Community Care (Northern Beaches) Limited

Submission to the Productivity Commission Inquiry

Caring for Older Australians

"Society creates the framework of institutions and rules within which the general problems of the elderly emerge and, indeed are manufactured. Decisions are being taken every day, in the management of the economy and in the maintenance and development of social institutions, which govern the position which the elderly occupy in national life, and these also contribute powerfully to the public consciousness of different meanings of ageing and old age"
(Townsend 1980:9)

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www.communitycare.org.au

Introduction

Community Care (Northern Beaches) Ltd. (CCNB) provides community aged care services across the 11 LGAs of Northern Sydney, supporting up to 2000 people living in the community at any one time. All of our projects operate out of the one office, located in Mona Vale, on the Northern Beaches of Sydney. The organisation has been providing care for frail older people, people with a disability, people with dementia and the carers of these people in our community for 20 years.

The organisation has strong, grass-roots relationships with the community and service system within the Northern Sydney Region. We value our community-based approach to service provision, needs identification and community development, and believe that we have a particular expertise in the provision of services to older people, particularly under a client-centred and directed case management model, using a strengths-based case management approach. We specialise in the provision of dementia services, and auspice a range of dementia specific projects, including Dementia Advisory, Respite, Case Management and Packaged Care Programs. We also provide a number of specific projects targeting the Aboriginal and/or Torres Strait Islander community and Culturally and Linguistically Diverse communities.

CCNB auspice 19 independent community care projects, attracting funding from a range of State, Commonwealth, Health, Disability and Ageing funding streams. Currently, our auspiced projects include: Community Aged Care Packages (CACP), Extended Aged Care in the Home Packages (EACH), Extended Aged Care in the Home Dementia Packages (EACHD), Community Options (HACC), Community Options (Dementia), Community Options (CALD), Older Parent Carer Case Management Service (ADHC), ComPacks (NSW Health), Transpac (NSW Health/DoHA), Dementia Respite (Challenging Behaviours) (NRCP), Respite for Employed Carers (NRCP), Respite Service (HACC), Dementia Advisory Service (ADHC), Aboriginal Advisory Service (HACC), Community Advisory Service (HACC), Dementia Monitoring (HACC), In-home Podiatry (HACC), Attendant Care (ADHC) and the Enable Me Project (HACC Demonstration Pilot, NSW Better Practice in HACC Project).The organisation is independently governed by a Board of Directors made up of a range of professional and community representatives.

Our Responses to the *Caring for Older Australians Issues Paper*

How well does the aged care system interface with the wider health and social services sectors?

CCNB can see great potential in more effectively aligning various health and community care sectors in responding to the needs of older people. Our experience in the provision of post-acute case management services (ComPack and Transpac) has demonstrated the capacity of the community/acute interface to work together in identifying and responding to the needs of older people.

We believe that greater integration of holistic care plans incorporating health and community support needs are vital in maximising the efficiency of both sectors, and for facilitating the best outcomes for older people. We believe that the foundation for such integration is high quality, multidisciplinary assessment for older people leaving the acute care system, and access to allied and primary health in the community to prevent admission. Experience within the ComPack and Transpac projects has further demonstrated that intensive, short term case management approaches that utilise a multidisciplinary assessment and access to allied health are highly effective at supporting older people through acute to community transition, and reducing rates of hospital readmission. Evaluation of the ComPack project demonstrated the capacity of the model to offer significant cost-savings (in the reduction of inpatient time and readmission) as well as better outcomes for older people through the establishment of community support structures that support physical, functional and quality of life goals.

We believe that greater use of allied health assessment services in the community, as a preventative rather than reactive measure, should occur to identify individual needs, and develop preventative strategies to improve individual's wellbeing in the community. International and national research and service pilots have demonstrated

the capacity of community-based allied health interventions/independence models with service provision (e.g. Re-ablement Project in the UK, TARGET Project in New Zealand, Home Independence Pilot in Western Australia, Active Service Model Pilots in Victoria, and the IMPACT/Better Practice in HACC Project in NSW) in the promotion of wellbeing, and prevention of unnecessary functional decline for older people living in the community. While potentially more resource intensive in the early stages, these models have proven the long term financial savings, in addition to positive health and wellbeing outcomes for older people. We strongly advocate for the increased availability of preventative, community allied health services within the aged care sector, and can see how such a model could be effectively managed in collaboration with the acute care sector.

