

PLANNING THE

DEMENTIA MATE WAREWARE WORKFORCE

A SUBMISSION TO THE 2024-2027 HEALTH WORKFORCE PLAN

Prepared by the New Zealand Dementia Foundation
as secretariat to the Dementia Mate Wareware
Leadership and Advisory Group

THE DEMENTIA MATE WAREWARE LEADERSHIP AND ADVISORY GROUP
TE WHAKARURUHAU MŌ TE MATE WAREWARE

SUBMISSION

About us

The Dementia Mate Wareware Leadership and Advisory Group | Te Whakaruruhau mō te Mate Wareware (the Leadership Group) was established by Health New Zealand | Te Whatu Ora in partnership with the Māori Health Authority | Te Aka Whai Ora to provide strategic advice to guide government and the central agencies to ensure delivery against the objectives and actions in the Dementia Mate Wareware Action Plan. The Leadership Group works in partnership with the Dementia Mate Wareware Network | Te Tūhononga mō te Mate Wareware. The Network provides the views and opinions of people who are involved with dementia mate wareware in Aotearoa New Zealand to inform and strengthen the Leadership Group's effectiveness and responsiveness.

About this submission

Te Whatu Ora, Te Aka Whai Ora, and Manatū Hauora requested the Dementia Ecosystem's engagement with this national process in their formal joint response to the Leadership Group's proposed 2024 work plan.

This submission to Te Whatu Ora | Health New Zealand's Health Workforce Plan 2024-2027 has been prepared by the New Zealand Dementia Foundation in its role as secretariat for the Dementia Mate Wareware Ecosystem, on behalf of the Network and the Leadership Group.

This submission draws on:

- Leadership Group discussions
- Existing guidance given by the Network (published in "Next steps for dementia mate wareware diagnosis and workforce development", April 2023 [1],
- The recommendations of the Aged Care Commissioner in her recent landmark "Amplifying the voices of older people across Aotearoa New Zealand" report [2],
- A brief scoping review
- Consultation through a Network Hui on April 4th, with the opportunity for online submissions

The Ecosystem's mahi about the dementia mate wareware workforce is greater than the scope of the Health Workforce Plan 2024-2027, but the opportunity to make this submission is welcomed. He waka eke noa.

The case for change

The 2024-2027 Health Workforce Plan needs to consider the workforce that supports people living with dementia mate wareware in Aotearoa New Zealand

This is essential because the workforce's needs are considerable at every stage of the dementia journey and at every level of the health system, there are already significant workforce training and availability gaps, and the number of people with dementia mate wareware in New Zealand is rapidly increasing.

Increasing numbers make workforce development urgent

- There were estimated to be around 69,000 New Zealanders living with dementia in 2020. By 2050, the number of people living with dementia is expected to have more than doubled to 167,000. [3]
- The incidence of dementia mate wareware rises sharply after age 75, and our population is ageing in the medium term.
- Dementia is increasing faster in Māori, Pacific, and Asian peoples [3].

Dementia mate wareware is an important player in the wider health system

- Dementia is a long term condition and its diagnosis and management are time- consuming for primary care.
- People living with dementia are admitted more often and for longer to acute hospitals (with an estimated 25,827 hospitalisations per year [3]) and have high rates of complications.
- At least half of all aged care residents are thought to be living with dementia, and dementia is a major factor in need for higher levels of care [4].
- Over a quarter of home-based support clients are living with dementia [5].

Current gaps make workforce development urgent

There are gaps across the dementia journey including:

- poor workforce capability to deliver diagnoses,
- lack of clinical management training and capability across the dementia journey
- under-funded NGO-led community support workforce,
- severe staff shortages in aged care, and
- under-recognition of the whānau workforce.

Availability of and access to service is inequitable

Access to appropriate dementia services is inequitable across special groups such as

- Māori,
- Pacific people,
- people living with young-onset dementia, and
- people living in rural areas.

There are still substantial regional inequities or “post code lotteries”.

The Dementia Mate Wareware Action Plan



One of the four objectives of the Dementia Mate Wareware Action Plan is to strengthen leadership and capability across the sector [6].

This is operationalised in respect to the workforce in the following actions:
Develop and implement a workforce strategy that addresses both the immediate capacity and capability issues and the long-term growth needs of the dementia mate wareware and aged care sector, recognising the impact of the ageing workforce, so there are enough appropriately skilled and qualified people available when needed.

Develop and implement a workforce strategy that increases and retains the number of Māori health practitioners working in the mate wareware sector, and increases the capacity and capability of Māori health providers to deliver mate wareware services.

The 2024-2027 Health Workforce Plan has the potential to make a significant contribution to meeting government's commitment to implementing the Dementia Mate Wareware Action Plan.

Direction of travel for the 2024 -2027 Health Workforce Plan

The Dementia Mate Wareware Ecosystem was asked to give an overview of the recommended direction of travel for the 2024-2027 Health Workplan Plan . The Ecosystem makes three interlinked recommendations to enable the Workforce Plan to contribute to the Dementia Mate Wareware Action Plan's goals:



1 Capability

The Workforce Plan must recognise that we need a dementia mate wareware capable workforce.



