

# **Discussion Document:**

# **Health Professions Workforce Consultation and Strategies**

**Encompassing Allied Health and Health  
Science (Health Professions):**

- **Second Health Professions Workforce  
Consultation Forum**
- **Development of Workforce Strategies for  
the Health Professions**

**Organisational Development Division  
October 2006  
WA Health**

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## EXECUTIVE SUMMARY

In WA Health, the Health Professions group incorporates more than twenty Allied Health and Health Science Professions. Together, they make up more than ten percent of the WA Health workforce, providing essential health care services. Planning for the future Health Professions Workforce is in keeping with WA Health Reform and implementation of the Clinical Services Framework.

The number of Health Professionals, the health care settings in which they work, the models of care and the skills required are considered in the plans for the Health Professions workforce. Throughout 2006, a consultation process has been undertaken with the Health Professions to determine workforce planning strategies as part of the WA Health *Healthy Workforce Strategic Framework 2006-2016*.

Part 1 of this Report contains the outcomes of the Second Health Professions Workforce Consultation Forum held on 12 June 2006. Both the second forum and the rural videoconference forum were well supported by individual Health Professionals. The forum workshop sessions framed issues into strategic concepts for the *Healthy Workforce Strategic Framework 2006-2016* areas of:

- Workforce supply and distribution
- Workforce design
- Workforce skills development
- Workforce data
- Workforce culture and environment

Workforce supply and distribution concepts focus on establishing a consistent level of service state-wide, promotion of the health professions and their roles and entry levels to the professions, as well as attraction and retention strategies, which includes particular actions for country and indigenous populations, flexible work practices and coordination of overseas recruitment.

Workforce design concepts reflect the need for competency based training and career structure with recognition of clinical specialties, training and career structures for the assistant and technical level workforce, enhancement of client care through strategic use of the health workforce including generic roles, appropriate administrative and clerical support for clinical services and increased client access to multidisciplinary care.

Concepts for workforce skills development propose the establishment of strong relationships between the education and health fields to promote re-entry systems to the health professions, access to learning and study, generic and interprofessional undergraduate and postgraduate courses, workforce entry programs, postgraduate training, research collaboration and the coordination of clinical fieldwork placements.

Workforce data concepts focus on the need for accurate and reliable data collection and sets, which is essential to the planning and implementation of the Health Professions Workforce strategies.

Workforce culture and environment concepts focus on health professional representation and leadership at all levels and improved partnerships between metropolitan and rural services and between tertiary, secondary and primary services.

Part 2 of this Report outlines the work being undertaken to identify and develop a wide range of strategies from the Health Professions consultation process. The strategies and specific projects are being progressed through the Health Professions Workforce section of the Organisational Development Division of WA Health, in conjunction with the Chief Health Professions Officer, the Health Professions Workforce Strategic Committee and the Healthy Workforce Committee.

Selected strategies that link with the WA Health *Healthy Workforce Strategic Framework 2006-2016* will form the priority areas for a Health Professions Workforce Strategic Plan. This Strategic Plan will guide the implementation of specific projects and actions.

Involvement of the Health Professions and other stakeholders is essential at all stages of consultation, development and implementation of the strategies. WA Health is grateful to the Health Professionals, particularly the participants at both consultation forums, for their contribution to the workforce planning processes.

# **PART 1 HEALTH PROFESSIONS WORKFORCE CONSULTATION AND STRATEGIES**

## **1. INTRODUCTION**

### **Background**

WA Health has undertaken extensive consultation for future workforce planning with the clinical service providers. Separate processes have been conducted for medical, nursing and health professions workforces. All support the implementation of the Clinical Services Framework (CSF)<sup>i</sup> and WA Country Health Services (WACHS) planning.

The *Allied Health and Health Science Professions Workforce Consultation Discussion Paper*<sup>ii</sup> and the *Report on the Allied Health and Health Science Professions: Workforce Consultation Forum*<sup>iii</sup> provide the background for the consultation with the Health Professions. Other background documentation includes the *Report of the Health Reform Committee (Reid Report, 2004)*<sup>iv</sup>, the *National Health Workforce Strategic Framework 2004*<sup>v</sup>, the *WA Health Strategic Plan*<sup>vi</sup>, the *Healthy Workforce Consultation Framework*<sup>vii</sup> and the *WA Health Clinical Services Framework*<sup>viii</sup>.

Leadership for the Health Professions Workforce is being established through the position of Chief Health Professions Officer and the position of Health Professions Workforce Advisor in the Organisational Development Division of Health System Support, WA Health. The Chief Health Professions Officer will provide a strategic and policy setting role while the Health Professions Workforce Advisor will undertake the operational aspects of the health professions workforce planning.

The benefits of long-term health workforce strategies for the health professions include:

- The establishment of common goals across the health, education and training sectors
- Clarifying the roles and responsibilities of each sector
- Identifying key priority areas for action
- Minimising crisis management
- Developing workforce skills which take time to grow
- Facilitating the integration of workforce planning with service delivery developments and goals from WA Health reform
- Ensuring opportunities arising from workforce developments at a national level are optimised

This Part of the Report provides an update on the consultation process and planning for the Health Professions workforce with information from the Second Health Professions Workforce Consultation Forum held in June 2006. This information has been developed into Health Professions Workforce strategies for inclusion in the *WA Health Healthy Workforce Strategic Framework 2006-2016*<sup>ix</sup>.

## 2. CONSULTATION PROCESS

The Health Professions<sup>x</sup> (Allied Health and Health Science Professions) Workforce Consultation process included two forums in 2006. More than 250 people attended the first forum, held on 1 March 2006. The second Health Professions Workforce Forum was held on 12 June 2006 and was attended by more than 220 people. Approximately 30% of people attending the second forum had previously attended the first forum, making a total of about 400 people who attended one or both forums.

Videoconference sessions were held after each of the forums to ensure participation by rural Health Professionals. Eight rural sites linked in to each of the videoconference sessions and provided an essential rural focus to the outcome information.

A synopsis of the collated information from the first forum was presented in the *Report on the Allied Health and Health Science Professions: Workforce Consultation Forum*.<sup>xi</sup>

The reports from both forums largely reflect the views of the forum participants and while WA Health does not necessarily endorse these, the views of the Health Professions expressed in the consultations have assisted in the development of strategies for planning and implementing a sustainable Health Professions workforce.

### Second Health Professions Workforce Consultation Forum

The second Health Professions Workforce Consultation Forum allied health and health science participant group was similar to the first forum. Participants included staff and external stakeholders, such as professional associations, registration boards, universities and training sector, industrial representatives, and private and non-government employers. Also in attendance were consumers and representatives from other professional and support groups.

The program for the second forum began with an opening address by the Director General of Health, followed by a progress update on the WA Health reforms by Dr Simon Towler, Executive Director, Health Policy and Clinical Reform in WA Health. Dr Towler's address was titled, *Clinical Networks and Planning for the Future*.

Dr Rosalie Boyce from Queensland University has been involved in both forums. At the second forum, Dr Boyce presented on *Developing Workforce Strategies for the Allied Health and Health Science Professions*, as a context for the proceeding workshops.

Participants were allocated to one of the three concurrent workshops: Workforce Supply and Distribution; Workforce Design; and, Workforce Skills Development. The task of the second forum workshops was to develop draft strategies and actions for the health professions workforce from the issues raised in the first forum.

For each strategy or focus area, workshop groups identified:

- Barriers and gaps
- Measures and targets

- Processes and actions needed
- Stakeholders and reference groups

The videoconference workshop session for rural and remote health professionals following the second forum, focussed on development of strategies relevant to rural services and health professions workforce. The rural participants worked in groups at their sites using the forum workshop format. The resulting information has been integrated into the collated results.

### 3. HEALTHY WORKFORCE STRATEGIC FRAMEWORK

Before outlining the main strategies developed from the second forum, this part of the Report gives information on the *Healthy Workforce Strategic Framework 2006-2016*, which provides the structure for development of workforce strategies.

