WORKFORCE AND TRAINING ROUNDTABLE

Friday 27th July 2018
Maylands

OUTCOMES REPORT

Context

The purpose of the Roundtable was to bring together key leaders within the workforce, education and training sector to contribute to a targeted discussion on the future of our workforce and training programs, in the context of sustainability

Key Outcomes

The workforce and training pipeline of the future will be **flexible, responsive, interdisciplinary, collaborative and compassionate**.

The standout measures will include **patient outcomes, health equity, access, joined-up planning, pathways and trust**.

In terms of the **work to be done**, the clear things were:

- Understand the starting point;
- The sensibility of a series of steps, not too big. Focus on the pragmatic;
- Talk to people of all parts of the care chain.

This is the most difficult part to deal with as it deals with actual people, systems and expectations.

To lead with pragmatic steps that always take into account:

- Equity,
- Access,
- Regulation,
- Patient journey,
- Government signals.

Facilitation and reporting by Tuna Blue Facilitation

TUNA BLUE

Introduction

Ingrid Cumming provided a Welcome to Country.

Hon Roger Cook, Minister for Health; Mental Health:

- Acknowledged and thanked Ingrid and acknowledged Wadjuk elders;
- Welcomed everyone to the final roundtable of the Sustainable Health Review and appreciated how engaged everyone has been;
- Acknowledged the managing directors in the room;
- Forums have been held in the community sector and there has been an IT mini expo showcasing opportunities, sessions have occurred on climate change and other themes;
- Today is probably the most important – how to move forward with a workforce to equip us for the challenges in the future;
- The conversation started with the SHR Interim Report, which identified a sustainable workforce as a primary objective;
- On engagement:
  - people are our greatest asset and we need to earn and maintain their respect,
  - we need meaningful engagement across all areas,
  - managing change demands sustained commitment,
  - we need to ask people what they think, and respect can come from just accepting that people's views are valid,
  - there are different perspectives in the room; diversity of opinion is a good thing. We can develop a consensus about our mission;
- The healthcare landscape is changing. The population is ageing and suffering from more chronic disease. Technology is advancing, and it can deliver more patient-centred care;
- Current health care professionals have to deal with the biggest changes being ushered into the health care system in modern history;
- Managing the teams that you are charged to lead is one of the biggest challenges you will face;
- The WA health system one of the biggest in the world, filled with skilled personnel;
- The WA Mental Health, Alcohol and Other Drug framework 2018 is being released. It aims to guide the development of a skilled workforce now and into the future. We need to extend this culture throughout our health workforce;
- This room is full of expertise with an unrivalled depth of knowledge. What you suggest today will guide the SHR;
- Today is not about arguing the case for change; it is about the steps to reinvigorate; the practical and sensible ways to take this forward;
- Thanked Robyn Kruk and SHR Panel for their work done to date.

Meredith Hammat, SHR Panel Member:

- Acknowledged Traditional Owners and Elders;
- Today's discussion is a really important part of the overall SHR;
- Many people here have been actively engaging with the SHR Panel to date;
- It is clear that the health system, at its heart, relies on its workforce to care for the people we love most. The heart of this process is making sure we have the right people with the right skills across a broad workforce. It is essential all these positions work together;
- The work is broadly changing and adapting because the world is changing dramatically. We need to think through how we adapt to the changing context while building the highly skilled workforce that we need.

Robyn Kruk, SHR Panel Chair:

- Acknowledged the Traditional Owners and the people who prepared the background papers for today;
- Nobody has accepted the current status quo as an acceptable, long-term position. People want to go forward in an acceptable, orderly way to get it right;
- There is nothing more levelling than fragility, dependence and fear as patients interact in the health care system. It can be disempowering for people who rely on the health care system;
- The workforce has a limited time in their professional roles to make a difference. The SHR Panel is relying on that ability today;
- All people here are evidence-based thinkers with a commitment to good care.

Stephen Duckett, Keynote Presenter:

- Acknowledged the Traditional Owners and elders;
- Reminded the room that Indigenous people have a life expectancy that is ten years shorter than the rest of the population, which is a continuing gap that needs to be addressed;
- People graduating today in health will still be working in 2058, and potentially 2068. Think back the same distance in the past to 1968 – there was no MediCare, no MRI technology, etc, the length of stay in hospital was twice as long. What we are looking at in the future is so different to what we have now and it gives us opportunities;
- There is research in the US occurring regarding the prevention of the onset of Alzheimer's, but the US system doesn't have enough people working in roles that could determine who should get the treatment. Those undertaking the research had in their minds limited existing workforce roles and did not consider the possibility that those roles could change based on need;