2 Capacity

The dementia mate wareware workforce must be recognised as a priority workforce area for bolstering.



3 Kaiāwhina

The Kaiāwhina Plan must be incorporated into the Workforce Plan.

"As the population of older people grows, so too will the population of people with dementia. An ageing population means that maximising the health, independence and well-being of people with dementia is a key part of ensuring the good health of New Zealanders"
- Ministry of Health | Manatū Hauora [7]

1

A dementia-capable workforce



Building a dementia-capable workforce is an essential factor in preparing for an ageing population and this needs to be addressed in the 2024-2027 Health Workforce Plan.

A dementia-capable workforce is well-trained and addresses the complex and highly variable needs of people living with dementia mate wareware and their caregivers [8, 9]. People living with dementia mate wareware engage with our health workforce from multiple health disciplines, settings, and providers across the care continuum,. At each touchpoint this workforce needs to be dementia capable. This requires integrated planning.

This dementia-capable health workforce must be representative and culturally competent to meet the needs of diverse communities, including tangata whenua and Pacific people. Whānau caregivers must be recognised and given better tools and resources to help provide care.[8]

"The cost of dementia today is more than the cost of heart disease, cancer and strokes combined. It is clear that dementia is a health and social care challenge of a scale we can no longer ignore... Behind the statistics, however, are real people who need good care and their families who need support. ..it is truly remarkable that those who work [with people living with dementia] receive so little training..."

-UK All-Party Parliamentary Group on Dementia

What this looks like

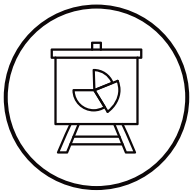
A dementia capable workforce is an integrated workforce consisting of both the clinical workforce resources (knowledge, skills, and competency) and the structural system resources that address the special needs of people living with dementia mate wareware and their whānau. [9]



What people affected by dementia mate wareware want from good care

- Staff with knowledge and understanding of dementia-specific needs
- Staff with the skills to provide personalised care
- Staff with the skills to provide culturally appropriate care
- Staff that involve whānau members as partners in care
- A workforce enabled to deliver personalised care

[10]



Framework to support dementia mate wareware capability across settings

- Staffing levels should be adequate, recognising that people living with dementia typically need more time
- Staff should be sufficiently trained in all aspects of care, including supporting people living with dementia.
- Staff should be adequately compensated for their valuable work.
- Staff should work in a supportive atmosphere that appreciates their contributions.
- Staff should have the opportunity for career growth.

[11]

How the workplan needs to change

The Health Workforce Plan needs to recognise and integrate the breadth of dementia capability needs

People living with dementia mate wareware should receive high-quality, person-centred, evidence-based care in every setting and location. [8, 9]. They should receive dementia capable care whether the support is directly related to their dementia mate wareware or not.

Our health workforce supports people living with dementia mate wareware in diverse roles

- Only some of these roles are in specialist dementia services.
- Only some of the roles are medical.
- Only some of the roles are directly employed by Health NZ | Te Whatu Ora

Dementia mate wareware impacts on whole workforce planning.

Examples of Roles Requiring Dementia Capability

By stages of the dementia journey

ACROSS THE WHOLE JOURNEY

Whānau:
Unpaid and paid.

Primary Care Team:
Comprehensive teams can include GPs, nurses and extended-scope nurses, health improvement practitioners/ health coaches/ counsellors/ cultural health workers/ social workers/ kaiāwhina/ navigators, primary health care assistants, pharmacists, and physiotherapists*.

AWARENESS AND RISK REDUCTION

- Health and communiy-based educators, including from ethnic communities
- Audiologists
- Public health clinicans
- Health promoters

DIAGNOSIS

- Neurologists
- Psychiatrists
- Radiologists
- Geriatricians
- Nurse specialists
- Clinical psychologists
- Allied health clinicians

*Primary care teams are are particulalrly central in diagnosis.

LIVING WELL WITH DEMENTIA

Community-based
- Social workers, OTs and nurses: navigators, key workers,educators, programme facilitators

Home-based care
- Kaiāwhina
- Nursing

- Occupational therapist driving assessors
- Needs assessors
- Pharmacists

CHALLENGES TO WELL-BEING

- Geriatricians
- Psychiatrists
- Nurses, allied health and nurse specialists in psychogeriatric community and inpatient teams
- Speech language, physical, and occupational therapists, dieticians, continence advisors, psychologists
- Needs assessors
- Emergency services
- Acute care

Home-based care
Aged residential care
- Nurses, Kaiāwhina, Diversional therapists

END OF LIFE

- Nurses, allied health, professionals, and kaiāwhina across
  - community,
  - residential
  - specialist palliative care
  - acute care

The dementia mate wareware workforce landscape

The workforce engaged in providing dementia care is wide and diverse, including home-based direct care, community-based post-diagnostic support, whānau and primary sectors. An integrated workforce facilitates more co-ordinated and person-centred care and planning, and helps our workforce to adapt and be used at their fullest potential. To achieve this, we need to understand the needs of our communities and the contributions of different practitioners and sectors and work together to ensure that there is the appropriate capacity, training, skill mix, and career pipelines in place. **This may involve developing new roles or reconfiguring existing ones to some extent**. [12]

Health NZ | Te Whatu Ora

Secondary care teams assist people living with dementia for whom achieving a diagnosis is difficult and when significant risks or challenges with behavioural, psychiatric, or neurological problems arise. Needs assessment and service coordination are also usually carried out by secondary care teams. People with dementia also have other health problems requiring secondary health care, including end-of-life care needs. Dementia mate wareware is associated with increased morbidity, and longer lengths of stay in hospital regardless of whether dementia is the primary reason for admission [3].