*In order to deliver clinical service and infrastructure reform in Western Australia, workforce planning needs to take account of the broader health workforce context – of growing shortages, increasingly poor workforce distribution and concerns about the capacity of current health workforce structures and systems to respond to and adapt to change.*<sup>viii</sup>

Workforce is recognised as a critical element in the delivery of WA Health reforms. The *Healthy Workforce Strategic Framework* has been developed to support the achievement of planned WA Health clinical, service and infrastructure outcomes and forms part of the *WA Health Strategic Plan*. The following workforce reform areas and objectives provide the workforce planning framework for WA Health.

#### Workforce Supply and Distribution

Objective: An appropriate supply and distribution of health workers across the WA health system to deliver the CSF, WACHS Planning and associated reforms

#### Workforce Design

Objective: Work roles and arrangements that support the delivery of new models of care, service and infrastructure reforms in Western Australia and address areas of workforce shortages

#### Workforce Skill Development

Objective: Health workforce education and training that is flexible, relevant and responsive to WA Health service delivery requirements including the specific needs of WA Country Health Services

#### Workforce Data

Objective: Workforce data capture, systems and processes that provide and maintain an evidence-based foundation for strategic workforce planning for WA Health

## Workplace Culture and Environment

**Objective:** The development of positive and vibrant workplace cultures and environments across WA Health based on professionalism, team work and accountability that facilitate and support innovation and continuous improvement in the delivery of health care

A set of broad strategies to achieve each of the Framework objectives has been developed. Current and future planned actions to meet these objectives have been proposed. This is a ten-year planning framework and the strategies and actions will develop and evolve with annual review. Comprehensive measures and targets for the workforce planning framework will continue to evolve in response to the *Clinical Services Framework* and health system planning processes.

The workforce objectives in the *Healthy Workforce Strategic Framework* will be implemented in accordance with the following principles:

- High quality and safe health services are provided to the people of Western Australia
- Evidence based planning and evaluation is promoted and utilised
- Health delivery budget parameters are met
- Workforce planning is integrated with clinical and operational service planning
- There is open engagement with health system staff and stakeholders
- Partnership with the private sector in areas of mutual interest is recognised
- Initiatives and approaches align with relevant national workforce policy and planning
- The implementation of the Policy Framework for Substantive Equality is supported

## **4.HEALTH PROFESSIONS WORKFORCE STRATEGIES**

The Second Health Professions Workforce Consultation Forum workshops developed workforce strategies and actions, using input from the First Consultation Forum. The strategies and actions have been synthesized under the main strategy areas in the *Healthy Workforce Strategic Framework*, namely Workforce supply and distribution; Workforce design; Workforce skills development; Workforce data; and Workforce culture and environment.

The following outlines the proposed strategies arising from the consultation forum under each of these areas. A Table that details these proposed strategies is provided in Appendix 1.

## **4.1 Workforce Supply and Distribution**

Strategy 1: To establish a consistent level of service through all the health professions state-wide. It was recognised that services provided to outer metropolitan and non-metropolitan populations were generally not at the same level of specialty as the metropolitan population. There is a need to improve service levels, particularly in rural communities through the delivery of timely and appropriate services. The use of technology such as the Picture Archiving and Communications System (PACS) and videoconferencing for clinical services could be considered.

Strategy 2: To attract and retain Health Professionals in country and indigenous populations. Initiatives that address country student placements, relocation and accommodation costs, continuing professional development opportunities, flexible workforce opportunities including professional rotations and exchange between metro and country should be considered. Further initiatives could include professional and peer support and resources, research opportunities and career structure and conditions.

Strategy 3: To attract rural and remote candidates to train in Health Professions. The rural and remote disadvantages with pre entry education standards, lack of access to technology and lack of local exposure to and knowledge of health professions were identified. Specific measures are needed, such as the percentage of rural and remote students in health courses, destination surveys for graduates and country placements on offer.

Strategy 4: To raise the profile of the Health Professions role in health service delivery through media promotion options. The Health Professions do not enjoy the same high profile as the medical and nursing professions. An ongoing media campaign and promotion using groups such as the allied health peak body would increase the awareness of the health professions to potential students, to the community and within health services.

Strategy 5: To attract, retain and coordinate the distribution and allocation of Health Professionals across the health system through measures such as flexible work practices and pool systems. It was felt that budget processes should focus on the future needs, with sufficient human resource funding and administrative support for the Health Professions. Past processes have resulted in poor physical resources and staffing levels and workloads that limit quality of care. Cultural change would improve responsiveness to innovations, reduce attrition and absentee rates and improve retention of corporate knowledge, intellectual property and experience. Bipartisan support is needed for long term strategic investment in the health workforce, together with family friendly practices such as flexitime, part time employment and transition to retirement, accompanied by a career structure that includes progression and qualification recognition.

Strategy 6: To investigate a system of multiple entry levels, such as cadet, assistant or technician, graduate and postgraduate levels. At present there

are no multiple entry levels into the Health Professions, limited career paths and a ceiling to promotion. Competency based progression, accepted competency for degree courses or assessment processes to measure competencies would provide a structure related to the levels of skills required in the Health Professions workforce. This proposal is complementary to Workforce Design Strategy 8.

Strategy 7: To have a coordinated systems approach to the attraction of overseas Health Professionals that provides support and management on arrival. WA Health has developed overseas recruitment programs, but lack of communication between department managers and central overseas recruitment resources has resulted in poor coordination of vacant positions and requirements for work in Australia including education, registration and visa requirements. Initiatives such as fast tracking well credentialed overseas professionals through registration processes, WA Health support for overseas graduates (often specialist level), allowing more than 3-months at one place for working holiday visa and the creation of positions for clinical practice supervision before registration could be developed.

## **4.2 Workforce Design**

Strategy 8: To investigate Health Profession competency-based progression that links professional training to the career structure and recognises clinical speciality level. As in Workforce Supply and Distribution Strategy 6, this initiative aims to investigate new career paths including advanced practitioner roles through the development of competencies for professions and training and support for technical and assistant staff. Such initiatives have implications for use in remote settings.

Strategy 9: To develop consistent training and a career structure for assistants and technicians. It was identified that the extra responsibility for health professionals to support this initiative may lead to some resistance from the workforce. Currently there is no baseline audit or standards for assistant and professional roles and training is not standardised. This initiative is aimed at meeting the future growth in department and profession workforce needs.

Strategy 10: To provide administrative supports to allow Health Professionals to carry out their clinical roles. The aim is to increase clinical work loads, reduce waitlists in clinic and community, enable clinicians to be more responsive to client needs with an increase in early intervention and services that are not currently available, increase the consistency and utility of data and statistics and increase staff satisfaction and retention of staff.

Strategy 11: To enhance collaboration between government and non-government services to increase client access to multidisciplinary (and multi-agency) care. Client assessments involve a large number of stakeholders and people. Better inter/ multidisciplinary communication is needed to address integration of care, streamlined practice, care standards and integrated

programs. Shared resources, avoidance of duplication of services and coordination of care for complex cases are the aims.

Strategy 12: To enhance and develop community based care that provides services to demographic populations in keeping with clinical service reform and that has multidisciplinary governance including health professions. It was identified that there is minimal coordination of primary health care, particularly for chronic diseases. This strategy aims to provide local populations with a range of educational and clinical services, decrease presentations to hospital emergency departments and provide greater consumer satisfaction and reduced family dislocation.

Strategy 13: To develop generic positions and roles in appropriate settings to enhance client care. There are historical barriers to positions such as discharge coordinators and case coordinators where generic positions can be limited to particular Awards. Opening roles with a revised perception of scope could assist with workforce shortages and further develop career pathways for health professionals. A review of services and positions with potential for generic roles is needed with benchmarking against service and roles nationally and internationally.

### **4.3 Workforce Skills Development**

Strategy 14: To develop strong relationships between education and training institutions, professional bodies, industry, consumers and government to plan for Health Professions education with graduate attributes to meet the needs of the industry, lifelong learning, ongoing professional development and postgraduate training incorporated into clinical education. A formal framework for communication at all levels would allow for improved systems for clinical placements.