- On workforce planning:
  - ‘Right person, right care, right time’ – this is an old phrase and way of thinking,
  - ‘Right person enables the right care at the right time’ – working with the patient rather than to the patient. This is still wrong. It should be:
  - ‘**Right member of the health care team enables the right care, at the right time**.’;
- Part of the job of good medical practice is recognising that the team changes and rotates;
- The fastest growing element of workforce in WA to 2022 is in health care;
- The WA population is growing and the 70+ age group is growing fastest. The balance in the workforce that is right now won’t be right in five-year’s time;
- By 2026, we will need 12% of school and university leavers to work in health. Something has to give – for example, engineers may miss out, which in an economy that relies on mining may be a problem;
- On the demand side:
  - automation,
  - digitisation,
  - genomics,
  - self-management, etc;
- We have to change the supply side to a workforce focus, giving a change in retention rates and roles;
- BEACH data shows that 19% of GP work is on less complex visits with no complexity and no major treatment. Could someone else have done those visits – a nurse, etc? This would free up a lot of GP time;
- A job satisfaction survey showed that people doing jobs that they were overqualified for led to higher levels of job dissatisfaction;
- A Grattan survey showed about a third of work could be done by less qualified personnel without reducing the quality of care;
- What can be done about role change?:
  - nurse- and midwife-led care can provide equal or slightly better care and a higher level of patient satisfaction,
  - self-management of conditions can lead to less need for intervention;
- We are not talking about making a huge step into the unknown, this is evidence-based;

- What's stopping us?:
  - professional culture. Each profession thinks they are totally unique and that the professional boundaries are ordained in scripture!,
  - tradition is another factor. If it was right in 1968, it must be right in 2018 or 2068,
  - people claim we can't delegate for factors such as professional indemnity, prescriptions, etc,
  - people are anxious that they will lose their job or be adversely impacted:
    - there will be jobs for everyone in the future, but those roles will be different;
- Use financial incentives for change to help people make the transition. Transition is hard as often we don't have managers with the skills to make these transitions;
- Some bureaucrats are risk-adverse. We need to authorise leaders in the system to innovate and be risk-takers in order to bring in evidence-based solutions going forward;
- We need to make sure all polices and incentives are aligned.

Questions to Stephen

- *What are your suggestions for how to implement these changes – these are not new concepts in discussion, but change hasn't occurred in the past.*
  - The system needs to change, not be replaced. Change needs to be slow and planned. People talk about the silver tsunami, but people age slowly. It's more the grey glacier! We need to implement changes that transform the system over time. Start small and build up.

- *Changes don't work if they will disrupt. The cost of some of the reform initiatives needs to be considered. Making even minor changes is hard. We need to look at how to develop a culture to implement things at a local level, but there is so much rigidity that we're not allowed to make changes.*
  - We must move on changing the culture to allow change to occur that is value-added. An example is giving blood – initially this was done mostly by nurses, then enrolled / registered nurses, then people trained specifically for the role with an enrolled / registered nurse present. It doesn't imply lesser quality of care. But, we need to ensure that we don't disrupt the teamwork involved.

- *Talking about job substitution, we tend to talk about clinical roles, but what about non-clinical roles and administration so that clinical teams can focus on clinical duties with administration support?*
  - It is often the case that clinical teams are pulled into administration tasks. The future may be that administration is a completely automated, digitised system. This may be more disruptive than the issue of hiring someone. We need to think about this possibility, which may be more profound than has been in the past.

- *Appreciated your ability to articulate professional culture traditions. In terms of Aboriginal workers – trained, qualified workers often can't put all their skills into use. There are barriers around professional culture, for example, immunisations could be undertaken by a qualified Aboriginal workforce but there may be systemic biases in place.*
  - Similar issues have occurred in Qld. First, look at whether there are rules and governance issues that are preventing it and illuminate that, then look at cultural issues that may be the cause.

- *Governance issues push down scope of practice as definitions are getting stricter;*
  - Sometimes this is a smoke-screen. For example, in occupational therapy, there is nothing that is specified as to what occupational therapists do, but the title only is controlled to prevent anyone calling themselves an occupational therapist. Patient rights needs to be right in the centre.

- *In the mental health space, the dynamics between clinicians, carers and patients is complex. In the presentation given, there was no mention about peer-workers;*
  - The presentation was limited to Cochran reviews and the like, but Stephen agreed as to the importance of peer workers at a time when people are vulnerable. In Victoria, the mental health system relies heavily on peer-workers and they are part of the solution.

- *In GP land the co-ordination of care, lip service is given to the feeling that they are under siege – many people think they can do it better. There is a feeling in GP land that they are just becoming glorified data entry clerks.*
  - 80% of what GPs do can't be done by anyone else. Have heard it implied that they are glorified clerks. GP in rural is different to metropolitan. The GP role is transforming in undesirable ways in rural Australia. In many small towns, there is just no other alternative and this might give worse access to health care in rural areas. We are not doing enough to support GP in rural areas.

Session One: First Thoughts

Question: When you think of a workforce and training pipeline in the future, what three words come to mind?