Primary care

Primary care teams make the majority of initial dementia mate wareware diagnoses, are central to post-diagnostic clinical management, and have a growing role in the dementia care workforce.

Along with the Aged Care Commissioner [2], we are pleased to see that Health NZ |Te Whatu Ora is undertaking a Primary Health funding review. We support its intention to promote comprehensive community care teams.

We note that medications that tackle the underlying causes of dementia mate wareware are on the horizon, and Aotearoa currently lacks the diagnostic capacity to accurately identify those eligible in time and to roll out the new treatments.

Home-based direct care

The majority of people living with dementia live in the community. Home and Community Support Services (HCSS) support can help enable people living with dementia mate wareware to remain in their own homes and communities. Support plans are developed considering the goals and aspirations of the older person and a focus on achieving maximum independence and normalised socialisation, including for example helping the client bathe, buy groceries, prepare food, exercise, socialise, and take medication.

Since April 2023, the person receiving funded HCSS care can choose to have a whānau or family member provide this care.

The Aged-Care funding and service models review by Health NZ | Te Whatu Ora is currently considering aspects of home and community support services.

Aged residential care

Around 30% of people with dementia mate wareware live in residential care as their ongoing needs require more support than community sources can provide. People with dementia mate wareware live at all levels of residential care: rest-home-level care for those who need some additional support with daily activities, hospital-level care for those requiring 24-hour nursing care, dementia level care for those with dementia symptoms who require personalised support and a secure environment, and specialist dementia /psychogeriatric services for people with advanced dementia mate wareware who need intensive 24-hour nursing care in a secure environment.

Health NZ | Te Whatu Ora is currently reviewing the funding and service models of aged residential care. This may have widespread implications for workforce planning, particularly if there is a much needed review of mandated minimum staffing levels and skills mixes. For example, at present the minimum standard staffing levels in dementia level care units are the same as for resthome level of care.

Community based post-diagnostic support

Alzheimers and Dementia organisations, along with other NGOs, have been the primary source of the dementia mate wareware post-diagnostic support services recommended by the Dementia Action Plan, such as navigation, education, peer support, cognitive stimulation therapy, meaningful activity and active day/respite programmes. 58% of funding for the dementia-specific NGOs is contributed through Health NZ I Te Whatu Ora contracts. [8] The needed growth in the paid workforce is severely hampered by a lack of funding. Alzheimers New Zealand and Dementia New Zealand have developed a shared model of care delivery, including workforce costings [13].

Community-based support includes work being done by culturally diverse organisations. There is increasing and welcome involvement of kaupapa Māori providers either independently or in partnership with a dementia NGO. This has been accelerated by the Budget 2022 Dementia Mate Wareware Initiative which commissioned seven pilot community dementia mate wareware services with a strong representation from Māori and Pacific peoples services.

Whānau

It has been estimated that in 2020 over 52.7 million hours of unpaid care was provided to people living with dementia mate wareware in Aotearoa, which would cost $1.19 billion if it were provided by paid carers [3]. **Our Network has stated clearly that whānau should be acknowledged and supported as an integral and important component of the dementia mate wareware workforce [1].**

The Health Workforce Plan needs to commit to improving dementia-relevant data

To plan better, we need to know more about how many people have dementia mate wareware and how many people living with dementia mate wareware are receiving (or missing out on) support from how many and what type of kaimahi within our health system.

We welcome:

- The work noted in the 2023 Health Workforce Plan to bring together national Health NZ | Te Whatu Ora sources of workforce data and intelligence
- The 2023 Health Workforce Plan's acknowledgement of data gaps and commitment to use available primary and community data to build a clearer picture of shortages.
- The 2023 Health Research Council funding for a national dementia mate wareware prevalence research programme.

There remains an urgent need to improve the systematic collection and collation of information about dementia mate wareware and broader national workforce data. This needs to include the large dementia workforce employed by a range of providers in what the 2023 Health Workforce Plan refers to as the 'funded sector': third-party providers critical for delivering health services. Improving the lack of high-quality national dementia mate wareware data, including basic prevalence data, is a priority.

A lack of comprehensive dementia mate wareware workforce data and analysis is an obstacle to effective workforce planning, which involves developing and setting targets, strategies, and milestones for ensuring a dementia-capable workforce in terms of both the number needed and basic competence [3,9]. The impacts of workforce gaps and mismatches on people living with dementia mate wareware and those who support them are rendered largely invisible.

