Community Services & Health
Industry Skills Council

NEW ROLES IN COMMUNITY SERVICES AND HEALTH SCOPING PROJECT

Report on Consultation Findings
June 2014

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Foreword

The Community Services and Health Industry Skills Council (CS&HISC) commissioned this consultation, which was undertaken by Bernadette Delaney of Delaney Associates Pty Ltd.

This consultation report outlines the findings from interviews held during September and October, 2013 . The consultation approach was based on early research documented in the report *New Roles in Community Services and Health Scoping Project: Interim Report .*

These consultations are part of a project with the overall objective of researching new and emerging skills and roles required in the nominated areas and identifying whether the content of units of competency and qualifications in the current training packages address these new skills and roles.

This report also provides mapping to current units of competency and qualifications.

The author would like to thank all of the consultation participants from the community services and health organisations who contributed their time to provide information and documentation to this project.

Acronyms

ABI	Acquired Brain Injury
ABF	Activity Based Funding
ACHI	Australian Classification of Health Interventions
ACS	Australian Coding Standards
AH	Allied health
AHA	Allied health assistant
AIN	Assistants in nursing
ANMF	Australian Nursing and Midwifery Federation
AQF	Australian Qualifications Framework
ATSI	Aboriginal and Torres Strait Islander
BSB	Business services training package
CALD	Culturally and Linguistically Diverse
CDC	Consumer directed care
CS&HISC	Community Services and Health Industry Skills Council
DC	Disability care
DRG	Diagnosis Related Group
ESL	English as a Second Language
GPS	Global Positioning System
HACC	Home and community care
HAS	Health service assistant
ICD-10-AM	(8th Edition) *The International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification*
LAC	Local area coordinators
LGBTI	Lesbian, gay, bisexual, transgender, intersexed
NDIS	National Disability Insurance Scheme
OT	Occupational therapy
PCW	Personal care worker
PSA	Patient service assistant
PSW	Personal support worker
TAE	Training and assessment training package
WHS	Workplace Health and Safety

Executive Summary

Introduction

This report, commissioned by the Community Services and Health Industry Skills Council, outlines findings from consultations undertaken in September and October, 2013. These consultations sought information on new roles and functions in six occupational areas: allied health assistants, health service assistants, clinical coders, aged care and home and community care (HACC), disability services and mental health.

The report is essentially about stakeholders' views on assistant and support worker roles and related training requirements to meet future challenges. Different views on the work roles and training required by assistants and support workers emerged in the consultations. These perspectives were shaped by the stakeholders' involvement with assistant and support worker positions and their knowledge of current training. Some stakeholders were involved in workforce redesign, whereas others were from professional associations or in direct service delivery.

Stakeholders concerned with addressing demand and labour supply issues saw the need for workforce reform, work redesign and flexible and transferable qualifications. On the other hand, other stakeholders believed it is essential to adequately equip the worker to deal with new challenges. Client advocacy groups emphasised the importance of using training to empower those receiving services. Finally, stakeholders engaged in direct service delivery emphasised the importance of support workers being trained in practical skills and tasks that will be useful on the job.

This report acknowledges that some recommendations regarding existing training package components may already be part of the current review but that further scoping may be required for developing new components.

Report structure

This report records what the stakeholders said in relation to the new and emerging roles, skills and knowledge and related tasks. This information is organised in these categories:

- changes influencing each of the occupational groups
- changes identified in roles and related new skills and knowledge
- training, which includes comments on current qualifications as well as noting training undertaken in the workplace to address skill needs
- conclusions and recommendations which focus on future steps, and
- appendices listing stakeholders and mapping to units of competency.

Consultations

The stakeholder groups and their representatives were identified in conjunction with the CS&HISC. They consisted of a range of cross sector participants as well as stakeholders from each of the following groups: allied health, health services, clinical coders, aged care and HACC, disabilities and mental health. A total number of 101 stakeholders participated in 80 interviews over an eight week period. There were also three detailed surveys responses received from:

- Occupational Therapy Australia based on responses from acute hospitals, rehabilitation, community and aged care settings as well as a focus group with Victorian occupational therapy senior clinicians and managers
- Speech Pathology Australia, and
- Australian Podiatry Council.

Factors causing role changes

In the consultations, stakeholders were asked to identify what type of factors were causing changes in the areas that they were working. The majority of those interviewed in the 'cross sector' category of stakeholders identified workforce changes as being the most significant influence. Consultations identified that allied health assistance work was changing due to the combined factors of increased demand coupled with funding issues.

In the health service assistant and the assistants in nursing roles, the main changes identified as influencing future work were funding, workforce changes and demand for services. The most important change identified as occurring in the clinical coding workforce was the shortage of clinical coders. This shortage was caused by the lack of suitable training and the changing role of coders, as hospitals increasingly need a range of health information and coding staff.

The increased demand for aged care and HACC services was identified as the major change in these sectors. Coupled with this demand were changes to be brought about by consumer directed care and funding, especially HACC funding. The main drivers for change in the disability sector were the impact of the National Disability Insurance Scheme (NDIS) and related consumer expectations and choice in care. There was a wide range of changes identified as occurring in the mental health sector, with the most significant being the increase in community based care. This was also linked to new approaches in mental health with an emphasis on recovery, working in interdisciplinary teams and an increase in peer support roles.

Changes in roles, new skills and knowledge

The three health sector positions considered were allied health assistants, health service assistants and clinical coders. Each of these roles were identified as requiring new skills and knowledge as appropriate to: the emerging contexts in which they work; the diversity of clients; health issues; increasing demands in communication and reporting; and changing work relationships.

According to stakeholders, health service assistants, including assistants in nursing, required the least change of any of the groups in this study. The allied health assistance area was notable for the overall lack of agreement between the states and territories about new and emerging roles. In contrast, all stakeholders agreed that the tasks and skills in the clinical coding area would need to be addressed by developing a suitable qualification.

A common feature of these three health roles is that they all work under supervision and in most cases that supervision is not remote. There were some suggestions that this was changing and remote supervision was increasing in rural areas for all of these roles, even for clinical coders.

The most significant changes in roles, tasks, skills and knowledge were identified by stakeholders in the aged care and HACC and disability sectors. There were new and emerging roles identified for each of these areas.

In aged care, the areas that stakeholders nominated for change were: implementing person centred care; communicating and reporting; working relationships; health issues; and handling both complex and diverse clients. The coordination level aged care worker will also require skills and knowledge about changes in funding, service models and diverse clients. Marketing in a contested environment will also be a new challenge for coordinators.

For disability service roles, stakeholders stressed that the person centred approach will require a major change for support workers. This change will mean that the direct care worker will not only be implementing a plan, but also monitoring and gaining feedback on client satisfaction with the plan. The consumer directed care will mean that the communication skills of the support worker with the client and the family will need to be highly developed. During consultation stakeholders suggested that this changed role will be challenging and that support workers will need to understand their role, including the limitations and expectations. They will need to know when and where to gain guidance and support for themselves and for the person they are supporting.

Training

Respondents were asked whether current training package qualifications met the requirements of these new and emerging roles. The majority of respondents identified gaps in training packages related to new and emerging areas. In many cases they offered some suggested changes, which generally required a review of units of competency. Many of these suggested changes are in keeping with those emerging areas identified in Section three and Appendix C of this report.

Respondents unanimously agreed that the current qualifications of clinical coders were inadequate. Some respondents, such as in the categories of cross sector, health services and allied health, did not know the detail of the training package qualifications and were therefore unable to comment. Most stakeholders suggested changes to current qualifications. These are recorded throughout the report.

Stakeholders consulted stressed that in the context of the demands for the workforce, especially in aged care, disability and mental health appropriate quality training was very important. There was a strong theme of the importance of safety considerations in ensuring that competence of the worker was balanced with labour demands in some areas and in some locations. Risk and safety were important indicators to consider in training design to ensure that workers are appropriately skilled when working with vulnerable clients.

Stakeholders identified gaps in training and nominated workforce training to address new and emerging needs.

Recommendations

The following recommendations were developed to address the changes identified in this report.

Scope of practice
Consultation on assistant and support worker roles confirmed that further detailed work is needed regarding these rapidly changing job roles. Even though there was a great deal of agreement about emerging new skills and knowledge from stakeholders interviewed, there was no consensus about the nature of new roles and responsibilities. There was a lack of consistency across states and sectors in the roles and functions of health assistants and support workers.

Recommendation 1

It is recommended that a consultation strategy be devised based on the information in this report. The strategy should further scope the job roles and in turn refine the units of competency and qualifications for assistant and support worker roles . It should devise a comprehensive consultation process to review, validate and obtain stakeholder feedback on the scope of the assistant and support worker roles in relation to new and emerging areas.

Person centred practice
All of the direct service positions in this study will be influenced by person centred practice. Also termed person centred care, consumer directed care, client focused care, client centred care and customer focused service. Stakeholders stressed that the person centred approach requires a major change in the way assistants and support workers will operate towards clients and in their jobs. Assistants and support workers need to understand the requirements of person centred care and how that defines the nature and boundaries of their job. They will require better understanding of the system, funding and the shift from an 'illness' to a 'wellness' model .

Incorporating the underlying philosophy (referred to in the report as 'person-centred practice') into HACC, disabilities, aged care and mental health training is occurring as part of the current review. Qualifications in allied health assistance (AHA) and health service assistants (HSA) will need to be reorientated to this underlying philosophy in core and elective units of competency.

Recommendation 2

It is recommended that Certificate III and Certificate IV qualifications in AHA, HSA, aged care and HACC, disability and mental health are reviewed to ensure that terminology and content reflect the required approach of person centred practice.

Recommendation 3

It is recommended that the mapping of new skills, knowledge and roles in this report be used as a guide to commence this review (Appendix C).

Supervision roles

For five of the occupational groups in this study, it was suggested that there was a need for higher order skills and knowledge to be reflected in Diploma level qualifications. For allied health, clinical coders and mental health these skills were related to complexity of practice. Whereas for aged care, HACC and disabilities there were new roles related to coordinating and brokering in relation to new funding models and consumer choice in service delivery. Further scoping of the qualifications required at this level is needed to meet industry requirements following the NDIS rollout. It would premature to do that prior to the program being fully rolled out.

Recommendation 4

It is recommended that current diploma qualifications related to new roles be reviewed and revised to ensure that they include units of competency that reflect the new and emerging senior roles for assistants and support workers (Appendix C).

Practical placements

Almost every stakeholder stressed that qualifications need to skill graduates in current work requirements and that this necessitated a work placement component. Assessment of skills and knowledge had to apply to realistic situations such as handling complex clients and using authentic work place documentation.

Recommendation 5

It is recommended that all assistant and support worker qualifications include a practical placement component in assessment requirements.

Allied Health Assistants

The allied health assistance area is notable for the overall lack of agreement between states and territories about the direction of new and emerging roles. There was no consensus on the new and emerging roles in consultation. In particular, there was no agreement about social work assistants, advanced allied health assistants and radiation assistants. Changes identified by stakeholders for AHA in the future covered: the changing work contexts; diversity in clients; improved knowledge on health issues; better communication skills; and changing working relationships, such as working in a multidisciplinary team. There needs to be agreement around new allied health assistant roles from the allied health sector in order to be able to adequately devise appropriate nationally recognised qualifications. This agreement is essential and urgently needed in order to promote national consistency in skills, as at the moment some states are developing their own training requirements.

Recommendation 6

It is recommended that further units of competency be developed to support emerging roles, skills and knowledge. Their development should include gaining support from the industry (Tables 2, 3 and 4 and Appendix C).

Health Service Assistants

Assistants in nursing (AIN) increasingly work in a range of different environments. Stakeholders suggested that new work contexts that need specific units are in aged care, including palliative care and mental health, including dementia. Currently, working mainly in acute hospital care

and aged care, it was suggested that AINs may extend their roles to include such settings as the newborn care unit, working with children and parents or in community settings.

Recommendation 7

It is recommended that further units of competency be developed in HLT32512 Certificate III in Health Services Assistance. These units should incorporate new work environments, especially in mental health and complexity in aged care, for assistants in nursing and patient service assistants (Tables 5 and 6 and Appendix C).

Clinical coders

There was unanimous agreement that there needs to be a qualification developed for clinical coders because of the lack of suitability of current qualifications. The current qualifications HLT32912 and HLT43212 do not have suitable units of competency to reflect workplace needs for coding. All stakeholders consulted agreed that the area of clinical coding work needed tasks, skills and knowledge to be redefined.

Recommendation 8

It is recommended that clinical coding units of competency are developed and used as the basis for a qualification at certificate IV level.

Clinical Coders – Auditing and Training

Recommendation 9

It is recommended that senior coding roles in auditing and training be included in a diploma level qualification (Tables 7 and 8 and Appendix C).

Aged Care and HACC

There are a range of new roles identified in aged care. They could be entirely new roles or changes to current coordinator and specialist roles (refer Tables 9, 10 and 11). The main areas in which support workers will be required to develop new skills and knowledge are implementing person centred care, health monitoring, work relationships and safety, working with diversity and handling complexities. The coordination level worker will require skills and knowledge in funding, service models and diverse clients. Marketing and attaining funds in a contested environment will also be a new challenge for coordinators.

Recommendation 10

It is recommended that new roles identified in aged care and HACC are supported by the development of units of competency to be included in the relevant diploma, CHC52212 Diploma of Community Services Coordination (Appendix C).

Recommendation 11

It is recommended that aged care and HACC qualifications at certificate III and IV are reviewed and reoriented to new service models and include a range of new units of competency for support workers (Tables 9, 10 and 11 and Appendix C).

Disability

In the disability sector there were a range of new roles identified by stakeholders. These were: client broker; business planner; team leader and senior support worker; planner; local area coordinator; dementia consultant; personal assistant; financial advisor; employment facilitators and specialist consultants. These roles need to be reflected in the CHC50108 Diploma of Disability. There were also a number of significant core areas that will require a change in how support workers go about their work and the skills and knowledge that they will need to support people more effectively and appropriately. These include understanding and applying person centred care and individualised funding, self management and applying boundaries and responding to a range of complex conditions.

Recommendation 12

It is recommended that current disability qualifications at certificates III, IV and diploma level are reviewed in line with the changing skills for coordinators and support workers in person centred care, individualised funding, changing work environments and complex conditions (Tables 12, 13 and 14 and Appendix C).

Mental health

Stakeholders believed that there is a need for people to have a greater skill level in the field of mental health, because the needs of the clients are more complex and there is a greater incidence of comorbidity. In mental health work, recovery approaches were considered necessary to be integrated into training packages and reflected in work approaches. Workers in this area are faced with increased complexity and dual conditions of co-existing mental illness and substance misuse problems, and dual disability. The use of peer workers was another important theme. It was also suggested that the training package is inadequate for the area of service coordination. There is a need for this to be reviewed as people can be leading teams without a qualification. This is likely to increase in the future.

Recommendation 13

It is recommended that current mental health qualifications at certificate IV and diploma level are reviewed to reflect recovery approaches and the complexity of clients (Tables 15, 16 and 17 and Appendix C).

Workforce training

Stakeholders outlined a range of inhouse and workforce training currently being undertaken by all sectors. These were intended to assist in preparing for changes in roles and tasks caused by the introduction of the NDIS, person centred care, as well as dealing with complex health issues and medication and other learning tasks necessary to fulfill the demands of their jobs. It would be beneficial if available units of competency and skill sets were promoted to the industry to ensure national standards in workforce development training .

Recommendation 14

It is recommended that CS&HISC promote the content of current qualifications in meeting workforce needs so that industry is better informed about what is available to use for skill development.

List of recommendations

Scope of practice	
Recommendation 1	It is recommended that a consultation strategy be devised based on the information in this report. The strategy should further scope the job roles and in turn refine the units of competency and qualifications for assistant and support worker roles. It should devise a comprehensive consultation process to review, validate and obtain stakeholder feedback on the scope of the assistant and support worker roles in relation to new and emerging areas.
Person centred practice	
Recommendation 2	It is recommended that Certificate III and Certificate IV qualifications in AHA, HSA, aged care and HACC, disability and mental health are reviewed to ensure that terminology and content reflect the required approach of person centred practice.
Recommendation 3	It is recommended that the mapping of new skills, knowledge and roles in this report be used as a guide to commence this review (Appendix C).
Supervision roles	
Recommendation 4	It is recommended that current diploma qualifications related to new roles be reviewed and revised to ensure that they include units of competency that reflect the new and emerging senior roles for assistants and support workers (Appendix C).
Practical placements	
Recommendation 5	It is recommended that all assistant and support worker qualifications include a practical placement component in assessment requirements.
Allied Health Assistants	
Recommendation 6	It is recommended that further units of competency be developed to support emerging roles, skills and knowledge. Their development should include gaining support from the industry (Tables 2, 3, 4 and Appendix C).
Health Service Assistants	
Recommendation 7	It is recommended that further units of competency be developed in HLT32512 Certificate III in Health Services Assistance to incorporate new work environments, especially in mental health and complexity in aged care, for assistants in nursing and patient service assistants (Tables 5, 6 and Appendix C).
Clinical coders	
Recommendation 8	It is recommended that clinical coding units of competency are developed and used as the basis for a qualification at certificate IV level.
Recommendation 9	It is recommended that senior coding roles in auditing and training be included in a diploma level qualification (Tables 7, 8 and Appendix C).
Aged Care and HACC	
Recommendation 10	It is recommended that new roles identified in agedcare and HACC are supported by the development of units of competency to be included in the relevant diploma CHC52212 Diploma of Community Services Coordination (Appendix C).
Recommendation 11	It is recommended that agedcare and HACC qualifications at certificate III and IV are reviewed and reoriented to new service models and include a range of new units of competency for support workers (Tables 9, 10 and 11 and Appendix C).
Disability	
Recommendation 12	It is recommended that current disability qualifications at certificate III , IV and diploma level are reviewed in line with the changing skills for coordinators and support workers in person centred care, individualised funding, changing work environments and complex conditions (Tables 12, 13, 14 and Appendix C).
Mental health	
Recommendation 13	It is recommended that current mental health qualifications at certificate IV and diploma level are reviewed to reflect recovery approaches and the complexity of clients (Tables 15, 16, 17 and Appendix C).
Workforce training	
Recommendation 14	It is recommended that CS&HISC promote the content of current qualifications in meeting workforce needs so that industry is better informed about what is available to use for skill development.

1. Consultation approach and methodology

1.1 Background to the consultations

This report provides information on consultations undertaken as part of the Community Services and Health Industry Skills Council (CS&HISC) new roles scoping project. Research undertaken by the CS&HISC in 2012 and 2013, and findings reported in its environmental scans, indicated the need for a project to scope new and emerging roles or functions in the community service and health sectors.

The main purpose of this scoping project is to identify changing and future work roles in seven distinct areas covered by CS&HISC Training Packages. These areas are:

- Allied health assistants
- Health service assistants
- Clinical coders
- Mental health workers
- Aged care workers and Home and Community Care workers (HACC)
- Disability services workers

These new functions and roles may require additional units of competency to be added to existing qualifications, changes in title and emphasis of existing qualifications or the development of new qualifications.

This project complements ongoing research and development work currently being undertaken by the CS&HISC in the current review of Training Package qualifications .

1.2 Stakeholder Consultations

The consultations involved a cross section of potential interviewees supplied by CS&HISC and identified by targeting currently advertised employment positions. This approach was employed to select a purposeful sample which would provide responses on issues of central importance to the project investigation. There were also several people referred to the project by those initially targeted. On the whole, individuals were targeted for consultation. In several instances they selected another person from their organisation to be interviewed.

The stakeholder groups and their representatives consisted of a range of cross sector participants as well as stakeholders from each of the groups: allied health, health services, clinical coders, aged care and HACC, disabilities and mental health.

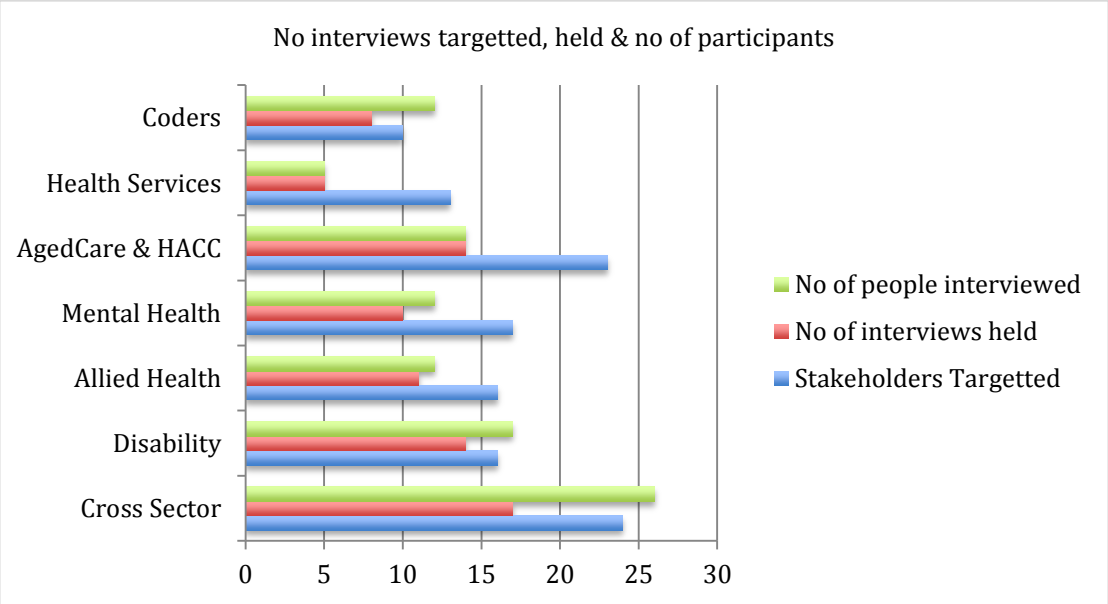
A total number of 119 stakeholders were targeted for consultation from these 80 interviews were scheduled. There were a variety of reasons why some of those targeted were not available including a change of position, on leave or failure to keep several appointments. The 80 interview sessions included both individual and group interviews, which resulted in a total of 101 people participating in the consultation over an eight week period.

