

## 10. A workforce for the future

### 10.1 Key findings

This report presents a range of proposals to improve Queensland's public health services. However, quality health services depend on sufficient numbers of competent, skilled clinicians being available at the front line. Patients expect to be treated by staff who are highly skilled and trained, dedicated to patient care and working in safe and supportive environments.

While Queensland Health has managed to grow its workforce in numbers, clinical staff report unsustainable workload levels and Queensland continues to have the lowest number of health professionals per capita of any State or Territory except for Tasmania.

Increasing clinician numbers is a challenging task. As an employer, Queensland Health faces significant challenges including:

- an ageing clinical workforce with major implications as the most senior and experienced clinicians begin to retire in coming years
- reduction in working hours – across the clinical spectrum - requiring more staff (with attendant ancillary costs) to provide the same level of service
- inadequate local supply of doctors and significant attrition rates of doctors employed in public hospitals, driving reliance on OTDs with special purpose registration to sustain workforce growth – likely to be felt for at least fifteen years
- a Visiting Medical Officer (VMO) workforce with potential to assist but feeling marginalised from the public system and already heavily committed to the private sector
- a reasonable local supply of nurses but shortfalls within Queensland Health arising from high attrition rates in the profession (up to 40% in the first two years) and a failure to fund and recruit nursing numbers in line with increasing demand
- insufficient data on allied health professionals to properly analyse supply issues, assess current shortfalls or inform future planning, but clear general indication of significant and critical shortage.

Consultations revealed that many clinical staff are angry, resentful and frustrated towards Queensland Health and feel disconnected from senior managers and leaders who they perceive focus only on budgets rather than patient safety and care. Clinicians felt disempowered, undervalued and marginalised and reported:

- unmanageable workloads and work pressure
- a coercive, bullying work environment
- frustration with too many layers of bureaucracy
- inadequate training and professional development opportunities
- insufficient time for teaching, research, training and professional development

- perceived lower remuneration compared with interstate public health systems
- lack of clinical input into decision making including budget allocations
- the enterprise bargaining system is divisive and escalates differences
- the most basic of entitlements not being provided to some staff
- safety concerns related to patient and carer aggression

The Review concluded that the breakdown of clinically related teaching, training and education for the workforce was the first casualty of an overburdened system. This is one of the most serious deficiencies confronting the organisation.

This poor treatment generally of the clinical workforce must be addressed urgently and comprehensively. Consultations confirmed that many clinicians are awaiting the outcome of this review and the current enterprise bargaining round before determining whether they will remain in the public sector. Additionally, districts are now reporting that some of their services are approaching crisis point and in danger of closing, due to worsening workforce pressures arising from the above issues and the damage to Queensland Health's reputation as an employer following events at Bundaberg.

These factors, in the context of global health workforce shortages and an environment of significant competition between jurisdictions for clinical staff, make intensive recruitment, retention and training initiatives mandatory in order to provide a sustainable public health service.

Below is a snapshot of the proposals put forward in this chapter. The proposed reforms will need to be accompanied by other significant work to create a workplace environment and culture which will attract and retain good clinicians. Many other system improvements recommended in this report, particularly in the areas of budget allocation, service planning and design, information systems and organisation culture, will also be critical in improving work conditions and ensuring clinical staff feel valued and are being genuinely supported. These broader issues are explored elsewhere in the report.

#### **Snapshot of proposed workforce reforms for doctors, nurses and allied health professionals**

1. Relief for the clinical workforce through immediate action to recruit more doctors, nurses and allied health professionals in a targeted manner to address service priorities and reforms
2. Immediate and long term measures to retain doctors, nurses and allied health professionals including reforms to improve organisational culture, provision of staff amenities, removing frustrations, providing safe working environments, peer support for isolated practitioners, just salary arrangements, more efficient work practices, simplified industrial awards and increased support for smaller districts through country service rotations
3. Innovative strategies to maximise the skills and availability of the clinical workforce including new workforce roles and increased interaction with the private sector
4. Showing a strong commitment to education and training and providing urgent remedial measures - including more training positions, measures to provide protected teaching time, and enabling all clinical staff to access work relevant training and professional development opportunities
5. Better workforce planning and monitoring of workforce trends including staff conditions and levels of satisfaction
6. Empowering clinicians by building clinical leaders and reconnecting them to service planning and decision making through clinician led networks (Chapter 6)

## 10.2 Profile of Queensland Health’s clinical workforce

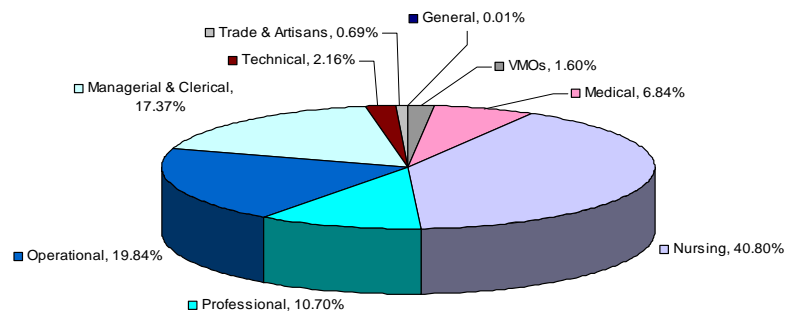
### 10.2.1 Queensland Health’s workforce

Queensland Health is the largest employer of health professionals in Queensland. In the consultations across Queensland Health districts, their dedication, professionalism and commitment to patient care was clearly apparent. The clinicians currently working in the system are the cornerstone of the public health system and play a critical role in supervising, training and mentoring the health workforce of the future.

Queensland Health currently employs 53,307 people across the organisation which equates to 43,782 full time equivalent (FTE) staff. As shown in the figure below, nurses make up the largest proportion of the health workforce (40.8 percent or 21,750 staff), followed by the operational category (19.8 percent or 10,577 staff) and managerial and clerical staff, (17.4 percent or 9,258 staff). The professional category which includes allied health professionals makes up 10.7 percent or 5,700 staff. There are 3,647 medical staff and 851 VMOs comprising roughly 8.4 percent of the total workforce.

#### Queensland Health headcount breakdown as at 19/06/2005

■ VMOs ■ Medical ■ Nursing ■ Professional ■ Operational ■ Managerial & Clerical ■ Technical ■ Trade & Artisans ■ General



Source: Queensland Health Human Resource Management Information System

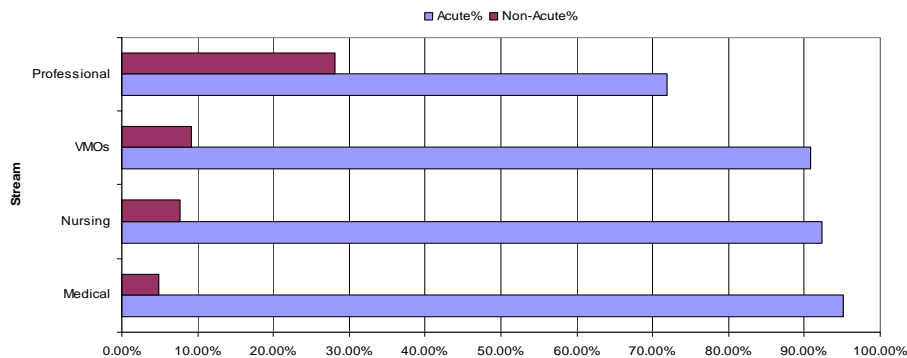
### 10.2.2 Distribution of staff

The majority of the Queensland Health workforce is located in metropolitan areas with 72 percent of doctors, 60 percent of nurses and 73.5 percent of Queensland Health’s professional staff working in Brisbane or other metropolitan centres. Roughly 60 percent of Queensland’s population live in metropolitan areas with the remainder residing in rural and remote parts of the State.

The nursing workforce is fairly evenly distributed in line with the State’s population needs. Clear mal-distribution of medical and professional staff is evident given the concentration in metropolitan areas at levels in excess of population requirements. For example: doctor to population ratios of 1 to 500 in urban areas and 1 to in excess of 3,000 in rural and remote centres. This reflects the difficulties in attracting and retaining staff in rural and remote areas and poses particular challenges in providing services on an equitable basis across the State.

Queensland Health’s clinicians work predominantly in public hospital facilities. As shown below, around 87 percent of doctors and 90 percent of nurses work in acute hospital settings. Allied health and professional staff represent the highest percentage of staff working in non-acute settings with 35 percent working in non-acute service environments which include community health centres and statewide services such as pathology and public health services. In some instances, community based services are located on the same premises as hospital facilities.

**Percentage of staff working in Acute and Non-Acute Settings**



Source: Queensland Health Human Resource Management Information System

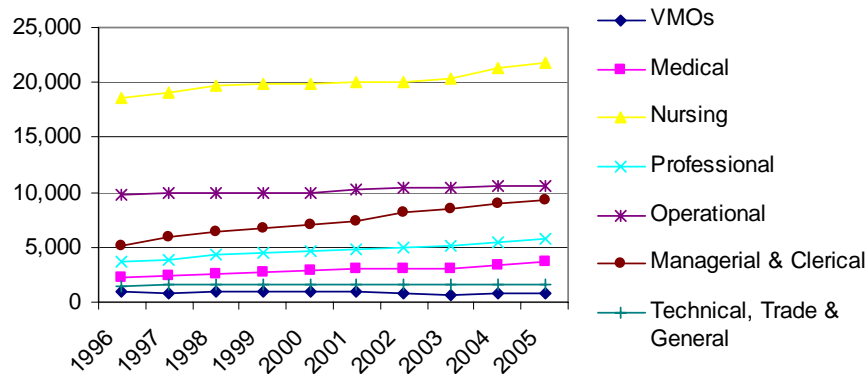
**10.2.3 Changes in staff numbers**

Despite global workforce shortages, Queensland Health has managed to grow its total workforce over the last nine to ten years. Since 1996, the overall workforce has grown by 27.2 percent or roughly 3 percent per annum, increasing from 34,420 full time equivalent (FTE) staff to 43,785 as at March 2005.

As shown in the graph below, the number of medical practitioners has increased by 69 percent from 2,027 FTE staff in 1996 to 3,434 in 2005. A significant proportion of this growth has been accomplished with the use of OTDs with special purpose registration who now make up 27 percent of Queensland Health’s medical workforce. This high reliance on OTDs is consistent with trends in other decentralised states such as Western Australia and the Northern Territory especially in regional, rural and remote areas.

The number of VMOs has decreased on a FTE basis from 407 in 1996 to 240 in 2005. This reflects reducing hours comprising a combination of budget imperatives and pressure on existing VMOs in the private sector. The overall number of VMOs has decreased from 883 to 851 over this period, reflecting a stable part time workforce.

**Queensland Health staff growth 1996-2005**



Source: Queensland Health Human Resource Management Information System

Nursing numbers have not shown the same level of growth as doctor numbers. The numbers of nurses working in Queensland Health has increased by 1,825 from 15,118 FTEs in 1996 to 16,943. This is an increase of 12.1 percent which falls short of population growth over the same period.

The professional category, which includes allied health professionals, has increased from 3,112 FTEs in 1996 to 4,961 in 2005, an increase of 1,848 or 59 percent (note the statistics on professional staff include allied health practitioners but also include other professions such as scientists, public health staff and other professions in Corporate Office including lawyers). The highest increase has been experienced in the managerial and clerical category which rose from 4,595 staff in 1996 to 8,433 in 2005, an increase of 3,839 or 83.5 percent.

Despite growth in particular areas, as shown in the table below, Queensland continues to employ fewer doctors, nurses and allied health professionals per head of population in the public hospital system than any other State or Territory except Tasmania.

**Full Time Equivalent Staff Numbers, All States and Territories Public Hospitals**

	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	TOTAL
FTE Total Nurses	31,865	24,028	14,661	8,158	7,813	1,806	1,479	941	90,751
Rate per 1,000	4.8	4.9	3.9	5.3	4.0	3.8	7.4	2.9	4.6
FTE Total Salaried Medical Practitioners	6,700	5,389	3,602	1,883	1,678	367	317	246	20,182
Rate per 1,000	1.0	1.1	0.9	1.2	0.9	0.8	1.6	0.8	1.0
FTE Diagnostic and Allied Health Professionals	10,005	10,784	3,231	2,230	1,965	349	349	261	29,174
Rate per 1,000	1.5	2.2	0.9	1.5	1	0.7	1.8	0.8	1.5

Source: Australian Hospital Statistics 2003/04 and ABS 3201.0 and 3220.0

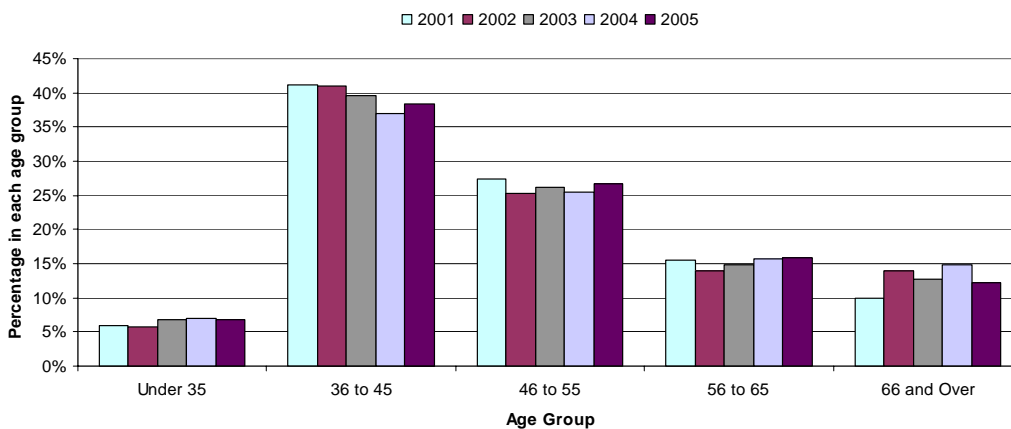
It is instructive to note that the above are hospital comparisons only. In terms of doctor numbers across the public and private sector including primary and acute care, Queensland, as revealed in the interim report, has 1860 less doctors compared to the national average. This is based on registration statistics which rely on each doctor voluntarily re-registering annually.