We draw attention to the Australian Government's 10-year National Dementia Data Improvement Plan [14] as an example of an approach to actively rectify data limitations. An Aotearoa New Zealand Dementia Data Improvement Plan could facilitate the achievement and analysis of the following:

- Robust dementia mate wareware prevalence and incidence data, including in Māori and other priority population groups (Pasifika, rural, and young-onset populations)
- Harmonised data collection about dementia mate wareware across sources and linking national data sets;
- Integration with comprehensive national workforce datasets, including new data sources as recommended by the Aged Care Commissioner (see also page 21)
- Key monitoring areas including workforce shortages, dementia mate wareware training, and ethnicity/diversity of the workforce.

The Health Workforce Plan needs to commit to putting whānau at the heart of what we do

The Dementia Mate Wareware Governance Ecosystem is committed to a whānau / family approach to all aspects of dementia mate wareware health and social support and to holding the voices of whānau in the heart of planning. We believe that whānau should be acknowledged and supported as an integral and important component of the dementia mate wareware workforce [1].

Many caregivers are "recruited" to dementia care because of personal circumstances, perhaps when they choose to provide care to a friend or family member with dementia mate wareware. Others enter this workforce as a career. Ways to encourage both groups to join and remain in the workforce need to be identified. [15]

Just like the rest of the workforce, we want to support and retain our valued whānau workforce. The action plan notes that this includes information, education, support, and flexible, available, and accessible respite services [2]. There is an important role for

- Social, psychological and emotional support,
- Receiving accessible and tailored information, about the dementia mate wareware, and about available care services and how to access them, and
- Having access to training and education to care for their whanau member with dementia and to develop coping abilities and strategies to maintain life balance. [16]
- Within Te Ao Māori this might include tautoko (support) from whānau ora navigators (a culturally-based and whānau-centred approach) with educational support by Māori, with Māori, for Māori.

We note the essential and underfunded role of Alzheimers NZ and Dementia NZ organisations, along with other community-based organisations, in providing this role support to the whānau workforce.

A new aspect that has emerged is supporting whānau as paid carers. In April 2023 a policy change enabled a person receiving funded home-based care to choose to have a whānau member provide this care. The whānau member is then employed by a home-based provider. We suggest that this provides a clearly defined target group for upskilling and entry pathways to staircasing. Furthermore, this target group who are often representative of the diverse ethnic communities receiving care. We particularly note the synergy with the commitment to strengthen Hauora Māori workforce pathways from whānau, hapū and iwi in the 2023 Workforce Plan.

Suggested initiatives to include in the 2024-2-27 Health Workforce Plan include:

- Enhancing and raising awareness of opportunities for support and education for all whānau carers of people living with dementia mate wareware through an online "Carer Gateway" (as it's called in Australia) that could link with
  - unregulated education opportunities for whānau dementia mate wareware carers, such as isupport (University of Auckland), Dementia Learning Centre (Alzheimers NZ) and Dementia STARs (NZ Dementia Foundation)
  - pathways to formal qualifications including micro-credentialling and careers
  - useful information such as funding entitlements e.g., Harris List, Ministry of Health, ElderNet
- Increasing planning for growing dementia navigator and health improvement practitioner roles that provide "tailored, strengths-based support to persons living with dementia and their care partners across the illness continuum and settings to mitigate the impact of dementia through collaborative problem solving and coaching." [17]
- Supporting the experience of being employed by an HCSS provider and engaging in training leading to relevant NZQA qualifications; and
- Identifying how existing local kaupapa Māori programmes with experience in supporting whānau dementia mate wareware carers, such as Te Puna Ora o Mataatua, can be scaled nationally.

Education is key

Currently, we do not have consistent accessible, ongoing, best-practice dementia education across disciplines and service contexts. We welcome the commitment in the 2023 Health Workforce Plan to develop a coherent health training system. We encourage the explicit inclusion of the tiered training needs framework for working with people living with dementia mate wareware and their whānau across the health and social care spectrum, following the example of England, Scotland and Australia:

- Awareness of dementia mate wareware, which everyone should have;
- Basic skills that are relevant to settings where staff regularly work directly with people living with dementia mate wareware, such as how to effectively communicate with people whose cognitive abilities are impaired;
- Enhanced practice skills, including those required for progressing to become dementia mate wareware specialist practitioners; and
- High-level leadership and clinical expertise [18,19].

We welcome the commitment to build training pathways for new models of care and wish to highlight the importance of strengthening the dementia capability of comprehensive primary care teams through training, including for diagnosis. As the 2023 Workforce Plan notes, allied health professions have been identified as key to the emergent Comprehensive Primary Care Team models of care, a model we strongly support. Strengthening comprehensive primary care teams may reduce an exclusive focus on individual doctor consultations and help to improve supply and accessibility, which will help to ameliorate significant issues accessing timely and accurate diagnoses of dementia mate wareware in primary care [1,20]. An example of a training initiative for comprehensive teams that could be scaled up is a dementia capability package for Health Improvement Practitioners, developed by Tū Ora Compass Health.

As the 2023 Health Workforce Plan notes, particularly for strategic workforces, the growth we need to see in domestic training will likely require new approaches to training – including interdisciplinary models. One way to drive local-led innovation in training could be to establish a dementia mate wareware training innovation fund [8]. This fund could be prioritised to help address gaps in dementia mate wareware education, for example:

- The new MANA — the Māori Assessment of Neuropsychological Abilities suite of tools, cultural aspects of care, whānau-centred approaches, and mātauranga Māori;
- Working with other priority groups: Pasifika, rural, and young-onset populations;
- Specific education and clinical networks for Pasifika and hauora Māori teams; and
- Improved education for Comprehensive Primary Care Teams, including around diagnosis.