Response

A wordcloud was generated.

The standout responses are: **flexible, responsive, interdisciplinary, collaborative and compassionate**.

Detailed Responses

- Leadership, Skill, Compassionate;
- Forward-thinking, Evidence based, Accessible;
- Quality, Diversity, Specificity;
- Different, Flexible, Mobile;
- Equity, Professional development, Skilled;
- Team based, Top of scope, Networked;
- Flexible, Innovative, Purpose;
- Transient, Burnt-out, Underprepared;
- Innovative, Compassionate, Responsive;
- Scope, Interdisciplinary, IT;
- Flexible, Agile, Multidisciplinary;
- Money, Opportunity, Disappointment;
- Connected, Seamless, Respectful;
- Well-trained, Experienced, Compassionate;
- Locally trained, Appropriate skills, Long term supports;

- Nimble, Multidisciplinary, Collaborative;
- Integrated, Mobile, Agile;
- Sustainable, Delivery, Education;
- Qualified, Enough, Skilled;
- University, TAFE, Mentorship;
- Team, Digital, Diverse;
- Change, Scarcity, Challenge;
- Contemporary, Flexible, Diverse;
- Shortage, Planning, Capacity;
- Coordination, Trust, Confidence;
- Responsive, Qualified and capable, Adaptable and flexible;
- Flexible, Relevant, Equitable;
- Flexible, Sustainable, Informed by need;
- Complexity, Shortage, Professions;
- Training, Accessibility, Support;
- Integrated, Planned, Quality;
- Demand, Skill, Interdisciplinary;
- Affordable, Fit for purpose, Engaged;
- Interdisciplinary, Connected, Evidence;
- Skilled, Compassionate, Technology;
- Responsive, Flowing, Speedy;
- Planning, Sustainable, Mobility;
- Flexible, Culturally diverse, Professional;
- Flexibility, Collaborative, Respectful;
- Not ready, Make it sustainable, Need dynamic leadership;
- Sustainable, Flexible, Generalist specialists;
- Technology, Diversity, Culture;
- Adaptable, Knowledgeable, Effective;
- Navigation over diagnosis, Health, Literacy;
- Unclear, Uncoordinated, Long;
- Job security, Training standards, Entry criteria;
- Proactive, Excellence, Kindness;
- Planning, Collaboration, Culture;
- High skilled, Secure jobs, Well paid;
- Collaborative, Capacity, Sustainable;
- Diverse, Consistent, Opportunity;
- Education, Partnerships, Relevance;
- Interdisciplinary, Flexibility, Skilled;
- Aboriginal, Cultural, Competence;
- Flexibility, Breadth, Professional Competence;
- Collaboration, Flexibility, Available;
- Interconnected, Diverse, Planned;
- Patient centred, Multi disciplinary, Health, human services;
- Leadership, Sustainability, Flexibility;
- Different, Overburdened, Personalised;
- Multidisciplinary, Primary care, Integrated;
- Professional, Flexible, Dedicated;
- Leadership programs, Common understanding, Care not service;
- Diversity, Flexible skill sets, Adaptive to modernisation;
- Training, Consultation, Respect;
- Flexible;
- Welcome and value students, Involved patients, Caring;
- Credentialed, Engaged, Patient centred;
- Flexible, Engaging, Responsive;
- Technology, Sustainable, Collaborative.

Session Two: A More Diverse, Modern, Fit For Purpose Workforce

Question: How will we know if we are creating a more diverse, modern and fit-for-purpose workforce? What are the measures for success?

As a context, **Robyn Kruk** encouraged the participants to talk about the broad aspect of health care, not to feel there is a need to focus in on specific areas such as hospital and to keep their eye on the horizon for the end point.

Plenary Responses

- It is encouraging to see how often **patient outcomes** is coming up and quadruple care. We need to think about health and human services – it's not really the consumer's role to know what type of staff is working with them but they need to know that they are safe;
- We have discussed a range of measures but the ultimate measure is to improve **health equity** as the top line, all other measures flow from that;
- When talking about better outcomes and satisfaction, we assume that there is a service for people to go to. If you can't access care, all of those things are obsolete. People need **access to the right care that they want**. Can't get an outcome if you can't get the care;
- Robyn – the pipeline has many parts to it. How do we actually see if we are creating a health and social care pipeline?:
  - one problem is we are looking at a workforce in health but not looking at other parts of the system – housing, employment, etc. We need all the other parts of the system here;
- **Joining up the planning** – every attempt to date hasn't worked. The State has very little impact on our training, etc. They are a passive purchaser and an importer of talent to bring in services.
- Agree with the general sentiment, need to **think system-wise**. At a macro view, we need all the pieces of the puzzle moving together. In physio, the population is changing and so demands are in constant flux. As automation kicks in and workforce demands change, we need flexibility built into governance and skill sets. We need a constant stream of skill sets that matches changing demand;
- The question is how do we know we are creating a modern, fit for service workforce – we need to look carefully at **all education programs**, including interprofessional skills, collaborative practices, and familiarity with digitisation;
- WAMH spent a lot of time looking at **pathways**. The direction needs to be charted so that we know what direction we want to go in and that we will have strategies to do so. There is an ongoing interest in the social services sector with key role in social determinants of health. How do people navigate the pathways – this is often looked at from a perspective of what it looks like rather than how people access it. It pushes people into places that are uncomfortable for them, such as hospital emergency departments in mental health. How do we put people where they are comfortable to ensure trust? Primary health care is critical for young people in instilling **trust**.