### 10.2.4 Age and gender characteristics of the health workforce

Like the broader workforce, Queensland Health’s workforce is ageing. The average age of a registered nurse working in Queensland Health in 2005 is 42 years of age while the average age of a senior medical officer is 46. The graphs below show the age distribution for both the nursing and medical workforce over the last four years. In the case of staff specialists, around 28 percent of the workforce is now aged 56 years or over.

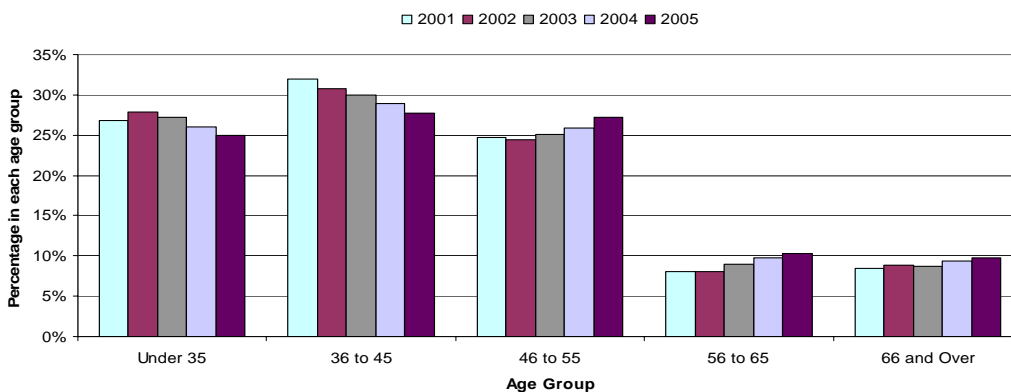
The ongoing impact of ageing is most apparent in the nursing workforce profile. In 2001, the majority of the nursing workforce were less than 45 years of age. It is now the case that almost half or 47 percent of the workforce is over 46 years of age and around 20 percent of nurses are in the over 56 years of age group. This has major implications for the future of Queensland Health in the context of growing workforce shortages as the most qualified and experienced staff can be expected to retire over the coming years.

#### Staff Specialist Age Profile Trends



Source: Queensland Health Human Resource Management Information System

#### Nursing Stream Age Profile Trends



Source: Queensland Health Human Resource Management Information System

Nursing remains a predominantly female occupation. Around 88 percent of nurses working in Queensland Health are women. The medical workforce is also becoming increasingly feminised with women making up an estimated 36 percent of the Queensland

Health total medical workforce. This is higher than national trends which show 31.9 percent of female medical practitioners working on a national basis in 2003<sup>96</sup>.

### 10.2.5 Reductions in working hours

Health professionals are working fewer hours per week than they used to. The latest Australian Institute of Health and Welfare (AIHW) Nursing Labour Force survey shows that more than half or 53.7 percent of nurses are now working part-time with the average number of hours worked per week having decreased from 32.4 hours in 1995 to 30.5 hours in 2001<sup>97</sup>. Queensland Health figures show the average hours worked for nurses is now 29.7 hours per week. This has major ramifications for workforce planning as it means that more staff are required to provide the same level of service.

While the trend is less apparent in the medical workforce, doctors are also reducing their hours worked and with more women entering the profession, the trend is likely to continue, with a further reduction in hours under consideration in the current enterprise bargaining negotiations. Queensland Health data show that the average number of hours which medical staff are contracted to work is 37.7 hours per week while VMOs are contracted to work on average 8.8 hours in the public system. However, in terms of actual hours worked, some specialists are working excessively long hours with many reporting they are working more than 60 hours per week to cope with increasing workloads<sup>98</sup>. A survey of all medical practitioners working in Queensland showed that around 73 percent of doctors work more than 40 hours and 18 percent of doctors are working more than 60 hours per week<sup>99</sup>.

### 10.2.6 Remuneration and conditions

The amount Queensland Health pays its staff is governed by awards and conditions under the government wide enterprise bargaining framework. It is difficult to draw direct comparisons between salaries paid by the various States and Territories for the different health professional groups as each have different awards, conditions and classifications. The table below shows that average salaries in aggregate are lower in Queensland for nurses and doctors. In the case of diagnostic and allied health professional staff, the national data suggests Queensland is higher than the national average salary range. This is likely to reflect wage differentials within the allied health group, and some constraints to professions within salary scale ranges, as it is generally reported from Queensland sources that this group is paid less than the national average.

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<sup>96</sup> Australian Institute of Health and Welfare, National Health Labour Force Series Number 32 Medical Labour Force 2003

<sup>97</sup> Australian Institute of Health and Welfare, Nursing labour force survey 2001

<sup>98</sup> Queensland Health Issue Paper for Bundaberg Hospital Commission of Inquiry Health Workforce Paper 2 Medical Workforce

<sup>99</sup> Queensland Health, Workforce Characteristics Medical Practitioners Re-registered in Queensland, 2001, 2002 and 2003.

### Average salary (\$) of full time equivalent staff<sup>(a)</sup>, public acute and psychiatric hospitals, states and territories, 2003-04

Staffing category	NSW <sup>(b)</sup>	Vic <sup>(c)</sup>	Qld	WA	SA <sup>(b)</sup>	Tas <sup>(d)</sup>	ACT	NT	Total <sup>(e)</sup>
Salaried medical officers	116,880	133,174	105,388	138,997	107,378	102,624	133,990	130,376	120,627
Nurses	65,284	62,315	57,422	61,407	57,546	56,202	61,661	64,828	61,969
Other personal care staff	n.a.	n.a.	38,273	39,944	n.a.	n.a.	42,712	52,350	39,134
Diagnostic & allied health professionals	53,769	43,356	59,419	54,823	50,328	59,505	51,805	62,147	50,515
Administrative & clerical staff	50,366	44,404	42,084	45,361	42,546	40,708	50,640	54,642	46,280
Domestic & other staff	36,914	42,645	38,665	39,348	34,923	47,853	40,034	41,831	38,995
<b>Total staff</b>	<b>61,481</b>	<b>60,756</b>	<b>56,719</b>	<b>61,417</b>	<b>56,307</b>	<b>56,742</b>	<b>64,075</b>	<b>65,003</b>	<b>60,083</b>

(a) Where average full-time equivalent (FTE) staff numbers were not available, staff numbers at 30 June 2004 were used.

(b) *Other personal care staff* are included in *Diagnostic & allied health professionals* and *Domestic & other staff*.

(c) FTEs may be slightly under-enumerated with a corresponding overstatement of average salaries.

(d) Data for 2 small hospitals not included. *Other personal care staff* are included in *Domestic & other staff*.

(e) The totals for *Other personal care staff*, *Diagnostic & allied health professionals* and *Domestic & other staff* are affected by reporting arrangements noted above.

n.a. Not available.

Source: Australian Hospital Statistics 2002-03

The Australian Nursing Federation (ANF) publishes information comparing pay rates for nurses on a quarterly basis. Some key statistics from the latest ANF publication are reproduced in the table below. It shows that Queensland pays less than the national average at all levels for nursing but is broadly comparable with Victoria and at the higher levels is marginally higher than Victoria. New South Wales generally has the highest rates of pay for nursing staff.

### Nursing Wage Comparisons - Public Sector Weekly Salary Data as at 1 June 2005

	NSW	ACT	QLD	NT	SA	TAS	WA	Vic	National Average
Enrolled Nurse Level 1	\$694.80	\$717.87	\$649.25	\$668.40	\$666.25	\$665.42		\$669.30	\$675.90
Enrolled Nurse Top Pay Point	\$756.20	\$783.55	\$720.50	\$755.56	\$752.45	\$721.80		\$767.00	\$751.01
Registered Nurse Year 1	\$787.80	\$748.20	\$732.55	\$755.56	\$737.40	\$728.89	\$737.56	\$738.40	\$745.80
Registered Nurse Year 8	\$1,106.40	\$1,032.00	\$986.35	\$999.60	\$968.40	\$975.59	\$958.53	\$986.70	\$1,001.70
CNC RN Level 2 Year 1	\$1,440.40	\$1,074.27	\$1,003.25	\$1,041.35	\$1,025.40	\$1,010.90	\$1,008.77	\$1,027.10	\$1,078.93
RN Level 3 Grade 1	\$1,525.20	\$1,209.94	\$1,150.35	\$1,158.82	\$1,210.35	\$1,161.13	\$1,217.10	\$1,039.30	\$1,209.02

Source: ANF, Nurses Paycheck Volume 4, Number 3, June 2005–August 2005

Medical practitioner pay rates are especially difficult to compare across jurisdictions given various classifications, loadings and allowances which are not captured in basic salary entitlements. There is no one formally recognised endorsed comparative data kept nationally, and therefore all local groups compile their own data and invariably include different components on top of base salary which are simply not comparable from State to State.

As enterprise negotiations in respect to medical practitioners' salary are currently progressing, the Review has not sought to favour any particular comparative list, but simply makes the observation that medical practitioners' salaries need to be perceived by all those in the workforce to be fair and just on the basis of fair comparisons with other States. Discussions with medical practitioners throughout Queensland indicated that it is their strong perception that current salary arrangements are below comparable arrangements in other jurisdictions.

Salaried medical officers and VMOs are paid under different terms and conditions within the Queensland Health system. One of the most concerning anomalies in salary rates for medical practitioners is the significantly lower rates that are paid for academic

appointments in medical schools compared to rates now paid within both the public and private sectors. The medical schools report that it is becoming increasingly difficult to attract eminent clinicians for academic posts and that professorial or joint appointments to the public sector are increasingly only possible if there is a significant loading offered to help bridge the difference in salary rates.

Comparable and reliable information on allied health staff salaries is not available and comparisons are difficult due to different progression arrangements based on experience.

When comparing Queensland's pay rates for health professionals with other States and Territories, it is important to note that Queensland wages in general across all occupational groups are lower than the Australian average by an estimated 5 to 6 percent. This in part reflects the lower cost of living in Queensland compared to States like New South Wales and Victoria.

In terms of comparisons with the private sector, specific information is not widely published. However, anecdotal evidence suggests that specialists working in the private sector can access gross incomes up to \$1.5 million per annum. This needs to be offset against the costs of running private practices which are estimated to be between \$250,000 and \$500,000 per annum depending on the type of specialty and practice involved. There are many private practitioners especially general practitioners (GPs) in rural areas who would earn only a fraction of this amount. Public sector specialists, on average, receive between \$200,000 and \$300,000 depending on specialty, hours worked and private practice component.

Fee for service arrangements in the private sector provide opportunities to increase incomes which are not as readily available in the public sector. Anomalies in funding for private and public medicine are a function of Commonwealth/State responsibilities with the States meeting the costs of public sector employed doctors and the Commonwealth meeting the costs of doctors working in private practice through payments under the Medicare Benefits Schedule. This situation is far from ideal and a major impediment to effective utilisation of Australia's medical workforce.

In the case of nursing, it is not possible to make meaningful comparisons between public and private sector remuneration, as the review has heard of significant variations in salaries for nurses working in the private sector, both above and below public sector remuneration.

In terms of allied health professionals, a significant proportion of the workforce is in private practice where services are covered by private health funds and consumer contributions. The ability of allied health professionals to earn higher incomes is therefore much greater in the private sector than the public sector, particularly for pharmacists.

### **10.2.7 Workloads**

A common complaint and consistently recurring theme for this review was the increasing workload being experienced by staff particularly those working in the acute public hospital sector. As shown previously, Queensland has the second lowest numbers of doctors, nurses and allied health professionals working in the public health system per

head of population. Workload intensity is also increasing in association with sicker patients and shorter hospital stays driving increased throughput.

Nursing staff in particular are experiencing major pressures given that nursing numbers have declined in real terms in Queensland Health over the last nine to ten years. During that same time, separations in public hospitals have been increasing in line with population growth leading to intensifying work pressures. The review also found evidence of additional administrative duties being imposed upon clinicians on top of clinical workloads. All categories of clinicians are reporting higher workloads particularly in rural and remote areas where it is difficult to attract and retain staff.