Opportunities for community service in-servicing with acute care social work departments and discharge planners has worked successfully in our area in enhancing referral flow from the acute care system into community care services. Due to the time limitations and nature of our acute care sector, we believe community care providers need to take the lead in offering information sessions within hospitals. Our experience is that once such relationships are developed, more appropriate referrals ensue, and this has a positive outcome for older people, carers, acute care facilities and community care providers.

We see great potential in improving referral pathways with General Practitioners to maximise access to the formal service system for older people whose need for support are identified by the GP. In our experience, for many older people, GPs are in an optimal position to identify decline/potential decline early, and make referrals to community care services. We have worked very hard in the development of relationships with GPs in our service area. We are now regular speakers at GP network dinners, and experience very close working relationships with a number of GPs and psychogeriatricians. This has paved the way for specific service pilots working with specific GPs (such as a new pilot for older people who want to retain independence and functional capacity through short term, intensive community case management and allied health interventions) in addition to a general increase in referrals, particularly within our dementia and community information services. In our experience, GP nurses are in a unique position to provide community service linkage, due to their work with older people in both clinic and community environments. We strongly support the employment of GP clinic nurses (and particularly those with dementia expertise) in maximising the potential interface between primary health and community sectors.

In relation to providing care for people from CALD and ATSI backgrounds, we believe that stronger links between acute care discharge planners and social workers with community cultural leaders and/or CALD/ATSI specific services could be promoted. Our experience shows that even when CALD and/or ATSI communities show lower levels of access to community aged care services, their identification within the acute care sector is very often the first link to the formal service system, and very important in capturing people's needs following discharge and effectively connecting them to appropriate supports. In the provision of ComPack (post-acute case management for people being discharged from public hospitals), we have found that through as a result of a chronic or acute episode, people from CALD backgrounds are referred and effectively linked to community supports to reduce hospital readmission and improve wellbeing in the community.

We are aware, that as a result of a range of historical and social factors, people from Aboriginal and/or Torres Strait Islander background may avoid health care services and/or not feel safe accessing mainstream services. At times, these individuals may not identify their Aboriginality at the point of admission. We believe more work needs to be done in increasing the cultural competency and safety of acute care facilities to better support Aboriginal people accessing acute services, in addition to access to Aboriginal Liaison/Community workers to support Aboriginal people with the acute care system and following an acute care stay. We are aware that particularly when an Aboriginal person doesn't 'look Aboriginal' from the point of view of admission staff, often the question relating to whether a person identifies as Aboriginal is not asked. This makes it difficult to know how many Aboriginal people are actually accessing the system, in addition to making it even more difficult for hospital staff to consider cultural protocols in providing support to Aboriginal and/or Torres Strait Islander people. We see significant opportunities for the acute health system to work with community care providers and cultural leaders to develop cultural protocols and improve

the experience of Aboriginal people, with the flow on effect of increasing trust and therefore access to acute and community service supports.

We recommend that:

a. **Multidisciplinary assessment in collaboration with community case managers is the most effective model for older people with complex health and/or support needs transitioning from an acute care admission into the community;**

b. **Access to allied health services in the community should be increased to enable more preventative approaches to physical and functional decline for older people;**

c. **Community aged care providers should take responsibility for the provision of hospital in-services to improve referrals into the community;**

d. **GP relationships and service/referral partnerships are optimised, and GP clinic nurses are employed to maximise referrals for older people indentified through GP clinics as needing community support;**

e. **Cultural competency training within acute care facilities and links with culturally specific community care services and cultural leaders is necessary to improve the cultural safety of acute care settings for people from CALD and ATSI backgrounds;**

f. **Aboriginal liaison and/or Aboriginal Community Support workers should be better utilised (and in some cases, employed) to provide culturally appropriate support to Aboriginal people accessing and discharging from the acute care setting. ALL people admitted should be asked whether they identify as Aboriginal or Torres Strait Islander to ensure data is collected, and culturally responsive care is provided.**

Is the current system equipped, or can it adapt, to meet future challenges?

While the ageing of the population is a significant factor which will continue to impact on the capacity of the aged care sector to respond to increasing demand, ongoing development of models of care that recognise the capacities of older people, and act in a preventative capacity will be paramount in managing demand into the future. It is often assumed that the need to ration and prioritise resources is due to resource scarcity to care for the ageing population. While it is not denied that greater resources would increase supply of such services to older people, the 'resource argument' has little bearing on the system's capacity (or lack thereof) to target resources appropriately, and ensure that the services provided respond to the expressed need of the person 'choosing' to access them. Resource scarcity, while possibly limiting access and choice, should not be the sole scapegoat for the system's deficits in targeting resources effectively.