The measures of success in detail:

- Patient satisfaction. Excellent outcomes;
- Improved clinical outcomes;
- Improved patient outcomes;
- Improved clinical outcomes;
- Patient experience measures indicate the system is consumer and community focused;
- Workforce satisfaction and models of leadership;
- Patient satisfaction. Aiming toward value based health care;
- Quadruple Aim;
- Measure meaningful change rather than output. Incentives to encourage understanding the problem;
- Improve timeliness of care;
- Increase of remote people partaking in university / higher education;
- Better patient experience (patient experiences more integrated / better coordinated care);
- Staff satisfaction;
- Improved patient experience;
- Desirable workplace;
- Retention;
- Sufficient staff to provide care;
- Number and distribution of GP proceduralists in country WA;
- Good workforce morale;
- Efficient system;
- No shortages of staff;
- Holistic coordinated patient care;
- Happy and satisfied workforce;
- Quality outcomes for ALL;
- Less patients in hospital;
- Staff retention;
- Reduction of repeat visits – successful treatment on first instance;
- Improve patient experience;
- Community health improves. People can get health care when needed;
- Workforce needs to reflect patients... Aboriginal people are high consumers of health... have low representation in workforce;
- Safe and quality care;
- Improved employee engagement;
- Job satisfaction improved;
- Staff satisfaction;
- Broader thinking about workforce planning, that thinks beyond numbers and clinical workforce requirements;
- Increased staff satisfaction;
- Reduction in chronic disease prevalence;
- Better clinical outcomes; job satisfaction, utilisation of workforce to full potential, seamless training pipeline;
- Workforce supply that meets demand;
- Workforce substitution in roles is the norm;
- Patient outcome and experience;
- Patient satisfaction with entire chain of care;
- The workforce uses and is comfortable with augmentated technology;

- Patient experience, staff experience, clinical outcomes, and cost apply to this and all other reforms, maybe add diversity too;
- Diversity of workforce roles and composition;
- Value based healthcare measures;
- There is a planned pipeline;
- Diversity of workforce – Aboriginal workforce rate 3% at least, CaLD, peer workers, effective consumer and community involvement;
- Not creating duplication and not increasing demand;
- Change of scope and roles to include much more social care;
- Ease of access to services;
- People attending the right place;
- Pain points in daily working lives are reduced over the employee lifecycle;
- Interdisciplinary health service teams in community providing coordinated health care;
- Improved health equity;
- Seamless integration of NGO, government, etc around the patient and carers;
- More collaborative team cohesion;
- Reduction in preventable admissions and readmissions;
- Patient experience;
- Public subjective perception as valid;
- The ultimate measure is improved health equity;
- Ratio of community based versus hospital based workers;
- Minimising adverse events;
- One system, not disparate services;
- Greater partnerships with social and community care. Cross agency;
- Harnessing career plasticity in millennial workers for the good of the health and social care system;
- Diversity within workforce streams;
- Clinical outcome and patient experience improvement;
- Enough staff;
- Workforce awareness of stepped care;
- Patient satisfaction;
- Better primary care and prevention;
- Health professions staying in post;
- Fewer people in hospital;
- Patients' needs are met;
- One medical record for all so we do not repeat tests, asking the same questions;
- Staff satisfaction;
- Reduced readmissions;
- Training outputs adequate for future needs;
- Patient determined outcomes;
- Needs based clinical focus;
- Staff engagement / satisfaction;
- Decreased hospital admissions for non-emergency reasons;
- Reduction in DAMA;
- Improving metrics around locally trained workforce in rural WA;
- People get the help they need in the environments that are most comfortable for them;
- Clear planning with buy-in from all stakeholders;
- Workforce awareness of cost effective care pathways;
- A stronger workforce in the community setting;