Three detailed survey responses were received from:

- Occupational Therapy Australia based on responses from acute hospitals, rehabilitation, community and aged care settings as well as a focus group with Victorian occupational therapy senior clinicians and managers
- Speech Pathology Australia
- Australian Podiatry Council

Figure 1 below shows the numbers approached for interviews, the number of interviews and participants.

Figure 1.1 Stakeholder categories consulted



1.3 Methodology

The following protocols guided the consultation process:

- A set of open ended, structured interview questions were developed along with a consultation guide (Appendix A). These questions were developed in consultation with the CS&HISC and reflected early work done in 2012 and 2013 on new and emerging roles. The structured interviews provided a standardized approach to gathering information. This ensured that the same set of worded and ordered set of questions was used with each respondent. The open-ended questions (apart from one question) meant that the respondents could answer the questions on their own terms and in as much detail as they liked (Appendix B lists the stakeholders).
- A consultation guide explained the background and context of the project. Stakeholders were provided in the consultation guide with information on proposed changes already identified in Stage 1 of this project and organised in relation to potential units of competency. These tables were commented on and adjusted in the interviews (Appendix C).
- An introductory email, with a letter from the CS&HISC Chief Executive Officer, Rod Cook and the interview questions were sent to targeted stakeholders requesting an appointment time and informing the respondents at the outset how long the interview

would last, its purpose and general outline. It was explained that confidentiality would be observed.

- These emails were followed up with phone calls and a mutual time was agreed upon. The consultation guide, providing more detailed information, was sent once the interview time was confirmed. In many cases stakeholders consulted within their organisations and prepared responses to the questions, prior to the interview.
- All interviews were recorded and sent to the participant to ensure that they had been understood and captured correctly. At this stage they could add further information to their responses, but this rarely happened.
- Each respondent was informed that they would be identified in this report as a stakeholder rather than particular comments being quoted and ascribed specifically to them. There were a couple of exceptions to this approach where relevant respondents agreed to be acknowledged.

1.4 Data analysis

A content analysis was conducted involving coding and classifying data from the 80 interview responses and the three submissions. All responses were coded to highlight the important messages, features and findings. This coding involved identifying common themes, creating response categories and once the data had been studied and categories determined, documenting emerging trends.

Some of the details on emerging roles were expanded by reference to current projects such as through NDIS and this was referenced accordingly. Throughout Stage 1 (the literature and background document review) and Stage 2 (the consultations) a sample of advertised employment positions in each area was collected to discuss with stakeholders.

1.5 Report structure

The report records what the stakeholders said in relation to the new and emeging roles, skills and knowledge and related tasks. This information is organised into these categories:

- changes influencing each of the occupational groups
- changes identified in roles and related new skills and knowledge
- training, which includes comments on current qualifications as well as noting training undertaken in the workplace to address skill needs
- conclusions and recommendations which focus on future steps
- appendices listing stakeholders and mapping to units of competency.

2. Changes influencing the workforce

2.1 Introduction

In consultation stakeholders were asked to identify the type of factors that were causing changes in the areas that they were working. They identified a multitude of influences and the analysis distinguished different patterns across the categories of stakeholders. This was important as it also provided insight into the concerns of particular stakeholder groups and the changes they predicted for the future workforce.

2.2 Cross sector views

Respondents who provided cross sector views were from peak bodies, state and territory health and human service departments, unions and professional associations and industry training organisations. Their comments on the causes of change spread across the occupational areas under discussion, but in most cases they had knowledge about only three or four specific areas.

Figure 2.1 Causes of changes identified by cross sector participants

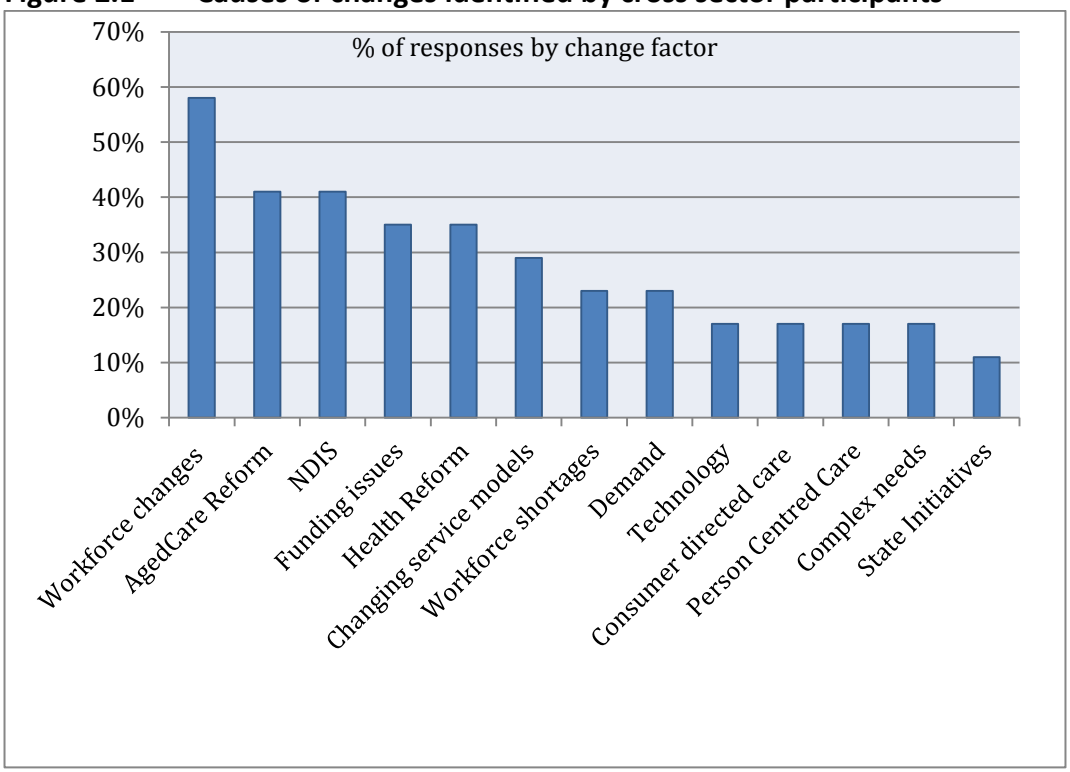


Figure 2.1 above shows the factors identified by cross sector stakeholders as causing change in the occupational groups under discussion in this project. The majority of those interviewed in the 'cross sector' category identified workforce changes as being the most significant influence. These workforce changes included growth in assistants and support workers and the ageing of the current workforce. There were particular concerns also about the standards of this workforce in high risk areas as expressed succinctly by this respondent,

> *With the increased reliance on the paid workforce it means there is an increased need for professionalism, qualifications and regulation of those occupations because of working with vulnerable people in Aged Care with dementia and mobility issues.*

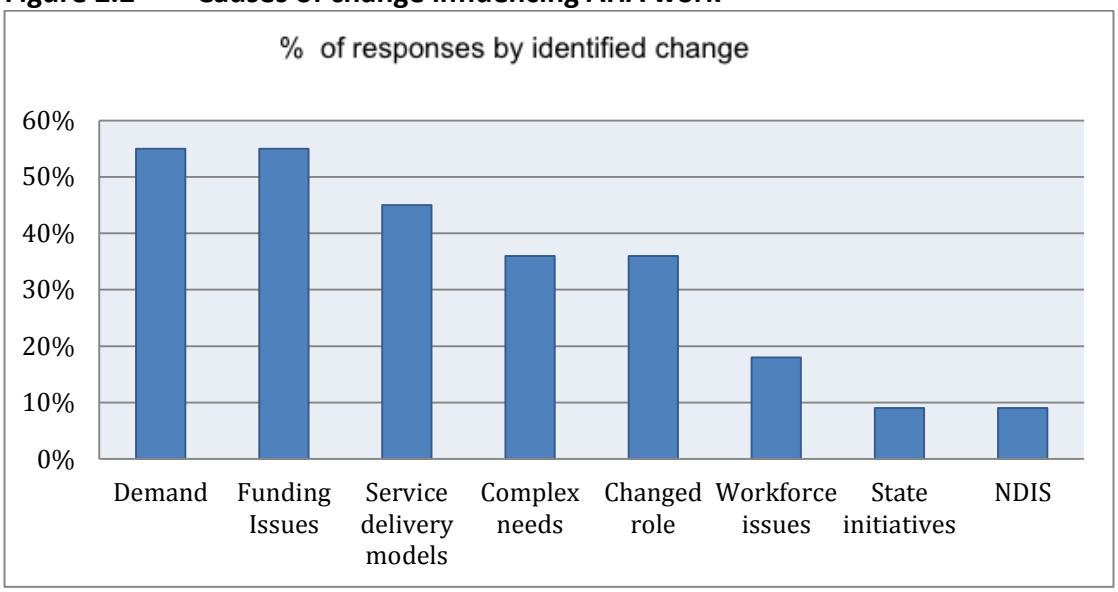
Other possible changes in the workforce involved employment arrangements, such as subcontracting and the overall management of health and community services into the future.

National reforms such as in aged care, health and the NDIS were bringing about change as were different funding models. Stakeholders mentioned cuts to government funding in the non government sector and moves to different funding models, based on the United Kingdom approaches, being introduced. The issue of funding and its impact, especially in health was frequently mentioned. Changing service models, such as supporting people in their homes and recovery approaches in mental health were important reforms that would necessitate changes in the workforce.

Workforce shortages, together with increasing demands and complexity of client needs, would also bring about changes in these occupational groups.

2.3 Allied health assistants

Figure 2.2 Causes of change influencing AHA work



Consultations identified that allied health assistance work was changing due to the combined factors of increased demand coupled with funding issues. The reasons given for the growth in demand were the ageing of the population, resulting in increases in client load for the health workforce, particularly in subacute and community work. Restraints on health budgets resulted in some stakeholders observing that it was considered too expensive to employ allied health professionals. As one manager stated "*Increased pressure on health services to deliver services combined with budgetary restraints means that we have to find cost effective ways of delivering health care*" whilst another said " *financial constraints mean that we need to do more with less."*

Changing service delivery models were also an important factor in allied health assistance work as evidenced in these comments,

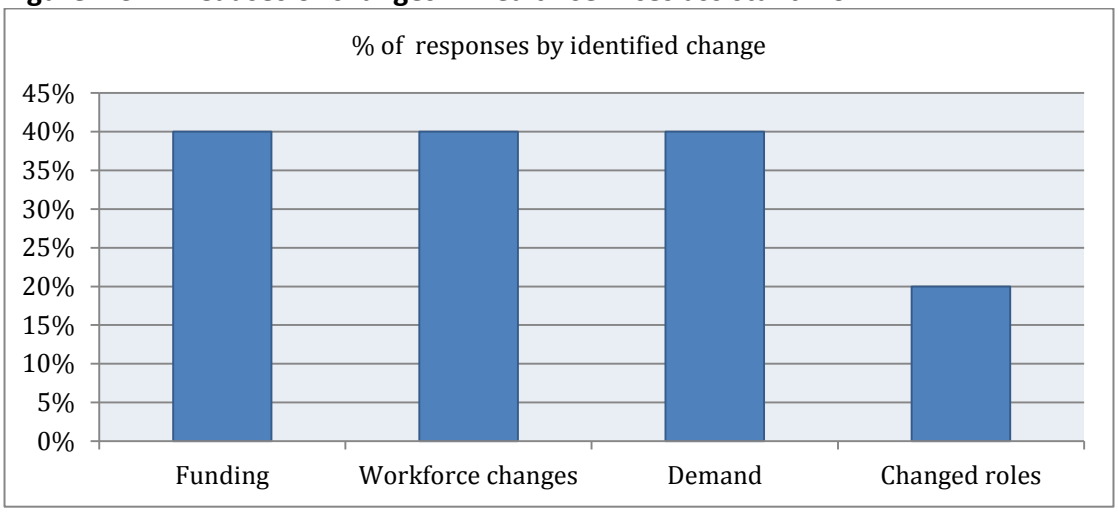
> *Changing models of care with a focus on moving patients out of acute care in the larger hospitals, and into subacute care in a facility closer to home. This model of care enables assessment and program development by the allied health professional and delivery of the program by the AHA (Allied health manager).*

AHAs provide an opportunity to deliver allied health services in smaller towns where allied health services are currently provided by visiting allied health professionals (Allied health manager).

The increased use of allied health assistance was positively viewed as they were moving more into areas such as part of a multidisciplinary model of care and home based care. HACC services were requiring dietitician services and assistants. Complex and chronic conditions related to ageing, obesity and diabetes were requiring an increase in allied health roles in the community. Assistants were accepted more as a valuable part of health services working with the professional guidance of the allied health professional. Contrastingly, there were concerns raised by professional groups of increasing use of AHAs as a substitute for allied health care professionals.

2.4 Health service assistants

Figure 2.3 Causes of changes in health services assistant work



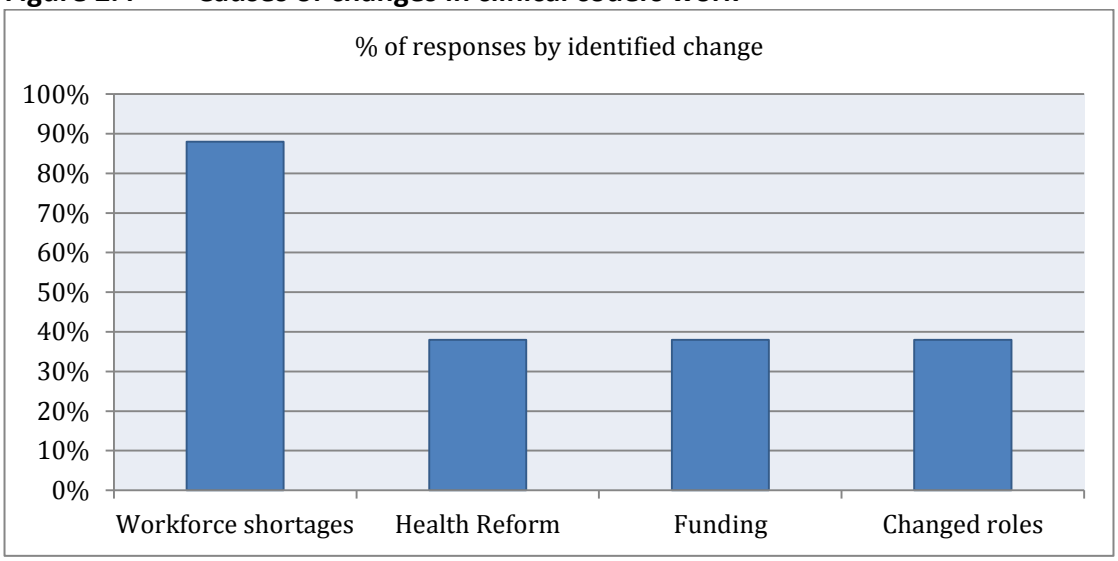
In the health service assistant role the main changes that were identified were funding, workforce changes and the demand for services (Figure 2.3). Funding requirements and management financial decisions had seen an increase in the use of assistants in nursing, but this seemed particularly in NSW.[1]

There was little change noted for other health service assistants such as patient services assistants.

Stakeholders suggested that the increase in services was influenced by general community demands in health, but also shortages of trained staff, particularly registered and enrolled nurses. Increased demands were identified in aged care, particularly to do with different levels of dementia.

2.5 Clinical coders

Figure 2.4 Causes of changes in clinical coders work



As figure 2.4 indicates the most important change identified as occurring in the clinical coding workforce was the shortages of clinical coders. There is a lack of information managers and clinical coders, with a demand for trained personnel across this field. This shortage has been caused by the lack of availability of suitable training together with the changing role of coders, and increases in the workload. There is increased reason for employing clinical coders as hospitals need a range of health information to be available for research and funding purposes. As one stakeholder explained,

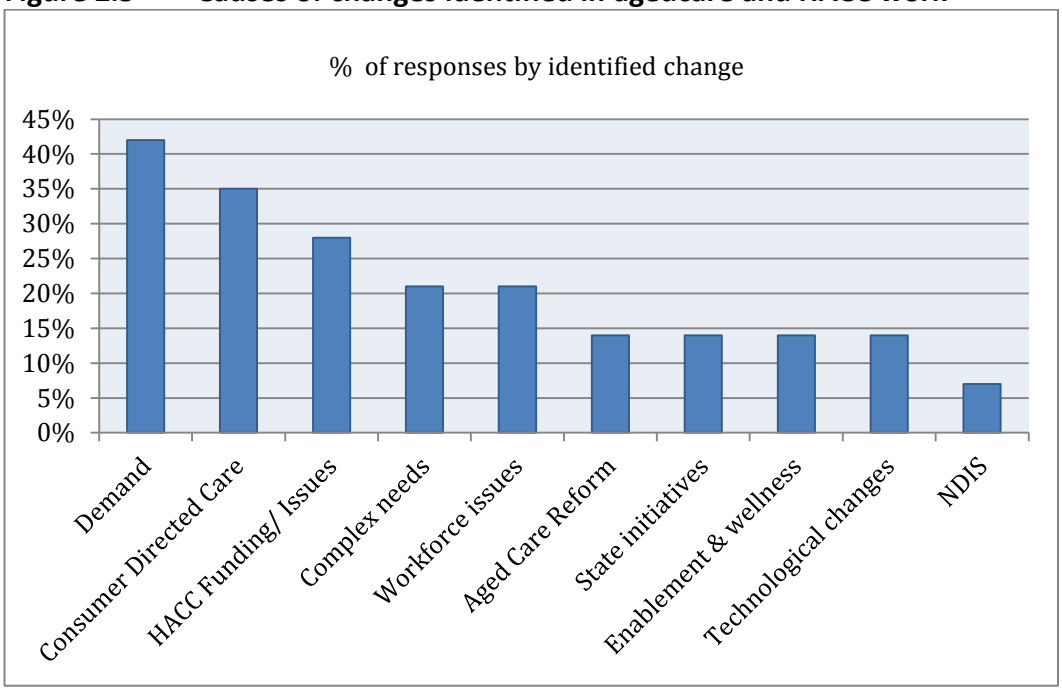
> *There can be a lot of simple surgery – cataracts, colonoscopy and other screenings and the coders responsibility has increased because accurate coding is needed to determine the funding arrangements (Information manager).*

Health reform and related funding models are important elements of change in the coding sector.[2] With national health reform, the increased implementation of Activity Based Funding (ABF) to a broader spectrum, as well as accurate coding being linked to funding, has resulted in a demand for coders. This is likely to increase in the future as there is even more of a focus on health budgets and hospital funding leading to the application of ABF to other areas in the health sector.

E-health initiatives such as implementing electronic medical records will result in health systems needing more coding staff .