Strategy 15: To develop flexible re-entry systems for former employees that include support for clinical education and clinical placements. A joint university and WA Health reference group could review the need for a re-entry program, conduct a cost-benefit analysis, develop the program and seek government funding as appropriate.

Strategy 16: To increase accessibility to flexible learning and study. This initiative would require a needs analysis for programs that include use of the Internet, 'simulated patient' models and part-time study. An ongoing workforce data survey could provide feedback on education service delivery.

Strategy 17: To investigate a generic Undergraduate Health Science course, followed by specialised studies. Options could be for either a 3-yr health science degree prior to a graduate entry masters in a particular health profession or a 4-yr health profession degree based on a generic 1<sup>st</sup> year of studies. This strategy would involve a review of teaching practices and international models and the identification of core competencies across the health professions. It was also identified that a process could be developed to

guide students into courses, rather than choices being guided by TER/secondary education scores.

Strategy 18: To develop a workforce entry program that includes metropolitan and rural rotations. Models for workforce entry programs are available from other professions such as nursing. A Health Professions program would allow for standardised training and consistency, competency levels and incentives for rural workers. Support and partnerships between stakeholders such as the health professions, area health services and universities are needed.

Strategy 19: To investigate postgraduate training for health professions to improve education in specific areas and consolidate and enhance skills under appropriately provided supervision. The aim is the retention of health professionals and improvement in the quality of service delivery, particularly in rural areas. Partnership between area health services and universities could develop a program to offer training in clinical areas for 1<sup>st</sup> and 2<sup>nd</sup> year postgraduates.

Strategy 20: To establish inter professional development and education programs with sufficient numbers to sustain cost effective postgraduate programs and ensure adequate variety in professional development for all professions. A generic teaching program could be agreed upon by all professions, involve the professional associations and be facilitated through tertiary bodies.

Strategy 21: To develop a research collaborative linking metropolitan and rural services, training institutions and national and international service research programs. There is no current infrastructure or framework to link the various disciplines, research funding is competitive and there is a perception that the health professions are 'poor cousins' in research funding. Pilot projects of collaboration models such as the 'healthy at home' project that links Curtin University, interstate expertise and data linkage service could be enhanced with a research collaborative linked to the Clinical Networks, to establish disease based research priorities.

Strategy 22: To ensure resources to support clinical education with collaboration between state and federal government, education and health departments and different educational institutions. A health professions group could coordinate lobbying for funding to support ongoing education, especially to the federal government with the assistance of NGO's, private providers and consumer groups.

Strategy 23: To ensure an appropriate level of clinical work placements in health profession training with feedback systems to identify and follow up issues, knowledge and appropriateness of clinical places. There is a recognised need for a better clinical placement process. There is also a need for incentives for students to do rural placements, funding for more community clinical placements that reflect current and future trends in health, university supervisors to provide support for student placements and the formation of

education, training and placement standards between employers and education providers and professions.

#### **4.4 Workforce Data**

Workshop participants were not asked to develop strategies for Workforce Data for the Health Professions. However, accurate and reliable data collection and sets were identified at the First Forum as essential to the planning for the Health Professions Workforce. This is implicit in the strategies developed under each of the other areas, particularly workforce supply and workforce design.

#### **4.5 Workforce Culture and Environment**

Strategy 24: To address health professions representation at Executive, Area and departmental level. Currently there is no structure in place within area health services and hospitals for health professions leadership. There are historical and cultural barriers with doctors and nurses in management and fragmentation among health professions. A structure is required that begins with the appointment of the Chief Health Professions Officer and established Health Professions representation in each area health service and with executive management roles across health professions. This would allow for strong links to the clinical networks.

Strategy 25: To improve partnerships between metropolitan and rural services and between tertiary, secondary and primary services to ensure:

- Adequate discharge processes, client care and services
- Respect, valuing and awareness of rural practice roles, specialty skills and clinical competencies
- Community and politicians awareness of health professions services
- Recognition of multi-skills in quantitative client care and career opportunities for remuneration in rural areas
- Filling of vacant rural positions in a timely manner
- Information on facilities in country areas and realistic expectations for service provision
- Support from tertiary hospitals for rural rotations and backfill
- Improved occupancy and retention of rural health professionals
- Complementary services and formalised agreements for client care

## PART 2 IMPLEMENTING THE HEALTH PROFESSIONS WORKPLAN

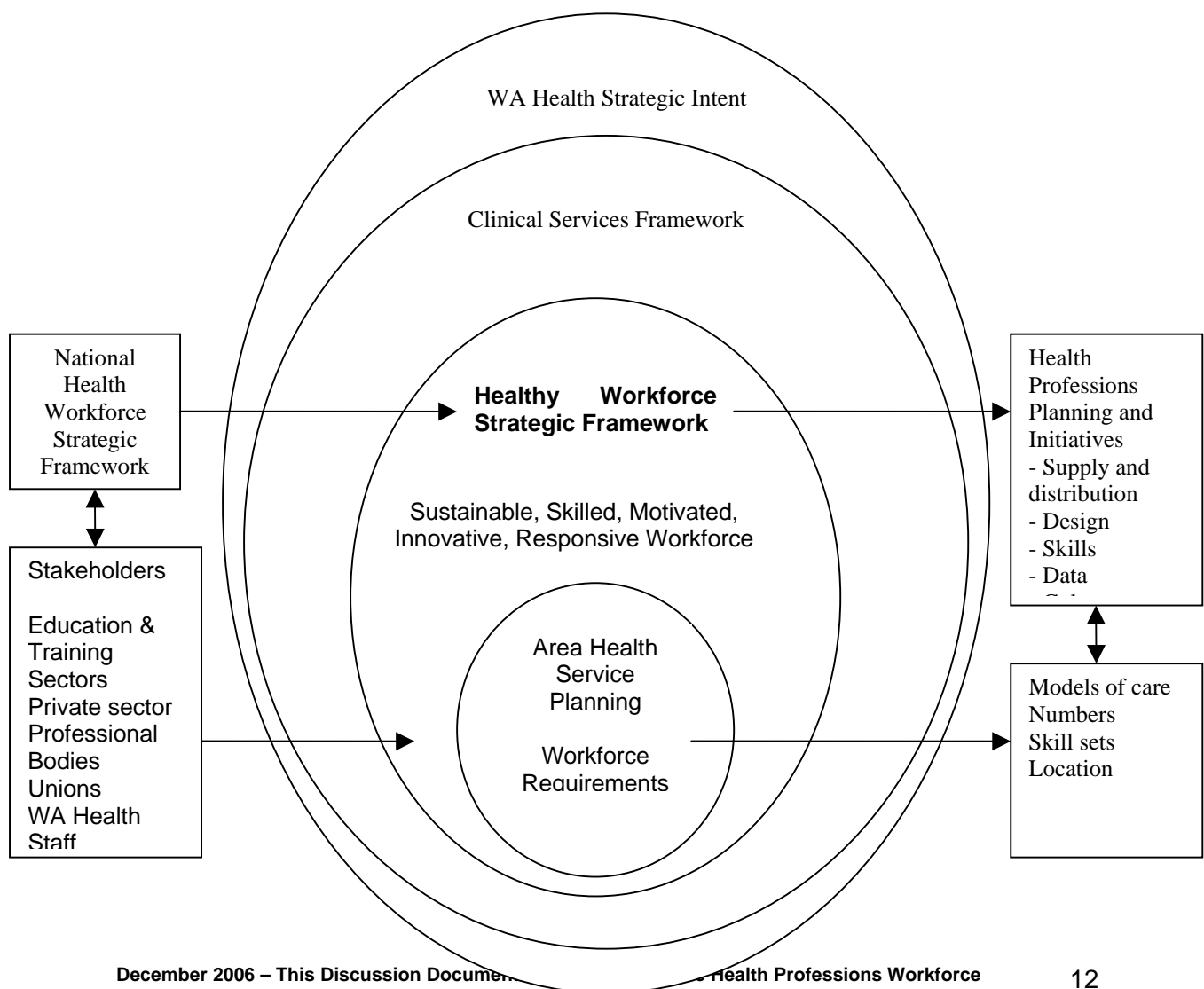
### 5. Workplan Foundation

Part 2 of this Report considers the development and implementation of a Health Professions workplan.