- Resourcing to ensure access to care and the availability of quality time to spend with the patient;
- The community uses technology to access healthcare and the workforce is structured to correspond with this;
- Integrated systems;
- More integrated education programmes;
- Communities involved in the decisions regarding service planning;
- Better retention rates;
- Greater agreed overlap in scope of practice between different health professionals;
- Minimised 'gaps' in service;
- A measurable increase in understanding and respect for other professional roles and Interprofessional Practice;
- Reduction in preventable hospitalisations;
- Meet PSC and Aboriginal Workforce targets;
- Access to community based care building integrated community health hubs;
- Culture, culture, culture;
- Empowerment for patients and staff. Listening and respect;
- If we keep devolving all the bits of work no one wants to do, what happens to job satisfaction of the devolvee?;
- All health practitioners work to their full scope of practice to improve care;
- Improved discharge with a greater coordination to reduce re-admissions;
- Manage risk that the patient may not be informed of the whole situation (but the life saving surgery ruined my tattoo!);
- Access to the right care at the right time;
- Genuine and effective workforce planning. Strategic focus rather than reactive
- Job satisfaction related to complex work – jobs need to be quality jobs;
- Improved patient care;
- Reduced hospital readmissions;
- Improved access;
- Gender and cultural diversity within each health care sector / specialty;
- Moving locus of control from sub-specialist tertiary towards community and general;
- Workforce satisfaction – specifically considering access to collaborative care and care pathways;
- Health workforce is no longer really talked about as just a health workforce;
- Ask health consumes what they see as success;
- Innovation and differentiated thinking is applied to keeping up with drug technology
- Student training core function in every health social care setting;
- Improved patient outcomes and consumer satisfaction;
- We need systems thinking about what it takes to deliver a service and build the jobs around that;
- Improved education programs that focus on inter professional skills, digital literacy, etc;
- Increase in care on country;
- Far less political;
- Workforce satisfaction with reference to confidence in risk management if care is shared or transferred;
- Increased access to health care in remote locations;
- Social services and health services managed by the same government department;
- Improved QOL measurement in group of health consumers who are being kept out of mainstream tertiary health services;
- We need more job analysis and to match our workforce planning to that – eliminate the barriers that makes work frustrating;
- Training provision to reflect whole of system workforce and service planning

- Workforce productivity and efficiency
- Every GP surgery has a Nurse Practitioner and an Endorsed Midwife;
- Education to all, health professions and consumers, what health care success looks like and what it means;
- Workforce satisfaction with respect to ability to innovate;
- PROPER, not pretend, integrated care;
- Develop teams not just individual professional groups;
- Increased referrals to peer support groups;
- Need a genuine HR information system to baseline and project the workforce requirement. Need this to identify future demand;
- Why do young people exit jobs? Measure why those who stay do so to develop work models for job retention in this component of the workforce;
- Health professions that can focus on wellness, community health and not just illness;
- Health (including primary care) and social care workforce plan would set a roadmap to enable cultural / system change;
- More flexible funding in primary health care that crosses professions;
- Workforce satisfaction with respect to ability to delegate / transfer tasks if can be safely done by staff with less specialist / costly staff;
- Graduates are employed;
- Continuing and targeted education and training (to meet system needs) is a fundamental aspect of every role;
- Success of continuing education;
- Balance between the number of services delivered in primary care versus hospital based;
- Employers invest in ongoing workforce training so it can evolve and adapt with changing needs and contexts;
- Single source of truth in workforce data;
- 100% culturally competent workforce;
- Increased Nurse Practitioners employed so they can provide health care outcomes that the community needs;
- Increased job opportunities for new medical graduates in rural areas;
- Increase clinical placements in the health sector to allow them to gain future workforce competencies required for capability;
- University hospital;
- Higher community to hospital workforce ratio;
- Clinical governance with agreed communication between different workers;
- Clear pathways for all staff that can lead to multiple types of roles within their career;
- Partnership skills;
- A workforce that is supported to take risks to improve patient outcomes. A supportive culture is essential to continuous improvement;
- Funding in primary health care – the main restriction to health care professionals working to the extent of their scope of practice;
- Clear future focused workforce capability requirements understood at whole of government level with an integrated planned approach to deliver;
- Coordination of care where patients receive 'fit for purpose' explanations about the care provided;
- Reduction in cynicism from healthcare workers;
- Why would the best people work in the non hospital when pay and resources are much less?;
- Health professionals better communicating with each other;
- Allow health student access to health services electronic records, etc so they can graduate digitally component;
- Purchasing and commissioning models help to drive workforce reform across the sector;

- Current education reinforcing existing health system and roles. Professional education needs a significant focus on the certainty of change;
- Evidence base;
- Critically review individual pathways of care and review who needs to do what;
- Growing the Aboriginal workforce in all disciplines;
- Having input from all parts of the pipeline into advisory boards;
- Clear and reliable demand and supply data to inform evidence based workforce planning and development. We need to IT systems to do this;
- Improving communication with the patient and clinical handover between the team of health professionals;
- Ensuring staff are trained for digital health care system;
- Fit for purpose health care design;
- Break down the tribes and packs – people protecting their territory;
- Identify areas of knowledge that need to be improved;
- Utilise NFP RTO training and resources that can be accessed;
- Quality of on line information accessed / accessible;
- Promotion of dialogue between education providers is interdisciplinary;
- Pursue reform, eg: legislative and regulator to enable health professionals to work to their full scope and facilitate workforce substitution;
- Professional training programmes need to change their focus;
- Accrediting professional bodies to allow other parties to feed into;
- More interdisciplinary teaching and practice;
- Greater responsiveness from professional programmes to community needs;
- Focus on transitions of care, funding currently is focused on inpatient care rather than ensuring good communication between providers;
- Start to conceptualise health and more than the absence of a disease : integrate the psychosocial.