2.6 Aged care and HACC

Figure 2.5 Causes of changes identified in agedcare and HACC work



The increased demand for aged care and HACC services was identified as the major change in these sectors (Figure 2.5). There was demand for aged care services in residential, community and home based. Coupled with this growth were changes to be brought about by consumer directed care and funding, especially HACC funding. Another important issue was the emerging client complexity in residential care, caused by older people coming to care, later, and presenting with comorbidity. This complexity was also due to a growth in dementia and other cognitive disorders. Other examples of complexity faced by service providers mentioned were younger people in residential care and more complex health related tasks requested in home care. State issues, the NDIS and aged care reform were commonly mentioned as being influential. However, a product of these reforms, consumer directed care was cited as most important. Other stakeholders recognised the whole approach to aged care and HACC would change,

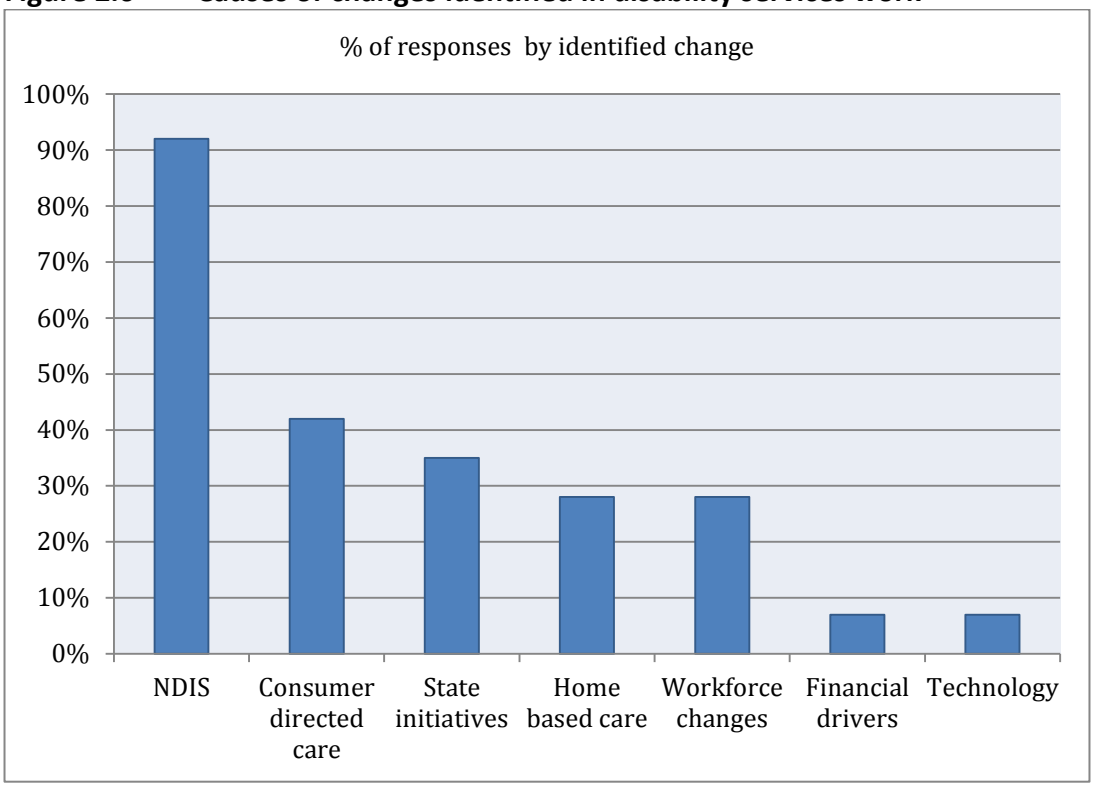
> *…….a new model of wellness and maintaining independence instead of 'helping people.' There are issues of choice and decision making. There will be more time involved with the person and the client can choose what services and from whom (Coordinator)*
>
> *Key themes of enablement & wellness not just person centred (HACC coordinator).*
>
> *There is a shift of focus from taking care to personalised support. Personalising support care work (Manager).*

Technological changes were identified from service providers who mentioned *"exploring e-medication records on a tablet and mobile automated run sheets for community workers with GPS navigation."* But this was rare. The main workforce issues identified and causing changes were increased demands on workers due to labour shortages, a large English as a Second

Language (ESL) cohort employed, or wanting to be employed, in the sector and an ageing workforce.

2.7 Disability

Figure 2.6 Causes of changes identified in disability services work



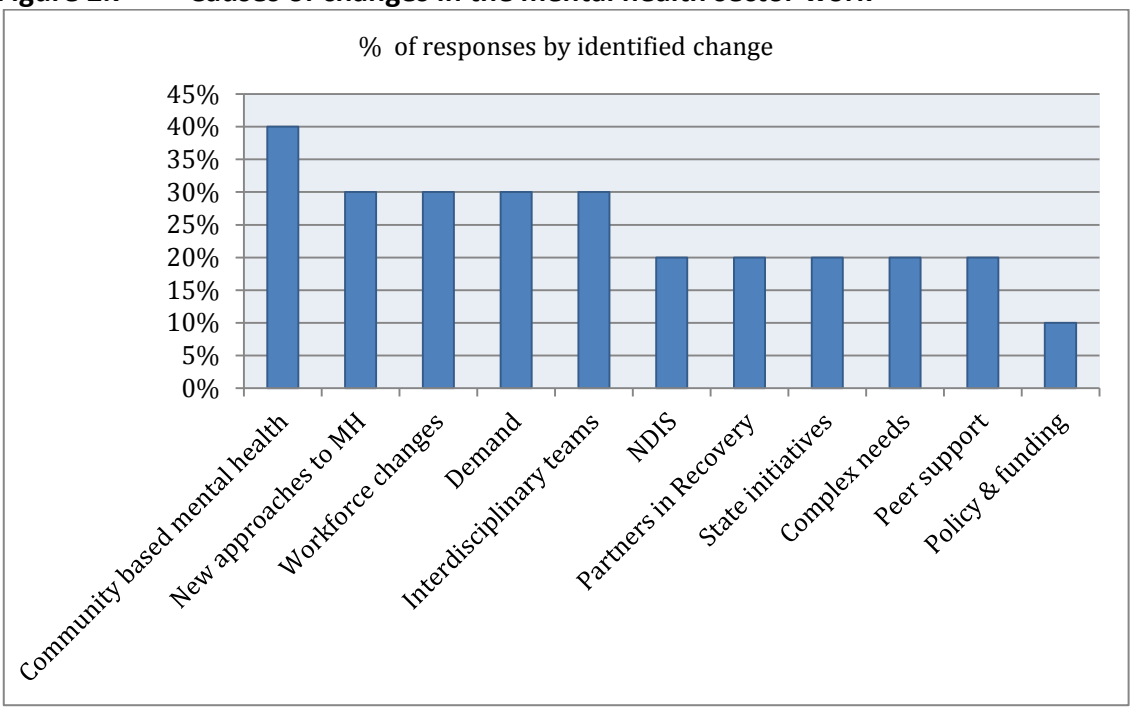
The main drivers for change in the disability sector were the impact of the NDIS and related consumer expectations and choice in care (Figure 2.6). State initiatives, such as mental health strategies, an increase in community care and a move away from institutional based care, were also mentioned as important. These reforms were also linked to new directions in the workforce with one of the most significant being the increase in subcontracting,

> *Subcontracting of services where the acquisition of funds, the planning and the case management is done by one organisation, but the direct care work is subcontracted out (Manager).*

> *Casualisation of the workforce with flexibility means that organisations could become a labour hiring organisation (Service provider).*

2.8 Mental health workers

Figure 2.7 Causes of changes in the mental health sector work



There were a wide range of changes identified as occuring in the mental health sector, with the most significant being the increase in community based care (Figure 2.7). This was also linked to new approaches in mental health, with an emphasis on recovery, working in interdisciplinary teams and an increase in peer support roles. State issues were also cited as important, with examples being the Victorian Reform of Mental Health Services and the Western Australian government budget cutbacks. Workforce changes were related to an increase in demand coupled with the complexity of clients, which necessitated the need for increased skills in workers. In particular, different cultural contexts and understanding approaches to mental health as well as complex needs associated with an increase of dual disability, mean that workers needed to be further skilled. Other workforce changes were a greater need for staff, the ageing of the workforce and younger and less experienced staff having to cope with complex situations,

> *There is a need for people to have a greater skill level in the field of mental health. By evaluating what works well with clients and what employees have responded to well - you gain a good idea of the needs of clients (Workforce planner).*
>
> *The needs of clients are more complex with co-morbidity resulting in a greater skill level required by mental health workers (State manager).*

2.9 Conclusions

Even though there are common themes identified as causing changes, each particular occupational area has its own instigators of change. The most commonality is in the health areas whereas aged care and HACC, disabilities and mental health are faced with a range of distinct changes that will influence support workers.

3. Changes in new roles, skills and knowledge

3.1 Introduction

This section records what stakeholders said about emerging roles as well as new tasks or changes in current roles. Stakeholders were asked to nominate the types of skills and knowledge that would be required to respond to these changes. They were provided with a chart for each occupational area, which nominated new skill areas, That was altered according to stakeholder responses as well as other data gathered in the project. Appendix C lists these charts.

3.2 Allied health assistants

The allied health assistance area is notable for the overall lack of agreement between the states and territories about new and emerging roles. This is summarised in Table 1 below.

Allied health assistants work under the supervision and delegation of allied health professionals. State governments, rural health professionals and local managers appear to be supportive of assistant roles whilst advocacy and peak groups for the sector offered a range of views. Stakeholders indicated that there were public safety issues associated with these roles and consequently, there needs to be adequate supervision arrangements of assistants, rather than using them as a substitute for professionally trained staff. Some stakeholders already working with AHAs stressed that there was a legitimate role even though it may be driven by funding and demand issues. Others were very supportive of the role and found that it had worked well. There was strong support in rural areas due to the difficulties of recruiting allied health professionals .

Allied Health professional bodies reported that there are concerns with recent trends when AHA are being requested to work more on their own without adequate supervision.

State governments in Victoria, NSW, WA and Queensland have developed supervision frameworks for working with AHAs. As the latest study in NSW found in relation to AHAs "*roles were defined differently within Health Services and the level of responsibility and services provided by AHAs within their localities varied greatly*".[3]

Table 1 below has listed the types of areas raised in the consultations where AHA are working or beginning to work.

Table 1 Mapping of existing and emerging AHA across states and territories

Key	
E	emerging
✓	existing

Allied health assistant	VIC	QLD	TAS	NSW	WA[4]	ACT	SA	NT
Allied health assistant	✓[5]	✓	✓	✓	✓	✓	✓	✓
AHA speech pathology	✓[6]	✓		✓	✓	✓	✓	
AHA OT	✓	✓	✓	✓	✓	✓	✓	✓
AHA physiotherapy	✓	✓	✓	✓	✓	✓	✓	✓
Exercise physiology assistant						E		
AHA rehabilitation	✓	✓		✓	✓			
AHA audiology	E			✓				
AHA podiatry				✓		E	✓	✓
AHA orthotics/prosthetics	E[7]			✓				
AHA multidisciplinary	E[8]							
Activities assistant	✓							
AHA nutrition & dietetics	✓	✓	E	✓	✓	Nutrition		
AHA medical Imaging	✓	✓	E	✓				
Radiation therapy/Medical	E[10]		E					
Radiography			E	✓		No		
AHA mental Health				E[11]				
AHA (social work)	E[12]	E[13]	E[14]			E		
AHA psychology[15]	E		E[16]					
Advanced allied health	✓[18]	✓[19]	E	✓		E[20]	✓[21]	
AHA emergency				E				
AHA stroke				E				
AHA rural		E			✓			
AHA in paediatric services	E							

With the new and emerging roles, social work assistants are being used in some states but opposed by both professional bodies : Australian Community Workers Association and Australian Association of Social Workers. In Victoria, Tasmania and Queensland there is active support for these roles, whereas in other states, it was stated that this work is adequately covered by welfare workers, counsellors or administrative staff.

Similarily, there is interest in the advanced allied health assistant role in Victoria, Queensland and ACT but this is also opposed in several states. AHA radiation therapy is supported in some states but opposed by the industry in others.

Some stakeholders felt that it was unnecessary to label new configurations and the generic term of AHA should cover most newer areas. It was also raised in discussion that there are some areas which overlap with other occupational groups. These were:

- AHA nutrition and nutrition assistants
- AHA audiology and nurse audiology
- AHA social work and welfare workers
- AHA emergency work is covered in NSW by clinical support officers.

Table 2 below lists some descriptions given in the consultations on emerging roles.

Table 2 Emerging roles for allied health assistants

Social workers assistant	Assist with social work services in sub-acute hospital settings in order to increase access to aged care patient needs; multi-skilled rehabilitation and involved in communication with social workers. These positions would be able to deal with information about a client and liaise with the GP, community services, or nursing staff accordingly. The role would vary according to the setting e.g. acute, disability.
Advanced allied health assistant	Assist in client care through the delegated provision of, and participation in, direct clinical activities to assist in maintaining clients' independence and quality of life at home, delivering prescribed programs in both community and clinic based settings, both individually and in a group context. Advanced AHA roles are emerging in acute and sub-acute inpatient settings, such as the "discharge support assistant". Advanced AHA are providing supervision and/or mentoring to inexperienced allied health assistants as required.
AHA emergency	Assisting in the emergency department providing support to AH professionals.
AHA medical physics & radiation therapy	Piloting in some states but not supported in others. This role includes undertaking in vivo dosimetry checks on all patients receiving external beam radiation and enhancing patient care.
AHA in pediatric settings	Roles include: Therapy assistants in schools running programs independently – rather than the traditional model using teachers' aids. Managing group dynamics. OT assistant – implement programs for children to increase social emotional skills or fine motor skills.

Respondents were asked to nominate any new tasks that would apply to current and future allied health assistant roles. Table 3 below presents the areas which stakeholders suggested that AHA work may change in terms of contexts, clients, roles in health, communication and working relationships. The senior or advanced AHA role would involve leadership and training.

Table 3 New tasks and roles for allied health assistants

New tasks AHA	
Changing contexts and clients	Communication and reporting
Respond to diverse client needs.	Communicate effectively: speaking, writing
Implement client centred care.	Use computers for information and reporting, e.g. excel.
Work in the community.	Access computerized record systems.
Respond to clients with mental health issues.	Use standard technology/tele -therapy/ information management /systems of documentation.
Work with clients with dementia.	Use e-health services as required.
Work with aged & complex conditions.	
Work in palliative care.	
Health	Working relationships
Adhere to clinical standards.	Understand own role.
Present health promotion and prevention information to individuals and groups.	Collaborate with members in a multidisciplinary team.
Work with clients with chronic diseases.	Use problem solving techniques and analytical skills.
Work to assist mobility issues in clients.	Follow ethical practices.
Work in the community with complex care.	Use self-management and motivational techniques.
Identify when referral is required.	Monitor funding mechanisms of allied health budget.
Use initial screening checklists, of a non-clinical nature, to identify hazards to service provision,	Support and monitor specific interventions implemented by allied health therapists, e.g.

New tasks AHA	
e.g. to identify a volatile social situation which may place a home visiting therapist at risk.	knowledge of how equipment should be appropriately set up in a patient's home, so that they may support an occupational therapist who has set up the equipment to monitor its appropriate use.
Screen for risks of falls.	Schedule activity sessions.
Conduct basic exercise program for stroke /arthritis.	Learn concepts and strategies to encourage clients to self-manage (chronic disease management).
Implement upper limb treatment program.	Learn ways to provide support and care to people with complex health conditions, including cognitive decline etc.
Senior Workers	
Provide leadership.	Train others.
Undertake planning.	Mentor others.

In order to undertake these new tasks the following skills and knowledge were identified in interviews by stakeholders that allied health assistance would need (Table 4).

Table 4 New skills and knowledge for allied health assistants

Skills	Knowledge
Demonstrate computer literacy	Knowledge of client centred care.
Keep electronic records.	Knowledge of bodily systems.
Use communication skills.	Knowledge of common medical problems and their implications.
Apply written documentation skills.	Understand the hospital or community health care provider environment.
Apply time management skills.	Understand the social impacts of disability.
Use negotiation skills with clients.	Understand infection control and types of products/techniques to use for different types of infections.
Use activity planning skills.	Understand dementia and its implications.
Apply problem solving and analytical skills.	Understand neurological diseases and their implications.
Use conflict resolution strategies.	Understand mental health issues.
Apply ethical conduct in work.	Understand complaint handling strategies and procedures.
Conduct exercise programs under supervision of the AHP, e.g. falls prevention.	Understanding human behavior.
Apply casts under supervision.	Understand mobility issues.
Monitor medicines.	Understand treatments prescribed by allied health professional.
Monitor and clean equipment.	Understand palliative care.
	Understand chronic diseases care.
	Understand prevention and health promotion in primary health care.
	Understand early intervention in primary health settings.
	Understand the appropriate use of referral to other health professionals, so this can be identified and discussed with the AHP/team.
	Understanding supervision and training of others.

3.3 Health service assistants

Assistants in nursing (AIN) provide care under the supervision and delegation of registered nurses and currently, work mainly in aged care and acute care.

AINs increasingly work more in the private sector in aged care settings and whilst the Australian Nursing and Midwifery Federation (ANMF) would like to see registration and increased regulation, particularly for patient safety, it has been suggested that private sector operators would find this an imposition.[22]

Most stakeholders felt that the job role had not changed but there was an increase in the number employed and the services in which they are employed. Mental health was identified as a new and emerging area. Essentially, the AIN role is limited as they work under supervision.

Table 5 below presents the areas which stakeholders identified that AIN work may change in terms of working contexts, roles in health, communication and working relationships. It was considered important to stakeholders for AINs to understand when to refer people and to understand their role in the scope of practice of nursing.

Table 5 New tasks and roles for AINs

New tasks AIN	
Working contexts	Communication & reporting
Work in coronary care.	Use information technology in the work role.
Work in aged care services, including palliative care.	Communicate with patients and other health care team members.
Work in mental health services.	Communicate with family members and carers.
Work in community settings.	Identify and communicate referrals.
Work in newborn care unit/children/families.	Communicate effectively with health care staff.
Escort patients within the hospital to activity areas.	Report writing.
Health	Working relationships
Monitor medications.	Work in a multidisciplinary team.
Check and record basic observations and report findings directly to the Registered Nurse (not allowed in some states).	Protect the rights and privacy of the patient by exercising advocacy and discretion in communications.
Identify deterioration and decline such as dehydration.	Organise own work and related safety.
Monitor health and safety of the environment.	Understand own role in the context of nursing work.
Respond to clients with complex conditions.	Work within a legal framework.

There were no changes in job roles identified for other health service or patient support assistants. Table 6 below lists some of the skills and knowledge stakeholders suggested AINs and patient support assistants would need in their jobs in the future.

Table 6 New skills and knowledge for health service assistance

Skills	Knowledge
AINS	
Manual handling techniques.	Understand medical terminology.
Written and verbal communication skills.	Understand healthy body systems.
Literacy skills.	
Basic computer skills.	Understand indigenous culture.
Ability to work in a multi-disciplinary team.	Understand diverse cultures.
Organizational skills.	Demonstrate knowledge of WHS.
Time management skills.	Understand the legal ramifications of AIN work.
Critical thinking skills.	Understand dementia patients.
Recognise and deal with stress in own work.	Understand boundaries and limitations of role.
Handling complex clients.	
Assistance in the management of medication.	

Skills	Knowledge
Patient Support Assistant	
Communicate well in verbal and written English..	Sound knowledge of English written & verbal.
Time management skills.	Understand working context.
	Understand infection control.
	Understand hand hygiene.
	Understand swallowing difficulties.

3.4 Clinical coders

All stakeholders consulted agreed that the area of clinical coding work needed tasks, skills and knowledge redefined. The work has not changed significantly but the responsibility of the role has increased because accurate coding is crucial to determine the funding arrangements for health providers. As a hospital manager suggested,

> *The role of a clinical coder will be more prominent rather than changed. There will be more awareness to how they fit in and how the funding of the hospital relates to the quality of their work. Actual job won't change.*

To gain competence in clinical coding, learning on the job is important and undertaking tasks and receiving feedback. Experience is also essential because of accumulated knowledge about different conditions, diseases and procedures. In Western Australia and NSW, the training is conducted as a traineeship in recognition that this is the most effective model.

Two stakeholders suggested this role could change further in the future to include an auditing role if doctors enter their own data and if there is a need for more specificity in data from researchers and financial managers.

Table 7 below presents the areas in which stakeholders suggested that coding may change: in the work context, health, communication and working relationships. New senior roles that are currently emerging and may increase in the future are auditor and educator, whereas a coding support clerk is an administrative support role that is emerging.

Table 7 New tasks and roles for clinical coders

Clinical coders	
Coding work context	Communication & reporting
Apply upgraded ICD-10-AM (8th Edition) to coding work.	Access, read and report from electronic medical records.
Apply ABF to increased areas apart from acute and mental health.	Write reports as required.
Undertake diagnosis-related group (DRG) coding.	Communicate effectively using medical terminology.
Assign codes to a range of procedures and conditions.	Communicate with medical and diagnostic unit staff.
Abstract clinical information and code appropriately.	Participate in internal audits.
Ensure completeness and accuracy of clinical coding.	Analyse and decipher clinical documentation.
Health	Working relationships
Interpret and use medical terminology.	Work in a team.
Undertake clinical updates on new procedures.	Follow coding managers instructions.
Be informed about the health system.	Communicate with coding staff.
Apply an understanding of hospital funding.	Manage time and resources.
Apply an understanding of patient journeys through the health system.	Work effectively in the health system.

Clinical coders	
Senior coders	
Auditor	Educator
Report on coders' documentation.	Train clinical coders.
Coding support clerks	
Prepare documentation for coding.	

Stakeholders identified a range of skills and knowledge that will be needed for these roles. There was a particular emphasis on the background health and coding knowledge that a clinical coder needs as well as careful reading and accuracy.

Table 8 New skills and knowledge for clinical coders

Skills	Knowledge
Demonstrate attention to detail in coding.	Understand the relationship between funding and coding.
Read and code accurately.	Understand medical conditions.
Apply good information technology skills.	Understand legal implications of medical records.
Apply accurate abstractions skills.	Understand the classification system.
Communicate with physicians to clarify records for coding.	Understand anatomy and physiology.
	Understand the health system and the patient journey.

3.5 Aged care and HACC

Respondents were asked to identify new and emerging job roles in the area in which they were working. In aged care and HACC many respondents indicated that the major work change would be around implementing person centred care and treating elderly people with respect and dignity. This is consistent with the nominated changes in 2.6 which are around consumer directed care, funding issues and complex needs. As one respondent said,

> *In personal care and support there is a change in how it is done rather than what is done.*

This was also apparent when identifying new work tasks,

> *There is not additional tasks but it is about flexibility of the workforce to provide person centred active support (involving client into the community) and it is about the services people will request and the worker being flexible.*

It was emphasized that the support worker would be involved in facilitating decision making but not care planning. Care planning being the role of the coordinator.

Consumer directed care was linked with the need to ensure social inclusion and social wellbeing and how this would be delivered in home based care as a new function. Social wellbeing was a particular concern with the related themes of enablement and wellness.