### **10.2.8 Turnover and absenteeism**

Data collected by the Department of Industrial Relations shows that for the March 2005 quarter Queensland Health had higher rates of absenteeism and a higher percentage of employees taking work cover leave as compared with the averages across the Queensland public sector. However, more valid comparisons would be with other health care sectors in other jurisdictions, as working in a health care environment carries its own inherent health risks. These comparisons were not possible due to limited access to interstate data.

A comparison of Queensland Health and Department of Industrial Relations data revealed a higher separation rate for staff in Queensland Health and for each professional group (medical, nursing, dental and professional) as compared with the wider Queensland public sector. (See Interim Report for detailed information for professional groups).

The Interim Report also analysed attrition and growth trends amongst the clinical workforce. This revealed net increases in medical, nursing and professional staff over the past three years. Within these groups, net increases were observed for senior medical staff and resident medical officers, registered and assistant nurses, and lower classifications within the professional streams. However, there was evidence of overall attrition for visiting medical officers, registrars, and enrolled nurses, and higher classifications within the professional stream.

### **10.2.9 Future requirements**

As discussed in Chapter 3, it is expected that demand for health services will steadily increase in line with the State's growing and ageing population at least for the next 20 years. Accordingly, it is expected that the workforce will need to grow in line with that increasing demand.

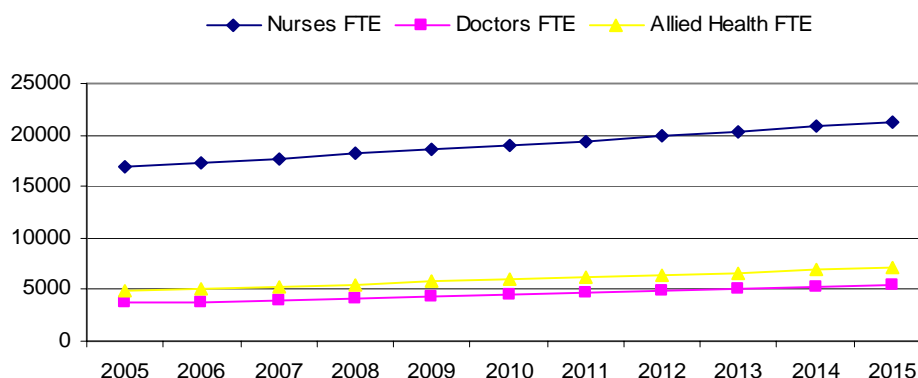
The following projections have been based on some previous work done by Queensland Health in 2001 which examined zonal workforce requirements<sup>100</sup>. The projections have been updated to reflect current workforce levels. They are based on existing patterns of service delivery and do not take into account current workforce shortages. Based on future demand for services in Queensland, it is forecast that Queensland Health will need:

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<sup>100</sup> Queensland Health (2004) Forecasted Zonal Workforce Position Requirements

- an extra 4,326 nurses by 2015 on a full time equivalent basis which equates to an additional 5,475 staff taking into account part time work or an extra 500-600 nurses per year;
- an extra 1,870 doctors by the year 2015 or an additional 2,289 staff on a headcount basis or an extra 160-180 doctors per year; and
- an extra 2,597 allied health professional FTE by 2015 equating to an additional 2,985 or 200-250 extra staff per year.

**Queensland Health Forecast Staff Requirements**



Source: Queensland Health Human Resource Management Information System

**10.2.10 Supply of health professional workforce**

**Overall supply of doctors in public and private sectors**

As shown in the table below, the number of doctors registered to practise in Queensland has increased by 18.3 percent over the last five years with an average additional 350 doctors registering each year. Medical graduate numbers from local universities have numbered around 200 per annum. However, these numbers have not been sufficient to replace the number of doctors who retire each year which is estimated to be between 350 to 450 per annum.<sup>101</sup> The growth in total medical registrations in Queensland has been achieved by increasing the numbers of OTDs with area of need registrations which have almost doubled from 540 in 1999 to 968 in 2004.

**Medical Registrants – Queensland 1999 - 2004**

	1999	2000	2001	2002	2003	2004	% Change
General Registrants	6,627	6,716	6,530	6,878	6,968	7,237	9.2%
Specialist Registrants	3,425	3,529	3,635	3,742	3,738	3,801	11.0%
Internship/surgical training*	259	275	266	234	281	n/a*	
Conditional Specialists	159	172	216	215	285	356	123.9%
Area of Need	540	688	843	827	871	968	79.3%
Area of Need Deemed Specialists	n/a	n/a	n/a	n/a	58	59	
Post Graduate	111	121	125	128	160	151	36.0%
General Practice	n/a	16	41	66	101	168	
Other	64	72	60	72	73	180	181.3%
<b>Total Registered Medical Practitioners*</b>	<b>11,185</b>	<b>11,589</b>	<b>11,716</b>	<b>12,162</b>	<b>12,535</b>	<b>12,920</b>	<b>15.5%</b>
<i>Additional Each Year</i>		404	127	446	373	385	

\* This category was absorbed into general registrants in 2004.

Source: Medical Board Queensland Annual Report 2003/04

<sup>101</sup> Queensland Health Workforce Characteristics Medical Practitioners Re-registered in Queensland, 2001, 2002 and 2003.

### Queensland Health's share of medical workforce

Queensland Health employs roughly 27 percent of the total number of doctors registered to practise in the State and has increased its share from around 24.5 percent in 1999 (noting that not all registered practitioners are actively participating in the workforce). This is consistent with the results of a recent survey conducted which shows that around two-thirds of medical practitioners work in the private sector<sup>102</sup>.

As noted previously, Queensland Health has been increasing its medical workforce by an average of 140 additional doctors each year. As with the general medical workforce, this has been achieved with increasing usage of OTDs with special purpose registration. It is estimated that currently 27 percent of Queensland Health's workforce or roughly 740 doctors are OTDs with special purpose registration.

The number of medical graduates is expected to increase from around 232 in 2004 to 540 in 2010. However, this will not address problems being experienced currently due to the long lead times of some 12-15 years needed to produce fully qualified medical practitioners. Until that time, Queensland Health will need to continue relying on OTDs to augment the local supply of doctors as do other States like Western Australia and the Northern Territory.

The gap between local supply and demand for medical practitioners in the public hospital system can be crudely approximated by examining the difference between the number of new entrants and attrition rates. As shown below, the additional graduates coming into the system will not be sufficient to replace the loss of permanent positions with an estimated shortfall of 125 in 2006 (noting the attrition rates are based on permanent separations only). At the same time, Queensland Health needs to employ extra doctors to meet growing demands. In order to fill the gap in local supply and grow the workforce to meet increasing demands for health services, Queensland Health needs to employ an additional 282 doctors in 2006 increasing to 291 in 2008. Note the gap declines as graduate numbers increase over the coming years.

#### Queensland Health Forecast Gap in Local Supply and Projected Need

	Projected				Additional	Need to
	Total	Annual Loss	Graduates	Gap	(Net)	Employ
2006	3,804	437	312	125	157	282
2007	3,967	456	355	101	164	265
2008	4,138	476	355	121	171	291
2009	4,316	496	518	-22	178	156
2010	4,502	518	540	-22	186	163

### Overall supply of nurses

In regard to nursing numbers, undergraduate nursing numbers have not been subject to the same constraints as doctor numbers and have increased from 1,323 enrolments in Queensland universities in 2000 to 1,756 enrolments in 2005, an increase of 32.7 percent. In terms of nursing registrations, the increase has not been as high with total registrations increasing from 43,009 in 2000 to 47,375 by 2004, an overall increase of 10.2 percent broadly in line with population growth.

<sup>102</sup> Ibid.

**Nurses Registered with the Queensland Nursing Council**

	2000	2001	2002	2003	2004	% Increase
Registered Nurses	35,874	36,817	37,613	38,744	40,102	
Enrolled Nurses	7,120	7,095	7,111	7,106	7,232	
Midwives	15	15	17	37	41	
<b>Total</b>	43,009	43,927	44,741	45,887	47,375	10.2%
<i>Net Additional</i>		918	814	1,146	1,488	

Source: Queensland Nursing Council Annual Report 2004

A major contribution to shortfalls in nursing supply are the high wastage rates, with many nurses leaving the profession altogether. According to a national survey of the nursing and midwifery labour force in 2003, approximately 10 percent of registered nurses and enrolled nurses were not in the nursing labour force, equating to 22,524 registered nurses and 5,322 enrolled nurses nationally who were not practising in the profession for which they are qualified. This does not include those nurses who have left the nursing workforce and also no longer hold registration. It has been estimated that total wastage rates from the profession could be as high as 40 percent in the first two to three years after graduation.

**Queensland Health's share of nursing workforce**

Queensland Health currently employs an estimated 21,749 nurses. As shown in the table below, nursing numbers have increased significantly over the last two years but prior to this had not kept pace with demand and in 2002, there was a net loss of 100 nurses. In terms of its share of the overall workforce, the table shows that the proportion of nurses employed by Queensland Health has fallen from 46.1 percent to 44.9 percent suggesting a drift of nurses to the private sector. Further research would be required in order to confirm this.

**Proportion of Nurses Employed by Queensland Health**

	2000	2001	2002	2003	2004	2005
Employed by Queensland Health (Headcount)	19,847	20,099	19,999	20,378	21,285	21,749
<i>Net Additional</i>		252	-100	379	907	464
Proportion of Nurses Employed by QH	46.10%	45.80%	44.70%	44.40%	44.90%	n/a

Source: Queensland Nursing Council and Queensland Health Human Resource Management Information System

To meet increased demand for health services, Queensland Health needs to increase its nursing workforce by an additional 500 – 550 staff per annum over the next three years. Undergraduate numbers will need to continue to increase in line with increasing demands taking into account wastage and turnover rates to avoid shortages developing in the future.

**Nursing Forecast Requirement**

	2005	2006	2007	2008	2009	2010
Nursing Headcount	21,749	22,249	22,761	23,284	23,820	24,368
<i>Additional</i>		500	512	524	536	548

There is insufficient data on which to undertake a similar analysis of the supply of the allied health workforce. The review found that Queensland Health does not collect and analyse detailed workforce information for planning purposes on a systematic basis across the organisation. Queensland Health needs to put in place robust workforce data collection and analysis systems and more detailed work needs to be undertaken on future demand and supply projections across all health professional groups.

### 10.2.11 Estimating current gap in workforce numbers

As noted previously, the forecasts of future staff requirements are based on current staffing levels and do not take into account existing shortfalls in capacity. There are a number of different approaches to estimating the current gap in workforce numbers, none of which provide an entirely accurate or reliable picture of the real level of need.

A standard approach is to use national staff to population comparisons. Queensland has the lowest numbers of health professionals per head of population of any State or Territory apart from Tasmania. Queensland would need to employ an extra 260 doctors, an extra 2,700 nurses and 2,350 extra allied health staff to reach the national average (based on 2003/04 national data which is the latest available).

However, this does not take into account differing workloads across the various jurisdictions. Queensland provides fewer hospital services per head than the national average and has higher levels of efficiency than the other States. Comparing staff workload ratios based on public hospital inpatient separations (2003/04) shows that Queensland Health is short approximately 1,000 nursing staff and 1,780 allied health staff but has similar levels of doctors. This shortfall is in addition to existing vacancies within Queensland Health which have not been filled. The workload measure has some limitations in so far as it does not take into account the demands associated with increasing outpatient and community health services, teaching and supervising junior staff, and rising workload intensity but considered a more realistic basis for comparison for hospital staffing than a staff per population ratio.

It is clear that Queensland Health needs to take immediate steps to increase the number of health professional staff working in the system. There are major gaps with respect to nurses and allied health staff compared to national average workloads and the only reason doctor numbers are comparable is due to the reliance on OTDs with special purpose registration.

Given the global workforce shortages that are being experienced, large one-off increases in staffing numbers will be difficult to achieve. Some Districts are already experiencing difficulties in filling existing positions while larger metropolitan Districts could employ more staff provided additional funding was made available. A staged approach based on the different needs of the various Districts is required to increase staffing levels to meet increasing demands. Recruitment strategies are discussed in more detail later in this Chapter.

## 10.3 Queensland Health's workforce management systems

An effective workforce management system would be expected to include long term workforce planning, effective recruitment and retention processes, appropriate remuneration and employment conditions, a fair and transparent staff complaints system, quality controls including credentialing and periodic reassessment of skills, access to training and professional development, and up to date workplace health and safety management systems. Most importantly, the workforce management system as a whole should support, value and nurture staff.

### 10.3.1 Key findings

While Queensland Health has a range of workforce management systems in place, they are not performing effectively. Systems are not integrated and in some cases impose significant additional administrative burden on staff. There is no long term strategy for workforce planning based on future service delivery needs, recruitment processes are drawn out and administratively cumbersome and staff experience difficulties in accessing basic ongoing training.

A high degree of anger and frustration was reported amongst some clinicians who feel under valued and marginalised from the system. The events surrounding Dr. Patel in Bundaberg in particular have highlighted significant problems with Queensland Health's current recruitment and credentialing arrangements as well as issues with the medical registration process, the latter to be addressed by the Public Hospitals Commission of Inquiry.