Session Three: The Critical Areas of Work

Question: What are the critical areas of work that need to be undertaken to shift the workforce and pipeline in that direction?

Stephen Duckett encouraged participants to consider the three things they need on Monday to get started on this, and what support they need? What are the blockages?

Robyn Kruk advised she really needed the participants to seriously consider the logical steps from here. Give us the pragmatic method to move forward.

Plenary Responses

- This discussion is too big, let's make it smaller. **Look at one high-cost area**, look at the best model of care and then look at what that service needs in order to function in the community. Focus on an outcome;
- Get **education providers and start small**, for example physio and physio assistance, and look at where there is overlapping service provision, look at where there needs to be registration due to risk of care, then look at the assistants. See what needs to be

done in the job descriptions that are covered by the university and covered by the TAFE:

  - make sure the university trains the physios to manage the assistants;
- Through State Training Board, **get people in one area** (Aged care) to put up their individual concerns and from a training point of view, the training is the same. The most important area of training may not be what you think it is. They thought it was Cert III but turned out to be accredited skill sets;
- There is a view that there needs to be skills, but no-one is providing the training. There are people with practical life education that don't have the opportunity or confidence to build on their skills. **They need reward for obtaining skills and confidence**. Look at the boring end of some positions, which is actually the rewarding work for the next group of people:
  - the demand for a social care workforce is so great that we can't continue how we're doing it now;
- People who can perform the training have not taken up the chance to do so in the past. We need **a regulatory and governance framework** for these processes to get off the ground, and need registered practitioners to do the training;
- Still preparing people to work within a hospital system in an illness-based setting. We want them working in primary care. We need to look at the **alignment of those in undergraduate training looking at primary care**. What do we do to look at the pipeline to ensure those graduating are prepared for what we need in the next five years? This is probably not included in the curriculum:
  - Universities would welcome a structured interchange. Are you actually asking them to produce the workforce that you need in the future?;
- More conversations are needed between the sector and the universities. These get caught up in funding issues;
- The limitation in projecting forward is the continual definition of health as being the absence of disease. **We need an integrated biopsycho social model**. Social drivers are not being addressed properly. One aspect is interdisciplinary teaching and regulatory bodies. Our curricula are set by external bodies. Universities don't get to drive what they teach, they get told via often outdated approaches;
- How to maintain currency during career, not just initial training? Health Consumers Council is releasing a document on **continual engagement**. There is so much wasted talent in our front-line physicians, but they are not empowered to act on it. We need a gentle revolution:
  - need someone in the Department of Health to sit down on Monday morning and determine the expectation of universities as to what a graduating nurse, for example, looks like. Spending time with registered nurses, mental health, etc;
- Everything that is being said is being incorporated into the current nursing accreditation system. Biggest thing is **clinical placement**. We can't get the placements, so we need to agree on what placements should look like and how we get them. This needs to be reflected in the curriculum;
- In a world that crosses between university education and clinical placement, there is opportunity for the two to meet, allowing some of the big structural barriers to be

addressed. We could rewrite every job description on Monday and include the provision of education, that allows clinicians to take on students as part of their role. It is not core business at the moment for clinicians to see education as part of their core business;