The monitoring of health was regarded as particularly important as there are more complex health issues experienced by the elderly. Stakeholders gave some examples where personal support workers (PSW) were monitoring medication. In fact, some larger companies that subcontract to smaller support worker organisations require that they have a medication

credential beforehand such as CHCCS305C Assist clients with medication. This is run by organisations such as the Royal District Nursing Service.[23]

Respondents felt that with changes in person centred care, it is important that PSW know their boundaries and are assertive in terms of their role and are mindful of safety in the home. Often compliance training is provided by the employing organisation on recruitment, but some issues involved problem solving on the job.

Palliative care in the home was identified as a new and emerging area for the support worker.

Table 9 New roles for aged care and HACC

Aged care	
Lifestyle coordinator	Coordinate and conduct assessments of individual residents' social, emotional, cultural, spiritual, physiological and intellectual needs and design and implement individualized and integrated leisure and lifestyle programs accordingly.
Senior worker in business development	Write submissions. Gain & monitor funding. Implement invoicing procedures.
End of life consultant	Work in palliative care.
Broker	This could be an entire role or part of a coordinator role. Identify & negotiate services. Audit brokerage services. Obtain subcontracted care work.
Client facilitators	Support choice and decision making in care plans. Negotiate a care plan and support its implementation. There will be different approaches with each client negotiating the care plan, enabling role, supporting advanced care and undertaking end of life planning.
Field technician	Support assistive technology, support workers using assisted technology (e.g. system on medication dispensing).
Case manager	Integrate services: not just coordination but ensuring services work together.

Table 10 below lists the areas that stakeholders identified for aged care and HACC workers undertaking new or changed tasks in their jobs. The areas that they nominated for change were in implementing person centred care, communicating and reporting, working relationships, health issues, handling complexities and caring for a diversity of clients. The coordination level worker would also require some changes in funding, service models and caring for diverse clients. Marketing in a contested environment would also be a new challenge for coordinators.

Table 10 New tasks for aged care and HACC

Support worker	
Person centred care	Communication & Reporting
Provide person centred services.	Report against a budget.
Support in daily living.	Deal with consumer records & information.
Apply duty of care principles.	Use information systems.
Maintain independence of client.	Communicate effectively with families and clients
	Write competently.
Support social inclusion.	Communication through various mediums.
Support social wellbeing.	Follow a support plan.
Implement care planning.	Record complaints and feedback to providers.
Maintain dignity in support approach.	Communicate with people who have dementia.
Health Monitoring	Working relationships and safety

Recognise healthy bodies.	Understand person centred care and work role.
Check nutrition and hydration.	Understand own role, changes and boundaries.
Monitor complex health related tasks	Understand how aged care fits in the community.
Basic training in nutrition advice	Apply assertiveness skills.
Assist with medication	Maintain client confidentiality.
Care for people with health problems	Resolve conflict with families.
Ensure health is not deteriorating - skin checks; check for bruising.	Identify when it is appropriate to refer.
Minimise risks with falls prevention exercise and balance advice	Use assistive technology.
Working with diversity	Handling complexities
Interact and care appropriately for diverse clients -LGBTI, CALD and ATSI consumers	Respond to dementia appropriately. Deal with difficult behaviours.
Provide person centred care for indigenous and CALD clients	Respond to mental health conditions such as depression and anxiety.
	Provide palliative care in the home.
Operational management/service coordination level	
Apply costs and service models.	Respond to diversity.
Implement service models.	Market in a contested environment.
Acquire, distribute and monitor funding.	Respond to complex issues, e.g. elder abuse.
Use business skills.	
Identify client needs.	

Respondents identified skills and knowledge that current and future workers may need to undertake these new tasks. Some respondents suggested that the emphasis was on a different way of doing things,

> *There will be a higher order level of skills across the board. Not new skills, but practiced at a higher level. It's harder to 'enable' than it is to do it for them. Changes in client relationships such as informed decision making and consent.*

Administrative skills using information technology for accessing and recording were considered to be important. The 2012 Aged Care Workforce Survey (2013)[24] showed that paperwork for records is still important but mobility in homecare will increase the need for electronic options. It was stressed often that literacy and ESL skills needed to improve. There is a trend for an increase in documentation to monitor spending in the community package and claims for funds having to be justified. Any documentation for personal care workers (PCW) is a challenge as they often do not have strong literacy skills and there are many ESL workers.

Table 11 New skills and knowledge in agedcare and HACC

Skills	Knowledge
Brokering skills.	Understand respect and individual rights.
Customer service skills.	Understand client options.
Applying consumer directed care.	Understand consumer rights.
Interpersonal skills and problem solving.	Understand consumer directed care.
Communication – written and oral.	Understand organizational policies.
Communicate empathy and understanding.	Understand people and introductory psychology.
Good English language skills.	Understand communication.
Writing skills.	Understand risk and duty of care.
Negotiation skills.	Understand complaint handling.
IT skills/technology to deal with patient records, conditions and medication.	Understand negotiation.
Budget planning and managing finances.	Understand record keeping.
Skills in end of life support.	Understand how health conditions impact on older

	people.
Skills in palliative care.	
Skills to deal with mental health (eg. agoraphobia, anxiety, depression).	Understand grief.
Skills to handle dementia.	Understand mental health.
Skills to handle behaviour management.	Understand dementia.
Food planning.	Understand complex behaviours.
Cooking skills.	Understand nutrition
Skills to monitor health.	
Senior Workers	
Writing submissions.	Understand new funding policy environment.
Business skills to operate in competitive environment.	Understand contested environments.
Case management.	
Brokering services for consumer directed care.	Understand policy options and context.
Auditing services.	Understand aged care standards.
Managing complaints.	
Enabling, facilitating and negotiating care planning.	
End of life planning.	Understand palliative care.

3.6 Disability work

As seen in Section 2.7, changes in the disability area that will influence work roles will relate to implementing the NDIS and, in particular, a person centred approach. Table 12 below lists the emerging roles identified through consultation.

Stakeholders suggested changes in these work roles will also occur in the organisations employing support workers as there would be more competition for the provision of work caused by the client directed model. Some organisations suggested that they may become 'brokers' of a range of services whilst others suggested that they may enter into subcontracting arrangements to deliver the support role.

Table 12 Emerging roles in disability work

Client Broker	Facilitating a range of services including community inclusion.
Business planner	Devising business plans for service providers, including attaining business in a commercial environment as well as sales and marketing.
Team leaders and Senior support worker	Developing and implementing the plan and understanding the concept of how to engage individuals by encouraging choice and control.
Planner	Assisting to navigate services and support for services and individuals .
Local area coordinator	Local area coordinators (LACs) will require knowledge and skills in a range of areas to support children, adolescents and young adults with disabilities and their families. These skills will include: communication, conflict management and basic counseling; cultural competency coaching; understanding of self-directed approaches, The Disability Act and services; community capacity and building training incorporating efficient networking skills, community profiling and risk assessments; empowerment abilities, to encourage clients' control over resource choices; having a holistic approach and being creative; and research and problem solving training.[25]
Dementia consultant	Specialist skills in dementia practice.
Personal assistant	Life coach, mentor and facilitator for a person with a disability.
Financial advisor	Individual information on financial entitlements.
Employment facilitators	Broker employment or support to undertake employment. Facilitate employment - Employment delivery sector support workers
Specialist consultants	Workers with specialized or higher level disability and disability related expertise (i.e. behavior management and disease management)

Stakeholders stressed that it is the person centred approach which requires a major change for support workers. It requires a changed role for the support worker in terms of implementing an active service model. This role will mean that the direct care worker will be implementing a plan and also monitoring and gaining feedback on client satisfaction with the plan. Consumer directed care will mean that the communication skills of the support worker with the client and the family will need to be well developed. The person centred approach will require "*a paradigm shift with a far more consultative approach. The system is shifting with an active service model but has it not drifted down to the delivery. There is a disconnect between the system and what is happening*" (General manager).

Consultations suggested that this changed role will be challenging and that support workers will need to understand their role including limitations, expectations and knowing when and where to obtain guidance and support for themselves and the person they were supporting. This challenge was also put in the context that staff in these roles in some geographical locations lack skills and competencies in communication and the English language. As one stakeholder stated,

> *It is not about additional tasks but it is about flexibility of the workforce in person centred active support (involving client into the community) . It is about the services people will request and the worker being flexible.*

and another,

> *because of the changes workers will be expected to have problem solving skills and better judgement as they will be working solo. They must be flexible and use practical problem solving judgement.*

The new tasks in disability work focused around the person centred approach, self management, individualised funding and other issues.

Table 13 New tasks for disability work

Person centred Approach	Self-management
Support a person centred approach to daily living.	Apply and know 'professional' boundaries of work.
Work with a person centred perspective by focusing on the needs and choices of the person.	Self-management of work duties and stress.
Support community inclusion, including negotiating role.	Apply assertive behavior in job role.
Communicate clearly with families and clients.	Identify referral procedures.
Facilitate skill development and individual plans.	Display self-motivation and initiative.
Recognise the rights of the individual.	Follow documentation requirements.
Work with strengths based focus and positive behaviours.	
Respect rights of clients.	
Practice advocacy.	
Individualised Funding	Complex conditions
Brokering.	Dealing with complexity care needs at home.
Documenting spending.	Caring for people with health problems.
Assist and support decision making.	Working with mental health issues.
Assist in gaining financial knowledge.	Dealing with abuse and neglect.
Use creative approaches to funding and accessing services.	Working with dementia.

Table 14 lists the new skills and knowledge identified by stakeholders that will be needed in disability work.

Table 14 New skills and knowledge in disability work

Skills	Knowledge
Articulate consumer directed care.	Understand policies.
Brokerage skills for CDC.	Understanding person centred reforms.
Customer service skills.	Understand the principles of respect and individual rights.
Empowerment skills with clients.	Understand human rights and responsibilities.
Behaviour management.	Understanding people, psychology.
Interpersonal skills and problem solving.	Understand communication.
Communication – written and oral, e.g. taking notes.	Understand how the organization works and how own work contributes to the organisation.
Communicate empathy and understanding.	Understand ethics and their application.
Good English language skills.	
Writing skills.	Complaints handling.
Numeracy skills.	
Negotiation skills.	
IT skills/technology to deal with patient records, conditions and medication.	
Business skills.	
Budget planning and managing finances.	
Skills in end of life support.	Understanding grief.
Skills in palliative care.	
Skills to deal with mental health, e.g. agoraphobia, anxiety, depression.	Understanding mental health.

3.7 Mental health

Stakeholders believed that there is a need for people to have a higher skill level in the field of mental health because the needs of the clients are more complex and there is a greater incidence of comorbidity. There are emerging jobs related to dealing with specific client groups.

New roles mentioned included consumer specialist worker – increased involvement with consumers and carers, aboriginal mental health liaison officer, community and support facilitators working with a team and interacting with different agencies and employers.

Table 15 New roles in mental health work

Consumer specialist specialist worker	Facilitating support and funding with consumers and carers.
Aboriginal mental health welfare officer	Ensure the accessibility of mental health services for Indigenous people. Assess needs, develop 'Individual Recovery Plans' and link with clinical and other support services.
Aboriginal mental health liaison officer	Assist and support in the use of mental health services.
Community rehabilitation and support worker	Community rehabilitation and support workers provide a range of rehabilitation and support to consumers, tailored to meet their individual needs.
Support facilitators	Work with a team and interact with different agencies and employers. Work with multiple agencies. Ensure programs maintain a recovery-oriented focus through developing relationships with all stakeholders and developing action plans that meet the client's service and support needs.
Service coordinator	Higher level care coordinator involved in networking, supervision, leading a

	team and reporting.

Some of the new tasks for mental health workers involve new approaches and promoting recovery.

Table 16 New tasks for mental health workers

Approaches	Working relationships and environment
Use self-directed and person centred care with clients.	Participate as a team member.
Apply psychosocial rehabilitation and recovery support practice (i.e. health and wellbeing).	Maintain records and resources.
Facilitate social inclusion.	Maintain ethical behaviour.
Practice trauma informed care and practice.	Convey information verbally and in writing.
Utilise talking therapy skills.	Manage conflict in a fair and transparent manner.
Address complex issues.	Describe the stages of recovery to facilitate a consumer's understanding of the recovery journey.
Identify and respond appropriately to stigma.	Manage time effectively.
Implement joint approaches to mental health and drugs and alcohol recovery.	
Coordinator	
Identify new and different networks.	Lead staff.
Develop partnerships.	

In mental health, the emphasis was on making sure that mental health workers understood the philosophies behind their work and work as part of a team. Coordinators may be in a position of providing leadership to small teams of support workers.

Table 17 New skills and knowledge for mental health work

Skills	Knowledge
Apply recovery approaches.	Understand 'lived experience'.
Provide direct support to consumers within their community.	Understand leadership.
Report on service provision.	Understand measurement and accountability of policies.
Apply directions as outlined in relevant acts.	Understand relevant mental health acts.
Increase inclusion for clients.	Understand stigma and its implications.
	Understand aboriginal cultures.
	Understand cultural diversity.
Work in a team	Working relationships & environment
Reflect on practice in team meetings.	Understand emotional intelligence and self-reflection.
Work in a team to resolve complex issues.	Communicate with families.
	Communicate with the mental health team.
	Assess and mitigate against work risks.
Coordinator	
High level communication skills.	Knowledge of health & welfare sectors.
Ability to support staff.	

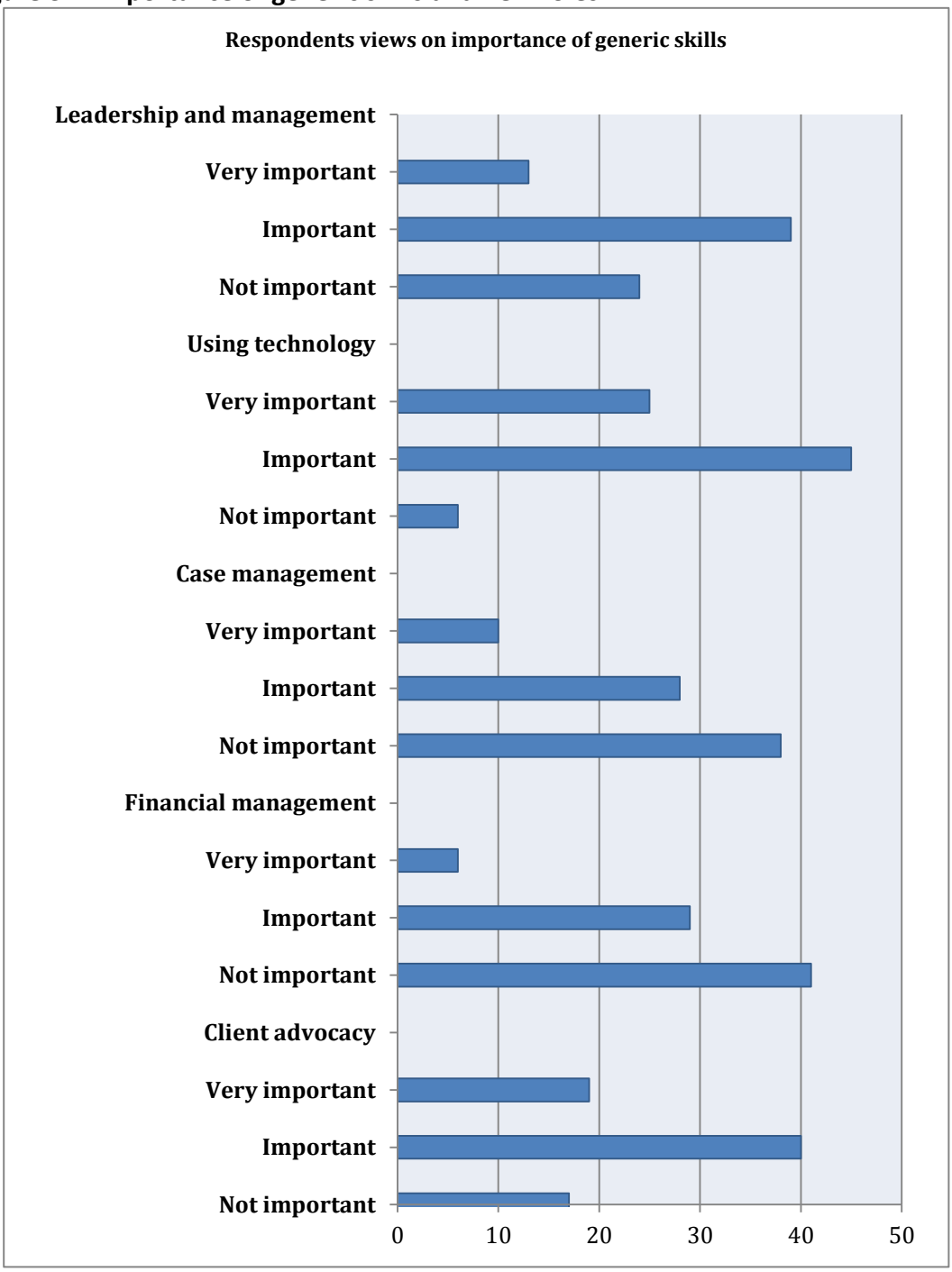
3.8 Generic skills

Respondents were asked to nominate whether the following generic skills were important in these roles or functions:

- Leadership and management

- Using technology
- Case management
- Financial management and
- Client advocacy

Figure 3.1 Importance of generic skills and new roles



The most important skills nominated were in using technology, leadership and management and client advocacy, whereas the least important skills were financial management and case management. Respondents pointed out that case management was not an appropriate term to

use with assistants and support staff, especially in the mental health sector. There were however, some respondents in the clinical coding area who nominated case management as important.

Leadership and management were not considered at all important for assistants in nursing who work under supervision. Other respondents suggested that supervision including mentoring and coaching were more appropriate terms for assistants and support workers rather than leadership and management.

Other generic skills cited as important were:

- cultural competence in relation to indigenous and CALD clients
- networking in the community, and
- working in a team.

3.9 Conclusions

The most significant changes identified were in aged care and HACC and disabilities because these jobs will involve a different emphasis, with consumer directed care and inclusiveness, and this needs to be reflected in the training. The monitoring of health was an important key area across these occupations as was improved communication skills. This will be a challenge, as many employees have poor literacy skills and ESL backgrounds. Another common theme was ensuring support workers understand their own role, its boundaries and referral mechanisms.

4. Training

4.1 Introduction

In considering new and emerging job roles and related skills and knowledge, it is important to ascertain the impact that these will have on relevant training package qualifications, units of competency and training approaches in general. Current training package reviews are already addressing some of these issues. This was commented on positively by those stakeholders who were aware of these processes. The current review is also strengthening assessment and practical placement requirements.

This section also records inhouse and workforce development training undertaken on the job to address new and emerging job roles or required skills and knowledge.

Stakeholders were provided, in their consultation guide, with proposed changes already identified in Stage 1 of this project and organised in relation to potential units of competency. These tables were commented on and adjusted in line with their responses and are contained in Appendix C.

This section will report on stakeholder views about:

- current training package qualifications in relation to new and emerging training needs
- units of competencies in relation to new and emerging training needs
- workforce development training to fill skill and knowledge gaps, and
- limitations and unmet needs in current training.

Some of the common themes across all stakeholder groups were:

- Core units of competency in all qualifications need to reflect the reforming approaches in the workplace around new service models as well as early intervention and prevention.
- Essential core skills for assistants and support workers should be based on an analysis of crucial risk factors relevant to the client groups that they support.
- Different working contexts and clients need to be reflected in qualifications.
- Imported business services (BSB) units of competency are not always suitable to the health environment.
- Clinical or practical placement hours are essential.
- Criticisms of the quality and duration of delivery, especially of Certificate III. This also included the quality of assessment practice and recognition of prior learning (RPL).

4.2 Training packages and new roles

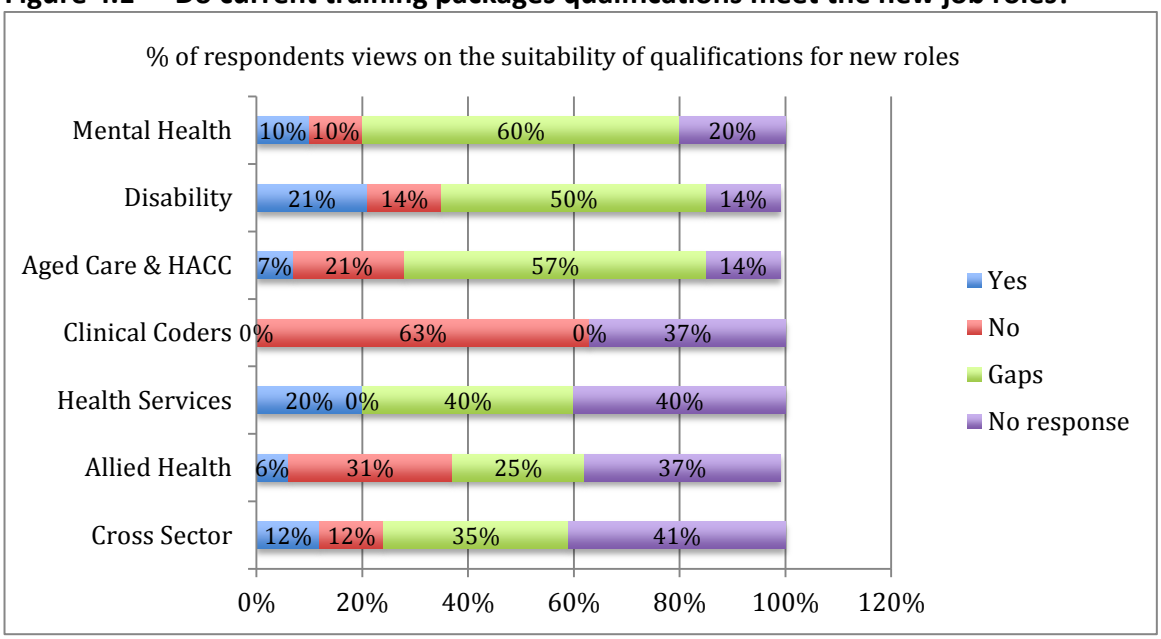
Respondents were asked whether current training package qualifications met the requirements of these new and emerging roles. Their responses fell into four categories which are illustrated in Figure 4.1 below.