Figure 1 demonstrates the interrelationship of the key elements in delivering workforce reform. WA Health commitment, communication and collaboration are needed to ensure integration of workforce planning and clinical service reform. Collaboration and planning with external stakeholders including the education and training sector and the private sector is essential. WA Health is also working with jurisdictions nationally to progress effective national health workforce structures and reforms.

**Figure 1: Healthy Workforce Strategic Framework – Delivering Workforce Reform**

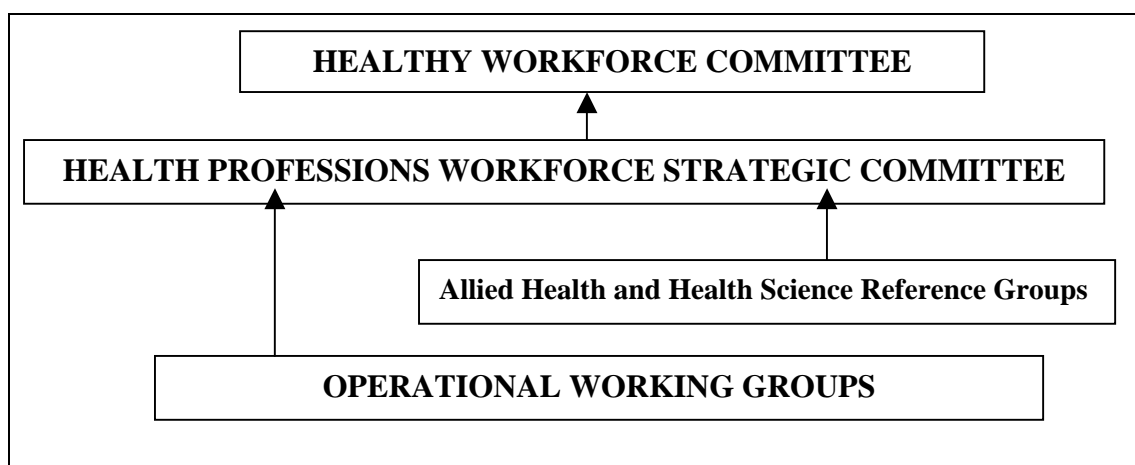
Adapted from Figure 5, *WA Health Healthy Workforce Strategic Framework* (page 8)



The strategies outlined in Part 1 of this Report from the Health Professions (Allied Health and Health Science) Consultation Forums will form the basis of project areas for inclusion in the *Healthy Workforce Strategic Framework Workplan*.

The suite of projects will be progressed within the Health Professions Workforce section of the WA Health Organisational Development Division under the direction of the WA Health Healthy Workforce Committee. Figure 2 shows the reporting and communication processes for Health Professions Workforce planning and implementation.

**Figure 2: Health Professions Workforce Reporting Processes**



## 6. Health Professions Strategies and Projects

The Health Professions Workforce Strategic Committee will direct the Health Professions Workforce planning through the development of an overarching strategy (see 6.1). This project will provide an action plan that will guide and drive the other Health Professions projects that align to the five areas of the *Healthy Workforce Strategic Framework Workplan*.

The Health Professions Workforce Strategic Committee will form an Operational Working Group for each of the five project areas:

- Health Professions Workforce Supply Project
- Health Professions Workforce Design Project
- Health Professions Workforce Skills Development Project
- Health Professions Workforce Data Project
- Health Professions Workforce Culture Project

The Operational Working Groups will develop and implement the projects, sub-projects and actions and report through the Health Professions Workforce Strategic Committee to the Healthy Workforce Committee.

## **6.1 Health Professions Workforce Planning Project**

### **Background and Justification**

The *Reid Report* identified the supply and demand issues that pertain to the health professions workforce and recommended (Recommendation 57) a comprehensive workforce planning, attraction and retention strategy be undertaken through the appointment of a senior adviser.

This project is to develop strategies that will underpin the work of the Health Professions Workforce Strategic Committee (HPWSC). This Committee will report to the Healthy Workforce Committee (HWC) and will be chaired by the Chief Health Professions Officer (CHPO).

### **Project Objectives:**

Develop strategic and operational plans to underpin the health professions workforce in keeping with the *WA Health Operational Plan 2006-07* Healthy Workforce objectives of:

- Attracting, recruiting and retaining adequate employee numbers
- Improving workforce participation and employee satisfaction
- Implementing workforce training, development and innovation frameworks

## **6.2 Building the Health Professions Workforce**

### **Background and Justification**

Workforce supply and distribution is one of the 5 priority areas in the *Healthy Workforce Strategic Framework 2006-2016*.

The strategies and actions to build the Health Professions workforce have been identified through the Health Professions Workforce Consultation process. Background information is also contained in recent reviews and reports on the WA health professions workforce where recruitment and retention issues were focus issues. The recent HSU claim that resulted in the Health Professions Work Value Review aimed to improve structures and conditions for health professionals.

The Health Professions Workforce Planning Project (see 6.1) will define the scope of the Building the Health Professions Workforce Project. The scope will, in turn, define the formation of the Operational Group for this Project.

### **Proposed Actions:**

Actions for this project identified through the consultation process and described as Strategies 1 to 7 in section 4.1 of Part 1 of this Report include:

- Establish a consistent level of health professions services state-wide
- Projected workforce needs for appropriate tertiary placement quotas
- Health professions recruitment, education and training frameworks
- Promotion of health professional roles in health service delivery
- Review of entry levels systems for health professions
- Coordinated attraction of overseas health professionals

- Feasibility study for health professionals re-entry programs and development of re-entry programs as appropriate
- Develop package of initiatives to attract health professionals including process to guide students' choice of health profession
- Specific actions to address the needs, attraction and retention for the rural and remote health professions workforce
- Develop consistent classification/pay structure for health professionals
- Attract rural and indigenous candidates into health professions careers

## **6.3 Health Professions Workforce Design**

### **Background and Justification**

Workforce design is one of the 5 priority areas in the *Healthy Workforce Framework 2006-2016*.

The strategies and actions for design and modelling of the Health Professions workforce have been identified through the Health Professions Workforce Consultation process. Background information is also contained in recent reviews and reports on the WA health professions workforce.

The Health Professions Workforce Planning Project (see 6.1) will define the scope of the Health Professions Workforce Design Project. The scope will, in turn, define the formation of the Operational Group for this Project.

### **Proposed Actions:**

Actions for this project identified through the consultation process and described as Strategies 8 to 13 in section 4.2 of Part 1 of this Report include:

- Review scope of practice and service models for local initiatives, national and international models and options, plan for pilot programs and implementation /mainstreaming of successful pilot programs
- Collaboration research such as 'healthy at home' project that links university, interstate expertise and data linkage service
- Implementation of care models with client access, government and non-government collaboration, multidisciplinary models, consumer feedback, links to Clinical Networks and services through use of IT
- Continuing professional development to match changes in skill levels
- WA health policy and systems that link competency-based progression to training and career structures, clinical speciality and standards
- Develop rural service models that include financial incentives, continuing professional development, mentoring and support
- Models of care delivery with assistants and professional supports, uniform training and career structure for assistants and technicians and administrative supports for clinicians
- Generic positions including indigenous roles, to enhance client care

## **6.4 Health Professions Workforce Skill Development**

### **Background and Justification**

Workforce skills development is one of the 5 priority areas in the *Healthy Workforce Framework*.

The strategies and actions for enhancing skills development in the Health Professions workforce have been identified through the Health Professions Workforce Consultation process. Background information is also contained in recent reviews and reports on the WA health professions workforce where skills development was identified as contributing strongly to recruitment and retention of health professionals.