We also welcome the aim of a ‘navigable’ nationwide health training system. Our Dementia Mate Wareware Network has highlighted the lack of a ‘single point of entry’ for finding out about existing dementia mate wareware training and education opportunities such as a centralised online dementia mate wareware workforce education information hub.

2

A priority workforce group



The dementia mate wareware workforce should be recognised as a priority workforce group under acute pressure in the 2024-2027 plan.

As the 2023 Health Workforce Plan acknowledges, vacancies are not currently equally distributed between service types. Current drivers of gaps within the dementia workforce include funding, differentials in pay and conditions, and stigma.

"Each of our health workforces are critical, but we know some are under particularly acute pressure. We will focus on immediate actions to boost workforces that are under more strain, particularly in the community, while we invest in growing more sustainable pathways."

-2023-2024 Health Workforce Plan



The health workforce plan should address stigma

One aspect of improving recruitment and retention is to address the stigma amongst around dementia mate wareware work and non-hospital settings, such as

- Caring for people is seen as less valuable and rewarding than curing people;
- Technically orientated roles are seen as more skilled and desirable, with more options to progress, which is reinforced by training emphases;
- The work is perceived as low status and ‘dirty work’, with poorer working conditions; and
- The work is associated with negative emotions, such as being a sad or depressing field [21,22].

We focus on the kaiawhina workforce, but here we consider the registered allied and medical workforce. To counteract stigma, professional training, career information, and workforce development plans should:

- Mandate and resource core geriatrics and dementia competencies in health and medical curricula to reduce barriers around confidence, skills, awareness, and stigma
- Raise awareness of the value and importance of working with people living with dementia mate wareware such as
  - Appreciating a ‘different type of care’ that is more holistically focused, with more patient contact and a focus on patient quality of life, enabling a fit with values
  - Appreciating the opportunity to “make a difference”;
- Raise awareness of dementia-related roles and clarify pathways for career progress in non-hospital settings; and
- Ensure access to relevant supportive practical placements. [20]

Efforts to improve the sector's resourcing will also help change perceptions about the ability to provide high-quality care. Part of an integrated workforce should be monitoring and action mechanisms for pay differentials between equivalent roles in Health NZ and non-Health NZ settings.

In the next subsections, we focus more specifically on two of the non-hospital settings that are dominant segments of the dementia mate wareware workforce: aged residential care and home and community support services.

Aged Residential Care (ARC)

Over 35,000 residents received care at ARC facilities in 2023 [23]. Based on interRAI NZ data, nearly half of all those living in aged residential care have some form of dementia [49%, 5]

The demand for a dementia-capable ARC workforce will continue to grow with an ageing population:

- Dementia mate wareware is an existing and increasingly significant driver of entry into residential care [4]. InterRAI data suggests that people living with dementia mate wareware are almost twice as likely to enter residential care as people without dementia [24].
- The age and proportion of residents with dementia and multiple co-morbidities at entry is increasing, and the growth in demand is for higher levels of care [4].
- Across residential care as a whole, the average caring task now requires higher skill levels in the workforce compared to 2000 and into the future [4].

Snapshot

Gap in RNs

1,200

Estimated gap of RNs in aged residential care. This may have dropped to 760 when pay parity with Health NZ was achieved for some of 2023.[23]

Recruitment

90%

% of ARC providers reporting difficulties recruiting staff [2]

Closures

66

# of specialist dementia care beds closed in 6 months from January 2022 to June 2023, primarily due to staffing shortages [23].

Turnover

31%

Annual turnover of staff in aged residential care in 2023. 35% -50% of departing RNs move to Health NZ hospitals [2,25]

Staffing alerts

400

# of notifications each month of ARC facilities not having enough RNs to maintain staffing levels [2]

Fully staffed

17%

% of ARC facilties that reported that they had their full RN complement.[25]

Migrant workforce

71%

% of ARC facilities who have staff on visas [25]. An estimated 24% of RNs and 45% of caregivers are on visas, with the most common countries of origin being India and the Phillipines [4].

Pressure

"We need to train, recruit (domestically and internationally), and retain our aged-care workforce, especially nurses in ARC (at least one-quarter of the roughly 4,800 nurse positions (around 1,200) are vacant in ARC according to the Aged Care Association). The aged-care workforce must be prioritised in future workforce planning"
-Aged Care Commissioner, 2024 [2]

Capacity for ARC care for people living with dementia mate wareware must be stabilised, especially for dementia and psychogeriatric levels of care

As the Aged Care Commissioner notes, the ARC sector has decreased its provision of hospital-level care, especially much-needed specialist dementia mate wareware (psychogeriatric) care, which provides enhanced services for people with advanced dementia mate wareware. From January 2022 to June 2023, the Aged Care Association reported that around 66 psychogeriatric care beds had closed among its members, with clinical staff shortages being cited as a reason for closures. [2] There is an urgent need to address the gap in nurses in ARC, especially for dementia level and psychogeriatric levels of care. This will require a multi-pronged approach, for example:

Staffing levels should be adequate

The aged residential care workforce is strongly and increasingly reliant on migrant staff. While the ARC sector's workforce grew by 11% between 2012 and 2019, the ARC temporary visa workforce doubled and the ARC skilled resident migrant visas workforce increased by 54% [23]. We welcome the initiatives in the 2023 Health Workforce plan to facilitate international recruitment to urgently fill workforce gaps and suggest that dementia ARC care should be consistently considered as a priority area, e.g.,

- Continuing 'green lane' immigration for ARC nurses'
- Access to the Health NZ health immigration centre,
- Targeted international recruitment activities and,
- Releasing the replacement programme to sponsor internally qualified nurses for bridging courses (NCAP) to become registered in Aotearora. Anecdotally one ARC manager reported they were considering paying for the Health Care Assistants concerned to go to Australia to complete the program there and return to work as RNs.

A sustainable aged care workforce that is aware of the special needs of tangata whenua and Pacific people will be made up of predominantly New Zealand nursing graduates. The need to recruit and retain domestic nursing students articulated in the 2023 Plan is amplified for dementia ARC. ARC is not a preferred destination or career pathway for sufficient New Zealand nurses [26] to keep the sector viable. A discussion paper by Hughes suggests a range of ways to work with tertiary providers, including a stigma-reducing campaign and opportunities for funding and support for nursing students choosing ARC as a destination after graduation. As the 2023 Workforce Plan notes, it is important to ensure students are exposed to diverse experiences while training, and we would recommend this specifically emphasises the opportunity for positive well-managed experiences of working in ARC settings with people living with dementia mate wareware.

Staff should be sufficiently trained

As already emphasised, training is key to a dementia-capable workforce. A further aspect of this is the importance of supporting ARC managers as leaders/champions of person-centred dementia care. We recommend filling the gap for nationally consistent provision of leadership training to support this*.

Staff should be adequately compensated

Health NZ | Te Whatu Ora hospitals are the leading destination for nurses leaving ARC given the historically higher pay rates. We welcome the government's commitment to continue paying out the $200m-a-year investment in pay parity for nurses and healthcare assistants working in the primary and community sectors. We would further welcome an ongoing mechanism for monitoring nursing pay disparities between Health NZ | Te Whatu Ora versus primary and aged care, which have again widened following a recent pay settlement for the Health NZ | Te Whatu Ora workforce.

Staff should work in a supportive atmosphere

We note the existing initiative in the 2023 workforce plan to boost retention through support for new domestic nursing graduates. Consideration could be given to a targeted programme of support for nurses beginning work in dementia ARC dementia care, with additional cultural and mentoring support for internationally qualified nurses to reduce particularly high levels of turnover. Working in a dementia-specific and residential care setting can be a culture shock for migrant staff. Dementia aged care facilities can be unknown in their home country, given cultural obligations to look after older people, and the medical concept of dementia may not be culturally recognised [27-29].

Staff should have the opportunity for career growth.

A key element to the retention of nurses into ARC and the development of nursing leaders in ARC is the opportunity for nurses to grow their careers in a supported and structured way. An initiative could provide a nursing council approved nationwide Professional Development and Recognition Programme (PDRP) for ARC specifically [26].

*In Te Waipounamu and Central regions, HealthNZ facilitators from the 'Walkingin Another's Shoes" person-centred dementia care education programme offer training for dementia care staff (kaiāwhina, allied health, nursing, and managerial staff).

Home and Community Support Services

Over 100,000 people receive Home and Community Support Services (HCSS) [13]. Based on interRAI NZ data, over a quarter of all those receiving home care have some form of dementia [28%, 5].

HCSS has a significant role to play in keeping people well in their homes and communities for longer and in reducing demand on ARC, emergency, and specialist services [2,30].

The demand for a dementia-capable home-based support workforce will continue to grow:

- Government health strategies include improving community support so that older people can stay longer in their homes where they wish to be [30].
- The majority (70%) of home-based support clients are older people [31] and there is an increasing presence of advancing dementia in clients.
- The shortage of dementia mate wareware and psychogeriatric care beds means that the availability of dementia-capable home-based support services is even more important [2].
- Working with clients living with dementia requires special skills, values and commitment. Kaiāwhina mostly work in isolation, and need to present an adaptive and continually personalised approach for each client [31].
- Home-based support options are especially important for those whānau and families for whom ARC is not an appropriate options on cultural or other grounds.

Snapshot

Vacancies
1,300

# of vacancies in HCSS workforce [31]

Closures
20

# of HCSS providers who ceased offering service between 2015 and 2019. Most of the remaining providers are in urban centres [31]. However most rural areas are not well servced by ARC, NGO, or Te Whatu Ora supports either.

Ongoing training
26%

% of care and support kaiāwhina who had not completed training provided by their employer in the last 12 months in the last avialble care workforce survey [32].

Training motivation
66%

% of HCSS care and support kaiāwhina wanting to undertake further study [32].