A range of external bodies play a role in the health workforce including the universities, the registration boards, the Commonwealth, the private sector and professional bodies such as the Australian Medical Association and the Queensland Nurses Union. Frustration was expressed by numerous organisations and stakeholder groups that their efforts to build partnerships and constructive relationships with Queensland Health had not been successful. This feedback highlights the opportunity for revitalised relationships with relevant external bodies as part of the Queensland Health reform agenda.

#### **Administrative systems**

Queensland Health operates a number of human resource information management systems including ESP, the rostering system and LATTICE, a personnel and payroll system, as well as systems for determining workloads such as TREND CARE. Staff reported a number of problems with these systems including the lack of training in the use of systems, the need to duplicate information in various systems and the significant administrative burden which reduced the time available for patient care.

Effective management of staff concerns, complaints and grievances is critical to workforce harmony, retention and sound management. Many Queensland Health staff reported that existing grievance systems are not resolving concerns for aggrieved staff or resolving workplace conflict. This issue is discussed in more detail in the context of complaints systems under risk management in Chapter 9, in discussion of performance management in Chapter 13 and organisational reform in Chapter 14.

#### **Workforce planning**

While the various systems produce important information, this information is not centrally analysed to inform policy development or workforce planning. Workforce plans have been developed in some districts and zones, and a corporate strategic workforce plan was recently released. However, there is no comprehensive plan which models future workforce needs and scenarios, options to meet future demand or includes specific targets, strategies, timeframes, governance arrangements and evaluative activity.

There is no Statewide assessment of staff satisfaction, with surveys occurring on an ad hoc, district by district basis. Similarly, exit interviews were undertaken on a district by district basis and it was not possible to obtain any clear, system-wide analysis of the results of exit interviews to inform future recruitment and retention strategies.

## **Quality and safety systems**

Thirteen health registration boards are responsible for regulation of health professions in Queensland, including medical, dental and allied health professions. The Queensland Nursing Council plays this role for the nursing profession. These bodies operate independently from Queensland Health and are responsible for ensuring clinicians are safe and competent to practise by determining professional standards, assessing applications for registration and investigating complaints, including proceedings against practitioners for unsatisfactory professional conduct.

Queensland Health has in place credentialing and clinical privileging policies and procedures to determine the scope of practise of doctors. The policies have been recognised as best practice and adopted nationally as a quality and safety initiative. However, events in Bundaberg have clearly raised questions about the adequacy of implementation of these systems. Assessment of current systems and recommendations for improvement are outlined in Chapter 9, as credentialing and clinical privileging are considered to be a critical foundation for effective quality and safety systems.

## **Recruitment and retention**

Queensland Health has implemented a range of strategies to improve recruitment and retention of clinical staff which have met with varying degrees of success. Strategies have tended to be piecemeal and vary according to discipline and location of services. In particular, there are longstanding problems with recruiting and retaining staff in rural and remote areas which are now becoming critical despite efforts to introduce various incentive programs.

One of the main problems in retaining medical staff is the lack of career pathways and the inherent features of the medical training model. As outlined in the workforce profile, the public health system loses significant numbers of doctors each year, with an annual separation rate of 11.5 percent. The public sector loses doctors annually to general practice (upon completion of second or third year postgraduate training) and to private specialist practice (upon completion of registrar training programs). Medical career structures currently follow this training pathway and while not unique to Queensland, they pose particular challenges in looking at ways to improve retention of the medical workforce.

Considerable work has been invested in improving retention of nurses in Queensland Health including more flexible working conditions (noting the majority of nursing staff now work part-time), changes to the career structure to enable progression and monetary recognition of additional qualifications. However, a number of deficiencies remain including a high level of dissatisfaction amongst staff regarding restrictions on the qualifications allowance, and anomalies in pay between Level 2 nurses and Level 3 nursing managers. The failure to address rising workloads for nursing staff in particular is seen as a major barrier to improving retention of the workforce.

A clinical advancement scheme is the main retention strategy recently employed for allied health staff which allows staff to progress to higher levels based on demonstration of outstanding clinical, teaching or research skills. While the scheme has yet to be fully evaluated, early indications are that it has been successful in improving retention of staff although as noted previously there are significant shortages for this group.

## **Enterprise Bargaining Arrangements**

Queensland Health has to deal with a complex range of awards and agreements which limit its ability to manage the workforce effectively and respond to changing service delivery needs.

There are nine parent awards that apply to staff within Queensland Health under the current enterprise bargaining arrangements including two awards for district health service nurses as well as the MX award (the arbitrated outcome of the last enterprise bargaining negotiations), and three awards for medical staff (one for senior medical officers and resident medical officers, one for medical superintendents and medical officers with right of private practice, and a third for public servant medical officers employed in Queensland Health Corporate Office and doctors employed in other government departments). In addition, VMOs are included in the enterprise bargaining arrangements although not subject to a specific award.

There is a separate award for district health services employees, which covers professional, technical, operational, dental and administrative streams and one public service award which applies to administrative, professional, technical, operational and nursing staff employed in Corporate Office (and nurses employed in other government departments) and for public servants employed in other government departments. Finally, there are two awards for building and engineering staff.

## **Education and training systems**

The Interim Report found that increasing service demands were impacting on the quality and level of education and training available in the public health system.

Systems maintained within districts to keep track of the education and training of its clinical workforce were underdeveloped and poorly maintained. In a number of districts visited, the clinical workforce reported that there was no systemic approach to clinical training, that teaching systems for doctors had all but broken down, and that clinical training for the nursing workforce had been replaced by mandatory training sessions relating to corporate office policy requirements. In summary, education and training systems are underdeveloped, and a significant effort will be needed to ensure that the public health system, which has a major obligation to teach and train medical practitioners and to train its clinical workforce, is in a position to do so. At the moment, arrangements are far too informal and subject to the vagaries of work pressures.

Clinicians reported that workload pressures and a lack of funding to backfill the positions of those attending training had resulted in limited opportunities to teach, train and mentor junior staff. Concerns were also expressed about skills shortages in particular areas and the need to enhance the practical clinical skills of new graduates and overseas trained health professionals.

Queensland Health's ability to directly influence and control the level of skills and training of its workforce is constrained in a number of ways. There are numerous institutions involved in health professional education and training including the universities, TAFE colleges, the medical colleges, national bodies such as the Australian Medical Workforce Advisory Committee (AMWAC) and the Australian Health Workforce Advisory Committee (AHWAC), the Commonwealth and the private sector, each with differing objectives, roles and responsibilities.

The current arrangements are less than optimal and based more on a loose coalition of interests which have grown over a number of years rather than any coherent or strategic approach. Queensland Health faces major challenges in terms of coordinating efforts across the various agencies and undertaking long term planning to meet future workforce needs.

The Review is suggesting a range of strategies to address health workforce issues. As noted in the interim report, there is no single solution to workforce pressures, hence the range of recommendations outlined below, including immediate to long term initiatives for doctors, nurses and allied health professionals.

## **10.4 Initiatives for doctors**

### **10.4.1 Relief for doctors: immediate action to recruit more doctors**

A single, large increase in doctors is unrealistic at a time of global workforce shortage and inadequate local supply. The following initiatives are suggested to build on existing Queensland Health efforts to increase the medical workforce over time.

#### **Active recruitment locally, interstate and overseas**

It is proposed that Queensland Health implement targeted as well as web-based marketing and recruitment campaigns locally, interstate and overseas. Overseas campaigns should focus in particular on the United Kingdom and other countries with doctor training equivalent to Australian standards, in light of feedback that OTDs from English speaking backgrounds and culturally similar environments integrate more easily into health practice in Australia. Automatic recognition of graduates from countries with similar education and training standards such as the United Kingdom, Canada, and Ireland may need to be considered as already occurs for New Zealand graduates. This is discussed further in streamlining the registration process below.

In addition to local medical graduates, fee paying overseas medical students are a potential recruitment pool for Queensland Health. Under changed immigration laws, it is possible for these students to apply for permanent residency upon completion of their degree, as opposed to previously where students had to return to their country of origin and then apply for a skilled migration visa. A targeted campaign promoting employment in Queensland Health could be designed to increase recruitment of locally trained doctors as permanent residents who may otherwise return to their country of origin.

It would also be useful for Queensland Health to routinely undertake exit polling of staff to determine the reasons for staff leaving their positions to inform recruitment activities.

#### **Streamlining assessment and registration**

In light of recent events, the Medical Board has introduced more rigorous screening and assessment processes for registration of OTDs. While these reforms are required, they may create significant delays in recruiting an OTD, a process which already requires long lead times. It is estimated that the current length of time to register an OTD in

Queensland is six months for a non specialist and twelve months for a quality overseas trained deemed specialist.

Anecdotal information from the recruitment industry suggests that doctors looking for work are choosing sites which are able to employ them rapidly such as New Zealand, where registration can occur in 21 days. One suggestion has been that Queensland should be able to automatically recognise qualifications from countries with similar educational standards such as the United Kingdom, Ireland and Canada. However, Queensland currently has the same requirements for registration as other States and any changes would need to be made on a national basis given mutual recognition legislation. This proposal should be considered as part of the development of the national registration scheme which has been approved in principle by Health Ministers and expedited as a matter of urgency.

### **Improving flexibility in recruiting doctors**

Anecdotal reports were received of inflexibility in recruiting doctors who return to Queensland after working overseas. Instances were cited where younger doctors had returned to Queensland seeking work in the public sector, only to be advised there were no current vacancies. This led to doctors who had trained in the public system, and were willing to return to full time public sector work, pursuing private sector opportunities.

A range of flexible options to provide for greater flexibility could be explored including:

- a phased retirement and succession process where senior doctors move to part-time work and offer support and mentoring to a younger doctor moving into the senior post
- encouraging younger doctors to perform rural and remote service in return for a guaranteed metropolitan position when a more senior doctor retires
- guaranteeing younger doctors a permanent position or sessional work upon their return from working overseas.

### **Simplifying Recruitment Processes**

The review heard that whole of Government job advertising restrictions impeded wide exposure of clinical vacancies and marketing of hospital reputation in job advertisements. In line with some other government departments, it would be helpful for Queensland Health to negotiate with the Department of the Premier and Cabinet a standing exemption under the advertising guidelines to increase flexibility in advertising positions.

The issue of staff and communities identifying with their local hospital arose frequently during the consultation process. In times of intense competition for staff, barriers caused by bureaucracy should be removed. As a general principle, it is therefore suggested that Queensland Health devolve recruitment to the facility level as far as possible. Centralised recruitment should be limited to those processes where multiple positions are being recruited across many sites eg interns and “area of need” registered practitioners.

Line managers also reported that whole of Government merit selection requirements impeded timely recruitment of doctors. The requirement to complete written applications addressing key selection criteria was seen as a disincentive to applying for public sector jobs. However, the Recruitment and Selection Directive allows significant flexibility in the selection tools that departments can use. It is therefore suggested that Queensland

Health clarify with line managers the range of flexible recruitment practices that can be used to recruit doctors.

### **Increasing student places**

In the long term, the most obvious way to increase supply of locally trained doctors is to increase student intakes in university courses. It would be prudent for Queensland Health to develop recommended student intakes in Queensland and seek from the Commonwealth Government an immediate increase in medical student places.

Recently, the Queensland Government announced state funded increases in placements at the Griffith University medical school of 35 in 2006, increasing to 50 per year from 2007-10. Over eight years, this will cost \$60 million. While funding for university places is a Commonwealth responsibility, Queensland Health could further increase intakes by funding additional bonded student places in all Queensland medical schools.

#### **10.1 Recommendations to provide immediate relief for doctors**

Queensland Health should:

- implement a local, interstate and overseas campaign to rebuild Queensland Health's reputation as an employer, including focused campaigns in the United Kingdom and other countries with equivalent doctor training (with the aim of recruiting 280 additional doctors to meet the shortfall in local supply and increasing demands for services)
- undertake routine exit surveys of staff to determine factors driving loss of staff so as to better inform and target recruitment activities
- increase flexibility in recruitment processes including advertising and selection processes
- clarify with line managers the range of flexible recruitment processes that can be used under the Recruitment and Selection Directive to recruit doctors
- maintain the capacity of local districts to undertake recruitment activities but introduce a centralised process for the recruitment of doctors with special purpose registration
- seek to expedite national efforts to establish uniform medical registration arrangements through the Australian Health Ministers Advisory Committee including automatic recognition of graduates from countries with similar educational standards such as the United Kingdom, Ireland, and Canada
- develop recommended student intakes in Queensland to inform negotiation with the Commonwealth to increase student places in all Queensland medical schools.

Area Health Services should:

- Through their workforce planning areas, facilitate and support districts to undertake career and succession planning with the existing medical workforce and resource districts to maximise recruitment and retention of younger doctors upon completion of their training or return from training overseas.

The Queensland Government should:

- seek from the Commonwealth an immediate increase in medical student places and/or consider funding additional bonded places in Queensland medical schools.