The Health Professions Workforce Planning Project (see 6.1) will define the scope of the Health Professions Workforce Skill Development Project. The scope will, in turn, define the formation of the Operational Group for this Project.

### **Proposed Actions:**

Actions for this project identified through the consultation process and described as Strategies 14 to 23 in section 4.3 of Part 1 of this Report include:

- Plan for lifelong learning, continuing professional development and postgraduate training education with identification of the needs of students and clinicians
- Accessible, funded and flexible education programs for rural and metropolitan health professionals
- Review of undergraduate programs for retention rates, course content re health care reforms, graduate attributes to meet industry needs, postgraduate clinical training and graduate program/ internships
- Consideration of Health Science courses with core competencies followed by specialisation and/or three-year health science degree prior to Graduate Entry Masters (GEM) in a specific health profession
- Clinical placement/fieldwork system with appointed clinical supervisors, agreed fieldwork places, and student access to placements
- Consideration of registration for all health professions,

## **6.5 Health Professions Workforce Data**

### **Background and Justification**

Workforce data is one of the 5 priority areas in the *Healthy Workforce Framework*.

The strategies and actions for design of the Health Professions workforce have been identified through the Health Professions Workforce Consultation process. Background information is also contained in recent reviews and reports on the WA health professions workforce.

The Health Professions Workforce Planning Project (see 6.1) will define the scope of the Health Professions Workforce Data Project. The scope will, in turn, define the formation of the Operational Group for this Project.

### **Proposed Actions:**

Actions for this project identified through the consultation process and described in section 4.4 of Part 1 of this Report include:

- Collection of relevant and meaningful data across the health professions to enhance workforce modelling and inform education delivery
- National engagement to ensure consistency of health professions data
- Integration of health professionals workforce planning with health service, clinical and infrastructure planning

## **6.6 Health Professions – Enhanced Partnership and Collaboration**

### **Background and Justification**

Workforce culture and environment is one of the 5 priority areas in the *Healthy Workforce Framework*.

The strategies and actions for the Health Professions workforce culture and environment have been identified through the Health Professions Workforce Consultation process. Background information is also contained in recent reviews and reports on the WA health professions workforce.

The Health Professions Workforce Planning Project (see 6.1) will define the scope of the Health Professions Enhanced Partnership and Collaboration Project. The scope will, in turn, define the formation of the Operational Group for this Project.

### **Proposed Actions:**

Actions for this project identified through the consultation process and described as Strategies 24 and 25 in section 4.5 of Part 1 of this Report include:

- Partnerships between health professions groups, with medical and nursing workforces and across metropolitan and rural services
- Improved leadership for the health professions with appointment of Chief Health Professions Officer and integration of health professionals into established leadership programs Vital Leadership and Leading 100
- Developed health professional leadership in the management of reform
- Developed workplace practices that support Equal Opportunity Employment, flexible and family friendly work places and encourage a work/life balance
- Strengthened relationships and partnerships between education and training institutions, professions, industry, consumers and WA Health

## Appendix 1: Full List of Forum Strategies

The following Table includes the full list of strategies developed by forum participants and used as the basis for the development of WA Health workforce strategies for the Health Professions

### Workforce Supply and Distribution

Strategy	Barriers and Gaps	Measures and Targets	Processes and Actions Needed	Stakeholders and Reference Groups
1. Establish a consistent level of service through all the health professions state-wide	<ul style="list-style-type: none"> <li>Attracting speciality clinicians to visit country sites on a rotational basis</li> <li>Provision of technology such as PACS and tele/videoconferencing at country sites to facilitate consistent services</li> </ul>	<ul style="list-style-type: none"> <li>Raised service levels in rural communities through timely services with 24 hour specialist care using remote reporting technology i.e. PACS/videoconf</li> <li>Reduced demand on metro hospitals by rural patient services</li> <li>Risk minimisation</li> </ul>	<ul style="list-style-type: none"> <li>Consultation to determine the disciplines involved in service</li> <li>Attract core specialist services to visit country hospitals</li> <li>Electronically transmit images and results</li> <li>Maintain sufficient bandwidth for efficient/ timely data transfer</li> </ul>	DoH, Hospitals, WACHS and Specific health professions
2. Attract and retain Health Professionals in country and indigenous populations	<ul style="list-style-type: none"> <li>Limited supported country student places to encourage return to rural areas once qualified</li> <li>Relocation/ accommodation costs, incentive lacking</li> <li>Limited support and resources, often isolated</li> <li>Lack of training in indigenous culture to work in special populations</li> </ul>	<ul style="list-style-type: none"> <li>Movement of professionals into rural areas and length of stay</li> <li>Improved career structure, pay and conditions</li> </ul>	<ul style="list-style-type: none"> <li>Metro and country rotations</li> <li>Incentives - study leave, tax exemptions, greater holiday leave, relocation</li> <li>Training in indigenous/ cultural needs/ approaches</li> <li>Generic health professional advisor to support workers</li> <li>Research opportunities</li> <li>No contracts less than 1-yr; plan for 5- yr permanent</li> </ul>	DoH, regional health centres and local communities, elders and indigenous communities, training schools/universities/TAFE, NGO's in regional areas, consumers and carers and local councils
3. Attract rural and remote candidates to train in Health Professions	<ul style="list-style-type: none"> <li>Relocation /accommodation</li> <li>Lack of family/other support</li> <li>Rural/remote disadvantages – entry education standards</li> <li>Access to technology</li> <li>Lack of local exposure to and knowledge of health professions</li> </ul>	<ul style="list-style-type: none"> <li>Baseline percentage of rural and remote students in health courses</li> <li>Destination surveys for graduates</li> <li>Review rural applicants to courses and percentages not accepted</li> <li>Country placements on offer and financial support</li> </ul>	<ul style="list-style-type: none"> <li>Incentives - study relocation from country/to rural fieldwork</li> <li>Country student HECS support</li> <li>Scholarships / bonded</li> <li>Recruit high school students to careers, foster links between candidates, resources, areas, unis and indigenous leaders</li> </ul>	Educational institutions, WACHS, professional organisations, DoH
4. Media campaign to promote Health Profession role in	<ul style="list-style-type: none"> <li>Cost and responsibility</li> <li>Motivation of people</li> </ul>	<ul style="list-style-type: none"> <li>Numbers recruited, uni places, more graduates in professions</li> <li>Attract to university and more</li> </ul>	<ul style="list-style-type: none"> <li>High level media campaign</li> <li>Promote in schools</li> </ul>	High school / uni students, professions, employers, health consumers, career