Workforce
18,500

# of people employed by Home and Community HEalth Association providers [31]

Support dementia capability in HCSS

As noted two-thirds of all people with dementia mate wareware in Aotearoa live in their own homes. It is crucial HCSS staff receive proper training and ongoing support to ensure high-quality person-centred support to people living with dementia mate wareware, especially as home-based support workers provide care with little immediate backup or support. However, a major 2019 workforce survey found that kaiāwhina in HCSS services reported fewer training opportunities and less provision of work time for training [28] than their colleagues in other settings. Over and above the qualifications framework, the following measures should be encouraged in policy to provide consistency in support and training for home-based kaiāwhina, including ensuring the appropriate capacity and capability of staff to mentor:

- Robust training in dementia care skills must be provided. This includes making dementia awareness training part of every new employee's induction process. Excellent models for such programmes already exist.*
- Support should be available for home-based support workers to help them deal with complex care situations, especially with clients living with dementia, including when clients decline care.
- Clear lines of escalation need to be provided to ensure that issues are addressed effectively. [33]
- Ongoing education opportunities are needed to support Kaiāwhina to maintain, update, and boost competencies [34].

Improve data on HCSS workforce gaps

The Aged Care Commissioner (2024, 2) proposes several recommendations to improve data collection, which we support. These improvements would provide necessary data to identify gaps and plan and evaluate quality improvement initiatives.

One of the recommendations is the implementation of a monitoring framework to oversee the quality, safety, and equity of the HCSS system.

Additionally, to better track gaps, HCSS providers could report shortages of care and support workers and nurses, analogous to the use of 'section 31' notifications of registered nurse (RN) shortages by ARC providers to HealthCERT at the Ministry of Health.

Another recommendation is a comprehensive national HCSS workforce dataset that is collated, shared, and regularly updated by Health NZ | Te Whatu Ora. This dataset would enable the HCSS workforce to be prioritised in future workforce planning.

An HCSS demand planner, similar to the Health NZ | Te Whatu Ora ARC demand planner that tracks current and projected demand for beds in ARC, would help capture current and future demand for HCSS across different regions. It would also assist in ensuring equity of access across the country.

Assessing consumer experience (including consumer experience of the reliability of support) must be a central feature of such a framework. We note that this must also include cultural appropriateness for tangata whenua.

*$1.2 million was committed in Budget 2013 to increase dementia training for home-based support workers enabling a brief face-toface person-centred care training package called 'Open Minds, Open Doors'. The time-limited project ran successfully with funding for a train-the-trainer model and backfill for staff to attend training.

3

Incorporate the Kaiāwhina Plan



In the dementia context, kaiāwhina are essential across all care settings.

Kaiāwhina hauora is a respectful term for the unregistered health workforce. We are using the term kaiāwhina to refer to direct care staff including home-based support workers, aged residential care caregivers and diversional therapists, and hospital aides, recognising that there are over 20 job titles in use [30]. One common feature of these roles is that professional qualifications above Level 4 are not required and there are no professional bodies regulating their practice, but this obscures the reality that this workforce can become very expert at its work indeed. For both residential aged care and home-based support services, the most common task for care and support workers is personal care rather than domestic chores [32].

"As the care needs of an aging population become increasingly complex, the role of unregulated care providers in healthcare delivery has also evolved .... Their evolving role should be recognised and efforts made to leverage their experience on interprofessional teams and reduce variations in education and employment standards."
-Afzal et al, 2018 [35]

The kaiāwhina hauora workforce

Because the direct care workforce is so large, and because they provide so much of the caring contact hours a person living with dementia mate wareware will receive, kaiwahina hauora are the foundation of a dementia-capable workforce [36].

Kaiāwhina hauora are an essential part of the dementia workforce across all care settings. They will often become the 'expert' in providing care for a particular person living with dementia mate wareware, providing most of the contact time to people living with dementia mate wareware on behalf of our health system. They build up a wealth of knowledge and skills that can help to identify changes in clients and facilitate successful care and treatment engagement. Kaiāwhina hauora often know the individual better than any clinician. They must be respected and valued as professionals. [33,37]

Snapshot

Home-based

18,500

Support worker kaiāwhina employed by Home Health Care Association [31].

Aged Residential Care

16,300

Carers and care assistant employed in ARC according to Employment NZ [35], with the Misinstry of Diable People Whaikaha placing the number at 21,000 [39]

HCSS workforce

86%

86- 95%of home-based workforce are support kaiāwhina [37].

ARC workforce

73%

% of ARC workforce that are health care assistants /caregivers. Nearly half have relevant Level 4 NZQA qualifications (48%) [25].

Retention

30%

% of kaiwhina who intended to quit in the next 12 months in 2019 [32].

Māori workforce

71%

% of the Māori health workforce who were in unregulated roles in 2017 [40]. An estimated 17% of HCSS support kaiāwhina and 14% of ARC care kaiāwhina are Māori.

The 2024-2027 Health Workforce Plan should acknowledge and integrate with the 2020-2025 Kaiāwhina Plan

The Kaiāwhina Plan for 2020-2025 is overseen in partnership by the Ministry of Health and Toitū te Waiora (the Workforce Development Council for Community, Health, Education and Social Services). We recommend closer integration with this mahi and the Kaiāwhina Advisory Group who guide it, alongside the new Health NZ | Te Whatu Ora National Workforce Taskforce Kaiāwhina Workforce Working group. The comments here are primarily drawn from the Kaiāwhina Advisory Group [34].