As a medium-sized, community based organisation, we pride ourselves on our capacity to identify and respond to the specific needs of our community. With strong links to marginalised communities in a local geographical area, we have been able to build trust, and develop a profile within communities with greatest levels of need (for example our CALD communities, Aboriginal communities, and older parent carers). We are concerned that the system is moving toward models that purport to reduce 'inefficiencies', and that are based on managerialist principles of 'bigger is better'. We believe this will have a very negative impact on the experiences of older people getting the support they need. While not disputing the capacity of big providers to provide quality care, we strongly advocate for the ongoing support and recognition of small community organisations that know their communities and are in a unique position to develop and customise service responses based on local needs. We believe both models are equally important, and that smaller organisations should not be overlooked in resource allocation purely as a result of perceptions that bigger organisations offer more efficient economies of scale. Competitive tendering processes that are able to discriminate and compare economies of scale benefits with quality outcomes as described by service users, should be further investigated.

We believe that the aged care system has unrealised potential in more effectively and efficiently targeting resources to meet individual needs. We believe that a greater focus on case management approaches that 'bring resources to people' as opposed to 'fitting people into service boxes' is central to more productive targeting of scarce resources. We also believe that the ongoing development of consumer directed care models should not be promoted based on perceived fiscal benefit, but only when such models are proven to meet the needs of older people more effectively (an outcome we do not believe has been 'proven' with adequate evidence). Without such a focus (and in the absence of evidence-based model development) consumer-directed care models will prove to be more costly, and not in the best interests of older people or the aged care system into the future.

Experience tells us that within a system of stringent guidelines, inflexibility and resource shortages, pressure to 'prove' eligibility for scarce resources carries with it a disincentive to highlight a person's strengths and capacities, which, within a strengths-based model of service provision, could be harnessed to support the person to cope with challenges and ultimately, reduce unnecessary dependency on the formal service system. Additionally, older people who cannot access support when they need it, are unlikely to identify functional improvements and relinquish service support when they no longer need it, if they are anxious about being able to access such support in the future. Such access patterns present significant challenges within the context of an ageing population and increasing demand for scarce resources.

Models that promote independence and control where older people choose to retain independence and control should be promoted, and funding for early intervention and promotion should be forthcoming to prevent unnecessary need escalation. We believe that high care support options are clearly vital in providing support to older people with the highest need. However we emphasise the need for a balanced approach in responding to high need, while at the same time preventing unnecessary decline. We believe the current aged care system is deficit-focused, and a shift toward approaches that identify and harness the strengths and capacities of older people will be vital in ensuring the capacity of the system to respond in the future.

We recommend that:

a. **Further research is conducted to identify the real benefits of consumer directed care models in the context of potential cost savings;**

b. **Competitive tendering processes and associated resource allocation should recognise the potential of small to medium sized providers in their provision of localised service responses;**

c. **Case management models are harnessed as an effective mechanism of targeting and attracting resources to meet individual needs and prevent unnecessary need escalation;**

d. **Early intervention/preventative approaches should be valued and funded in addition to approaches that respond to high, complex needs; and,**

e. **Aged care service and funding guidelines should be reviewed in relation to increasing flexibility to more effectively respond to individual need, to provide targeted support when older people need it.**

Should there be greater emphasis on consumer-directed care in the delivery of services, and would this enable more older Australians to exercise their preference to live independently in their own homes for longer with appropriate care and support?

We are aware that CDC pilots within Aged Care have achieved mixed results. Recent pilots have demonstrated a benefit in increasing some aspects of choice and control for older people, such as choosing providers of their care, more direct choice and control over the way care is provided, and the capacity to negotiate and determine the role of the provider/case manager in the provision of their care.