health service delivery	<ul style="list-style-type: none"> <li>Executive support and non-utilisation of peak body</li> </ul>	overseas professionals	<ul style="list-style-type: none"> <li>Recruitment webpage</li> <li>Funded clinical training for unis</li> </ul>	changers, and Government
5. Attract, retain and coordinate distribution and allocation of Health Professionals across the health system through measures such as flexible work practices and pool systems	<ul style="list-style-type: none"> <li>Budgets focus on past not future, lack HR and admin</li> <li>Managers not empowered to manage</li> <li>Staffing and workload limit care quality</li> <li>Rewards system inequitable</li> <li>Poor physical resources</li> <li>Need for cultural change - response to innovation</li> </ul>	<ul style="list-style-type: none"> <li>Reduced attrition/absentee rates and training costs of new staff</li> <li>Job satisfaction surveys and increased response to feedback</li> <li>Improved shift cover, filling of vacancies and reduced overtime</li> <li>Retain corporate knowledge, intellectual property/ experience</li> <li>Clinical governance and evidence based practice</li> </ul>	<ul style="list-style-type: none"> <li>Bipartisan support for long term health workforce strategies, resources to achieve outcomes</li> <li>Family friendly practice, part/flexitime, transition to retirement</li> <li>Career structure, progression and qualification recognition</li> <li>Accepted workload standards</li> <li>Re-skilling, development</li> <li>Empower managers</li> </ul>	Workforce, employers, professions, Area health executive, HR and Finance departments, consumers, community, NGO's and Government
6. System of multiple entry levels, such as cadet, assistant or technician, graduate and postgraduate (see Workforce Design Strategy 8)	<ul style="list-style-type: none"> <li>Medico-legal issues</li> <li>Single entry level, no career path, ceiling to promotion</li> <li>No competency based progression/degree courses</li> <li>No resources, drive or leadership for change</li> </ul>	<ul style="list-style-type: none"> <li>Competency levels established</li> <li>Career path with higher levels for specialists, e.g. nurse practitioner</li> <li>Increased pool of candidates to employ</li> <li>Increased number of senior staff at higher levels</li> </ul>	<ul style="list-style-type: none"> <li>Career path with competency assessment</li> <li>Multiple entry levels e.g. cadet, assistant, graduate, postgrad</li> <li>Uni courses for technical/assistant staff</li> <li>Education provider links</li> </ul>	Education providers - TAFE, universities, schools, professional associations, Unions and Government
7. Coordinated systems approach to the attraction of overseas Health Professionals with support and management on arrival	<ul style="list-style-type: none"> <li>Lack of communication between service managers and DoH overseas recruitment resources</li> <li>Poor coordination of vacant positions, requirements for work in Australia including education, registration and visa requirements</li> </ul>		<ul style="list-style-type: none"> <li>Website/ agency recruitment</li> <li>Links between DoH, professions, health services</li> <li>Accreditation and registration of overseas qualifications</li> <li>Support for overseas specialists and &gt;3 months working visa</li> <li>Positions for clinical practice supervision before registration</li> </ul>	

## Workforce Design

Strategy	Barriers and Gaps	Measures and Targets	Processes and Actions Needed	Stakeholders and Reference Groups
8. Health profession competency-based progression linking training and career structure and recognising clinical speciality level (see Workforce Supply and Distribution Strategy 6)	<ul style="list-style-type: none"> <li>No career path and ceiling to promotion</li> <li>No competency based progression, acceptance of competency for degree courses or assessment process to measure competencies</li> </ul>	<ul style="list-style-type: none"> <li>Competency levels established</li> <li>Career path with higher levels for specialists, e.g. nurse practitioner</li> <li>Increased pool of candidates to employ</li> <li>Increased number of senior staff at higher levels</li> </ul>	<ul style="list-style-type: none"> <li>Career path including Advanced Practitioner role through competencies with assessment and support for staff to achieve</li> <li>Accept technical and assistant staff to university courses</li> <li>Education provider links for part time clinical and course</li> </ul>	Education providers - TAFE, universities, schools, professional associations, Unions and Government

	<ul style="list-style-type: none"> <li>No resources, drive or leadership for change</li> </ul>		<p>positions</p> <ul style="list-style-type: none"> <li>Implications of the use of this strategy for remote settings</li> </ul>	
9. Consistent training and career structure for assistants and technicians	<ul style="list-style-type: none"> <li>More profession responsibility</li> <li>No baseline/standards for assistant/ professional roles</li> <li>No representative body for assistants and technicians</li> <li>Training is not standardised, need to maintain standards</li> <li>HECS may be a disincentive</li> <li>Some Registration Acts</li> </ul>	<ul style="list-style-type: none"> <li>Data on assistants, duties, training, graduates, placement</li> <li>Improved competency and care</li> <li>Course content, training implementation and evaluation</li> <li>Career progression for profession</li> <li>Alignment and consistency of positions and pay scales</li> <li>Meet future growth</li> </ul>	<ul style="list-style-type: none"> <li>HSU/DoH work value review of assistants/ technicians</li> <li>Identify positions as models for competencies and roles</li> <li>Cost/ benefit analysis</li> <li>Identify existing positions for classification review</li> <li>Establish training course</li> </ul>	Unions, Government, professional associations/ bodies, educational institutions, ITAB, consumers, current workforces
10. Administrative supports to allow Health Professionals to carry out their clinical roles	<ul style="list-style-type: none"> <li>Clerical assistant training</li> <li>Lack of consistency in data entry / interpretation of codes</li> <li>Funding restrictions and risk that more administrative support may reduce budget for clinicians</li> </ul>	<ul style="list-style-type: none"> <li>Increased clinical workload, reduced waitlists</li> <li>Staff satisfaction surveys, role advancement and staff retention</li> <li>Client contact and response</li> <li>Consistent data and statistics</li> <li>Increase in early intervention</li> </ul>	<ul style="list-style-type: none"> <li>Review administrative roles undertaken by clinical staff</li> <li>Benchmark local practices</li> <li>Develop data translation system</li> <li>Training for clerical assistants</li> <li>Develop best practice clerical to clinician ratios</li> </ul>	Current workforce, Consumers, GP's, Employers and other data processing officers
11. Collaboration between government and non-government services to increase client access to multidisciplinary (and multi-agency) care	<ul style="list-style-type: none"> <li>Large number of stakeholders and people in the assessment</li> <li>Limited time and inadequate communication to organise</li> <li>Lack of resources to access evidence based practice</li> <li>Clinical governance/legal re consent and confidentiality</li> <li>GP/consultant awareness; Funding/ billing arrangements</li> </ul>	<ul style="list-style-type: none"> <li>Clinical network strategies / KPIs</li> <li>Best practice care models</li> <li>Access to clinical pathway, standards/ integrated programs</li> <li>Inter/multidisciplinary services</li> <li>Continuing education with rural access and links to universities</li> <li>Share resources, avoid duplication of services and coordinate complex cases</li> </ul>	<ul style="list-style-type: none"> <li>Gap analysis of needs, access, capacity, other providers</li> <li>Local, national and international processes and models</li> <li>Develop education, structure, governance, eligibility criteria</li> <li>Trial, evaluate, adapt inter disciplinary /interagency models</li> <li>Promote teamwork</li> <li>Leadership and coordination</li> </ul>	GP's, consumers, clients, carers, NGO's, Private practitioners, Government (3 tiers), teaching organisations, professions, research
12. Enhance and develop community based care with services in keeping with clinical service reform and that has multidisciplinary health professions	<ul style="list-style-type: none"> <li>Political influence, funding from three tiers of government</li> <li>Coordinate primary health for chronic diseases</li> <li>No physical sites at present</li> <li>Limited staffing</li> <li>Limited specialist services</li> </ul>	<ul style="list-style-type: none"> <li>Decrease in presentation to hospital emergency departments</li> <li>Greater consumer satisfaction</li> <li>More community health centres staffed to meet community needs</li> <li>Local population has a range of educational and clinical services</li> </ul>	<ul style="list-style-type: none"> <li>Health professions as primary practitioners in primary health</li> <li>Data for needs and staffing</li> <li>Community health centres with developmental and preventative</li> <li>Collocate services for amenities</li> <li>Links with stakeholders</li> </ul>	Consumers, AMA, Divisions of general practice, DoH, Area Health services, NGO's, Educational facilities, population health, community and community groups
13. Develop generic positions and roles in appropriate settings to enhance client care, e.g. discharge coordinators and case	<ul style="list-style-type: none"> <li>Historical barriers with Award positions - revise scope roles</li> <li>Presumption that generic workers will solve shortages</li> <li>Risks in reducing health</li> </ul>	<ul style="list-style-type: none"> <li>Review of services and positions with potential for generic roles</li> <li>Qualified applicants for positions, and measures, e.g. lower LOS and admission rates</li> </ul>	<ul style="list-style-type: none"> <li>Identify roles where generic positions would enhance client care, e.g. discharge and case coordinators, care coordinators</li> <li>Job descriptions for services</li> </ul>	Unions, training institutions, consumer and community representatives, professions, employers, health professionals and nursing professionals

coordinators	professionals in clinical roles, diversification of workforce • Career pathways for health professionals underdeveloped	• Benchmarking against service and roles inter/nationally • Health professional knowledge /skills, interdisciplinary teams	• Evaluate implementation of strategy, e.g. pilot of generic positions in a range of different services and settings	
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## Workforce Skills Development