Staffing levels should be adequate

Significant funding settlements, from 2014 onwards, recognise, enable, support and promote Kaiāwhina role. They include the In Between Travel Settlement (2014), the Guaranteed Hours Settlement (2017), and the Care and Support Workers Pay Equity Settlement (2017). These are helping provide system stability and reduced staff turnover. The Kaiāwhina Plan has a number of actions to reimagine attraction and recruitment including:

- Increasing visibility for Kaiāwhina roles and rewards.
- Working with institutions such as the Manatū Hauora, the Accident Compensation Corporation, the Ministry of Social Development, Te Puni Kōkiri, the Ministry for Pacific Peoples and the Ministry of Business, Innovation & Employment on national recruitment initiatives [34]

Staff should be sufficiently trained

Provision for training is an important part of the funding settlements. Analysis of the Care and Support Workforce Qualification Attainment in December 2019 found that there has been an increase in the proportion of kaiāwhina holding qualifications. [34]

Due to financial pressures, an unintended consequence of tying qualifications to pay has been that managers prefer to roster and recruit 'less expensive' levels 1 and 2 qualified staff [30b]. As will be discussed further below, there are calls to standardise job descriptions, including 'senior kaiāwhina', alongside applying funding models that take into account the cost of employing kaiāwhina across the levels [41].

We welcome the announcement of Te Aka Whai Ora funding for seven hauora Māori partners who are being funded to strengthen their kaiāwhina workforce through training and development opportunities ($1.6 million funding), and encourage the inclusion of dementia mate wareware capability in these projects.

Staff should be adequately compensated

While the pay equity, in-between travel settlement, and regularisation of working hours were all important gains, there are still concerns about a need for more consistency with which they have been applied. Matters relating to pay parity and the consistency of application of employment terms and conditions will continue to benefit from close monitoring and attention, not only to whether they facilitate a sustainable expert workforce but whether they lead to unwanted unexpected consequences such as deterioration of other important health and social service workforces.[34]

Staff should work in a supportive atmosphere

Further work is still required to raise the profile of kaiāwhina and to have the value of their contribution more consistently acknowledged and respected by employers, managers, and other team members. There have been positive acknowledgements of the role and work of care and support workers during COVID-19. Focussed work on Kaiāwhina being valued as equally important team members in the interprofessional team will need to continue over the period of the 2024-2027 Workforce Plan to build on the momentum achieved.[34,41]

Staff should have the opportunity for career growth.

There is a need to value and enable ongoing professional and interprofessional development opportunities for kaiāwhina.

If care work is to be professionalised and seen as an actual career, then recognised continuing professional development paths are critical. Kaiāwhina need to know that progression is tailored to their strengths and preferences and to be able to specialise in areas such as dementia. Learning and development in supporting whānau with dementia mate wareware should be endorsed in funding models to be valued and rewarded by employers.[33,37] This includes clarity of role and formal recognition of senior kaiāwhina positions such as “Clinical Support” in aged residential care. There is the potential to view the workforce gaps differently and look for innovative solutions. There is an opportunity to analyse roles and assess whether tasks could be done by a different profession or workforce group, and with appropriate support and supervision, kaiāwhina will be at the forefront of this.

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Appendix: Note on data used and its limitations

Prevalence

It has been estimated that in 2020 there were 69,713 living with dementia mate wareware in Aotearoa NZ, which represents 1.4% of the total population. The number of people living with dementia is projected to more than double to 167,483 by the year 2050, comprising 2.7% of the total population and 10.8% of the population aged 65+ [3]. These figures may be conservative; for example, soon-to-be-released research suggests prevalence may be 12 to 15% higher than this estimate [42].

The estimate applies prevalence data derived from international epidemiological studies to the Aotearoa NZ population. We recognise this method has shortcomings, but it is the best available estimate while awaiting the first large-scale dementia prevalence research programme in the country, announced in 2023.

InterRAI data provides an up-to-date estimate of the proportion of people receiving needs-assessed services who have a diagnosis of dementia, although this data set is also limited by:

- Its reliance on the comprehensiveness and accuracy of diagnosis of dementia by primary and/or secondary care, which is known to be poor;
- Its use of cognitive impairment algorithms that rely on referral for further assessment[43]; and
- Its inherent limitation that only some citizens with dementia mate wareware have received an InterRAI at all, let alone a comprehensive version.

Workforce data

We have collected workforce data from various secondary sources, including industry summaries, to try to provide some visibility to the majority of the dementia mate wareware workforce, which does not work for Health New Zealand directly, but is nonetheless largely funded by it. However, we would like to note that some of these sources are one-off reports that are not regularly updated, and they may be reported in a manner that is biased towards demonstrating particular industry perspectives. Thus, some data might be several years old and presented as intelligence rather than raw data, but it remains the best available information to hand.

Costings

We have not provided costings for any recommendations but are happy to provide advice to Health NZ to help develop these.