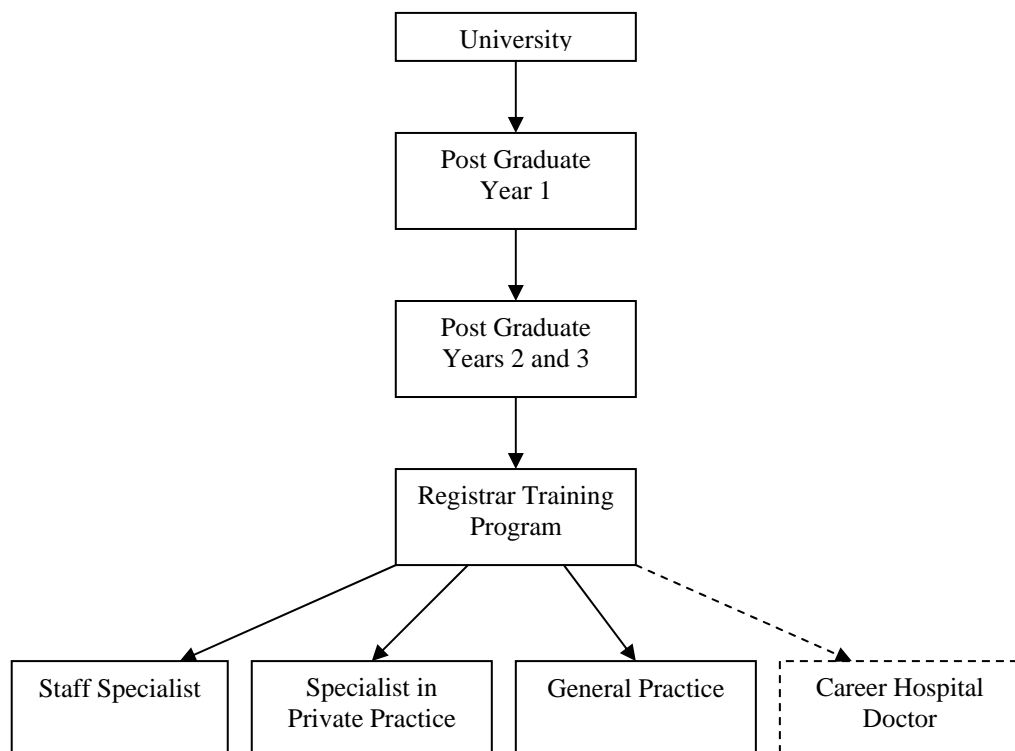
### 10.4.2 Improved retention measures

#### Creation of a hospital generalist career pathway

One of the main solutions to Queensland Health’s medical workforce shortages lies in its ability to retain younger staff in the system longer and prevent the drift to the private sector. As noted previously, the public sector loses doctors annually to general practice (upon completion of second or third year postgraduate training) and to private specialist practice (upon completion of registrar training programs).

Illustrated below is the current hospital based medical training model which actually drives constant turnover. The public sector loses doctors annually to general practice (upon completion of second or third year postgraduate training) and to private specialist practice (upon completion of registrar training programs). Medical career structures currently follow this training pathway and while not unique to Queensland, they pose particular challenges in looking at ways to improve retention of the medical workforce.

#### Hospital Based Medical Training Model



Doctors who do not undertake specialist training can move into Medical Officer and Senior Medical Officer positions. However, these positions are generally used to employ generalists in non-metropolitan hospitals and tend not to feature in larger hospitals. If the number of career medical officer positions were increased in larger hospitals, it may be possible to retain greater numbers of doctors who would otherwise move into specialist training and/or private practice. This in turn could reduce reliance on OTDs with special purpose registration.

To support this, a hospital generalist career structure could be developed, including relevant support such as a training program and attractive remuneration arrangements to recognise the advanced skills and training of these professionals. It is understood that a consortium of universities is currently considering establishing a training course for hospital generalists. It is suggested that Queensland Health therefore work with this consortium to design a career pathway and training course.

### **Higher Education Contribution Scheme (HECS) Debt Relief**

Given the long period of study required to produce medical graduates, many doctors are graduating with significant debts. This increases the attraction of private medical practice which, with higher remuneration, offers a way to repay debts quickly.

In order to retain junior doctors and registrars upon completion of their training in public hospitals, Queensland Health could offer to pay part or all of doctors' HECS debts in return for a period of bonded service.

### **Visiting Medical Officers**

Strategies to recruit more VMOs into the public health system must be accompanied by initiatives to ensure existing and future VMOs feel more valued within Queensland Health and to respond to particular concerns raised by VMOs. Queensland Health needs to improve its communication with VMOs, make the best use of their expertise and take an active interest in their workplace situation. Efforts should be made to include VMOs in key advisory and decision making forums, including scheduling meetings at times that are appropriate for VMOs. Strategies to provide protected teaching time for medical staff, discussed later in this chapter, should include VMOs as well as full time medical staff and should be prioritised for existing staff who have contributed to the public health system in the first instance.

### **Enterprise Bargaining Arrangements**

Based on consultations with staff and unions, the review found a number of deficiencies in previous enterprise bargaining processes. In particular, this process encourages an adversarial approach which limits the potential for negotiation on critical issues including workforce reform. The interest based bargaining approach used in the current round for salaried medical officers provides a more appropriate model particularly given the challenges in managing a large and complex workforce.

Fair remuneration is essential in retaining medical staff in Queensland's public hospital system particularly in an environment of worsening workforce shortages. The review notes these issues are currently under consideration as part of the enterprise bargaining process with salaried medical officers and VMOs. Depending on the outcome of the enterprise bargaining process, Queensland Health will need to review the loading paid to clinical academics working in the hospital system to ensure they remain comparable with salaried medical officers.

Queensland Health needs to continue working constructively with staff and unions to address impediments to workforce reform both within and outside of the enterprise bargaining process particularly with regard to:

- outsourcing work, especially in areas of acute workforce pressures and/or high demand

- negotiating flexible employment arrangements for doctors including reduced and flexible hours, and a mix of public and private work (including appropriate rights of private practice arrangements).

It is suggested that in the future VMO arrangements might best be managed through contractual arrangements. This would be consistent with other employment arrangements between Government and private consultants or contractors and would allow greater flexibility for both parties to manage and respond to service delivery demands.

It is also recommended that Medical Superintendents/Directors of Medical Services be placed on contracts, in line with other members of district health executive teams. This will be particularly important if Medical Superintendents benefit from increased remuneration under the current enterprise bargaining arrangements, as doctors in Medical Superintendent positions may earn more than they would if they aspired to move into other leadership roles such as District Managers or senior leadership roles in corporate office. Queensland Health will need to consider how high performing Medical Superintendents can be encouraged into other senior leadership roles given the potential income disparity that may arise.

### **Safe working environments**

In district visits, all clinical staff, including medical staff, raised serious concerns about patient and carer aggression. Concerns were also raised with the mandatory training in aggression management currently being implemented by Queensland Health. This was seen as another example of a well intentioned corporate office policy failing to meet health service needs. Major concerns included failure to target the training to areas of highest risk, unrealistic training time which cannot be accommodated in front line services, and insufficient resourcing to enable staff participation.

It is therefore recommended that the course be reviewed in light of district feedback and implemented in a modified form as a matter of priority. For example, implementation should be managed locally, linked to district risk management systems, include resourcing to support backfilling, and be targeted to areas of most concern including emergency departments, mental health inpatient wards and paediatric wards.

### **Other measures to show Queensland Health values its staff**

There are a range of measures Queensland Health could introduce to show it values its medical staff including:

- ensuring doctors are not working excessively long hours which compromises safe practice
- improving organisational culture and empowering clinicians to influence service planning and resource allocation decisions
- providing appropriate amenities such as meeting and training rooms, tea rooms and personal storage spaces
- providing appropriate induction programs and information about entitlements, with access to entitlements explicitly recorded in individual performance and development plans
- providing access to timely travel and accommodation services
- establishing peer support networks for isolated workers, as discussed in chapter seven in the section on rural and remote issues.

**10.2 Recommendations to improve retention of the medical workforce**

The Queensland Government should:

- encourage enterprise bargaining approaches that are interest based rather than adversarial, which address the lack of flexibility and complexity of the current arrangements and occur as close as possible to clinicians and service delivery.
- negotiate with VMOs to achieve a move from award based to contractual arrangements
- pending the outcome of the enterprise bargaining process, adjust the level of clinical loading paid to clinical academics working in public hospitals

Queensland Health should:

- plan and develop a hospital generalist career structure and work with the university consortium to develop a training program to support this new role
- offer HECS payment in return for a period of bonded service to retain junior doctors and registrars upon completion of their training
- urgently implement strategies to improve organisational culture and foster strong leadership and change management capacity within the department, discussed in chapter four
- ensure doctors are provided with timely, quality travel and accommodation services.

Area Health Services should:

- ensure doctors have access to revised and better targeted and resourced training in managing patient and carer aggression
- Create peer support networks along professional groupings or streams of care to improve support for isolated workers.

Districts should:

- discuss and agree with VMOs the best way to establish and improve communication
- provide amenities such as meeting and training rooms, tea rooms and personal space (eg lockers) where feasible and in consultation with doctors
- ensure all medical staff are made aware of their entitlements through a clear induction process, that these entitlements are included explicitly in individual performance and development plans and that medical staff are supported to access their entitlements.

**10.4.3 Maximising the value of the medical workforce****Increase interaction and partnership with the private sector**

Two-thirds of Queensland's practising doctors work in the private sector. It is essential that Queensland Health increase its interaction with the private sector to maximise use of the local medical workforce and reduce reliance on OTDs with special purpose registration. Four avenues are suggested.

*1. Increase numbers of VMOs*

Increasing the use of VMOs has been suggested to increase the availability of medical services in the private sector. Strategies to increase the use of VMOs will obviously be affected by the demands of their private practice. With reports of average weekly working hours in excess of 60 hours, the opportunity for VMOs to totally reduce Queensland Health's reliance on OTDs with special purpose registration seems unlikely to be able to be achieved.

Increased use of VMOs can therefore be considered as only one element of strategies to increase availability of doctors.

### *2. Incentives for existing medical staff and VMOs to perform additional work*

Queensland Health could offer incentives to medical staff and existing VMOs to perform additional work in areas of pressure or backlog, provided this does not result in unsafe working hours and compromise safety.

### *3. Outsource Selected Services*

Queensland Health could explore contracting out some services in areas of extreme service pressure or workforce shortage. It is suggested that contracting out be subject to the principle that additional work should be offered first to full time staff or VMOs to do out of hours (as noted above) before this is offered to practitioners not currently contributing to the public sector.

### *4. Explore new practice and partnership arrangements with general practitioners*

It has been suggested that GPs can have a more supportive and direct role in providing outpatient services for patients pre and post operatively than is currently the case. This is more likely to be feasible in metropolitan areas as some general practitioners in rural and remote areas are working excessive hours to maintain their practice.

## **Increasing availability of doctors in rural and remote areas**

On 24 August 2005, the Queensland Government proposed creation of Rural General Medicine as a specialty career path in an effort to increase the attractiveness of working for Queensland Health in rural and remote areas. This would enable doctors to live in country areas and practice across a number of specialties. This is supported as a strategy to increase recruitment and retention of medical staff within Queensland Health.

However, in small centres lacking a sufficient population base to support a full time salaried medical officer, there is an opportunity for Queensland Health to make better use of private procedural general practitioners. This option may also apply in larger centres requiring additional medical capacity. Procedural GPs could be employed by Queensland Health on a sessional basis or through outsourcing of medical services under contractual arrangements, in line with the model successfully used in Longreach (described in chapter seven in the section on rural and remote issues).

To increase the skill base of rural generalists, the Commonwealth Government has contracted the Australian College of Rural and Remote Medicine to administer key components of the Medicare Plus Training for Rural and Remote Procedural GPs program. This program supports procedural rural doctors for skills maintenance and up skilling in anaesthetics, obstetrics and surgery covering both formal (courses) and informal (clinical attachments) delivery modes. It is in the form of a grant of \$15,000 per doctor per financial year based on 10 days training at \$1500 per day. This funding is also available for procedural medical officers undertaking only rural hospital based work.

There is an opportunity for Queensland Health to partner with the College in delivering training to doctors interested in this opportunity. This would increase availability of suitably skilled rural generalists. Additionally, this could be used as an avenue to recruit additional private procedural GPs into public service. For example, Queensland Health could offer training for GPs in return for providing services in the public system either

through sessional work or innovative arrangements such as the Longreach group practice model. In assessing opportunities, it would be helpful for Queensland Health also to work closely with the Rural Doctors Association of Queensland.

In addition to the above measures, alternative models of care and workforce roles are also required, to reduce reliance on purely medical service models. Workforce roles including nurse practitioners, advanced rural and remote nurses and paramedic primary care providers are discussed in chapter seven and should be developed as a matter of urgency.

### **Trialling consultant led services**

In the interim report, the possibility of adopting a consultant led service model was canvassed. For example, in some parts of Canada specialists provides clinical services directly to patients on a fee-for-service basis, with junior medical staff employed specifically for training purposes rather than service provision. The hypothesis is that adoption of this model would reduce the requirement for OTDs with special purpose registration at resident medical officer level.

A small sample of metropolitan and regional hospitals could trial a mixed medical service model to test this hypothesis. Under this approach, junior doctor places would be retained for training purposes and some wards would therefore continue with the existing service model used in Queensland. However, junior posts that cannot be filled with Australian trained doctors would be converted into consultant positions, drawn from full time medical staff or VMOs. In these instances, wards would adopt a consultant led model, in line with the Canadian approach and Australian private hospitals. Outcomes of such a trial could assist in better medical service design which retains junior doctor positions only to the extent that they serve local training needs.

