope via advanced training and collaboration with other practitioners.

If you have any further questions or would like to discuss this submission, please contact Dr Moe Mahat at Mohamad.Mahat@accpa.asn.au

Yours sincerely

Anne Liddell
Head of Policy and Advocacy
Aged & Community Care Providers Association