Strategy	Barriers and Gaps	Measures and Targets	Processes and Actions Needed	Stakeholders and Reference Groups
14. Strong relationships between education and training institutions, professional bodies, industry, consumers and government	<ul style="list-style-type: none"> <li>Organisational culture - North/South area divide, executive recognition of health professions, representation</li> <li>Leadership to coordinate and develop communications</li> <li>Diversity of professions, negotiating power, opinions, agenda, priority, expectation</li> <li>Engagement/consultation between stakeholders</li> <li>Commitment, accountability to guide infrastructure, resource</li> <li>Coordination for student clinical placements</li> </ul>	<ul style="list-style-type: none"> <li>Communication framework</li> <li>Health Profession Education with:                             <ul style="list-style-type: none"> <li>Graduate attributes to meet industry needs</li> <li>Lifelong learning, ongoing professional development</li> <li>Postgraduate education</li> </ul> </li> <li>Clinical placements systems with:                             <ul style="list-style-type: none"> <li>Clinical supervisor positions</li> <li>Formal agreement regarding clinical placements in health</li> <li>Increase number of students able to access placements</li> <li>Multidisciplinary education programs to better equip grads</li> </ul> </li> </ul>	Chief Health Professions Officer to coordinate networks/frameworks for: <ul style="list-style-type: none"> <li>Health professions education</li> <li>Communication</li> <li>Workforce planning</li> <li>Discipline specific bodies</li> <li>Course curriculum, external advisory, students, etc</li> <li>Review student retention, workforce, other models, competency based outcomes</li> <li>Joint positions with universities</li> <li>Identify postgraduate training needs e.g. workforce entry programs and videoconference</li> </ul>	Clinicians, Area Health services, professions, tertiary institutions, DEST/DoET, Unions, consumers, community groups and NGO's
15. Flexible re-entry systems for former employees	<ul style="list-style-type: none"> <li>Limited resources for new 'Bridging' course including funding and support for clinical education/ placements</li> </ul>	<ul style="list-style-type: none"> <li>Course structured by unis/DoH with theory and clinical training</li> <li>Course may have a multidisciplinary approach</li> </ul>	<ul style="list-style-type: none"> <li>University/ DoH group to review need for program, conduct cost-benefit analysis, develop program and seek funding</li> </ul>	Universities, teaching hospitals, DoH
16. Accessibility to flexible learning and study	<ul style="list-style-type: none"> <li>Non-traditional education may not be appropriate for all courses and lose human 'face to face' interaction</li> <li>Cost may be prohibitive</li> </ul>		<ul style="list-style-type: none"> <li>Needs analysis for programs including Internet, 'simulated patient' model, part-time study</li> <li>Workforce data survey to inform education service delivery</li> </ul>	Consumers, clients, professions, registration boards, universities, unions, Productivity Commission, private sector and NGO's
17. Generic Undergraduate Health Science course, followed by specialisation	<ul style="list-style-type: none"> <li>Health Sciences attrition rate</li> <li>Resources for fieldwork placements, course funding</li> <li>Uni/health professions 'silos'</li> <li>Differing Uni courses, competitive scores and definitions of allied health</li> <li>Reciprocal qualifications interstate and internationally</li> <li>Legislative barriers</li> </ul>	<ul style="list-style-type: none"> <li>Attrition, number of graduates, and in health science courses</li> <li>Stronger sense of allied health and more options for students</li> <li>Stronger working relationships and networks</li> <li>Creation of a single registration body</li> <li>Identified roles for generic allied health professionals</li> </ul>	<ul style="list-style-type: none"> <li>Option of 3-yr health science degree and graduate entry masters or 4-yr degree with generic 1<sup>st</sup> year</li> <li>Review of teaching practices and international models</li> <li>Engage funding bodies</li> <li>Identify core competencies</li> <li>Process to guide students, rather than use of TER score</li> </ul>	Universities, students, media and health promotion, professions, Registration boards, State and commonwealth government

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<p>18. Workforce entry program that includes metropolitan and rural rotations</p>	<ul style="list-style-type: none"> <li>• Standardised training and preceptor resistance</li> <li>• Funding positions and HECS (for country training)</li> <li>• Rural issues - availability of housing and relocation</li> <li>• Inflexible graduate education</li> <li>• Disparate professional base, across professions and areas</li> </ul>	<ul style="list-style-type: none"> <li>• Graduate and course numbers, numbers of applicants against number of positions, esp. rural positions and percentage completing program</li> <li>• Assessment of competency based training; length of stay (staff turnover), reduction in fly in/out workers and exit interviews</li> </ul>	<ul style="list-style-type: none"> <li>• Analyse program and resources including costs and places</li> <li>• Investigate models in other professions, i.e. nursing</li> <li>• Program with standards and consistency, competency levels and incentives for rural workers</li> <li>• Partnerships with stakeholders</li> </ul>	<p>Health Professions, Government, community, consumer groups, universities and educational bodies</p>
<p>19. Postgraduate training for health professions</p>	<ul style="list-style-type: none"> <li>• Improved education in specific areas</li> <li>• Consolidate/enhance skills under appropriate supervision</li> </ul>	<ul style="list-style-type: none"> <li>• Retention of health professionals</li> <li>• Improved quality of service delivery, particularly in rural areas</li> </ul>	<ul style="list-style-type: none"> <li>• Partnership between area health services and universities</li> <li>• Offer training in clinical areas for 1<sup>st</sup> and 2<sup>nd</sup> year postgraduates</li> </ul>	<p>Universities, area health services, professions and graduates</p>
<p>20. Inter professional development and education programs</p>	<ul style="list-style-type: none"> <li>• Professionals/ professional bodies unwilling to participate</li> <li>• Lack of defined teaching program across professions</li> <li>• Recognised study leave</li> <li>• Funding e-learning/ lecturers</li> </ul>	<ul style="list-style-type: none"> <li>• Sufficient numbers to sustain programs; cost effective program</li> <li>• Variety among professions</li> <li>• Assessments and evaluation of clinical outcomes and courses</li> <li>• University and DoH cooperative</li> </ul>	<ul style="list-style-type: none"> <li>• Mandatory professional development</li> <li>• Generic teaching program</li> <li>• Facilitate through on-line, e-learning, hospital, campus</li> <li>• Business case for resource</li> </ul>	<p>All professions, universities and tertiary institutions, registration boards and licensing bodies, employees and postgraduate students</p>
<p>21. Research collaborative linking metropolitan and rural services, training institutions and national/international research programs</p>	<ul style="list-style-type: none"> <li>• No infrastructure/ framework to link various disciplines</li> <li>• Competitive research funding and organisational change</li> <li>• Health professions are 'poor cousin' in research funding</li> </ul>	<ul style="list-style-type: none"> <li>• NHMRC funded research projects</li> <li>• Models of care accepted as national or international benchmarks</li> <li>• Pilot programs are integrated as service care models</li> </ul>	<ul style="list-style-type: none"> <li>• Service initiatives supported by a funded research program</li> <li>• Multidisciplinary collaboration to collect outcome measures</li> <li>• Pilots of collaboration models</li> <li>• Clinical Networks research link</li> </ul>	<p>Professions, special interest groups (research) within professions, DoH, consumers, universities and health services</p>
<p>22. Resources to support clinical education</p>	<ul style="list-style-type: none"> <li>• Collaboration – state/ federal government, education/health and educational institutions</li> <li>• Lobbying at federal level may result in WA not being heard</li> <li>• Lack of WA health profession leadership for federal lobby</li> </ul>	<ul style="list-style-type: none"> <li>• Professional groups lobbying on areas of concern (e.g. health training) to federal and state government departments of education and health</li> </ul>	<ul style="list-style-type: none"> <li>• Coordinated lobby for funding, assistance of NGO's, private providers, consumer groups</li> <li>• Research care delivery models that use students/ assistants</li> <li>• Trial/ pilot different models of student placement</li> </ul>	<p>Professions, registration bodies, consumers, educational institutions, health insurers, NGO's and state and federal Departments of Health</p>
<p>23. Appropriate level of clinical work placements in health profession training with feedback systems to identify and follow up issues, knowledge and appropriateness of clinical places</p>	<ul style="list-style-type: none"> <li>• Insufficient clinical places and increased community focus, from factors including privatisation, academic tenure</li> <li>• Clinical areas not funded</li> <li>• No formal relationships between educational institutions and work sites</li> </ul>	<ul style="list-style-type: none"> <li>• Avenues for consumers feedback</li> <li>• Funding for health professions in community and mental health</li> <li>• Education providers have knowledge of current work issues</li> <li>• Relationship between educational institutions and work sites</li> <li>• Accuracy of discipline compliance requirements</li> </ul>	<ul style="list-style-type: none"> <li>• Clinical u'graduate places with joint clinical/university positions</li> <li>• Incentives for students to do rural placements</li> <li>• Funded community fieldwork that reflect current/ future trends</li> <li>• University supervisors to support student placements</li> <li>• Standards for fieldwork</li> </ul>	<p>All health care deliverers, consumers and providers</p>