Respondents who said that training packages would meet emerging job roles, in disability and aged care, were usually involved in the current review by the CS&HISC.

The majority of respondents identified gaps in training packages in relation to new, emerging areas. In many cases they offered some suggested changes, usually in terms of a review of units of competency. Many of these suggested changes are in keeping with those emerging areas reflected in Section 3 of this report. They are also recorded and mapped to existing qualifications in Appendix C.

In the area of clinical coders there was unanimous agreement that the current qualifications were not appropriate. In the respondent categories of cross sector, health services and allied health there were large numbers of respondents who did not know the detail of training packages qualifications to comment. These are recorded as 'no response' in the figure below.

Figure 4.1 Do current training packages qualifications meet the new job roles?

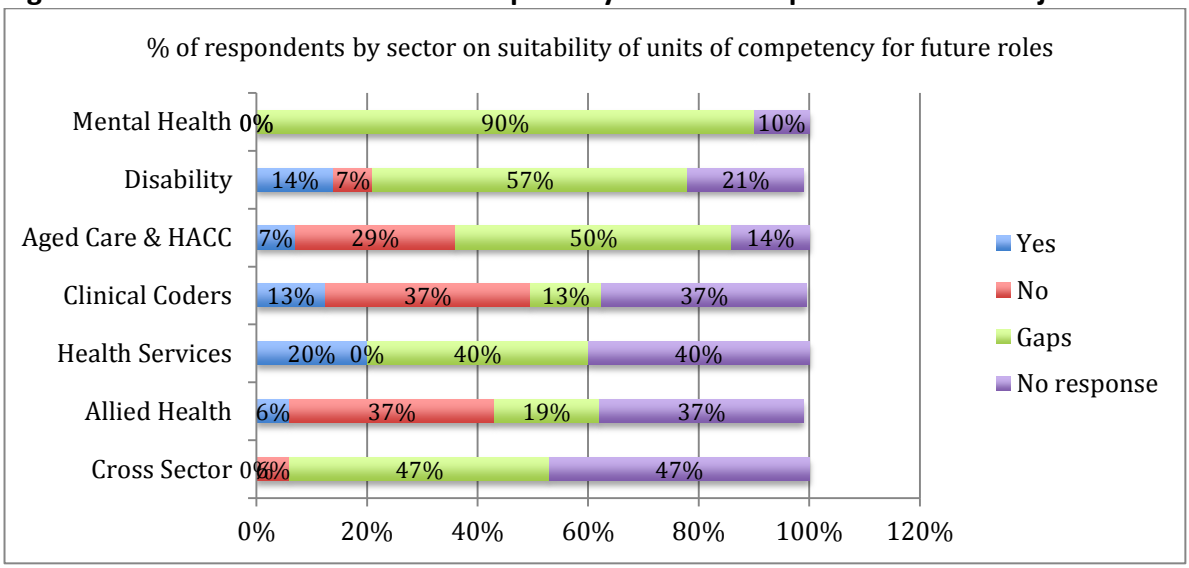


In answering the question on training packages, respondents made positive comments about competency based assessment and a large selection of electives. There was only one respondent who suggested that there were too many electives and that this is confusing for employers.

Many respondents also stressed the importance of the delivery of the qualification and the inclusion of practical placements or on-the-job training. In many cases respondents did not separate the training package requirements and the delivery of training,

> *The delivery of the Training Package could improve. For example, a Workforce Innovation Project is addressing the quality of training through better recruiting, less RPL, more time spent on training and more topics covered. This is a good model.*

Figure 4.2 Do current units of competency meet the requirements of new job roles?



As Figure 4.2 above shows, responses about whether units of competency reflect the skills and knowledge for these new roles was consistent with views about qualifications in the allied health, aged care and HACC and the health services areas. Clinical coder respondents' views on units of competency were more varied than their views on qualifications. In the mental health sector, respondents identified gaps in the units of competency. Similarily, there were disability respondents who felt that current units of competency did not address the future needs and there was a larger cohort who could offer suggestions for improvement. For cross sector respondents there were slightly more no responses recorded.

There were a couple of respondents from disabilities and allied health that remarked that there was repetition across the units of competency.

4.3 Allied health assistants

Respondents had diverse views about the Certificate III and IV in Allied Health Assistance qualifications with some describing the range of electives as good whereas others saw them as limited. Respondents referred to the grouped electives for physiotherapy, podiatry, occupational therapy, community rehabilitation and nutrition and dietetics.

As one experienced practitioner stated,

> *Certificate IV AHA is good, provides plenty of streams and is relevant. It is flexible and we are happy with the content as the units work well when delivered in different contexts.*

Other respondents found that offering a few electives for each area of AH specialty was limiting and often did not provide the AHA with enough skills to use on the job.

Other respondents identified gaps and said,

> *The Certificate IV in Allied Health Assistance currently does not address motivational issues, interviewing skills, supervision and leadership skills.*

We consider that the skills required for the potentially changed roles of AHAs in the future, involving more specialised and complex patient care, will not adequately be covered by the current courses available .

Many respondents from hospitals and the allied health profession preferred their AHAs to undertake the certificate IV because of the work requirements. These respondents believed that this should be the minimal level qualification. The allied health managers stressed the need for AHA qualified graduates to have skills in practical tasks such as running exercise groups or monitoring nutrition plans, under the supervision of the allied health professional. They also required communication skills to work as part of a multidisciplinary team as well as with clients. They suggested that the core should be relevant and supported with plenty of electives to select from according to the training needs. There was also a suggestion that infection control skills and knowledge needed to be more substantial.

Extend training beyond a basic knowledge of infection control, as AHAs need to be aware of the types of products and techniques to use for different types of infections .

There were some concerns raised about the podiatry electives being at a high level,

The current package offers many core and elective units that could be tailored to meet quite a wide variety of AHA roles, especially if wanting a generic qualification. However the four core podiatry units for a student wishing to be a AHA podiatry specialist are more reflective of the work an AHA may be exposed to in a high level, broad scope private practice rather than an aged care or community health work place.

whereas another hospital manager found them not to be suited to their environment in terms of training AHAs.

Other electives suggested were in mental health, dementia, health promotion, basic exercise programs and patient centred care. It was suggested that the three units related to mental health in the ertificate IV AHA were suitable to form an elective group for mental health work:

- CHCMH411A Work with people with mental health issues
- CHCM301C Work effectively in mental health settings
- HLTCSD306D Respond effectively to behaviours of concern.

A new role mentioned was an advanced allied health assistant, but there were varying views on this role as can be seen in the state and territories chart (Table 1). As there is a leadership role emerging with more experienced allied health assistants, it was felt that the scope of an advanced allied health assistant needs to be explored with the potential development of a AHA diploma. Several respondents pointed out that such a title (advanced AHA) is problematic as it would not necessary be reflected in state awards.

An advanced allied health assistant project was undertaken in the ACT from February–July 2013. The project consisted of a literature review, consultation with other states, consultation with allied health assistants and their managers across ACT Health, Calvary Healthcare and Therapy ACT, consultation with allied health assistant students as well as consumers. The project report is currently being finalised.

Respondents discussed newer areas for AHA electives in audiology but thought there maybe overlap with nurse audiology. Several respondents mentioned that the AHA nutrition electives may overlap with Certificate III in Nutrition and Dietetics Assistance, and that the current prerequisite units of competency, for nutrition and dietetics electives, in the AHA Certificate IV needs review.

Some stakeholders received feedback from industry expressing concern that three pre-requisite units required for students to specialise in nutrition and dietetics appeared to contradict the principle that the dietitian is responsible for developing menus, and prescribing therapeutic diets and meals. It was acknowledged that these prerequisite units were incorporated from the Certificate III in Nutrition and Dietetic Support.

These units are:

- HLTNA304D Plan meals and menus to meet cultural and religious needs
- HLTNA303D Plan and modify meals and menus according to nutrition care plans
- HLTNA302D Plan and evaluate meals and menus to meet recommended dietary guidelines.

Further feedback expressed concern that the current training units do not adequately support AHAs to acquire the competencies required in the current service delivery environment. Another barrier mentioned in relation to delivering the nutrition and dietetics specialisation was the number of prerequisite and required units (7-8) for students to meet the requirements of this specialisation. It was felt that the requirements were onerous and repetitive and could be streamlined to better reflect the role of an AHA in nutrition and dietetics services.

Finally, respondents emphasized the importance of AHA supervision frameworks summed up succinctly by this stakeholder:

> *Any potential changes to training should reflect that allied health professionals are responsible for patient diagnosis and overall care and treatment plans, while the AHA is involved in the delivery of care and treatment.*

4.4 Health service assistants

Assistants in nursing (AIN) work in a range of different contexts and stakeholders suggested that units of competency should be reviewed with this in mind. Currently, the context reflected in the training package qualification (HLT32512 Certificate III in Health Services Assistance) for AIN work is in acute care. Consultations suggested new contexts that need specific units are in aged care and mental health. An addition of mental health competencies and aged care competencies were suggested as employment in both these areas is increasing for AINs.

Stakeholders suggested that assistants in nursing (AIN) electives should reflect a range of different work contexts and that the communication unit (HLTHIR301C Communicate and work effectively in health) needed further contextualisation.

BSB imported units were not always considered suitable and needed better contextualisation. There are two imported units in the core as well as elective units:

- BSBFLM303C Contribute to effective workplace relationships (core)
- BSBMED301B Interpret and apply medical terminology appropriately (core)
- BSBFLM312C Contribute to team effectiveness (elective)

- BSBINN301A Promote innovation in a team environment
- BSBMED301B Interpret and apply medical terminology appropriately
- BSBWOR301B Organise personal work priorities and development

It was suggested that there is the need for a legal unit of competency to cover the scope of practice for the AIN in privacy and confidentiality.

Practical placement was considered a vital component of the delivery of the qualification. In this qualification for AINs the importance of placement was stressed, as expressed by this stakeholder,

> *Clinical hours will assist in the qualification being delivered correctly and in the correct time frame allowing students to actually achieve clinical competence.*

There was little change noted for other health service assistants such as patient services assistants.

4.5 Clinical coders

Clinical coder respondents were dissatisfied with the current qualifications as there was only one unit of competency related to entry level coding and the other units did not prepare staff to work in coding roles. In NSW, the clinical coders were being trained using Certificate III and IV in Health Administration, but there was recognition of limitations in the specific units of competency for coding in these qualifications. All stakeholders stressed that trainee coders need exposure to the real world through placements and access to authentic patient records and case studies. A prerequisite of computer competence is also required.

An on-the-job component was considered essential and worked well where there were traineeships, as in NSW and WA. The Victorian Health Department has developed their own competencies for clinical coders and are exploring accreditation. Health Workforce Australia has reviewed existing and future competencies required for developing the future health information workforce.[26]

There are insufficient coding units and the imported business units are not considered suitable. Respondents questioned the level of the current units and suggested *HLTCC402B Complete highly complex clinical coding* was more suited to a diploma level. Other respondents suggested that you need experience to do the unit HLTCC401B Undertake Complex Clinical Coding and extensive experience to do HLTCC402B Complete highly complex clinical coding. This stakeholder summed up others' views,

> *Certificate III in Health Administration The qualification has only one clinical coding unit of competency (HLTCC301B Produce coded clinical data) and standard medical terminology (BSBMED301B Interpret and apply medical terminology appropriately). The medical terminology unit is not sufficiently detailed to provide adequate background knowledge for students undertaking the clinical coding unit HLTCC301B.*
> *Certificate IV in Health Administration*
> *This qualification includes two coding units at significantly different levels HLTCC401B Undertake complex clinical coding and HLTCC402B Complete highly complex clinical coding.*

Other units do not reflect the workplace needs or roles of clinical coder and senior clinical coder. For example, senior clinical coders are expected to code at fairly complex levels not necessarily to supervise, coach or mentor other staff. Many of the Certificate IV units imply a supervisory role. HLTCC402B should be placed at a diploma level .

Another commented that the existing roles required the following:

Trainee clinical coder – HLTCC301B Produce coded clinical data (certificate III level)
Clinical coder – HLTCC401B Undertake complex clinical coding (certificate IV level)
Senior clinical coder – HLTCC402B Complete highly complex clinical coding (diploma level)
And for new roles such as the Clinical coder educator and auditor roles:
CC Educator – HLTCC402B plus TAE or skillset
CC Auditor – HLTCC402B plus La Trobe University auditing course.

The Victorian Health Department have identified through their research that additional units of competency are required. They have identified a capability framework, in the following areas:

- work effectively in the health system
- prepare to work as a clinical coder
- apply knowledge of the health system for clinical coding
- access and use information from medical records
- abstract clinical information to support clinical coding
- assign codes to an episode of care
- ensure quality of clinical coded data[27].

They also suggest through industry feedback that a qualification should be at a certificate IV level and include some already existing units in the Health Training Package.

Stakeholders said that at the moment clinical coders complete the Health Information Management Association of Australia (HIMAA) qualification, which consists of the three existing units of competency.

On-the-job training is important:

Current training needs to be strengthened. On the course scenarios are given but they are not realistic as to what happens in a hospital. Need on-the-job or placements in the training (Coder Manager).

Stakeholders identified limitations in current graduates in the following areas:

- understanding of the health system
- understanding the role of a clinical coder and practical experience
- understanding of hospitals' systems and medical records
- understanding and applying medical terminology, anatomy and physiology and pharmacology
- skills in abstracting and applying coding standards

- communication skills – both between coders and other health information workers and clinicians.

4.6 Aged care and HACC

In aged care and HACC stakeholders identified that changes were needed to meet emerging skills. As one interviewee stated:

> *Training packages are a catch up but provide a solid base. It is good they are reviewed and updated because they cannot always catch emerging skills.*

There were many suggestions for improvement indicating what needed to be added to the units of competency and the qualifications:

- responding to mental health issues apart from dementia
- aged care and sexuality
- diversity in aged care (e.g. lesbian, gay, bisexual, transgender and intersex (LGBTI))
- palliative care
- cultural diversity
- financial skills
- communication skills
- work health and safety (WHS) for home workers
- nutrition
- health issues such as hydration
- technology
- working with families (suggested as a core unit).

Several aged care respondents expressed support for the CS&HISC new qualification around 'individual support'. Other stakeholders suggested that the core units in future aged care and community support qualifications should be:

- *WHS in the home.*
- *Dealing with families and clients (How to deal with competing priorities in the family: with individuals; conflict with families and communicating with families).*
- *Health problems such as alcohol problems. Obesity means that carers in homes will have to make higher level decisions, face ethical dilemmas, address health and safety decisions and understand medical conditions.*
- *Home workers will be involved in complex processes, such as client advice in relation to getting the best outcome for the client and managing the competing interests.*

Stakeholders suggested that skills sets such as for 'medication' are not properly picked up. Another specialist organisation suggested that the skill set for dementia needed review to have units of competency which focus on communication with people living with dementia,

understanding why behaviours have changed and how to develop strategies and implement responses to these behaviours which enhance the well-being of people living with dementia.

Several stakeholders mentioned that the delivery time for the aged care qualifications was not sufficient.

4.7 Disability

Disability stakeholders also offered many suggestions as to how training package qualifications could improve. There needs to be a strong emphasis on placement in all the qualifications and training related to disability.

It was suggested that medication training was needed for administering eye drops and topical medicines. This is covered in *CHCCS305C Assist clients with medication*, an elective in certificate IV, but may not be commonly delivered and if the student does not have practical experience, they would not gain this skill adequately. Other areas mentioned were :

- positive behaviours skills set
- person centred care - dignity, rights, supported decision making
- managing finances
- human rights
- understanding philosophies of working with disabilities
- understanding healthy bodies
- handling complex behaviours[28] and challenging behaviours
- problem solving
- communication skills
- working more autonomously
- decision making and good judgement
- transport skills
- facilitating community inclusion

It was suggested that 'person centredness' needs to be highlighted and that it is covered in specifically designed commercial short courses. Suggested units to be included should cover client relationships, community inclusion, management of behaviours of concern, the aged and degenerative conditions (Table 23).

One respondent suggested that there should be reference to national disability service standards in the advanced diploma and technology skills in the certificate III. It was suggested that an appropriate diploma should be available for a management role of which there currently is with CHC50108 Diploma of Disability. New additional tasks for supervisors and coordinators under the NDIS will need to be added to CHC50108.

As mentioned in 4.6 there was some feedback from a specialist organisation on the lack of suitability of the dementia skill set,

Dementia skill set *CHCAC416A Facilitate support responsive to the specific nature of dementia*

CHCCS401C Facilitate responsible behaviour
CHCICS404B Plan and provide advanced behaviour support
HLTCSD306D Respond effectively to behaviours of concern
The focus is very much around the clinical and organisational processes related to "behaviours of concern". Other than CHCAC416A, the units in this skill set outline performance criteria, knowledge and skills which are applicable for interactions with people who have more cognitive ability than people living with dementia. The skill set should contain units which focus on communication with people living with dementia, understanding why behaviours have changed and how to develop strategies and implement responses to these behaviours which enhance the well-being of people living with dementia.

There was a case put forward by one organisation that disability qualifications include some units on facilitating employment as this will become a more important role under the NDIS.

Some stakeholders said that providing support across these three areas – aged care, HACC and disability – had common skills and that this will allow for transferability of skills for the workers. This was because with the changes in the underpinning philosophy, the three areas are moving closer together. These trends were supported by other stakeholders who suggested the importance of 'understanding healthy bodies' as an essential core and its relationship to mitigating risk factors as well as ensuring support workers were appropriately trained with underpinning knowledge as well as WHS.

4.8 Mental Health

In mental health work, recovery approaches were considered necessary to be integrated into training packages as reflected in work approaches. Workers in this area are faced with increased complexity and dual conditions of co-existing mental illness, substance misuse problems, and dual disability. The use of peer workers was another important theme.

Stakeholders' views on mental health worker training along with the other sectors stressed the importance of having a practical component in the training package,

> *As long as there is a practical component. If there is no practical experience this is a barrier. There needs to have been some experience in engaging and working with clients. We have seen gaps in new graduates in their ability to interact, and put into place the theoretical knowledge of their qualifications (Human resources manager).*

> *There must have exposure to severe and persistent mental illness through placements in mainstream facilities (Specialist mental health worker).*

Similarily, they stressed that it important to use correct terminology and suggested that both 'support' and 'care' imply certain approaches that are counter to empowerment. Stakeholders stressed that it is important that recovery principles are adhered to and reflected in the terminology. *Certificate IV in Mental Health* was regarded as addressing this adequately

> *The Certificate IV in Mental Health in the CHC08 Community Services Training Package has been welcomed by the sector as it better reflects the roles and approach within the community mental health sector and provides an opportunity to explore a recovery focus within the course(Peak body).*

Newer areas suggested by stakeholders as gaps in current qualifications included:

- business skills
- communication including writing skills
- working in a team including time management skills
- basic information technology skills
- duty of care
- understanding of stigma and discrimination, and
- understanding dual diagnosis.

It was suggested in the area of service coordination that the training package is inadequate and there is a need for these skills as people can be leading teams without a qualification and this is set to increase in the future.

Stakeholders in mental health mentioned more than any other area the importance of articulation of VET qualifications to higher education.

4.9 Delivery of training package qualifications

Stakeholders often spoke about the quality of training and in many cases this was linked to the length of time spent on a certificate III or IV,

> *Training packages are 'getting there' and need further work, but the training delivery is not always consistent and true to the training packages (HACC, Training and Workforce Development Manager).*

Criticisms of the duration of certificate III and IV qualifications training and the lack of practical placements were often mentioned. All stakeholders stressed the importance of learning in the workplace. In some states, this was addressed through traineeships in allied health assistants, assistants in nursing and clinical coders.

There were many concerns expressed about too much RPL and the quality of the assessment.

4.10 Limitations in current training

Stakeholders were asked to nominate any limitations or unmet needs in training and these were common across all groups:

- access to training, especially for rural organisations
- availability of training or particular qualifications in their local area
- funding to pay for training and staff replacement
- variability in the quality of training
- people training online without any practical placements, and
- unsuitable instructors who do not have varied and current vocational experience.

Allied health assistants

For AHA training a limitation identified by several stakeholders was that training stops at certificate IV level and that limited numbers of RTOs in their immediate location, deliver the

certificate IV. Stakeholders also said that it was essential to have basic discipline-specific knowledge applied through adequate specific skills training, delivered in practical experience-based training.