### **Redesigning work practices to increase efficiency**

District visits highlighted the administrative burden imposed on doctors. There was a consistent view expressed that much of this work could more appropriately be performed by administrative support officers to increase availability of doctors to perform clinical work.

Opportunities to redesign work practice have been identified to increase efficiency and availability of doctors to provide clinical care which include:

- Systematic implementation of outcome based clinical pathways into the health care work environment. This is based on the finding that a major Brisbane hospital which successfully improved clinical care and reduced paperwork, thereby freeing up clinicians' time.
- Devolution of non-clinical tasks to non-clinical categories of staff - for example provision of adequate secretarial support to ensure timely completion of referral letters and management of clinics.
- Negotiating opportunities at the local level to introduce flexible hours of work to increase productivity. For example, negotiation of four day weeks based on 4x10 hour shifts could be used as a basis to increase theatre hours and surgical throughput each day and increase activity after hours and on weekends subject to availability and interest of clinicians.

### **Development of country service register and incentive package**

The review identified significant problems with retention of staff in rural and remote areas. The current practice of sending junior doctors to the bush without adequate support and supervision is a major cause for concern. Some districts have developed a register of clinicians willing to perform country service on a short or longer term basis to assist in relieving vacancies and staff leave. A number of doctors expressed interest in performing short term rural and remote service on a rotational basis and this goodwill should be used to assist smaller districts.

It is recommended that each Area Health Service establish a register of interested clinicians, including doctors, and develop an incentive package to make the rotations attractive. For example, accommodation, meals, living allowances and travel must be provided. Other benefits might include offering additional recreation leave in return for a certain amount of country service, enabling the package to be promoted as a working holiday.

### **Enhancing technology**

There is scope for Queensland Health to better leverage its existing medical workforce using technology to provide “outreach” support to regional or remote facilities experiencing workforce shortages or with insufficient service volume to warrant a local specialist workforce. Use of telehealth was discussed in detail in chapter seven, along with recommendations for enhancement.

In addition to telehealth, a range of new and emerging technologies are being used elsewhere to maximise the health workforce and undertake lower order tasks previously fulfilled by staff, including use of virtual reality and robotic technology. It would be prudent for Queensland Health to monitor evaluation of new technologies and undertake cost benefit analysis to determine their suitability for local implementation.

#### **10.3 Recommendations to maximise the value of the medical workforce**

Queensland Health should:

- Offer increased sessional work to the existing VMO workforce and increase numbers of VMOs in the public system
- Offer incentives for existing medical staff and VMOs to perform additional sessions especially surgery
- Outsource services in areas of acute service and workforce pressure, subject to work first being offered to existing medical staff and VMOs
- Monitor evaluation of new technologies used in other jurisdictions and undertake cost benefit analysis to determine suitability for local implementation

Area Health Services should:

- Facilitate trials of consultant led services in a small sample of metropolitan and regional hospitals
- Facilitate and resource districts to devolve non-clinical tasks to non-clinical categories of staff including provision of adequate secretarial support to doctors
- Establish a register of clinicians – including doctors – willing to undertake country service rotations and design a country service incentive package
- Incorporate use of technology such as telehealth within service and workforce planning to maximise opportunities for medical outreach to smaller districts

Districts should:

- Explore new practice and partnership arrangements with general practitioners, in association with the medical College and the Rural Doctors Association of Queensland, particularly in the management of outpatients clinics and provision of medical services in rural and remote

communities by procedural general practitioners on a sessional or outsourced basis

- Negotiate opportunities to introduce flexible hours of work to increase productivity subject to staff availability and interest

Clinical networks should:

- Lead implementation of outcome based clinical pathways to improve care and streamline work practices

#### 10.4.4 Improving medical education and training

##### Undergraduate medical education

Responsibility for the education and training of medical practitioners rests in the first instance with the universities and the Commonwealth as the primary funder of the tertiary sector.

As noted in the interim report, the shortage of doctors currently being experienced across Australia is a direct consequence of Commonwealth decisions to reduce medical student intakes in the early 1990s. While this situation has been remedied with the increases in student intakes introduced over the last few years, the long time period associated with producing fully qualified medical practitioners means the current shortages and the reliance on OTDs with special purpose registration will need to continue for at least another ten years or more.

The considerable lead times in the ability of universities and other institutions to respond to service delivery needs highlight the importance of undertaking strategic planning so that responses can be put in train to address issues before they reach crisis point.

While it is traditionally the Commonwealth's responsibility to create and fund student places in universities, the State could choose to directly fund additional places and these are typically attached to a bonding requirement which allows the State to direct the placement of practitioners. The Queensland Government has recently announced state funded increases in medical school placements of 35 in 2006, increasing to 50 per year from 2007-10. The need for the State to step in and fund university places underscores the lack of alignment between the Commonwealth funded tertiary education sector and State service delivery needs. If contemplating further placements the State might consider inviting expressions of interest from all Queensland medical schools.

##### Clinical student placements

During their university study, student doctors spend time working in public hospitals on clinical placements. Universities rely on the health system to provide around 60 percent of teaching in clinical settings.

There is a real concern that the budget pressures on both sectors have detracted from efforts to build cooperative relationships. Universities argue that their funds to support clinical placement are limited noting that in some universities less than 40 percent of university funding is now provided from public monies. While the Commonwealth provides a specific allocation per student to the universities to support clinical teaching, this falls well short of the costs of providing teaching and supervisory support to students in hospitals, the burden of which falls mainly on Queensland Health.

The universities appoint clinical academic staff who are located in public hospitals with responsibility for student teaching and education. These staff often hold joint appointments with the hospital and are involved in direct clinical care provision. This can lead to tensions in serving both the needs of the university as well as the hospital. Universities also report difficulties engaging with Queensland Health on better ways of managing academic appointments with responsibility for decision making spread at various levels across the organisation.

The problem of a lack of funding to support clinical placements of students in the State's public hospitals needs to be urgently addressed.

Queensland Health has recently moved to establish Deeds of Agreement with the medical schools attempting to clarify roles and responsibilities. Unfortunately, neither party is funded to support these agreements and in the absence of this funding, the ideal sought in the Agreements will simply not be realised.

It is recommended that the universities and Queensland Health seek increased financial contributions from the Commonwealth to support the States in meeting the costs of supervising and teaching students on clinical placements. Further consideration also needs to be given to a greater role for the private sector in supporting student placements to reduce the burden on the public system.

### **Hospital based training – roles and responsibilities**

Queensland Health's primary training and education responsibilities begin when health professional graduates gain employment in the public hospital system. In the case of medical graduates, formalised education and training arrangements continue for a number of years in the hospital setting as doctors undertake an apprenticeship based training which leads to the acquisition of specialist qualifications which in the case of some specialties can take 10 years or more (after graduation).

Training medical students in this way has long been the role of the public sector and is reflected in the world-class reputation of our major teaching hospitals in producing highly trained and skilled medical practitioners.

The responsibility for medical practitioner training in the hospitals is shared with the medical Colleges who are responsible for accrediting hospitals to undertake training in particular specialties. As with the universities, these arrangements appear to be based on understandings which have evolved over time. This can lead to a lack of clarity about the roles and responsibilities of the respective parties and concerns about Queensland Health's commitment and ability to financially support medical training in an environment of escalating service demands.

### **Training needs versus service delivery needs**

Numerous reports were received from clinicians about not having sufficient time to teach or train staff as the system copes with increasing service demands. Junior medical staff also reported they were not receiving the appropriate level of support or supervision. Many clinicians felt there had been a deliberate attempt by Queensland Health to diminish the role of teaching and training and increase the focus on meeting service needs. This led to major concerns that workforce shortages would be further exacerbated as the opportunity to undertake teaching and research were considered to be one of the key attractions of working in the public hospital system.

What I cannot accept is the appalling lack of support for junior medical staff in ensuring the development of generic clinical skills in a methodical and standardised approach. ... The only sponsored course in 3 years made available to me was a 2 day preparatory course prior to rural relieving work which is compulsory for all metropolitan based junior doctors.

Queensland Health has evolved a task oriented approach to its workforce and lost its perspective as a training institution. The attitude of our employer is that work comes first and training not at all, yet we are expected to maintain high standards, gain increasing independence of practice, and eventually (if we obtain specialist qualifications..) to work for them as underpaid/overworked specialists.

*Source: Submission to Queensland Health Systems Review, July 2005*

Teaching and research are central to the ability of the public sector to continue to attract and retain staff. Many clinicians reported that the opportunity to undertake teaching and research was one of the main reasons they sought work in the public sector. Public hospitals treat the sickest and most complex patients and the work provides challenges and opportunities to develop collegiate relationships and contribute to the advancement of medical knowledge and improved outcomes for patients which are not available in the private sector.

It is acknowledged that training and teaching students is an integral part of service provision and difficult to neatly separate out from day to day tasks. However, mechanisms must be established to provide protected time for teaching to ensure that adequate time and resources are dedicated to this task.

### **Shortages of specialist training positions**

As noted in the interim report, Queensland is currently not meeting Australian Medical Workforce Advisory Council recommendations regarding medical specialist registrar training positions in a number of specialities including gastroenterology, haematology, medical oncology, ear, nose and throat, orthopaedics, emergency medicine, obstetrics and gynaecology, pathology, psychiatry and radiology<sup>103</sup>. This translates to future shortages in these specialities.

In addition, as outlined in the interim report, Queensland has a relatively lower share of registrar training positions with 16.5 percent of the total number of recognised training programs compared to the State's 19.2 percent share of the national population. In order to reach the national average, Queensland would need to increase its training positions by an estimated 170 positions.

Training positions are currently not evenly distributed throughout the State with the majority of positions located in metropolitan areas. While trainees undertake some rotations in regional and rural areas, most specialist education programs are conducted in Brisbane which disadvantages trainees in rotation hospitals in outlying areas. There is also a perception amongst trainees that specialist colleges favour metropolitan based experience over rural and regional training which further lessens the attraction of these types of placements.

Training infrastructure is variable across facilities with some hospitals struggling to gain accreditation from colleges. This only compounds workforce shortages in the longer term as evidence suggests that doctors who undergo their training in rural and regional areas are more likely to decide to stay and practise in those areas. The inability to provide

<sup>103</sup> Australian Medical Workforce Advisory Committee Annual Report 2003-04

adequate training in provincial hospitals will therefore have longer term repercussions in terms of attraction and retention.

There needs to be a strong focus on increasing training numbers outside metropolitan areas. The concept of formalised training networks that link tertiary teaching hospitals with rural and regional hospitals is being examined in other jurisdictions and is something which should also be explored in Queensland.

The Government has recently announced an additional 20 registrar training positions to bolster specialist training in the system. While this goes some way to addressing the problem, further positions are required to meet existing shortfalls.

It is worth noting that the ability to fill specialist training positions is influenced by the supply of available doctors and there are indications that Queensland Health is now experiencing difficulty filling existing training positions. A staged and planned approach to increasing specialist training positions is therefore required to better align training numbers with service priorities.

Both Victoria and New South Wales have established specialist bodies to deal with medical training issues. Victoria set up a Medical Workforce and Training Advisory Committee in February 2004 to devise strategies to address deficiencies with its medical training arrangements and New South Wales has recently announced it will be revamping its Medical Training and Education Council. Given the breadth of issues and the complex nature of the various interrelationships in medical education, Queensland needs to consider adopting a similar dedicated body to progress work in this area and to work with the other States on developing national responses. The Queensland Medical Education Council was established around 12 months ago to focus on medical training and education issues. It is suggested that the role of the Council be strengthened and a program of targeted reform be set.

### **Increasing medical graduate numbers**

As noted in the interim report, the number of medical graduates is expected to increase from 232 in 2004 to 540 in 2010. This will place further strains on the system in terms of the increase in the number of intern positions required and the ability of senior staff to provide sufficient training and support. It is therefore critical that planning commence immediately to deal with the influx of graduates into the system. This planning needs to be coordinated and involve high level commitment from all relevant stakeholders including the colleges, the universities and the private sector.

### **Alternative models of medical training**

The chronic shortage of medical practitioners and the expected influx of new medical graduates over the next five years calls into serious question the ongoing sustainability of the current medical training model to meet future medical workforce needs. It is clearly resource intensive in terms of the supervision requirements placed on hospital staff. The duration of specialist training, which can take up to ten years or more after graduation in the case of some specialties, undoubtedly compounds shortfalls of practitioners in particular areas.

Alternative approaches to the traditional medical training have been suggested during the course of this review. Contemporary education, teaching and training methods tend to be based more on the acquisition of knowledge, skill and competence rather than a focus on

the passage of time and need to form a stronger basis of teaching and training the clinical workforce post-graduation. There are some Colleges which are actively exploring these options. A national approach to this issue would be desirable given the critical role of the medical Colleges and the fact that it would not be desirable to have different arrangements for doctor training across the various States and Territories. It is pleasing to note that a number of Colleges are already seeking ways to incorporate more of an increased competence approach with teaching approaches, including simulation to compress teaching times.