- On Monday morning, we know we need clinical placements, but if we actually establish a framework as to what constitutes **clinical placement standards**, then look at diversity within that – NGOs could take clinical placements;
- The biggest silo we have is that we expect WA health to be everything to everyone. We need to keep people as healthy as they can be so that they are not interacting with WA Health as much as they are. All of our conversations keep coming back to the hospital setting:
  - this is one of the areas that placements are competency-based, to ensure people coming out of them can go into other areas;
- Most modern healthcare occurs **in community setting not hospital**s. We are working with aged care providers, Silver Chain, etc. There are major financial constraints, paying people for their time, and accreditation in a crowded curriculum. University is only the beginning of the training journey. Our job is to prepare them for postgrad, mostly done in tertiary hospital but hopefully that can be done in community settings;
- Increasing emphasis on prevention, but don't see the **preventative health workforce needs** reflected in workplace planning. Could easily ensure that the WA workforce planning includes the workforce as a whole. There are implications for the education of new recruits and continuing education in the unregulated professions – happens in a very ad hoc way. There are some skill sets that are missing or not very strong;
- A rural clinical school started in 2002, and predicted that most students would fail placement but could come back to try again. They have a good model of integration with the community, local hospital, AMS, community groups, etc. Students do well and come out more confident and job ready when they start as interns. This is an existing model and made up as each town can provide it. On Monday, the challenge is not what we do with our students **but what to do with the graduates** – give them the opportunity to go back into the rural community rather than the tertiary hospital, so that they can see where they could go with their career;
- Regarding rural – the issue is placing more people in the country. Funding can be obtained from different sources, but it is not necessarily a funding issue. Things that you think are barriers can be overcome, as there are assumed rules that aren't actually a rule;
- We need the capacity to take on the students; clinicians are expected to take it on top of normal workload. Looked at providing a university position who's role it is to manage placements, but this needs to be a balance between providing life experience and allowing clinicians to continue their normal practice;
- Looking at who the money is spent through – workforce development can't happen until the Government gives signals that it will shift how it spends money. If only 20% of demand for community support is being met, there is a huge missed opportunity. Government needs to heed these messages and indicate that it will fund accordingly and elaborate on how we can use resources. Some targets are needed as to how that shift will be made in order to balance the system (eg: targets for Area Health Services over the next five years). There have been no **signals as to Government investment**

priorities. There is a whole sector that wants to partner in but can't, for example, Step up Step Down. It's not just about what happens in area health services;

- Use a model of **student-led clinics**, shared relationship with provider and university – co-funded positions to supervise assistants in less complex cases. There is a lack of understanding on both sides as to how partnership models could be used best. On Monday morning, we need to test where else these models could be used;
- In nursing and midwifery, the workforce is being produced for mental health but the students can't get the jobs, so they disappear into other areas and don't come back. There is a big problem with finding clinical placements and those that are available are given to interstate students. On Monday, industry and universities to get together and see why students are coming from interstate and **what we can do to get placements made available**;
- We need an understanding of where we are now, a focussed look on the data. Re: interstate students, some live in WA but are enrolled in interstate universities;
- Another thing we need to be doing is decreasing demand by helping the workforce **to promote self-care**. We need to be better at helping people to help themselves, with an enabling culture reflected in how we train people;
- The principle is important that we look at stepped care, identifying opportunity for more generic providers, but we need to have a clear definition of **complex-care pathways**. The physio concept (ie: reduce orthopaedic waiting lists by using physiotherapy input much more effectively) sounds like a good idea and hopefully formed by people who have looked at the whole pathway to find how it can be done better, not just intensive intervention. Don't want to do it at the expense of comprehensive pathways.

In Summary

Robyn Kruk:

- The clear things we heard:
  - understand the starting point,
  - the sensibility of a series of steps, not too big. Focus on the pragmatic,
  - talk to people of all parts of the care chain;
- This is the most difficult part to deal with as it deals with actual people, systems and expectations;
- We have to lead with pragmatic steps that always take into account:
  - equity,
  - access,
  - regulation,
  - patient journey,
  - Government signals.

Responses in Detail

- Workforce planning that is effective!;
- The technology is here. We need to start engaging with it now;
- Health and social services providers seeing work based student training as core business;
- EMPOWER hospital administrators to effect REAL cultural change by REMOVING or REFORMING those people who pose barriers, removing cronyism, etc;
- Consumer involvement in training to ground the workforce in patient centred care;
- Getting Unis / TAFEs, Department of Health, Area Health Services, WAPHA, etc in same page;
- Genuine workforce planning which requires a HR information system that is fit for purpose such as SAP rather than a payroll system!;
- Governance changes;
- Less red tape;
- More freedom of how funding can be used;
- Certainty of workforce;
- Failure of communication;
- Pipeline;
- Rather than treat 'bits' of people, see the whole person. And how services interact - in consultation and agreement with the patient;
- Assess how people want / prefer to access services to determine the workforce that is necessary;
- Interdisciplinary training and professional development;
- Quality clinical placements to allow health students to gain experience needed for practice;
- Address the incentives that reinforce the behaviours and power imbalances of certain professions;
- Health literacy and empowering health consumers;
- Try future forecasting of the workforce not based on the needs now, but on what the workforce will need 10 years from now;
- Address the short term contracts issues and improved pride and passion will return – leading to improved outcomes;
- Real new accreditation system that focuses on quality care;
- We need evidence to support primary care;
- Start prioritising funding to pay for technology and professional development that supports engagement and use of it;
- Funding models, workforce modelling and data for the future needs;
- Identify the structural barriers and impediments to better patient conversations and more time with the patient;
- Shorten pipelines, skill escalators, to enable mid life and mid career entry and shifts;
- New funding arrangements between Uni / VET / health care;
- Break down the tribes and packs. Lessen the silo effect. Keep everyone focused on a holistic system and outcome;
- The crowding out effect of the NDIS on the hospital workforce;
- Clinical placements, clinical placements, clinical placements;
- Discharge planning;
- Trauma focused care as core competencies for all disciplines;
- We need to increase clinical placements to allow students real experience;
- A system to recognise that health services must provide clinical placement;
- The future health workforce needs quality clinical places;
- Areas of risk may occur if patient handover is not done correctly, however recognising workforce constraints and demands may have an impact;
- Placement for health students in the health sector;