Health service assistants

Stakeholders identified the quality of training, RPL and limitations in gaining experience as the major concerns about current training.

Clinical coding

According to stakeholders, the current training options for clinical coders were not considered suitable and had to be supported by on-the-job training. NSW and WA were exceptions as they had established traineeships. Stakeholders said that graduates can experience difficulty finding employment due to a lack of exposure to practical coding, and a lack of essential knowledge about funding and coding topics.

Information managers also lacked time to train coders on the job. Another stakeholder suggested that the time required to complete coding competencies was also a concern. For example HLTCC301B needs 200 hours.

Aged care and HACC

Stakeholders felt that aged care and HACC training needed to cover staff movement between contexts such as residential and in home and community care. Also, it was suggested that WHS in a home setting needs further work.

Disability

In the disability sector the quality of training and the suitability of trainers delivering the theory was regarded as a concern. There were examples given by stakeholders of the short duration of the training and no work placement. Other RTO stakeholders suggested that work placements were a vital component of the qualifications and exposure to apply the learned theory was essential. Other concerns raised were being able to address the literacy needs of students in the training and the seemingly extensive use of RPL.

Mental health

Stakeholders identified these limitations in current training:

- lack of resources for peer support training
- quality of training and RTO monitoring
- accessing training
- students not being trained to work with people, due to no experience with people in the course and no practical placement
- lack of transferability between working contexts
- uniformity across diplomas in disability and mental health
- a suitable diploma, and
- better training in communication, care plans and funding (business management), managing rostering and change in the organisation.

4.11 Training to address changing roles

Respondents were asked about workforce training that occurred outside the training package to address current skill needs and also unmet training needs where there was no identified training. The two questions asked were:

- Are you aware of the current training that is undertaken to address these changed roles (e.g. In-house training)?
- Can you identify new areas or emerging areas where currently no training exists?

Table 18 lists the examples of training or the lack of training reported by stakeholders.

Allied health assistants

Training for AHA relates directly to the tasks that they need to perform on the job. Often there would be additional skills taught on the job as well as workplace procedures. One stakeholder commented on the quality of this inhouse training

> *This training is non-standard, can be ad-hoc, and is often described as inadequate – particularly when the AHA works across a number of units and disciplines. It is also subject to time and resource limitations .*

There were however examples of consistent workforce training

> *… a small number of departments report a systematic approach to AHA training, with one respondent reporting that this training may continue for more than one year to ensure that all competencies for working at the organisation are reached.*

Table 18 AHA workforce training

Workforce training	No identified training
AHA-OT - in basic occupational therapy tasks, and to respond to changing roles/functions.	Advanced AHA - no formal training.
In-house competencies on home modifications for the AHA –OT.	AHA occupational therapy – technologies.
In house for podiatry assistant.	AHA psychology.
On the job AHA occupational therapy training.	AHA social work.
Hydro -therapy and its importance.	AHA medical imaging.
Clinical documentation & protocols.	Patient centred care/consumer care.
NDIS and work changes.	Dietetics and nutrition.
Aboriginal health issues.	Clinical areas, such as mental health, stroke, dementia - but best addressed on the job.
Diabetics.	
Palliative Care.	

Health service assistants

Health service assistants were provided with inhouse training on a number of client care strategies and information about certain conditions.

Table 19 HSA workforce training

Workforce training	No identified training
AIN	
Person centred care/ client directed care.	Understanding the scope of one's own practice.

Workforce training	No identified training
Disability.	
Awareness of professional roles.	
Field placement in an acute setting.	
Legal issues.	
Behaviours of concern.	
Dementia.	
Aggression minimization.	
Mandatory compliance training.	
Online modules e.g. suicide prevention.	

Clinical Coders

The Health Information Management Association of Australia Limited (HIMAA) delivers three units of competency from the HLT07 Health Training Package for clinical coder training. These units of competency are mapped to three clinical coding courses previously delivered by HIMAA in Australia as Introductory ICD,10-AM, ACHI and ACS, Intermediate ICD-10-AM, ACHI and ACS and Advanced ICD-10-AM, ACHI and ACS.

HIMAA also delivers a comprehensive medical terminology course which meets the prerequisite knowledge requirement for the unit of competency HLTCC301B Produce coded clinical data. This comprehensive medical terminology course is not nationally recognised training but is recognised within the health information profession throughout Australia as the benchmark for comprehensive medical terminology training for clinical coders.

Table 20 HIMAA course

Unit of Competency	HIMAA clinical coding course
HLTCC301B Produce coded clinical data.	Introductory ICD-10-AM, ACHI and ACS.
HLTCC401B Undertake complex clinical coding.	Intermediate ICD-10-AM, ACHI and ACS.
HLTCC402B Complete highly complex clinical coding.	Advanced ICD-10-AM, ACHI and ACS.

Inhouse training undertaken by clinical coders included the following listed in Table 21.

Table 21 Clinical coder workforce training

Workforce training	No identified training
Information technology.	Hands on experience, e.g. traineeship.
Clinical seminars conducted by doctors, e.g. neurosurgery, cardio seminar.	No coding specific course.
Application of skills.	No training exists in clinical costing.
Body systems.	No specific coder educator course.
Auditing for managers – La Trobe University.	Auditing course for clinical coders.
Health information management degree - Curtin University (addressing existing roles).	
Coding units and comprehensive medical terminology – HIMAA (addressing existing roles).	

Aged care and HACC

Stakeholders felt that in aged care and HACC there was a great deal of ad hoc training and it was important to link it back to training packages. Workforce training was undertaken which focused on working with different clients, conditions and new policy approaches.

Table 22 Aged care and HACC workforce training

Workforce training	No identified training
ICT skills.	Different contexts.
E-learning.	WHS in the home.
Consumer directed care.	Assistant technology.
Identifying client needs.	CDC financial skills (packaging up care).
Enablement training.	Technology training.
Mental health first aid.	Case management.
Mental health and ageing.	Nutrition.
Working in diverse teams	Infection control.
Understanding and implementing professional boundaries.	Wound care.
Aggression management in dementia.	Management of diagnosed mental illness.
Preventing elder abuse.	Financial (BSB unit not appropriate).
Technology.	
Dementia.	
Sexuality.	
Palliative care.	
Nutrition .	
Coordinating support workers.	
Food handling.	

Disability

Workforce training in the disability sector was to prepare for the NDIS and focused on client centred care. There was a need for further training in this sector.

Table 23 Disability workforce training

Workforce training	No identified training
Human Rights Framework.	Rights and values.
Person centred care.	Planning.
Client directed care.	Understanding the scope of one's own practice.
Fire and evacuation.	Local area coordinating and community development.
Challenging behaviours.	Positive behaviours skill set.
Advocacy.	WHS for an autonomous worker .
Client financial management.	Supportive decision making- clients with cognitive impairment or communication disability.
Current views in disability.	Dealing with behaviours of concern.
Inclusion.	Specialist dementia.
Dementia.	Leadership including team effectiveness and reflective practice.
	Aboriginality and disability.
	Mental health.
	Management and leadership.
	Client broker.

Mental health

Approaches to mental health work were covered in the range of workforce inhouse training offered and new approaches suggested further training sessions were needed around care plans and financial management.

Table 24 Mental health workforce training

Workforce training	No identified training

Workforce training	No identified training
Induction pack for partners in recovery.	Trauma informed care and practice.
Support for facilitators (talking therapy).	Business acumen.
Working in a multidisciplinary team.	Cultural considerations in the health context.
Mental health first aid.	Practical placement component.
Recovery model training.	Care plans and funding (Business management).
Care coordination training.	Managing rostering.
Transition to support facilitator.	Change in the organisation.
Manual handling.	Communication.
Hand washing.	
Aggression management.	

4.12 Conclusions

There were suggestions of changed or further development of competencies in training packages to meet future needs. There was support for eradicating repetition in units of competencies. A significant number of respondents did not know the qualifications and competencies in enough detail to comment.

Consultations stressed that in the context of the demands for the workforce, especially in aged care, disability and mental health that appropriate training was very important. There was a strong theme of safety ensuring that worker competence was balanced with demand in some areas and in some locations. Risk and safety were important indicators to consider in training design, so that workers would be appropriately skilled when working with vulnerable clients.

5. Conclusions and recommendations

This section makes general recommendations as well as specific ones relevant to each occupational area and current qualifications. The details in relation to the mapping to current units of competence is contained in Appendix C.

5.1 Changes in assistant and suppport worker roles

Assistant and support worker roles are changing rapidly due to service delivery models requiring new skills and knowledge in the areas and client groups in their work.

In this consultation stakeholders identified different causes for changes occurring in the job roles of assistants and support workers in the community service and health sectors. In addition, common factors across all areas were the NDIS, workforce changes, funding and consumer directed care.

The most significant changes in jobs noted by stakeholders were in aged care, HACC and disability work because these jobs will involve a different emphasis with consumer directed care and inclusiveness. This will need to be reflected in the training. Monitoring of health was an important key area across these occupations, as was improved communication skills. As many employees have poor literacy skills and ESL backgrounds, this will be a challenge. Another common theme was ensuring support workers understood their own role, its boundaries and referral mechanisms.

Scope of practice

This consultation on assistant and support worker roles confirmed that further detailed work is needed regarding these rapidly changing job roles. Even though there was a great deal of agreement about new skills and knowledge there was not a consensus about the nature of new roles and responsibilities. There was a lack of consistency across states and sectors in the roles and functions of health care assistants and community support workers, which was evidenced in these consultations as well as through a scan of employment advertisements.

The three health sector jobs work under supervision which in turn determined the type of skills needed by the people in these jobs. Disability, aged care and mental health jobs were demanding more of the support or assistant who may work on their own.

All of the roles in this project showed significant changes. Further consultation is required to determine the scope of the occupation under study. All of these areas will be subjected to changes that need to be reflected in qualifications and units of competency

Recommendation 1

It is recommended that a consultation strategy be devised based on the information in this report. The strategy should further scope the job roles and in turn refine the units of competency and qualifications for assistant and support worker roles. It should devise a comprehensive consultation process to review, validate and obtain stakeholder feedback on the scope of the assistant and support worker roles in relation to new and emerging areas.

Person centred practice

All of the direct service positions in this study will be influenced by person centred practice. Also termed person centred care, consumer directed care, client focused care, client centred care and customer focused service. Stakeholders stressed that it is the person centred approach

which required a major change in the way assistants and support workers will operate towards clients.

Client led models of practice place the 'needs of the client at the centre' rather than the needs of the service provider or worker. In most cases stakeholders suggested that assistants and support workers will be implementing plans devised by supervising staff, but the support worker needs to understand the requirements of both person centred care and how that defines the nature and boundaries of their job. They will require a better understanding of the system, funding and moving from an 'illness' to a 'wellness' model.

Certificate III and certificate IV qualifications in AHA, HSA, aged care and HACC, disability and mental health will need to be reorientated with this underlying philosophy reflected in the core and elective units of competency. Language in the qualifications should reflect contemporary usage, such as ' support' rather than 'care' and reflect appropriate approaches such as 'recovery'. This was particularly the case in aged care, HACC, disabilities and mental health work

Recommendation 2

It is recommended that Certificate III and Certificate IV qualifications in AHA, HSA, aged care and HACC, disability and mental health are reviewed to ensure that terminology and content reflect the required approach of person centred practice.

Recommendation 3

It is recommended that the mapping of new skills, knowledge and roles in this report be used as a guide to commence this review (Appendix C).

Supervision roles

For five of the occupational groups in this study it was suggested that there was a need for higher order skills and knowledge to be reflected in diploma level qualifications. For allied health, clinical coders and mental health these skills were related to complexity of practice. For aged care, HACC and disabilities there were new roles related to coordinating and brokering in relation to new funding models and consumer choice in service delivery.

Recommendation 4
It is recommended that current diploma qualifications related to new roles be reviewed and revised to ensure that they include units of competency that reflect the new and emerging senior roles for assistants and support workers (Appendix C).

Practical placements

Almost every stakeholder stressed that qualifications need to skill graduates in current work requirements and that this necessitated a work placement component. Assessment of skills and knowledge had to apply to realistic situations such as handling complex clients and using authentic work place documentation.

Recommendation 5
It is recommended that all assistant and support worker qualifications include a practical placement component in assessment requirements.

Allied health assistants

The allied health assistance area was notable for the overall lack of agreement between the states and territories about new and emerging roles. There was no consensus on the new and emerging roles. **Social work assistants** were being used in some states, but were opposed by both professional bodies: Australian Community Workers Association and Australian Association of Social Workers. In Victoria, Tasmania and Queensland there was active support for these roles whereas in other states it was stated that this work was adequately covered by welfare workers, counsellors or administrative staff.

Similarily, there was interest in the **advanced allied health** assistant role in Victoria, Queensland and ACT but this was also opposed in several states. AHA radiation therapy was supported in some states, but opposed by the industry in others. Other areas identified were: AHA emergency; AHA medical physics and radiation therapy and AHA in paediatric settings.

Changes identified for AHA cover the working contexts, diversity in clients, improved knowledge on health issues, better communication skills and changing working relationships, such as working in a multidisciplinary team.

There needs to be more consensus around new allied health assistant roles from the allied health community in order to be able to adequately devise appropriate training.

Recommendation 6
It is recommended that further units of competency be developed to support emerging roles, skills and knowledge. Their development should include gaining support from the industry (Tables 2, 3 and 4 and Appendix C).

Health service assistants

Assistants in nursing (AIN) increasingly worked in a range of different contexts. Consultations suggested new contexts that need specific units were in aged care, including palliative care and mental health, including dementia. Currently, working mainly in acute hospital care and aged care, it was suggested that AINs may extend their roles to include such settings as the newborn care unit, working with children and parents or in community settings.

With AINs there was an increased need to understand health issues, especially healthy body systems and identifying risks in aged care such as recognizing deterioration and decline; falls prevention; dehydration; medication safety and to know when to refer. This needs to be reflected in the training.

Stakeholders suggested that was important that the AIN understood their scope of practice and safety in the workplace as well as working in a team and a legal framework. The communication unit (HLTHIR301C Communicate and work effectively in health) needs further contextualisation. The BSB imported units were not always considered suitable to the health context and the requirements of working in multidisciplinary teams with clear supervisory arrangements.

Recommendation 7
It is recommended that further units of competency be developed in HLT32512 Certificate III in Health Services Assistance. These units should incorporate new work environments, especially in mental health and complexity in aged care, for assistants in nursing and patient service assistants (Tables 5 and 6 and Appendix C).

Clinical coders

There was unanimous agreement that there needs to be a qualification developed for clinical coders, because of the lack of suitability of current qualifications. All stakeholders consulted agreed that the area of clinical coding work needed tasks, skills and knowledge redefined.

Both NSW and Victoria have undertaken reviews of the current qualifications and Victoria has developed competencies. Most other States have clinical coder committees. This work should be built on to develop national competencies suitable to the job (refer Section 3.4).

New roles that were emerging and may increase in the future are auditor and educator. Both are senior roles, which could be developed at a diploma level.

Recommendation 8
It is recommended that clinical coding units of competency are developed and used as the basis for a qualification at certificate IV level.

Recommendation 9
It is recommended that senior coding roles in auditing and training be included in a diploma level qualification (Tables 7 and 8 and Appendix C).

Aged Care and HACC

There were a range of new roles identified in aged care. These included: lifestyle coordinator, senior worker in business development, end of life consultant, broker, client facilitator, field technician and case manager. These could be entirely new roles or changes to current coordinator and specialist roles (Tables 9,10 and 11). The coordination level worker will require skills and knowledge in funding, service models and diverse clients. Marketing and attaining funds in a contested environment will also be a new challenge for coordinators.

Aged care and HACC support workers will be required to facilitate decision making, support social inclusion and social well being to enable independence and wellness. The main areas in which they will be required to develop new skills and knowledge are implementing person centred care, health monitoring, work relationships and safety, working with diversity and handling complexities. The complexities include dementia, mental health and depression and palliative care in the home (Table 10).

Recommendation 10
It is recommended that new roles identified in aged care and HACC are supported by the development of units of competency to be included in the relevant diploma CHC52212 Diploma of Community Services Coordination (Appendix C).

Recommendation 11
It is recommended that aged care and HACC qualifications at certificate III and IV are reviewed and reoriented to new service models and include a range of new units of competency for support workers (Tables 9, 10 and 11 and Appendix C).

Disability

In the disability sector there were a range of new roles identified by stakeholders. These were client broker; business planner; team leader and senior support worker; planner; local area coordinator; dementia consultant; personal assistant; financial advisor; employment facilitators and specialist consultants. These roles need to be reflected in the CHC50108 Diploma of

Disability. This qualification covers workers who are responsible for the coordination and management of agencies delivering services to people with a disability. These roles will change significantly in the NDIS.

There were also a number of significant core areas that will require a change in how support workers go about their work and the skills and knowledge that they will need to support people more effectively and appropriately. These included understanding and applying person centred care and individualised funding, self management and applying boundaries and responding to a range of complex conditions.

Recommendation 12
It is recommended that current disability qualifications at certificate III, IV and diploma level are reviewed in line with the changing skills for coordinators and support workers in person centred care, individualised funding, changing work environments and complex conditions (Tables 12, 13 and 14 and Appendix C).

Mental health

Stakeholders believed that there was a need for people to have a greater skill level in the field of mental health because the needs of the clients were more complex and there was a greater incidence of comorbidity.

New roles mentioned included consumer specialist worker – increased involvement with consumers and carers, aboriginal mental health liaison officer, community and support facilitators working with a team and interacting with different agencies and employers.

In mental health work, recovery approaches were considered necessary to be integrated into training packages and reflected in work approaches. Workers in this area were faced with increased complexity and dual conditions of co-existing mental illness and substance misuse problems, and dual disability. The use of peer workers was another important theme.

It was suggested that the training package is inadequate for the area of service coordination. There was a need for this to be reviewed as people can lead teams without a qualification. This is set to increase in the future.

Stakeholders in mental health mentioned, more than any other area, the importance of articulation of VET qualifications to higher education.

Recommendation 13
It is recommended that current mental health qualifications at certificate IV and diploma level are reviewed to reflect recovery approaches and the complexity of clients (Tables 15, 16 and 17 and Appendix C).

Workforce training

Stakeholders outlined a range of inhouse and workforce training currently being undertaken by all sectors. These were intended to assist in preparing for changes in roles and tasks caused by the introduction of the NDIS, person centred care, as well as dealing with complex health issues and medication and other learning tasks necessary to fulfill the demands of their jobs. It will be beneficial if available units of competency and skill sets were promoted to the industry to ensure national standards in workforce development training. Accessing and understanding training packages can be difficult for industry personnel.

Recommendation 14

It is recommended that CS&HISC promote the content of current qualifications in meeting workforce needs so that industry is better informed about what is available to use for skill development.

Appendix A Consultation questions

Identifying the occupational areas where new roles or new functions will occur

1. In which occupational group/s do you think changes are occurring in terms of the functions undertaken for existing job roles?

Allied health assistants
Health service assistants
Clinical coders
Mental health workers
Aged care workers
Home & Community Care HACC
Disability services workers

Names of job roles that will be the focus of the interview

2. What is causing the changes in the area where you are working?
3. Are you aware of any new and emerging job roles in or related to the above areas of work? Are these new jobs or new tasks in current jobs?

Changes in roles and new skills and knowledge

4. Are you aware of any additional duties/ tasks/skills or knowledge **current** workers need to respond to because of changes in their work?
5. Do current training package qualifications meet the requirements of these new job roles?
6. Do the current units of competency reflect the skills and knowledge for these new jobs?
7. Are you aware of any additional duties/ tasks /skills or knowledge **future** workers will need?
8. How important are these skills in these new roles or functions?

Leadership & management**;** Using technology; Case management; Financial management; Client advocacy; Other

9. Will the titles of jobs in these occupational groups change?

Training

10. Are you aware of the current training that is undertaken to address these changed roles?
11. Can you identify new areas or emerging areas where currently no training exists?
12. Are there any limitations or unmet needs in the current training?

New Approaches

13. Are you aware of any reports or projects currently being undertaken to respond to these changing roles or functions?
14. Do you have any further comments?