We believe that CDC models based on greater choice and control within existing packaged care arrangements is possible, and we can see potential benefits for service users. However, we also believe that the existing service system is a long way off being able to offer true 'choice' for older people, and we are concerned that premature implementation of CDC models within the aged care sectors, built on a rhetoric rather than reality of choice, will be detrimental to the interests of older people and unmanageable within existing legislative guidelines and service structures. We believe CDC models sit well in conjunction with case management models, where clients can choose the level and type of case management support they need to source and implement support based on their choices. Such case management should be flexible, and able to be provided with varying levels of administrative support, and episodic in nature, so that older people can use it when they need it. We see potential for CDC models such as those recently released by the Commonwealth Department of Health and Ageing that are administratively similar to existing packaged care models, but offer greater levels of choice and control for older people. We don't see that the sector is ready or able to support fully cashed out CDC models, nor are we convinced that such models are effective at meeting the needs of older people, based on available evidence to date.

At any stage that CDC may be more broadly introduced in the aged care sector, we do not believe that they should replace existing models, but act as an additional choice for individuals whose needs will be effectively addressed as a result of higher levels of consumer control.

We do see an opportunity for more research and piloting of the models within the aged care sector, and support current agendas of this nature.

As a provider of aged care services under a pure brokerage model (i.e. we do not employ direct care workers, and 'broker' all direct care from a range of reputable, quality direct care agencies) we believe that this model of service delivery does enable high levels of choice for older people. Brokerage allows us to access thousands of workers from accredited agencies with proven expertise in the provision of aged care services. It allows us to focus on our areas of expertise: high quality case management and care planning, while providing access to a diverse workforce with specific and diverse skill sets. It allows us to explicitly set the quality standards we expect, and take advantage of market forces to ensure we get it, at a competitive price. Older people can identify the specific skills and qualities they need and desire, and the brokerage model allows us to source staff based on these specifications. Staff can be changed at the discretion of clients, and the organisation is not faced with employment dilemmas and potential associated disincentives to change staffing arrangements. Brokerage models enable a high degree of continuity of care (for example, an older person can move between any of the 19 projects we auspice, and retain the same direct care worker), which is also the case for clients moving between systems of care (e.g. a person with a disability can receive support through one of our disability services, then move onto an aged care package program, each funded by different levels of government, while experiencing no change in direct care staff). While clearly not the only effective model of direct care provision, we do see the brokerage model having much broader implications across the aged care sector, particularly in light of proposed COAG reforms.

We recommend that:

a. **More research is conducted in evaluating the outcomes and cost implications of various models of CDC for older people, prior to implementation within the sector; and,**
b. **Brokerage models are recognised and promoted as a mechanism for increasing consumer choice within existing service models and service structures.**

Should Australia have an 'aged care system' as currently conceived, or should a broader conception of care and disability policy be more appropriate, with the needs of the aged being one part of this continuum?

CCNB believes the need for a discrete aged care system is fundamental to identifying and responding to the needs of older people now and into the future. We do see the whole-of-life approach as a preferential model in conceptualising people's needs. However, we also know in practice, that particularly in relation to the intersection

between disability and aged care service provision older people can often be overlooked, when compared with more chronic, multifaceted and complex needs associated with disability.

We support reforms that differentiate aged care from other human service sectors, however strongly advocate for consistency in structure, access and entitlement across sectors to enable transition and ensure equity, while still focusing on the unique needs and experiences of target populations. Our experience in the provision of aged care services, disability services and HACC (with a mix of ageing and disability) is that where target groups include ageing and disability, disability tends to dominate access, even when target population demographics contradict access trends. We believe this is due to an extreme difficulty in 'comparing' needs that are often based on the discreet issues and needs faced populations experiencing ageing or disability. We know that the concept of 'relative need' often discriminates against older people whose needs may be more chronic in nature, as opposed to the more 'immediate' and complex needs of people with a disability.

We recommend that:

a. **Reforms differentiate an aged care system from a broader conception of care and disability policy, however systems are set up consistently to maximise access, equity and continuity for people moving between systems.**

Will the announced changes in government roles and responsibilities benefit aged care users and improve the administration of the aged care system? Will the changes facilitate greater integration in the delivery of support and care services? In particular, what will be the implications for the administration and delivery of HACC and community care packages?

CCNB expresses some concern in relation to the implication of aged care/disability splits under the proposed COAG reforms. In particular, we identify specific groups of people we believe, will be most specifically affected by these proposed changes, namely, people with a physical disability who are ageing, people with disability and dementia, younger people with dementia, and younger people with ageing illnesses.