- Increased and more coordinated management of clinical placements which is a major issue in producing sufficient graduates;
- Top tier leadership development;
- Consistent use of skills and roles across services;
- Training and support for front line managers and supervisors;
- More cultural safety trading in university courses;
- Recognition of skills that an Aboriginal workforce can contribute to health care;
- Patient input into curriculum;
- Clinical placement;
- Reform Medicare rebates to support highly trained professionals and assist in function / treatment sharing;
- Improved recruitment practices. Think outside the square and be contemporary at least!
- Leadership and professional development training for health workforce;
- Buy a fit for purpose HR info system that tracks employee education;
- Review educational programs, including enrolled nurses, to encourage collaboration and additional clinical upskilling;
- Establish a workforce executive who is empowered to problem solve / trouble shoot innovations to shift care to community and less expensive care;
- Enable us to have an agile workforce by genuinely changing the IR setting. IR rules restrict genuine change;
- Instigate pilot programs to trial new models in localized contexts and scale up!
- Focus on building awareness of care pathways / stepped care;
- Develop new models for integrated services in rural areas to develop sustainable workforce. Start with understanding the need of community;
- Develop a realistic approach to using other staff, ie: delegation and supervision
- Map out overlaps in professional scope of practice, consult with staff about how that work might be safely and efficiently carried out;
- Move VET health professional training to University Associate Degrees;
- Identify particular care pathways and use team to shift care to lower step of care, community and less specialised / costly care provider;
- Pick an area that needs reform. Analyse the jobs / tasks required / map to educational pathways / streamline entry pathways / track success;
- Break down the barriers between the assistants and health professionals by moving the assistants training to the university sector;
- Improve the workflow between the professions and remove the artificial barriers
- Build awareness in doctors of opportunities to delegate less specialist work in n safe cost effective way – while preserving spec. training
- Prescribing rights – broaden out, eg: designated prescribing;
- Establish apprenticeships for areas of need. Contract with TAFE to build and deliver courses. Employ graduates;
- PT and therapy assistants speak to WACHS. Peer and unqualified workers trained on the job to specific tasks or clients;
- Training of professionals reflects current job market and not emerging roles, most significantly primary health care;
- Community placement to allow health professionals students to gain a wellness philosophy;
- Provide internships for Uni and TAFE grads. Give grads a toe hold into the system to demonstrate their worth for a year so they can move up;
- Build skills to identify high prevalence, easy to train, low risk skills that can be developed as competencies that can be provided by any provider;
- Contract with universities to educate for specific roles. Stop being a passive consumer of what they pump out or form our own university;

- Not just the worker, transdisciplinary models of delivery. Much delivery could be generically trained skill sets or competencies;
- More respectful focus on admin and clerical roles and creating quality jobs - stop seeing them as targets for retrenchment – use them;
- Ensure specialist skills are trained developed while also building process for appropriate skills to be translated to interdisc. Competency;
- Build simple system to identify, develop, accredit and train high prevalence, low risk competencies – should include care pathway mapping;
- Maintain / develop critical specialist health skills / training programs while also building general skills and competencies in cheaper staff;
- Speak to students / graduates – are they job ready, was something missing from the curriculum, from prac, etc?;
- Those staff taking responsibility for students during placements need to have the time (workload) to provide the training / guidance;
- Fund 4 more psychiatry consultation / liaison posts as critical training block and essential to build capacity in acute / community generalists;
- Student supported clinic based on Rockhampton Chronic and Sub Acute clinic;
- Keep an eye on the equity of quality jobs – not all professions are treated equally in interprof teams re opportunities for research development;
- Prevention funding mechanisms to support. Currently focused on managing existing illness;
- WA Labor and WA Liberals sign a bipartisan agreement on innovation in WA health – stop healthcare change being politically fraught;
- Develop secondments for health and social care professionals to spend time within education programs contributing to and learning about students;
- Build library of care pathways and health journey maps that can be analysed to identify best competencies to be developed / trained / developed;
- Structured interchange' between consumers, State and Commonwealth Health Departments, tertiary and VET education providers, professional bodies, sector representatives;
- Mandate trauma-focused care as a core competence across professions to ensure providers understand why 'lifestyle' conditions aren't chosen;
- Actively seek to increase Aboriginal participation at all service and policy levels, and recognise community credibility as valued expertise;
- Indicate statutory funding responsibilities and likely budgets in workforce planning and engagement, assess implementation of DoH / MHC policy.