Appendix B Stakeholders

Organisation	Name		Position
Allied Health Professions Association (AHPA)	Lin	Oke	CEO, Allied Health Professionals Association, Australia
Allied Health Professions Association (AHPA)	Christina	Wilson	Senior Advisor Professional Issues, Speech Pathology Australia (AHPA representative on CS&HISC Direct Care)
ACT Health Directorate	Leanne	Pagett	Allied Health Assistant Clinical Development Coordinator
Royal Rehabilitation College, NSW	Sue	Steele-Smith	Allied Health Workforce Manager
Allied Health Directorate Western NSW Local Health District , Bathurst	Angela	Firth	Allied Health Workforce Manager
Nepean Blue Mountains Local Health District, Penrith, NSW	Brenda	Elliot	Head of Department, Physiotherapy
Heathcote Health Services, Victoria	Di	Kenyon	Director Clinical Care
St Vincent's Community Rehabilitation Centre, Melbourne	Peter	Hawkins	St Vincents Melbourne Team Leader
Calvary Health Care Sydney	Jodie	Ellis	Senior Clinical Dietician
Bairnsdale Regional Health Services, Victoria	Bernadette	Brown	Manager Workforce Capability and Culture
Australian Community Workers Association	Sha	Cordingley	Chief Executive Office
Australian Association of Social Workers	Glenys	Wilkinson	CEO
Monash Health	Annette	Davis	Allied Health Assistant Advisor, Workforce Innovation, Strategy & Education
Dieticians Association of Australia	Annette	Byron	Senior Policy Officer
Occupational Therapy Australia	Submission from members		
Speech Pathology Australia	Submission from members		
Australian Podiatry Council	Submission from members		
NSW Community Services and Health ITAB	Susan	Scowcroft	Executive Director
Community Services Health & Education Training Council Inc, Western Australia	Ian	Andrews	Executive Director
Health and Community Services Workforce Council, Queensland	Wallis	Westbrook	Executive Director
Health and Community Services Workforce Council, Queensland	Jeff	Pang	Policy Assistant
Health and Community Services Workforce Council,	Vicki	Meyer	Policy & Products Coordinator

Organisation	Name		Position
Queensland			
Human Services Training Advisory Council , Northern Territory	Judith	McKay	Executive Director
Health Services Union (HSU)	Mark	McLeay	
Australian Nursing and Midwifery Federation (ANMF), Canberra	Jodie	Davis	Federal Education Officer
United Voice	Amanda	McCormack	Research Officer
Community and Public Sector Union	Karen	Batt	Federal Secretary Community and Public Sector Union Victoria
Health Workforce Australia (HWA)	Deborah	Law	Policy & Strategy Manager
National Employment Services Association (NESA)	Caroline	Smith	CEO
National Employment Services Association (NESA)	Max	Croft	Professional Development Manager
Department of Health and Human Services, Tasmania	Lee	McGovern	Chief Allied Health Advisor
Department of Health, Victoria	Kathleen	Phillip	Chief Allied Health Advisor of Victoria
Department of Health, Victoria	Claire	Brett	A/Senior Policy Advisor, Workforce Innovation and Allied Health , Health Workforce Unit
Department of Health, Victoria	Christina	Giacominato	Senior Policy Adviser Education & Training Health Workforce
Department of Human Services, Victoria	Nigel	Brand	Principal Policy Advisor, Human Services Workforce Policy
Department of Human Services, Victoria	Jenny	Vizac	Manager, Sector Development Office for the Community Sector
Department of Health Victoria	Dan	Jefferson	Manager, Health Workforce Unit[29]
Ministry of Health ,NSW	Robyn	Burley	Director of Workforce Planning & Development Branch
Ministry of Health , NSW	Timothy	Burt	Associate Director, External Relations, Workforce Planning & Development Branch
Queensland Health	Paul	Stafford	Acting Executive Director Leadership Unit
Rural Health Alliance	Wendy	Downs	
Rural Health Alliance	Gordon	Gregory	Executive Officer
Rural Health Alliance	Helen	Hopkins	Policy Advisor
Mental Health Coordinating Council (MHCC)	Tina	Smith	Senior Policy Officer Workforce Development
VICSERV, Victoria	Sue	Harrison	Coordinator
Queensland Voice QLD	Noel	Muller	President
blueVoices NSW	De	Backman-Hoyle	National Mental Health Consumer Carer Forum (NMHCCF)
Richmond PRA/Buckingham House	Donna	Shrubsole	Coordinator, Street Surry Hills
Specialist Aboriginal Mental Health Service	Michael	Mitchell	
Mental Health Directorate ,Central Adelaide Local Health	Anthony	McPhail	Acting Manager, Elpida House,

Organisation	Name		Position
Network, SA			Community Rehabilitation Centre,
Central Adelaide Local Health Network, SA	Jane	Dray	Clinical Psychologist
Central Adelaide Local Health Network, SA	James	McCance	Mental Health Social Worker
Mission Australia, WA	Gia	Harris	Recruitment Consultant
Southern Cross Care (WA) Inc.	Linda	Locke	Manager community mental health
Tasmanian Health - South Statewide Mental Health Services	Sharmayne	Batt	Team Leader
Leading Aged Services Australia, ACT	Patrick	Reid	CEO
Aged and Community Services Australia, ACT	Colleen	Rivers	Policy & Consultancy Manager
Anglicare	Sue	Cook	Acting Director Service Delivery, Anglicare Southern Queensland
Hammond Care, NSW	Natalie	Duggan	Head of Education
Leading Aged Services Australia (LASA) Queensland	Tina	Ison	Education Institute Manager
Benetas, Victoria	Ellen	Flint	Head of Education
Enable College, SA	Amanda	Quarrell	Workplace Trainer Enable College previously Operations Manager HACC
Comlink, Queensland	Vicki	Smout	Services and Development Manager
West Coast Home Care, West Coast Community Services, SA	Diane	Graham	Eyre & Western Collaborative Project Officer Port Lincoln, South Australia
East Maitland Community Health Centre, NSW	Sharon	Lawrence	Site Senior Dietitian and Senior HACC Dietitian
Community West Inc.WA	Jane	Sterck	Training and Workforce Development Manager
OTEN, TAFE NSW	Michelle	Watters	Head Teacher, Community Services
Carers Victoria, Victoria	Denise	Whimpey	Carer and Community Education Officer
Centacare, Rockhampton, Queensland	Di	Cooper	Team Leader, Community Care Services
TAFE NSW	Jill	Church	Casual teacher/Experienced nurse
Cootamundra & Temora Health Service, Cootamundra NSW	Joanne	White	Team Leader, Transitional Aged Care Coordinator
Ramsay Training Institute, Queensland	Catherin	Craft	Clinical Program Coordinator
Bairnsdale Regional Health Services	Alison	White	Team Leader, Food Services Manager
Healesville & District Hospital	Pam	Hughes	Manager, PSA
Western Sydney Local Health District	Alan	McMurty	Nurse Workforce Manager
National Disability Services	Ken	Baker	ACT
National Disability Services	Phillipa	Angley	ACT
Newidale Inc	Debbie	Dyke	NSW

Organisation	Name		Position
IAS	Penny	Judge	NSW
Alzheimers Australia	David	Sykes	General Manager, Learning & Development
Alzheimers Australia	Lois	Cyngler	RTO Manager
Australian Federation of Disability Organisations	Stephen	Gianni	Acting CEO of AFDO
House With No Steps (NSW, ACT, QLD)	Gary	Watkins	General Manager Education & Training
Carers Link, Barossa and Districts, SA	Vicki	Williamson	Executive Officer
Disability SA	Michelle	Hosking	Funds Management, Quality and Service Development Team,
Canberra Institute of Technology, ACT	Heidi	Duncan	Teacher Coordinator Cert III Disability, CIT, Canberra, ACT
Barkuma	Peter	Wilkes	SA
Gosford TAFE , NSW	Bernice	Axsentieff	Teacher/Coordinator Disability
Department for Communities and Social Inclusion , SA	Sandra	Wallis	Regional Manager, Disability Services, Accommodation
Person Centred Development South Recreation Team Disability Services Department for Communities and Social Inclusion, SA	Tania	Smitham	Program Manager
Person Centred Development South Recreation Team Disability Services Department for Communities and Social Inclusion, SA	Anna	Hughes	Senior Project Officer
Disability Services - Business Compliance Unit Department for Communities and Social Inclusion, South Australia	Sharon	Donnison	Training Coordinator
Health Information Management Association of Australia Ltd	Richard	Lawrence	CEO of HIMAA
Health Information Management Association of Australia Ltd	Lyn	Williams	Manager of HIMAA
St Vincents Private Hospital Melbourne, Victoria	Nicole	Payne	Health Information Services Manager
Hunter New England Local Health District, NSW	Denis	McKay	Manager Clinical Coding
St John of God Murdoch Hospital, Perth, WA.	Tracy	Briggs	Manager Clinical Coding
Pavilion Health - Australia PH Prime Care, NSW	Karyn	Duncan	General Manager Health Information Services
NSW Health Centre for Education and Workforce Development	Maria	Stephanou	Project Manager/Course Coordinator Clinical Coding
NSW Health RTO	Salma	Badr	Acting Director
NSW Health RTO	Belinda	Miguel	Clinical Coding Trainer, Statewide Clinical Coding Training Project
NSW Health RTO	Wending	Zhang	Clinical Coding Trainer, Statewide Clinical Coding Training Project
NSW Health RTO	Vicki	Nicolaou	Clinical Coding Trainer, Statewide Clinical Coding

Organisation	Name		Position
			Training Project
Health Workforce Branch Victorian Health	Julie	Brophy	Manager Health Information Workforce Strategy

Appendix C Mapping to units of competency

In this appendix, the tables for each nominated occupation, outline the existing role and skill changes and related units of competency. These tables were originally constructed from the Stage 1 literature review, previous work undertaken by CS&HISC, e-scan submissions, relevant qualifications and sample job descriptions.

These tables have been commented on by stakeholders through the consultation interviews and adjusted accordingly.

Allied Heath Assistants

In the allied health assistant area, the literature and CS&HISC escan submission reviews suggested that there is an increased demand for allied health assistant roles. An allied health assistant is – "*A person employed under the supervision of an allied health professional who is required to assist with therapeutic and program related activities. Supervision may be direct, indirect or remote and must occur within organizational requirements*. [30] However, the role of allied health assistants or support workers varies across Australia depending on the State or Territory, the work location, level of training, and number and type of allied health professions they support.[31] This was reflected in consultations.

Whilst some allied health assistants only work within one discipline (e.g. OT Assistant), many assistants work across disciplines, providing assistance to multiple health professionals or working in a team of health workers. The traditional areas are in physiotherapy assistant, occupational therapy assistant and speech therapy assistant. The emerging areas include social work, radiation, emergency services, medical imaging and audiology, and a generalist works in rural and remote settings, mental health, aged care residential facilities, smaller clinics and generic departments such as 'emergency'.[32]

Role	New additional skills that will be required	Existing units of competency	Recommended action
Allied Health Assistant (AHA)			
Current qualifications	HLT32412 HLT42512	Certificate III in Allied Health Assistance Certificate IV in Allied Health Assistance	
Advanced allied health assistant [33]	Supervision, management and leadership[34]	None identified	Scope to be explored through further research & consultation. Consultations suggested an AHA Diploma.[35] [36]
Advanced allied health assistant [37]	Monitoring of medicines	HLTAP301B Recognise healthy body systems in a health care context CHCCS424B Administer and monitor medications	Scope to be explored. Identified in Continuous Improvement Plan for the Health and Community Services Training Packages[38]
Allied health assistant	Consumer advice on services - for Service Navigation in aged care[39]	No existing unit	Recommend a unit is developed at supervisor level.
Allied health assistant	Case management	CHCCM401D Undertake case management	Recommend title change to 'Organise patient/client program' because AHA does not undertake case management
Allied health assistant	Patient centred care		This needs to be embedded across all units of competency in Cert III and Cert IV
Allied health assistant	Complex needs & clients	CHCCS416A Assess and provide services for	Recommend that title changes to "Assist in

Role	New additional skills that will be required	Existing units of competency	Recommended action
		clients with complex needs	the assessment and provision of services for clients with complex needs".
Allied health assistant	Work as part of a multidiscipline team member[40]	BSBFLM312C Contribute to team effectiveness BSBWOR502B Ensure team effectiveness	Recommend new unit be developed. BSB units are not suitable.
AHA - Emergency department assistants[41]	Multi- tasks in emergency department	None identified	Recommend that the scope of this role be explored.
Allied health assistant	Nutrition	HLTNA304D Plan meals and menus to meet cultural and religious needs HLTNA303D Plan and modify meals and menus according to nutrition care plans HLTNA302D Plan and evaluate meals and menus to meet recommended dietary guidelines	These units need review as they do not adequately support AHAs to acquire the competencies required in the current service delivery environment.
Allied health assistant- Community settings[42]	WHS in community based care or domestic setting	CHCWHS312A Follow safety procedures for direct care work HLTRAH302C - Undertake home visits CHCCS416A Assess and provide services for clients with complex needs	Situated in the workplace not in the home. Recommend that current WHS unit is adapted
Allied health assistant	Work in the community	HLTRAH302C Undertake home visits	Recommendation from stakeholders to include as a core unit
Allied health assistant	Health promotion in the community	No existing unit identified	Recommend a new unit is developed
Allied health assistant	Infection control	HLTIN301C Comply with infection control policies and procedures	Recommend a stronger emphasis on infection control and AHA tasks such as cleaning equipment.
AHA- community with specific clients/ Care management	Chronic illness	CHCCS411C Work effectively in the community sector HLTAP401B Confirm physical health status CHCICS408B Provide support to people with chronic disease[43]	Units may need a health rather than community focus.
Allied health assistant	Aged clients	CHCAC317A Support older people to maintain their independence CHCAC318B Work	Units may need a health rather than community focus. Units currently under review- CHCAC317A

Role	New additional skills that will be required	Existing units of competency	Recommended action
		effectively with older people CHCAC319A Provide support to people living with dementia CHCAC412B Provide services to older people with complex needs	Support older people to maintain their independence – deleted and replaced by CHCCCS Support client independence and wellbeing CHCAC318B Work effectively with older people replaced with Respond to the needs of older people CHCAC412A Provide services to older people with complex needs retitled to Facilitate services to older people
AHA – aged care	Dementia	CHCAC416A - Facilitate support responsive to the specific nature of dementia CHCCS401C - Facilitate responsible behaviour CHCICS404B - Plan and provide advanced behaviour support HLTCSD306D - Respond effectively to behaviours of concern	Skill set needs review to have units of competency which focus on communication with people living with dementia, understanding why behaviours have changed and how to develop strategies and implement responses to these behaviours which enhance the well-being of people living with dementia.
AHA – medical physics and radiation[44]	Radiotherapy service to expand its quality assurance program to undertake in-vivo dosimetry checks on all patients receiving external beam radiation, enhancing patient care.	None identified	Recommendation that scope to be further explored with the industry.
AHA - Mental health[45][46]	Applying recovery approaches in mental health[47]	HLTCSD306D Respond effectively to behaviours of concern CHCMH301C Work effectively in mental health CHCMH411A Work with people with mental health issues	Recommendation that scope to be explored with the industry to ensure suitability of these units.
AHA Podiatry	Foot Care[48]	HLTAH404C Assist with basic foot hygiene[49] HLTAH405C Assist	Recommend that these units need review in light of job requirements in aged

Role	New additional skills that will be required	Existing units of competency	Recommended action
		with podiatric procedures HLTAH406C Assist with podiatry assessment and exercise HLTIN302C Process reusable instruments and equipment in health work	care and community health.
AHA	Nutrition[50]	HLTAH420C Support the provision of basic nutrition advice/education[51] HLTNA301D Provide assistance to nutrition and dietetic services[52]	AHA in nutrition and dietetics should be limited to plans prescribed by a dietitian- not units 302, 303 and 304 on plan meals[53] Recommend scope is explored -there may be overlap with HLT31512 - Certificate III in Nutrition and Dietetic Assistance
AHA Nutrition		(Pre requisite units) HLTNA304D Plan meals and menus to meet cultural and religious needs HLTNA303D Plan and modify meals and menus according to nutrition care plans HLTNA302D Plan and evaluate meals and menus to meet recommended dietary guidelines	These units need review to reflect AHA current service delivery environment.
AHA	Child & Youth[54]	Not identified	Recommendation that scope to be further explored with the industry
AHA	Social Work Assistant in Health setting[55]	Not identified	Recommendation that scope to be further explored with the industry Competencies developed in Victoria
Psychology assistant		Not identified	Recommendation that scope to be further explored with the industry
Allied health assistant-rehabilitation	Basic exercise program for stroke	HLTAH403C - Deliver and monitor exercise program for mobility	Required to be adapted for stroke/needs additional information on effective instruction

Role	New additional skills that will be required	Existing units of competency	Recommended action
Allied health assistant-rehabilitation[56]	Running exercise classes	None identified	Recommend exercise programs for arthritis & stroke
AHA – Audiology-general & paediatric [57]	Assistants with children in audiology	HLTAU403D Conduct hearing assessments HLTAU501D Conduct screening hearing tests for children	This role may conflict with nurse audiology. Include Audiology units in Cert IV AHA [58]

Health Service Assistants

Currently, most health service assistants are working as patient services assistants or assistants in nursing. The 2013 CS&HISC e-scan submission analysis indicated that changing job roles for assistants in nursing would tend to be more specialized for acute care, aged care, mental health, parent craft as well as extending the scope of assistants to an 'advanced' level. The 2011-2012 Health Workforce Australia Work Plan refers to investigating this extension of scope in settings such as mental health, high cost acute care and primary care.[59] Consultations confirm these new directions.

Role	New additional skills that will be required	Existing units of competency	Recommended action
Health services assistant			
Current qualification	HLT32512	Certificate III in Health Services Assistance	
AIN	Acute care[60]	HLTCSD305D Assist with client movement HLTCSD306D Respond effectively to behaviours of concern HLTCSD208D Transport clients HLTAIN301CAssist nursing team in an acute care environment HLTAIN302CProvide support in an acute care environment HLTCSD201D Maintain high standard of client service	Recommend that all of these units need to be reviewed to ensure that there is client focused care and a range of contexts including: coronary care, new born unit.
AIN - Aged care	Aged care clients	No current units under client care electives	Recommend that additional units on aged care be included in the qualification.
AIN - Palliative care[61]	AIN- Palliative care[62]	No current units under electives	Recommend that additional units on palliative care be included in the qualification.
AIN - Mental health[63]	Clients with mental health issues	CHCMH411A Work with people with mental health issues CHCM301C Work effectively in mental health HLTCSD306D Respond effectively to behaviours of concern.	Client care group of electives need to expand to include further electives on mental health e.g. dementia, head injuries
AIN - parentcraft[64]	Working with parents & children	No existing units	Scope needs to be defined
Assistants in nursing (AIN)	Community context [65]	No existing units in HLT32512 - Certificate III in Health Services Assistance except HLTCSD307D - Care for the home environment of clients	Recommend further units developed to suit HSA working in the community
Assistants in nursing	Communication	HLTHIR301C -	Recommend that this

Role	New additional skills that will be required	Existing units of competency	Recommended action
(AIN)	skills	Communicate and work effectively in health	needs review in line with communication requirements of AINs. Needs further contextualization and emphasis on client centred communication.
AIN and patient service assistant	Communication skills	HLTAMBFC301D Communicate with clients and colleagues to support health care	Recommend to consider this unit as more suitable for AIN core unit
AIN and patient service assistant	Work in a team	BSBFLM312C - Contribute to team effectiveness (elective)	This frontline management unit is not suitable and has critical assessment that emphasizes team leadership. Recommend a team unit be developed which reflects the health working environment
AIN	Work in a multidisciplinary team	BSBFLM303C - Contribute to effective workplace relationships (core)	Recommend a suitable unit be developed to suit health environment that highlights understanding roles in the team and working under supervision
AIN	Acute care[66]- legal issues[67]	Partially covered in HLTHIR301C - Communicate and work effectively in health	Legal issues need to be strengthened in this unit.
AIN	Health issues- Checking vital signs	HLTAIN301C - Assist nursing team in an acute care environment	States 'may' (*Procedures for collecting client clinical data may include*) instead of being definite. Need to decide 'essential' or 'may'.
AIN	Health issues- Identify deterioration and decline	HLTAP301B Recognize healthy body systems in a health care context	Recommend this unit strengthened to identify changes and refer when appropriate and to identify and act on risk factors. This unit emphasizes 'apply knowledge'.
AIN	WHS in community based care or domestic setting	HLTWHS200A Participate in WHS processes	Recommend adapted to a range of contexts and clients. It needs to include stronger

Role	New additional skills that will be required	Existing units of competency	Recommended action
	Supporting multiple chronic conditions in the community		emphasis on one's own personal safety as well as understanding boundaries & limitations of role.
Patient services assistant	Communicate well in English verbal & written	No unit	Recommend LLN advisory strategy to address.

Clinical Coders

Coders are a growth occupation. There are current shortages identified in several 2012 e-scan submissions.[68] Changes in e-health, personally controlled electronic records and funding accountability will see increased roles for clinical coders. Focus on health budgets will increase their profile in health settings.