**Workforce Data** Accurate and reliable data collection was identified at the First Forum as essential to the planning for the Health Professions Workforce. This is implicit in the strategies developed under each of the other areas, particularly workforce supply and workforce design.

## Workforce Culture and Environment

Strategy	Barriers and Gaps	Measures and Targets	Processes and Actions Needed	Stakeholders and Reference Groups
24. Health professions representation at Executive, Area and departmental level	<ul style="list-style-type: none"> <li>No structure in place in area health services and hospitals</li> <li>Historical and cultural barriers – doctor/ nurse management</li> <li>Fragmentation among health professions</li> <li>No lead in health executive</li> </ul>	<ul style="list-style-type: none"> <li>All departments to have access to health professional representation</li> <li>Improved multidisciplinary clinical pathways for client care</li> </ul>	<ul style="list-style-type: none"> <li>Recruitment of Chief Health Professions Officer</li> <li>Health Profession Directors in each area health service</li> <li>Links between clinical networks</li> <li>Infrastructure funding, resources and staffing to support roles</li> </ul>	
25. Improved partnerships between metropolitan and rural services and between tertiary, secondary and primary services	<ul style="list-style-type: none"> <li>Inadequate client discharge processes, care and services</li> <li>Respect, value, awareness of rural practice roles, specialty skills, clinical competencies</li> <li>Community/politicians not aware of services</li> <li>Multi-skills in client care, career opportunities, remuneration not recognised</li> <li>Clinical service time spent on admin and data collection</li> <li>Lack of training, supervision and infrastructure</li> <li>No shared value between government/ NGO services</li> <li>Lack of housing, different housing for nursing/ medical</li> <li>Vacant positions; funding lost when positions not filled</li> <li>Facilities in country and unrealistic expectations</li> <li>Rural allied health not well-known; lack of consultation re patient discharge</li> <li>Lack of support from tertiary hospitals for rural rotations/backfill</li> </ul>	<ul style="list-style-type: none"> <li>Increased (videoconference) consultation, planning between metro/rural Health Professions for discharge, pathways-out referrals</li> <li>Discharge procedure created for WA Health</li> <li>Improved occupancy/retention of rural health professionals</li> <li>System of performance development and competencies</li> <li>Student placements mapped for recruitment/retention capacity</li> <li>Clinician/ community satisfaction surveys to identify and address obstacles to clinical practice</li> <li>Complementary services and formalised agreements for client care</li> </ul>	<ul style="list-style-type: none"> <li>Improve awareness, value of staff, celebrate rural, metro and health professions differences</li> <li>Rotations with move between metro, country and regions</li> <li>Clinical client management protocols with uniform rural and metro discharge and referrals</li> <li>Career equity between metro and rural based on rural knowledge and conceptuality</li> <li>Access to rural education, training and supervision; professional development</li> <li>Uni 'safari' to scope placement opportunities, inform students</li> <li>Address housing shortage</li> <li>Expectations for qualifications to avoid un/under qualified</li> <li>Awards for country service</li> <li>Respect from metro specialists, with enhanced metro, rural and inter-region partnerships</li> <li>Clinical services network recognition of country roles in rehabilitation, referral pathways</li> </ul>	<p>Telehealth coordinators, health professions, WACHS allied health reference group, employment agencies servicing mental health areas, tertiary child and adolescent hospitals, universities, regional managers, regional directors, HCN/HR, GEHA/real estate, Clinical Networks/Executive Director, Health Policy and Clinical Reform</p>

## References

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<sup>i</sup> Department of Health WA. 2005. WA Health Clinical Services Framework 2005-2015, Perth. [Available at: [Hhttp://www.health.wa.gov.au/HRIT/csf/docs/clinicalframework.pdf](http://www.health.wa.gov.au/HRIT/csf/docs/clinicalframework.pdf)H]

<sup>ii</sup> Department of Health WA. 2006. Allied Health and Health Science Professions Workforce Consultation Discussion Paper . [Available at: [Hhttp://www.health.wa.gov.au/HRIT/workforceframework/forum.cfm](http://www.health.wa.gov.au/HRIT/workforceframework/forum.cfm)H]

<sup>iii</sup> WA Health, Organisational Development Division. *Report on the Allied Health and Health Science Professions: Workforce Consultation Forum, May 2006.* [Available at: [Hhttp://www.health.wa.gov.au/HRIT/workforceframework/forum.cfm](http://www.health.wa.gov.au/HRIT/workforceframework/forum.cfm)H]

<sup>iv</sup> Health Reform Committee. 2004. A Healthy Future for Western Australians: report of the Health Reform Committee, Perth: Department of Health WA [Available at: [Hhttp://www.health.wa.gov.au/HRIT/publications/docs/Final\\_Report.pdf](http://www.health.wa.gov.au/HRIT/publications/docs/Final_Report.pdf)H]

<sup>v</sup> Australian Health Ministers' Conference. 2004. National Health Workforce Strategic Framework, Sydney [Available at: [Hhttp://www.health.nsw.gov.au/amwac/pdf/NHW\\_stratfwork\\_AHMC\\_2004.pdf](http://www.health.nsw.gov.au/amwac/pdf/NHW_stratfwork_AHMC_2004.pdf)H]

<sup>vi</sup> Department of Health WA. 2005. Strategic Intent 2005-2010, Perth [Available at: [Hhttp://www.health.wa.gov.au/HRIT/publications/docs/Strategic\\_Intent\\_2005-2010.pdf](http://www.health.wa.gov.au/HRIT/publications/docs/Strategic_Intent_2005-2010.pdf)H]

<sup>vii</sup> WA Health 2006 *Healthy Workforce Consultation Framework* [Available at: [Hhttp://www.health.wa.gov.au/hrif/workforceframework/docs/consultation.cfm](http://www.health.wa.gov.au/hrif/workforceframework/docs/consultation.cfm)H ]

<sup>viii</sup> Department of Health WA. 2005. WA Health Clinical Services Framework 2005-2015, Perth. [Available at: [Hhttp://www.health.wa.gov.au/HRIT/csf/docs/clinicalframework.pdf](http://www.health.wa.gov.au/HRIT/csf/docs/clinicalframework.pdf)H]

<sup>ix</sup> WA Health 2006 *Healthy Workforce Strategic Framework 2006-2016* [Available at: [Hhttp://www.health.wa.gov.au/HRIT/workforceframework/index.cfm](http://www.health.wa.gov.au/HRIT/workforceframework/index.cfm)H]

<sup>x</sup> "Health Professions" hereon in refers to Allied Health and Health Science Professions as defined in the Health Services Union Award

<sup>xi</sup> WA Health, Organisational Development Division. *Report on the Allied Health and Health Science Professions: Workforce Consultation Forum, May 2006.* [Available at: [Hhttp://www.health.wa.gov.au/HRIT/workforceframework/forum.cfm](http://www.health.wa.gov.au/HRIT/workforceframework/forum.cfm)H]