Under existing service funding and provision arrangements, we identify significant differences between the State and Federal systems. We are concerned, that in the absence of similar care arrangements and models across the disability and aged care sectors, continuity of care for individuals as they age is considerably compromised. As providers of aged and disability services, we are concerned about the capacity of the disability sector to adequately respond to age-related conditions (such as dementia). Under the proposed reforms, individuals under the age of 65 would be the responsibility of the State (and predominantly, 'disability providers'), and we are concerned that service structures may not be adequately evolved to care for younger people with age-related conditions, that would be more effectively managed within the aged care (soon to be Federal) system.

Similarly, as a person with a physical disability ages, we are concerned that the continuity of care into the aged care system may prove disruptive to the care needs and arrangements of a person with a disability. Currently, care philosophies between disability and ageing sectors are diverse, and we question how such diversity will be managed to ensure continuity and quality care for people with a disability as they age. We are also concerned that service levels (or 'upper limits') are not consistent across sectors, and we question what this will mean for people with a disability as they age.

While we strongly advocate for 'whole of life' approaches when it comes to identifying needs and planning for future care and support options, we do support the separation of ageing and disability services in relation to administration and provision.

We believe there is scope for better alignment of models across sectors to increase consistency and continuity for individuals moving between systems. Packaged care opportunities with similar administrative and service philosophies would be effective, in addition to an emphasis on the capacity of case management models across

sectors to operate in responding to individual need rather than operating based on stringent service type guidelines and eligibility criteria.

We recommend that:

a. **In planning for COAG reform in relation to the split of ageing and disability services, specific attention should be given to how the system will respond to people with a disability as they age, younger people with chronic and/or age related conditions, and younger people/people with a disability and dementia;**

b. **Collective cross-sector planning efforts should focus on ensuring consistency of models and administration of ageing and disability services to maximise continuity of care for individuals moving between systems;**

c. **Consideration needs to be given to mechanisms to support whole of life approaches for people with a disability as they age; and,**

d. **Case management models that operate based on individual need rather than service availability and specific service-type boundaries should be preferential to compartmentalised service-specific models.**

Should common system entry points and assessment be developed, and if so, what are the opportunities and risks?

CCNB supports reforms that increase the quality and consistency of service access processes. However, we are concerned that current reform agendas aiming for a 'one stop shop' model are relatively untested, and require more specific planning to ensure the theory of streamlined access is translated into a more accessible service system for older people. We are not aware of scoping processes that have effectively evaluated central intake outcomes in comparison to localised intake approaches within fiscal, administrative and client outcome domains. We are concerned that moves towards centralised intake are costly and disruptive, and not based on quantitative and qualitative evidence in relation to what such reforms will achieve.

As specialist providers of case management services with older people, the value we place in comprehensive, person-centred assessment is fundamental to an older person's likelihood of accessing effective, targeted support in response to a person's individual needs. While we respect that full, comprehensive assessment is not always required (for example, when an older person identifies a specific service requirement, and is able to articulate their needs and negotiate the service access process independently), we do believe that comprehensive assessment, early in an older person's care trajectory is a hugely preventative factor. This particularly relates to opportunities to reduce unnecessary need escalation (resulting from a lack of appropriate need identification early on), and an effective cost containing mechanism in ensuring only the most effective, targeted service supports are accessed (resisting a 'scattergun' referral approach that can occur in the absence of comprehensive assessment).

We are concerned that any concept of 'single point of entry' is underpinned by a basic assumption that people enter the system in the same way, and at the same stage. It is also underpinned by a positive concept of consistency, which, on the one hand advocates for consistent experiences in accessing the system (for example eligibility and intake processes), however which also, arguably, denies the capacity to respond to individuality, allow for differences in the ways a person may access the system and to the diverse needs of people in relation to eligibility assessment and process. The reality that many people actually need significant support in 'accessing the access point' presents additional challenges to this type of reform agenda. Additionally, as entry points to the system progressively become more about resource gatekeeping and 'screening' rather than holistic need identification and appropriate service matching, the capacity of such reforms to improve access (their fundamental purpose) is significantly compromised.

We are concerned at moves to separate assessment and intake from service provision, and particularly in the case of case management, believe that the provision of comprehensive assessment as an overall component of the case management approach is central to the provision of targeted, integrated care.