The level of services provided in the private sector has been increasing steadily, primarily in response to the Commonwealth Government's policies to encourage more people to take out private health insurance. This has meant that specialists are also performing more work in the private sector, particularly in the surgical specialties.

Given the trend to increasing private sector activity and increasing medical student numbers, it would be useful to explore greater possibilities for the private sector to be involved in specialist training. The case for private sector training is strong as the majority of the costs of training medical specialists falls on the public sector at a time when specialists are increasingly taking up career options in the private sector and their skills and expertise are being lost to the public sector.

All State Governments are concerned about this issue. In its submission to the Productivity Commission Study into the Health Workforce, Victoria argues that the private sector should make some specific financial contribution for these benefits and that doctors trained in the public system should be obliged to complete a set period of time in the public sector or treat public patients in their private practice<sup>104</sup>.

### **Overseas trained doctors with special purpose registration**

Overseas trained medical practitioners with special purpose registration have varying levels of skills and competencies and require specific attention in terms of support and training to ensure safe and competent practice. The current education and training system does not cater adequately to the training and education needs of OTDs with special purpose registration, particularly those who are relatively young and inexperienced, and urgent changes in this area are required.

Queensland Health has developed a proposal to upgrade the Centre for International Medical Graduates to ensure that OTDs receive adequate training assessment and supplementation where necessary prior to employment in Queensland Health. This proposal should be implemented as a matter of priority. Training for OTDs should have a strong clinical component but also be designed to provide familiarity with the culture and operation of Queensland's Health system including processes for prescribing medications and ordering tests.

Additionally, Queensland Health should provide ongoing support, training and professional development to assist doctors with special purpose registration to achieve the Australian standard as identified by Australian Medical Council certification and/or Fellowship of an Australian College.

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<sup>104</sup> Victorian Government Submission to the Productivity Commission Study into the Health Workforce July 2005, p.43

**10.4 Recommendations to improve medical education and training:**

Under the new structure, Queensland Health should establish a dedicated medical workforce planning group to undertake the following specific tasks:

- assess the adequacy of current and planned undergraduate medical student places to meet future workforce needs;
- review the number, mix and distribution of current medical training places across the public health system;
- develop a strategic plan for the placement of trainees and detail priority areas and locations to be addressed;
- explore options with the universities, professional colleges and other relevant agencies to improve education and support of the medical workforce;
- progressively increase registrar training numbers in line with AMWAC recommendations;
- develop clinical training networks which link teaching hospitals in metropolitan and provincial centres with non-teaching hospitals in both metropolitan and rural areas
- review the suitability of the current apprenticeship based training model to cope with increasing medical graduate numbers and opportunities to fast track training programs; and
- examine avenues for greater private sector involvement in medical training

Queensland Health should:

- review the membership and operation of the Queensland Medical Education Council to strengthen its role in providing strategic direction and advice on medical education issues.
- seek support from the Commonwealth and the State to increase the level of funding available to support the teaching and training of students on clinical placements within Queensland's public health system given this is an area of shared responsibility.
- explore with the Colleges opportunities to further consolidate teaching and development time under specialist training programs linked to competencies.
- introduce mechanisms to provide protected time for senior clinicians and trainee specialists involved in teaching and training junior staff and ensure that sufficient resources are available to support this role.
- work with the Commonwealth to examine strategies for seeking contributions from the private sector and medical practitioners who choose to leave the public sector, towards the costs of clinical training.
- expedite the implementation of the new training model for overseas trained doctors with special purpose registration so they can achieve full registration within four years.

**10.5 Initiatives for nurses****10.5.1 Relief for nurses: immediate action to recruit more nurses**

Given the lack of growth in nursing numbers in real terms, additional funding should be made available to area health services to enable growth of nursing positions Statewide in line with the forecasting in section 10.2. This should be accompanied by a concerted effort to recruit additional nurses into the public health system along the lines proposed below. High workloads are a major concern for nurses and nursing representatives have reported this to be a major driver of nursing turnover. Immediate increases to the nursing workforce would assist in reducing and managing workloads. As noted previously, it is estimated that Queensland is short around 1,000 nurses based on its workload in public

hospitals compared to other jurisdictions. These comparisons are based on public hospital inpatient workload only and do not include any shortfalls in community, outpatient and other health services.

It is important that planning for an increase in nursing positions includes a specific focus on specialty shortages, including critical care nursing, midwifery, theatre and mental health nursing. In expanding the nursing workforce, it is important that there also be consideration of skill mix requirements by recruiting a mix of registered nurses, enrolled nurses and assistants in nursing. Whilst there is a need to increase use of ancillary staff such as assistants in nursing, studies have shown a clear correlation between positive patient outcomes and appropriate staffing, with sufficient registered nurses. Strong clinical leadership is required to drive statewide nursing workforce planning which aligns with broader services planning.

### **Refresher and re-entry schemes**

There are high wastage rates in nursing, with many nurses leaving the profession to pursue other career opportunities. Given Queensland already faces acute nursing shortages and these are predicted to worsen, every effort must be made to attract nurses back into the profession.

In Victoria, provision of free refresher, re-entry or supervised practice programs for former nurses has resulted in over 2,200 nurses re-entering the public health system. The initiative involves funding being allocated by the health department directly to public health care facilities through a submission based funding round for up to 240 nurses per annum.

In New South Wales, the Nurse Reconnect Program has encouraged 1,186 nurses back into the nursing workforce since its launch in 2002. This program offers paid, individualised, supported transition back into the workforce for both full-time and part-time positions, in general and specialty areas.

In Queensland, former nurses fall into two categories with differing arrangements in place to support return to practice:

- Nurses who have been absent from the workforce for under five years and remain registered or enrolled require refresher courses in order to resume practice. Currently, such nurses can apply for employment in a Queensland Health facility and arrange access to a government funded refresher course (of approximately six weeks duration). Whilst this training is free of charge, nurses are unpaid for any supervised practice undertaken during the training.
- Nurses who have been absent from the workforce for more than five years and are no longer registered or enrolled must undertake re-entry education and undergo competence assessment by the Queensland Nursing Council. Currently, such nurses can apply for up to \$3,000 through a Queensland Health nursing re-entry scholarship scheme to assist in meeting the costs of re-entry education and competence assessment. As this scheme only commenced in February 2005 it is too early to assess its success. The scheme replaced previous arrangements where nurses were provided with re-entry courses by Queensland Health facilities. Feedback from health facilities was to discontinue this arrangement as many of the re-entry candidates were considered unsuitable to return to practice.

Based on the New South Wales model, take up of refresher courses may be increased if a base level salary is offered to nurses for the duration of the course. No change is proposed to the re-entry scholarship scheme as this is a new initiative designed to address concerns with prior arrangements. Additionally, a focus on nurses who have been absent for five years or less is recommended given that nurses with recency of practice are more favourably placed to re-integrate into nursing.

Whilst broadly based media campaigns might be useful, it is considered more appropriate that the existing nursing workforce be commissioned to secure re-engagement of former experienced colleagues known to be still interested in working within Queensland Health but possibly requiring more flexible working arrangements. Existing nurses could be offered a range of incentives to perform this attraction role including sponsorship at conferences or study, an additional period of development leave, such as review of practice in other jurisdictions or straight out financial incentives. A period of guaranteed service would be sought from returning personnel. The opportunity for career paths including advanced nursing roles and expanded nurse practitioner roles should also be used as an incentive.

Based on the successful Victorian and New South Wales models, it would be useful for a support program to include:

- Funding support for districts to enable them to develop customised, tailored refresher courses for former nurses;
- Availability of support for return to full-time or part-time positions;
- Payment of a base grade wage for nurses participating in refresher courses;
- Continuation and evaluation of the scholarship scheme for nurses absent more than five years; and
- Establishment of quantitative and qualitative data collection from nurses who access support, to enable ongoing evaluation of the success of the initiative and opportunities for improvement.

It would be helpful for Queensland Health also to undertake routine exit polling of staff to determine the factors influencing nurses' decisions to leave the system so that recruitment activities can be better targeted.

These initiatives are likely to offer diminishing returns over time, as there will be a finite pool of former nurses who can be attracted back into the workforce. This initiative should therefore be seen as a short-term effort to boost nursing numbers and will need to be supplemented with longer term strategies to increase supply of nurses overall.

It is important that sufficient new nursing positions are created to ensure that former nurses are not competing with nursing graduates. Given the significant shortfalls in nursing numbers, an immediate expansion of the nursing workforce is required which can accommodate both groups.

### **Maximising the recruitment of graduate nurses into Queensland Health**

Queensland Health has established a centralised, online recruitment system for graduate nurses. The web based system is highly efficient and may be replicated in other states. However, Queensland Health has been unable to maximise the number of graduate nurses recruited into the public health system because appointments can only be made to existing junior nursing vacancies. Given the limited growth in the Queensland Health nursing workforce, this means there is limited capacity to recruit all interested graduates into the

system. At the end of recruitment processes in the past two years, Queensland Health estimates there have been between 100 and 150 graduates for whom there have not been positions available, with some of these nurses going interstate to seek employment. This represents a lost opportunity each year to grow the nursing workforce.

In future years, it is recommended that Queensland Health budget for additional growth in the nursing workforce to better accommodate interested graduates and maximise the recruitment of younger nurses with contemporary education and training. This expanded recruitment will require a commensurate increase in resourcing to districts to support transition programs to improve the “work readiness” of graduate nurses recognising the particular needs of specialty areas such as operating theatre, intensive care and emergency departments. Provision of such training could be prioritised in larger districts in recognition of the economies of scale offered in larger facilities.

To this end, it is recommended that each Area Health Service assess the potential to resource major metropolitan and regional hospitals to support a larger intake of graduate nurses and provide transition to work training. Once the graduate nurses were “work ready” some could then be appointed to more remote districts and the required number retained by the larger hospital to meet service requirements.

### **Stabilising the nursing workforce**

Anecdotal reports were received of a high reliance on agency nursing staff to meet workforce shortfalls. An analysis of State-wide Queensland Health data revealed that in 2003/04, 185 full time equivalent (FTE) agency nurses were used and in 2004/05, 187 FTE agency nurses were used – respectively, this accounted for 1.09 percent and 1.08 percent of the full time equivalent nursing workforce in those years.<sup>105</sup>

One rural hospital and several metropolitan hospitals were found to be relying on significant numbers of agency nurses. Anecdotally, the review heard that one metropolitan hospital was using agency nurses to the extent that nearby hospitals were unable to access agency nurses on occasion.

Nursing relief pools comprising permanent staff are successfully used in some Queensland Health hospitals to reduce reliance on more expensive agency nursing staff. To address the high reliance on agency nurses in particular hospitals, it is recommended that relief pools be established as a matter of priority. Other strategies successfully used in Queensland Health hospitals are:

- operating at full nursing establishment numbers to enable build up of the casual and part-time workforce to provide additional capacity during peak times and back up sick leave; and
- encouraging and approving more annual leave during summer months to increase availability of the workforce during winter months when demand increases.

A review of staff/nursing ratios would also assist in ensuring there are sufficient numbers of permanent staff to cope with fluctuating workloads.

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<sup>105</sup> This data is indicative only. Queensland Health advises there may be some under-reporting of agency staff where they are placed on short-term contracts in health districts.

This highlights the importance of strong management and leadership in solving workforce problems, in addition to more obvious structural or funding solutions which, on their own, may not improve workforce management.

It would be prudent also to explore opportunities to work more cooperatively with the private sector to maximise the use of the existing nursing workforce through job sharing and other types of flexible arrangements.

### **Simplifying recruitment processes**

In line with the suggestions for doctors, recruitment processes for nurses could be simplified through:

- negotiating a standing exemption under the advertising guidelines to increase flexibility in advertising nursing positions
- devolving nursing recruitment to the facility level as far as possible, with centralised recruitment limited to those processes where multiple positions are being recruited across many sites eg graduate nurses
- clarifying for line managers the range of recruitment techniques that may be used to recruit nurses including a review of the appropriateness of current selection criteria

### **Increasing student places**

The most obvious option to increase supply of nurses in Queensland is to increase student intakes in university and vocational education and training courses. It is therefore recommended that Queensland Health urgently develop recommended student intakes to enable the Queensland Government to:

- seek from the Commonwealth Government an immediate increase in university nursing places to boost numbers of registered nurses;
- provide increased support to accommodate the clinical placement of larger numbers of student nurses including in acute hospital settings, community, aged care and outreach services; and
- increase places for nursing students in the vocational and education sector (eg TAFE colleges) to boost numbers of enrolled nurses and assistants in nursing.

#### **10.5 Recommendations to provide immediate relief for nurses**

The Queensland Government should:

- Increase the number of graduate nurses employed annually
- Provide infrastructure support to enable Queensland Health facilities to accommodate the clinical placement of larger numbers of student nurses
- Increase places in the vocational education and training sector for enrolled nurses and assistants in nursing.

Queensland Health should:

- Provide incentives to the existing nursing workforce to encourage former nursing colleagues back into the workforce and promote available support (such as paid refresher courses), with a target of an additional 1,500 nurses (phased in over three years in addition to the need to continue growing the workforce by an average of 500 to 600 nurses per annum).
- Undertake routine exit surveys of staff to identify the factors driving loss of nursing staff and to

inform recruitment activities.