Role	New additional skills that will be required	Existing units of competency	Recommended action
Clinical Coders			
Current qualifications	HLT32912 HLT43212	Certificate III in Health Administration Cert IV in Health Administration	
HLT32912 Certificate III in Health Administration			Clinical coding clerk is not correct terminology – this needs to be changed to clinical coder.
HLT32912 Certificate III in Health Administration		HLTCC301B Produce coded clinical data	Recommendation to review entire qualification as only includes one unit on coding
Clinical coder	Medical terminology	BSBMED301B Interpret and apply medical terminology appropriately).	New unit required as not sufficiently detailed to provide adequate background knowledge for clinical coder
HLT43212 Cert IV in Health Administration		HLTCC401B Undertake complex clinical coding HLTCC402B Complete highly complex clinical coding	Recommendation to review coding qualification- The current units do not align properly with the AQF levels even within the existing roles. A better model would be: Trainee clinical coder – HLTCC301B Produce coded clinical data (Cert III level) Clinical coder – HLTCC401B Undertake complex clinical coding (Cert IV level) Senior clinical coder – HLTCC402B Complete highly complex clinical coding (Diploma level) Units in this qualification do not reflect the workplace needs or roles of clinical coders.
Advanced clinical	Depth of knowledge,	HLTCC402B Complete	Recommend Diploma

Role	New additional skills that will be required	Existing units of competency	Recommended action
coder	extension of scope of job role	highly complex clinical coding	of Clinical Coding be explored
Advanced clinical coder - auditor	Perform audits on medical records and coding completions[69]		Recommend Diploma of Clinical Coding be explored
Clinical coder	Educator	Train coders	Recommend consider appropriate TAE units
Clinical coder	Anatomy & physiology	No unit identified	Recommend development
Clinical coder	Knowledge of hospital funding	No unit identified	Recommend development
Clinical coder	Knowledge of the health system, the patient journey, medical procedures	No unit identified	Recommend consider a Victorian unit "Apply knowledge of the health system for clinical coding".
Clinical coder	Allocate codes using International Classification of Diseases, ICD-10-AM	HLTCC401B Undertake complex clinical coding	Recommend to revise unit to make in more relevant to new coder
Clinical coder	Allocate to the correct Diagnosis Related Group (DRG)[70]	HLTCC401B Undertake complex clinical coding	Recommend development
Clinical coder	Communicate with medical and diagnostic staff	No unit identified	Recommend development
Clinical coder	Legal and ethical aspects of health information	No unit identified	Recommend development
Clinical coder	Accuracy & quality	No unit identified	Recommend development

Aged Care and Home and Community Care (HACC)

Reform is changing aged care and home and community care (HACC) across Australia with the redesign of programs and changing expectations of carers and other workers in these sectors. There is a merging of Aged Care and HACC with increased services provided in the home. Consultations identified that aged care workers will need increased skills especially responding to acute and chronic conditions as well as mental health in relation to depression and anxiety. HACC workers will need understanding of medications, oral health and footcare.

Role	New additional skills that will be required	Existing units of competency	Recommended action
Aged care/HACC			
Qualifications	CHC30212 CHC40108	Certificate III in Aged Care Certificate IV in Aged Care	
	CHC30312 CHC40212	Certificate III in Home & Community Care Certificate IV in Home & Community Care	
	CHC52212	Diploma of Community Services Coordination	
Supervisor	Management	CHC52212 Diploma of Community Services Coordination	Recommend new skills in costs & service models, acquiring funding, marketing in a contested environment be included in the Diploma
Aged care/HACC supervisor	Person centred plan	CHCAC507E Plan & monitor service delivery plans	Recommend that unit is revised to reflect consumer choice in devising plan and stronger role of coordinating the support workers' implementation of the plan.
Coordinator	Health promotion and prevention with individual clients and groups	No identified unit	New unit to be developed. Could adapt HLTAHW003 - Provide basic health information to clients
Aged care/HACC supervisor	Case management[71]	CHCCM503C Develop, facilitate and monitor all aspects of case management CHCCM504D Promote high quality case management CHCNET404B Facilitate links with other services CHCORG428A Reflect on and improve own professional practice	Recommend that Skill Set be reviewed to reflect person centred approaches

Role	New additional skills that will be required	Existing units of competency	Recommended action
		CHCORG506E Coordinate the work environment	
Coordinator/ Support worker	Case management	CHCCM404A Undertake case management for clients with complex needs	Recommend to review to increase emphasis on person centred approaches. Should be in the Diploma.
Coordinator	Navigating services[72]	No unit identified in CHC52212	Recommend new unit developed or skill reflected more strongly in core units
Aged care support worker	Assist with independent living- Services to be person-centred[73]	CHCAC317A Support older people to maintain their independence	New unit being created CHCCCS Support client independence and wellbeing
Aged care support worker	Person centred care	CHCSS00066 Client oriented service skill set- CHCCOM403A Use targeted communication skills to build relationships CHCORG423C Maintain quality service delivery CHCCS314B Deliver services to meet personal needs of clients CHCICS304B Work effectively with carers	This skill set needs to reflect new approaches.
Aged care/HACC support worker	Client oriented service skill set	CHCCOM403A Use targeted communication skills to build relationships	This unit needs to include writing and negotiation skills. Communication with clients' needs to inform clients and facilitate choices.
		CHCCS314B Deliver services to meet personal needs of clients	This unit needs to reflect client choice more strongly rather than delivery of services.
		–CHCICS304B Work effectively with carers	This unit needs to be reviewed
		CHCORG423C Maintain quality service delivery	This unit needs to be reviewed
Aged care/HACC support worker	Social well being	CHCAC317A Support older person to maintain their independence	Unit needs strengthen to actively address barriers and include creative approaches to problem solving.
Aged care/HACC	Work ethically	CHCCS411C Work	This unit needs to

Role	New additional skills that will be required	Existing units of competency	Recommended action
support worker		Effectively in the Community Sector	reflect CDC in the content on ethics
Aged care/HACC worker	Financial skills relevant to consumer choice	No unit identified	Gap around financial and communication skills- includes invoicing and information management via technology. Knowledge of funding arrangements needed.
Aged care/HACC worker	Working with individuals & their families	CHCICS410A Support relationships with carers and families	Recommend to reflect new approaches especially facilitating decision making.
Aged care/HACC worker	Elder abuse	CHCICS409A Recognise & respond to suspected abuse of vulnerable people	Recommend to be included in Certificate III in Aged Care. Recommend unit includes stronger reference to rights of the elderly
Support Worker	Care plans Individualised & goal based[74]	CHCAC318B - Work effectively with older people	Recommend review and include strategies for support worker – focused on understanding rather than applying strategies.
Support Worker	WHS in domestic setting[75]	CHCWHS312A Follow WHS safety procedures for direct care work	Recommend this unit needs to strengthen reference in the home with identifying hazards for aged client & support worker.
AC Support worker	Manage stress in work environment	CHCWHS312A Follow WHS safety procedures for direct care work	Refer above
AC Support worker	Dementia	CHCAC416A - Facilitate support responsive to the specific nature of dementia CHCCS401C - Facilitate responsible behaviour CHCICS404B - Plan and provide advanced behaviour support HLTCSD306D - Respond effectively to behaviours of concern	Skill set needs review -units of competency which focus on communication with people living with dementia, understanding why behaviours have changed and how to develop strategies and implement responses to these behaviours which enhance the well-being of people living with dementia.

Role	New additional skills that will be required	Existing units of competency	Recommended action
Aged care worker	Acute & Chronic conditions	CHCAC412B Provide services to older people with complex needs	Recommend to include in Cert III Aged Care but needs to change the focus for a support worker.
Aged care worker	Complex needs	No unit identified	Recommend new unit developed.
Aged Care /HACC- medication assistance, oral assistance	Medication	CHCCS305C Assist clients with medication CHCCS424B Administer and monitor medications [76]	Recommend review in light of chronic conditions and changes to at home care.
Support worker	Specialist palliative care[77]	CHCPA301B Deliver care services using a palliative approach CHCPA402B - Plan for and provide care services using a palliative approach[78]	Currently under review- CHCPA301B Deliver care services using a palliative approach CHCPA402B - Plan for and provide care services using a palliative approach.
Aged Care worker	Depression & anxiety[79]Handling depression and anxiety in the older person	No unit identified	Recommend new unit.
Support worker	Mental health	CHCMH411A Work with people with mental health issues	Recommend new unit- CHCMH411A not suitable.
Support worker	Management of behaviours of concern[80]	CHCICS305B Provide behaviour support in the context of individualised plans	This unit needs to be adapted to include more strategies that the support worker can use.
HACC	Nutrition	HLTFS302 Prepare foods suitable for a range of food service settings HLTNA302 Plan and evaluate meals and menus to meet recommended dietary guidelines HLTNA303 Plan and modify meals and menus according to nutrition care plans HLTNA304 Plan meals and menus to meet cultural and religious needs	Recommend to be adapted to the HACC environment and role.

Role	New additional skills that will be required	Existing units of competency	Recommended action
HACC- footcare	Basic footcare	CHCIC306B Provide basic foot skin and nail care	Unit needs review to strengthen indicators of referral and related signs of health. Needs to be clearer on actual foot practices.
Food services assistant	Hygiene practices	CHCAC316D Provide Food Services	Needs review to specifically refer to hand hygiene and understanding infection control.

Disability

NDIS was identified as changing disability worker roles in the community and these workers will need to understand chronic diseases and behaviours of concern. There will also be expectations from people with disability to have greater control over their funding and support. Generally, there will be broader skills required by staff in the disability sector due to an increase in needs of people with a disability who are receiving services, e.g. mental health issues, acquired brain injury, etc. Disabilities amongst the aged will demand increased attention.

Role	New additional skills that will be required	Existing units of competency	Recommended action
Disability			
Qualifications	CHC30408 CHC40312	Certificate III in Disability Certificate IV in Disability	
	CHC50108	Diploma of Disability	
Disability support worker	Person centred care[8182] Supported decision making	CHCICS303A Support individual health and emotional well being	Choice & dignity Human rights needs to be included[83] Unit to be adapted to include disabilities.
Disability support worker	Positive behaviours	CHCICS305B Provide behavior support in the context of individualized plans	Review and adapt with new emphasis on client centred care.
Disability support worker	Positive behaviours skill set[84]	Behaviour support skill set	This skill set needs to cover assessment based intervention, behaviour support plans, reduction in restrictive approaches, skill building.
Disability support worker	Empower clients	CHCDIS302AMaintain an environment to empower people with disabilities	Stakeholder recommends-Robust unit.[85]
Disability support worker	Changes in client relationships-informed decision-making and consent Planning & customer service[86]	CHCAD401D Advocate for clients CHCDIS322A Support community participation and inclusion CHCCS400C Work within a relevant legal and ethical framework	Recommend review for person centredness. Ethics to include more on client.
Disability support worker	Facilitating community inclusion for people with disabilities	CHCDIS322A Support community participation and inclusion CHCCS411C Work effectively in the community sector, CHCICS407B Support positive lifestyles, HLTHR403C Work effectively with culturally diverse clients and co-workers	Related to an organizational rather than individual approach. Needs to be an active role by the Disability worker. Recently unit merged with CHCDIS323 Contribute to skill development and

Role	New additional skills that will be required	Existing units of competency	Recommended action
			maintenance and retitled to Contribute to skill development to support inclusion
Disability support worker	Facilitate employment	CHCES311B Work effectively in employment services CHCES415A Monitor and improve contracted employment services CHCES511B Manage contracted employment services	Recommend these units are adapted and included to support the role of facilitating employment.
Disability support worker	Communication negotiation	None identified	Recommend development
Disability support worker	Problem solving Exercising good judgment	None identified	Recommend development
Disability support worker	WHS in domestic setting[87]	CHCWHS312A Follow safety procedures for direct care work	WHS in the home-risk assessment & management[88]
Disability support worker	Working autonomously and managing stress in work environment	None identified	Recommend development
Disability support worker	Legal	CHCCS400C Work within a relevant legal and ethical framework	Recommend strengthening legal aspects
Disability support worker	Working with individuals & their families[89]	CHCICS410A Support relationships with carers and families	Whole family support
Disability support worker	Navigating services	None identified	Recommend development
Disability support worker	Medication[90]	CHCCS305C - Assist clients with medication	Recommend review in terms of dealing with a range of complex conditions.
Disability support worker	Mental health	CHCMH301C Work effectively in mental health CHCMH411A Work with people with mental health issues CHCMH402B Apply understanding of mental health issues and recovery processes DSM manual – assess of types under DC	*CHCMH301C* Content reviewed and streamlined, unit retitled to Respond to the needs of people with mental health issues Needs to be less broad[91]
Support worker	Management of behaviours of concern[92]	CHCICS305B Provide behaviour support in the context of individualised plans	This unit needs to be adapted to include more strategies that the support worker can use.

Role	New additional skills that will be required	Existing units of competency	Recommended action
Disability support worker	Management of behaviours of concern[93]	HLTCSD306D Respond effectively to difficult or challenging behaviour	Needs to be contextualized to the community sector
Disability support worker	Acquired brain injury	ABI – CHCDIS301C Work effectively with people with a disability	Elements covered include disability types and causations within which ABI should be covered.
Disability-Aged	Working with the Aged	CCHCDIS313A Support people with disability who are ageing CHCDIS409B Provide services to people with a disability with complex Needs CHCLD315A Recognise stages of lifespan development	Recommend as an elective in qualifications.
Disability-chronic & complex needs	Chronic diseases	CHCICS408B Provide support to people with chronic disease	Extension of client groups. Recently changed to CHCCCS4XX Address the needs of people with chronic disease
Disability-degenerative conditions		CHCDIS301C Work effectively with people with a disability - elements covered include disability types .	Degenerative conditions should be covered in elements .
Disability-dementia		CHCAC416A CHCCS401C CHCICS404B HLTCSD306D	Needs review. Other than CHCAC416A, the units in this skill set outline performance criteria, knowledge and skills which are applicable for interactions with people who have more cognitive ability than people living with dementia. The skill set should contain units which focus on communication with people living with dementia, understanding why behaviours have changed and how to develop

Role	New additional skills that will be required	Existing units of competency	Recommended action
			strategies and implement responses to these behaviours which enhance the well-being of people living with dementia.

Mental health

The focus of community mental health is recovery and social inclusion. The mental health peer workforce is an emergent adjunct workforce in response to a recovery oriented practice model. Peer support workers in the areas of mental health and drugs and alcohol will increase. Training on risk assessment and safety to do with behaviours of concern will be important , with increased community work and visiting clients in their homes.

Role	New additional skills that will be required	Existing units of competency	Recommended action
Mental Health			
Qualification	CHC40512 CHC42912	Certificate IV in Mental Health Certificate IV in Mental Health Peer Work	
	CHC50412	Diploma of Community Services (Alcohol, other drugs and mental health)	
	CHC52212	Diploma of Community Services Coordination	
Advanced practitioner[94]	Practice leadership Service coordination[95]	CHCORG406C Supervise work CHCORG423C Maintain quality service delivery	CHC52212 - Diploma of Community Services Coordination- qualification to include mental health service coordination units. Increased in number of mental health electives.
Advanced practitioner[96]	Talking therapies	No unit identified	New unit to be developed
Advanced practitioner[97]	Recovery -oriented practice	CHCCW503A - Work intensively with clients CHCMH501A Provide advanced supports to facilitate recovery CHCMH405A Work collaboratively to support recovery process	CHC50312 - Diploma of Community Services (Mental health) Units in this Diploma may be altered
Service coordination[98]	Care coordinating		Recommend referral to *MHCC Service Coordination Workforce Competencies.*
Coordinator	Service Coordination		Needs analysis in a contested environment to be included into CHC50108
Support worker	Person centred approach	Strategies to be included across units- not just theory.	Recommend to integrate across units emphasizing rights and values, understanding and acting on inclusion, strengths based approach, knowledge and understanding of how this applies in daily

Role	New additional skills that will be required	Existing units of competency	Recommended action
			practice.
Support worker	Fostering independence rather than dependence	CHCICS406B Support client self-management	Recommend adapting to become a core unit of Cert IV.
Support worker		CHCMH402B Apply understanding of mental health issues and recovery processes CHCMH411A Work with people with mental health issues	Recommend review in light of recovery approaches.
Support worker	WHS in domestic setting	CHCWHS312A Follow safety procedures for direct care work[99]	Recommend adapt to community/domestic setting.
Support worker	Communication skills	CHCMH403A Establish and maintain communication and relationships to support the recovery process	Recommend unit reviewed and altered to further include practical skill to achieve good communication skills, conflict resolution problem solving suitable for support worker.
Support worker	Communication with clients	Increased knowledge and skills related to specific client groups such as cognitive impairment & comorbidity, complex and chronic conditions, clients who are difficult to engage.	Recommend development.
Support worker	Communicating with families	CHCMH403A Establish and maintain communication and relationships to support the recovery process CHCYTH511B Work effectively with young people and their families	CHCMH403A – strengthen element 3 to include conflict, negotiation and problem solving. CHCYTH511B Recommend includes all families.
Support worker	Community networking skills[100]	None identified	Recommend development
Support worker	Business skills	None identified	Recommend development
Support worker	Understanding dual diagnosis	None identified	Recommend development
Mental health-substance abuse, drugs & alcohol[101]		CHCAOD408B Assess needs of clients with alcohol and/or other drugs issues	Under review-CHCAOD411A Provide interventions for people with alcohol and other

Role	New additional skills that will be required	Existing units of competency	Recommended action
		CHCAOD411A Provide interventions for people with alcohol and other drug issues	drug issues
Mental health work	Responding and understanding complex needs	CHCCS416B Assess and provide services for clients with complex needs CHCCS504B Provide services to clients with complex needs	Consider CHCC504B to addresses complex needs better.
Support worker	Management of behaviours of concern[102]	CHCICS305B Provide behaviour support in the context of individualised plans	This unit needs to be adapted to include more strategies that the support worker can use.
Support worker	Duty of care	CHCWHS312A Follow safety procedures for direct care work[103]	Recommend development.
Peer support[104]	Trauma informed care practice[105] Drug & Alcohol Issues[106]	CHCPW404A Work effectively in trauma informed care	This unit to be included in the Certificate IV

Appendix D References

1 Evidenced in the review of employment positions (2013) and confirmed in consultation interviews(2013)

2 Health Workforce Australia [2013] Health Information Workforce report (October, 2013)

3 NSW Health (2013) Allied Health Assistant Framework p6.

4 2009 Western Australian Health Department Report on AHA

5 includes rehabilitation and paediatrics

6 includes palliative care

7 Alfred Health

8 Monash Health pilot

9 Two models in ACT – Canberra Hospital – technical skills such as menu monitoring whereas smaller hospitals and the community sector use AHA Nutrition to be involved in client engagement/ running healthy weight group.

10 Alfred Hospital, Melbourne pilot 2012-2014

11 Evidenced in employment advertisements and 2013 New Roles Consultation

12 Alfred Hospital, Melbourne pilot 2010-11

13 2010 Allied Health Workforce Advice and Coordination Unit , Queensland Health Models of Care

14 Department of Health & Human Services (2003), Tasmania Allied Health Professional Workforce Planning Group p7 http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0009/38079/ah-socialwork.pdf; North Western Tasmanian Health 2013

15 Little knowledge of this emerging role in NSW

16 Some discussion around psychology technicians

17 HWA Australia (2012) Caring for Older People Project Final report p77 (advanced scope Assistant Occupational Therapy role)

18 Austin Health (2007) Evaluation of an Advanced Allied Health Assistant (Physiotherapy) Role on an Acute Medical Ward

19 Queensland Health (2012) Development of an advanced Allied Health Assistant role in chronic disease -diabetes and renal disease in the Aboriginal and Torres Strait Islander population; Innovations in Models of care for the Health Practitioner Workforce in Queensland Health

20 http://health.act.gov.au/professionals/allied-health/allied-health-projects

21 http://www.aha-sa.asn.au/topic.aspx?section=1&id=147

22 Mason Review of Australian Government Health Workforce Programs p282

23 http://www.rdns.com.au/education-research/projects/courses

24http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-nat-agedcare-workforce-census-survey

25 DisabilityCare Australia (2013) Developing Training Guidelines for Local Area Coordinators Working with Children and Young People with Disability and their Families

26 Health Workforce Australia (2013) Health Information Workforce report p31(October, 2013)

27 Victorian Department of Health (2013) Clinical coding capability framework

28 Terminology used by the stakeholder

29 Referred to 2013 EScan submission to CS&HISC

30 Community Services and Health Industry Skills Council – HLT42512 Certificate IV in Allied Health Assistance

31 Department of Health Western Australia (2008) Chief Health Professions Office, Discussion Paper: Allied Health Assistants, Assistants in Allied Health and Health Science Workforce Project, Department of Health Western Australia, p4

32 Ibid p11

33 Queensland Health e-scan submission to CS&HISC (2012); Victorian Health Department EScan Submission to CS&HISC (2012); ACT Health e-scan submission to CS&HISC (2012); Department of Health and Human Services, Tasmania, e-scan submission to CS&HISC (2012); Queensland Government 2011 Innovations in Models of Care

34 Victorian Health Department EScan Submission to CS&HISC (2012) (for Grade 3 AHA roles).

35 2012 ACT Health Directorate e-scan submission to CS&HISC

36 2013 New Roles consultation

37 Queensland Health e-scan submission to CS&HISC (2012); Victorian Health Department EScan Submission to CS&HISC (2012); ACT Health Directorate e-scan submission to CS&HISC (2012); Department of Health and Human Services, Tasmania, e-scan submission to CS&HISC (2012); Queensland Government 2011 Innovations in Models of Care

38 Queensland Health e-scan submission to CS&HISC (2012)

39 HWA project – ACT Health- Aged Care and Rehabilitation Services

40 2013 CS&HISC Environmental Scan p 11

41 2012 ACT Health Directorate e-scan submission to CS&HISC

42 Victorian Department of Health (2012) Supervision and delegation framework for allied health assistants Dept of Health www.health.vic.gov.au/workforce; 2012 Minister for Health, Queensland e-scan submission to CS&HISC; Department of Health and Human Services, Tasmania, 2012 e-scan submission to CS&HISC

43 Certificate IV in Aged Care

44 2012 Queensland Health e-scan submission to CS&HISC , 2013 Victorian Health Department Medical radiations and imaging technology workforce strategy Strategic plan to enhance supply, recruitment and retention in the medical radiations and imaging (allied health) workforce from 2013 to 2017 p15

45 South Australia Allied Health Assistant Project- Case Study; Department of Health and Human Services, Tasmania, 2012 e-scan submission to CS&HISC

46 2013 New Roles Consultation

47 Department of Health and Human Services, Tasmania, 2012 e-scan submission to CS&HISC

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