We support reforms that better define consistent access and intake processes, however prefer the Victorian model of 'no door's the wrong door' in relation to service access. We believe that centralised access models, as a concept, offer potential efficiencies such as better use of technology, lack of duplication in data collection, and improved capacity to capture access and referral data centrally to inform policy and planning processes. We see great potential for the development of consistent approaches to intake, however advocate for multiple access points (which we believe would be most effectively operated within multi-service outlets within specific geographical areas) as opposed to centralised phone intake models. We believe that multiple intake points locally enable access strategies that are responsive to specific community needs. We also believe that in the absence of processes that are capable of providing face-to-face comprehensive assessment when required, centralised intake and assessment points (e.g. phone assessment and eligibility screens) run the risk of overlooking individual needs, and miss opportunities for the effective targeting of resources. We appreciate that face-to-face assessment is more resource intensive, however also believe that such approaches have a preventative function that impacts on longer term wellbeing and fiscal outcomes.

We would like to specifically identify, that in the case of Aboriginal service provision, centralised assessment and entry points that do not accommodate for cultural safety (which includes processes that are personalised, trust-building and culturally specific) are inappropriate and ineffective for meeting the needs of Aboriginal and/or Torres Strait Islander people, and can in fact, prevent these communities from accessing support.

We recommend that:

a. **Consistent approaches are developed and defined for system entry and assessment, however that such approaches are implemented at various localised intake/access points;**

b. **Rigorous outcome based scoping and evaluation of potential reforms need to take place to justify extensive resource injection and disruption for clients, carers, families and service providers;**

c. **Assessment is not separated from the care planning/provision process, particularly in relation to the provision of case management; and,**

d. **Face-to-face, comprehensive assessment processes are preferred over phone assessment for all older people, but particularly in the case of Aboriginal and/or Torres Strait Islander people.**

What are the key issues concerning the current formal aged care workforce, including remuneration and retention, and the attractiveness of the aged care environment relative to the broader health and community care sector?

CCNB is concerned about the aged care sector's capacity to attract and retain a skilled workforce now, and into the future. We fundamentally believe that aged care workers are under-paid and under-recognised. As an employer of tertiary qualified case management staff (and not of direct care staff), we are firm believers in the development of Employee Collective Agreements that engage and empower staff to identify preferred collective employment conditions to enhance organisations' capacities to attract and retain qualified staff. We see remuneration as one (albeit very important) component of overall employment benefits, which needs consideration in conjunction with employment conditions that encourage and support professional development opportunities, enable family friendly work arrangements, and reward performance and expertise (as opposed to purely length of stay).

We believe as an industry, the aged care sector is not an 'attractive' employment option, particularly for younger Y-generation staff. The 'welfare' construction of the aged care sector is outdated, and not conducive to the attraction of career oriented, highly skilled staff. The reality exists, that the aged care sector is a dynamic and evolving sector, and this is the profile that should be promoted if the sector wants to retain passionate, career-driven employees. Our experience in the recruitment and retention of younger staff members (with a retention rate of over 93% in 5 years) is that younger people want dynamic leadership, mentoring, and access to professional development

opportunities, in addition to remuneration that is fair and capable of supporting a quality of life comparable to other similar industries.

We believe upward pressure on Award levels is fundamental to remuneration escalation, and that appropriate funding and indexation for aged care service provision is vital for the ongoing recruitment and retention of skilled staff. We believe that the removal of Public Benevolent Institution Status and associated fringe benefit allowances would have dire implications on an industry that already struggles to keep up with remuneration comparability.

More effort on an industry level needs to be invested in cross-sector career opportunities. This could involve, over time, strategies to allow people to carry long service leave entitlements with them throughout the sector, sector mentoring opportunities, job swaps and collective approaches to career development initiatives. As an industry with a large proportion of 'older' workforce, wishing to attract 'younger' workforce, opportunities for knowledge transmission and mentoring are relatively untapped.

Broader presence within academic institutions (primary, secondary and tertiary) to promote the industry is another untapped mechanism for increasing the sector's profile at a point where younger people are making career decisions.

We recommend that:

a. **Innovation in the development of employment conditions and collective agreements should be considered as an opportunity to attract and retain staff;**

b. **Opportunities to share knowledge and offer sector mentoring should be explored, particularly in the recruitment and retention of younger staff;**

c. **Industry constructions based on outdated 'welfare models' need to be replaced with industry profiles that emphasise the dynamic, evolving nature of the aged care industry;**

d. **Cross sector collaboration in the development of career opportunities need to be explored to enable the industry collectively to attract and retain skilled and passionate staff; and,**

e. **Opportunities for industry promotion within academic institutions should be further explored.**