- Support the existing nursing workforce to attract and recruit senior nursing staff back into the workforce in targeted specialties including critical care, mental health, theatre and midwifery
- Continue and evaluate the nursing re-entry scholarship scheme as a strategy to attract nurses who are no longer registered or enrolled
- Increase flexibility in recruitment processes including advertising and selection processes and devolve recruitment responsibility to the facility level
- Develop recommended nursing student intakes in Queensland to inform negotiation with the Commonwealth to increase student places

Area Health Services should:

- Be resourced to support districts provide paid nursing refresher courses for registered or enrolled nurses wishing to resume practice
- Receive funding to support annual growth in the nursing workforce to maximise recruitment of graduate nurses and provide training to support their transition into clinical practice recognising the needs of nurses transitioning into specialty areas such as theatre, intensive care and emergency departments

Districts should:

- Establish in-house relief nursing pools and implement other strategies to better manage the existing nursing workforce as noted above (where this is not already occurring)

## 10.5.2 Measures to improve retention of the nursing workforce

### Remuneration and Conditions

It is important that nurses perceive that they are being paid justly and fairly. As a principle, it would be prudent for Queensland Health to remain competitive with other public health systems interstate in respect of remuneration and conditions, taking into account cost of living and other jurisdictional differences.

The review notes that issues around remuneration and conditions will be addressed as part of the up-coming enterprise bargaining process. As noted previously, the review has concluded that it would be helpful for the enterprise bargaining process to be reviewed to address the lack of flexibility and complexity of current arrangements.

Given the need for urgent workforce reform, enterprise bargaining processes could be used to remove impediments to:

- extending the scope of practice for nursing;
- negotiating flexible employment arrangements; and
- creating temporary positions for training purposes eg temporary positions could be created for a cohort of allied health or nursing graduates to provide them paid work experience and skill development (as occurs for medical interns) until permanent opportunities arise for which the graduates would be able to apply more competitively.

It would also be prudent to consider extending paid maternity leave to support the predominantly female nursing workforce, as part of whole of Government enterprise bargaining.

### **Clinical career pathways**

During district visits, some nursing staff highlighted the limited career pathways for nursing wishing to continue clinical practice rather than take on management/operational duties. Both Assistants in Nursing and Enrolled Nurses can progress to advanced positions within current award structures. For registered nurses, there are currently nine nursing levels (NO1-9). From the NO3 level onwards, nursing duties tend to combine clinical with management roles. This means there are limited opportunities for advancement for highly skilled and advanced nurses beyond the highest paypoint at the NO2 level. In other states, there are clinical nurse specialist roles which allow for clinical advancement.

There are also anomalies with NO3 nurse unit managers receiving less than NO2 nurses due to the fact that NO2 level nurses receive penalty rates. This could be addressed through either extending the working hours of NO3 nurses so they can also access penalty rates or increasing the pay rates of NO3 nurses.

The nursing qualification allowance offered some incentive for remaining in clinical roles. For this reason, managerial qualifications do not attract the allowance given that managerial skills can be rewarded through management career progression. However, the outcomes of the implementation of the allowance have led to serious disaffection amongst many nurses. This situation could be remedied in one of two ways. Either the allowance should be paid to any nurse with a university or equivalent qualification relevant to their current job or the allowance should be ceased and replaced by better clinical career pathways, discussed below.

To keep the most highly skilled nurses in clinical practice, it may be useful to create a new position recognising and rewarding advanced or highly specialised nurses. This would recognise advanced skills used within the existing scope of practice for nurses and would be separate from any new award arrangements negotiated in the next enterprise bargaining round for nurse practitioners, who will be qualified and endorsed to work beyond the existing scope of nursing.

Recognition of advanced nurses could be done through new award arrangements or through a Clinical Advancement Scheme, in line with the model used for allied health professionals. The advantage of such a scheme is that each candidate could be assessed on a case by case basis with a range of criteria such as qualifications, experience, excellence in research or training and clinical leadership. However, this would be a profession-driven advancement process.

In contrast, a new award for advanced nursing could allow Queensland Health as an employer greater capacity for workforce redesign, including clinical leadership positions that can support training and development of the junior workforce as well as advanced nursing positions to perform tasks under medical supervision that are currently performed by doctors. For this reason, it is recommended that Queensland Health plan the number and distribution of its potential advanced nursing workforce and recognise this through a new award or additional paypoint within existing award structure.

### **Increasing flexible working arrangements**

Section 10.2.5 showed the increasing tendency for nurses to work fewer hours per week, suggesting a high degree of flexibility for nurses in accessing part-time work. However, the review heard anecdotal reports from nurses who had not been able to negotiate part-time work or access leave entitlements. As an employer, it would be prudent for Queensland Health to maximise retention of its nursing workforce by accommodating flexible working hours and part-time work.

Additional flexible options could also be implemented such as job sharing, four day 40 hour weeks and initiatives to facilitate work and family balance.

A coordinated approach across the public sector was also recommended by key nursing representatives in respect of child care assistance for shift workers. Many individual nurses proposed that Queensland Health establish and manage child care centres on health facility campuses as has been done at the Alfred Hospital in Victoria.

It is important that Queensland Health support the predominantly female nursing workforce, as well as females in other professions and fathers who are juggling work and parenting responsibilities. However, it is questionable whether Queensland Health should enter the business of establishing and running child care centres at a time when major reform activity is needed to improve the core business of running health services.

It is suggested that Queensland Health discuss with the child care sector opportunities to collocate privately operated child care centres with health campuses. Precedents exist where other private businesses have located on hospital campuses and this model enables Queensland Health to focus more appropriately on health promotion and service delivery. This option may also require some level of subsidy as child care centres built on hospital campuses have previously not proven to be viable as private businesses.

### **Enabling mobility for nurses within Queensland Health**

Anecdotal reports were received of nursing staff wishing to transfer at level between districts being required to compete in merit based selection processes to win an equivalent position in another district. Given the tendency to appoint local applicants, it was contended that external applicants – including Queensland Health employees from other districts – were being prevented from transferring between districts. This was seen to result in aggrieved employees seeking employment outside the public system.

It would be helpful for districts to take a State-wide view of recruitment and retention and facilitate mobility at level between districts for existing Queensland Health staff. Through their enhanced role in workforce monitoring and planning, Area Health Services should ensure that this occurs.

### **Improving organisational culture**

Queensland Health must urgently implement strategies to improve organisational culture and foster strong leadership and change management capacity within the department. This is essential in retaining nurses in Queensland Health particularly in the current environment. Proposed clinical networks will provide an avenue to reconnect nurses to decision making, service planning and budget allocation.

### Other measures to value nursing staff

The review found that nursing staff feel particularly undervalued as employees of Queensland Health. The organisation needs to take immediate steps to show support for its nursing staff including:

- the provision of appropriate amenities such as training and meeting rooms and access to safe car parking;
- recognition and consistent application of employment conditions;
- providing appropriate induction programs and information about entitlements, including training and development, with access to entitlements monitored through individual performance and development plans;
- providing peer support networks and professional supervision for nurses who currently work in positions with little peer support including isolated practice and sexual health nurses (as discussed in chapter seven);
- ensuring a safe working environment including training for aggression management as discussed in measures to value medical staff; and
- improving travel and accommodation services.

#### 10.6 Recommendations to improve retention of nursing staff

The Queensland Government should:

- Review the process for enterprise bargaining to address the lack of flexibility and complexity of current arrangements and seek to provide fair remuneration and conditions
- Use nursing awards to create clinical career pathways to encourage advanced and extended practice roles and clinical leadership positions
- Consider extending paid maternity leave to support female clinicians, in particular the predominantly female nursing workforce
- Use enterprise bargaining to remove impediments to workforce reform including extending scope of nursing practice, negotiating flexible employment arrangements and creating temporary positions for training purposes

Queensland Health should:

- Undertake a feasibility study to determine the level of subsidy that may be required to support viable child care services located on health campuses
- Enhance clinical career pathways for nurses through creation of advanced and extended positions – including nurse practitioners - under a new award or additional paypoint in the existing award structure
- Urgently implement strategies to improve organisational culture and foster strong leadership and change management capacity within the department, discussed in chapter four.
- Ensure nurses are provided with timely, quality travel and accommodation services.

Area Health Services should:

- Create peer support networks along professional groupings or streams of care to improve support for isolated nurses
- Ensure nurses have access to revised and better targeted and resourced aggression management training.

Districts should:

- Make every effort to accommodate flexible working hours and part-time work
- Explore with private child care providers opportunities to collocate child care centres on large health campuses
- Take a Statewide view of recruitment and retention and facilitate mobility at level between districts for existing nursing staff.

- Provide amenities such as meeting and training rooms and safe car parking where feasible and in consultation with nurses
- Provide all new nursing staff with an induction which includes information about entitlements, with access to entitlements supported and monitored through individual performance and development plans

### 10.5.3 Measures to maximise the skills and availability of the nursing workforce

#### Creation of advanced nursing and new or extended nursing roles

Nationally and internationally, workforce roles are being redesigned to better align skill level with task complexity and improve patient outcomes. This work falls into two broad categories:

- 1) *Advanced practice roles*, where clinicians use their skills to an advanced level. In this situation, clinicians work within the existing scope of practice for their profession.
- 2) *New or extended roles*, where clinicians may require additional training and competency assessment before performing new tasks and legislative change may be required eg to allow limited prescribing rights.

Such roles may enable unsupervised practice by non medical staff (eg nurse practitioners) or extended practice under medical supervision (eg advanced nurses). This section first highlights opportunities for advanced nursing practice roles and then explores opportunities for new or extended nursing roles.

The review has deliberately not prescribed the nature of advanced and extended nursing roles because these need to be developed in the workplace in the context of service planning and developing new models of care. One approach to developing new health workforce roles is designing university courses, as has been adopted in the case of nurse practitioners. However, the review considers that the best way for all new and future roles is to identify the competencies required and the best way to obtain them, which may be either through university training, training in the workplace, simulation/procedural training (eg at the Skill Development Centre), or a combination of these.

#### 1) *Developing advanced nursing roles – for immediate implementation*

Within their existing scope of practice, advanced nurses can perform some roles currently being undertaken by medical staff such as cannulation, patient discharge, ordering investigations such as pathology and performing colonoscopies. In some hospitals, advanced nurses are taking on these roles. In particular, Queensland has a well developed system to enable appropriately trained registered nurses to receive endorsement for advanced practice in rural and isolated areas, including administering and supplying some drugs under a therapeutics protocol.

There has been no modelling undertaken within Queensland Health to identify how many advanced nursing roles could be created or in which clinical settings or geographic areas. Advanced nursing is therefore emerging on an ad hoc rather than systemic basis. Urgent work needs to occur within Queensland Health to identify and plan an advanced nursing

workforce. It is important that planning involves medical and nursing leaders to enable design of team based care with appropriate training and supervision for advanced nurses.

For example, it is understood there are doctors within Queensland Health interested in training nurses to perform colonoscopies under medical supervision. This would create more interesting work for nurses whilst increasing the availability of doctors to perform more complex tasks. It is recommended that State-wide planning immediately occur involving doctors and nurses identifying: the settings in which this role enhancement could safely occur, appropriate training arrangements for nurses and systems to assess competency and credential nurses. Such modelling could be undertaken for advanced nursing opportunities which could occur in the areas experiencing the greatest medical workforce pressures, including rural and remote areas and specific specialties such as gastroenterology.

It is essential that such reforms are driven by teams of doctors, nurses and allied health professionals, not people removed from front line clinical work. Under the proposed structural arrangements for Queensland Health, workforce reform has been devolved to area health services. As a starting point, it is recommended that these areas be resourced to facilitate local, team based development and implementation of advanced nursing roles in areas experiencing service pressures or workforce shortages. Where relevant, this work should be managed by clinical networks with local clinical champions to drive change.

## **2) *Extended roles for nurses– nurse practitioners***

The nurse practitioner role is distinct from advanced nursing in that it enables nurses to operate without medical supervision within agreed protocols. Queensland Health is already trialling the nurse practitioner role, has amended legislation to support the role and, in anticipation of nurse practitioner Master's degree courses commencing in 2006, has announced 20 scholarships per annum to support nurses wishing to undertake this course.

Some of the scholarships could be full-time to expedite availability of qualified nurse practitioners from 2008. Equally, some scholarships could be made available to support nurses studying part-time while working in Queensland Health to avoid losing them entirely from the workforce during their training. In addition to scholarships, Queensland Health could consider providing paid study leave to existing nursing staff to support them undertake the Master's degree course.

However, planning or modelling has not been undertaken to identify the number of nurse practitioners that could be accommodated within the public health system or in what geographic areas or clinical networks. This would be helpful to inform workforce planning and development of university curricula commencing in 2006.

It is recommended that Queensland Health undertake urgent assessment of the size and nature of the potential nurse practitioner workforce and begin immediate negotiations with universities to ensure alignment between Queensland Health's needs as an employer and course content. Additionally, it would be helpful for Queensland Health to work with universities to establish a longitudinal study of nurse practitioners to assess outcomes of the nurse practitioner model and impacts on workforce retention and satisfaction.

It is acknowledged that nurse practitioners may also work in private practice settings in addition to Queensland Health. It is therefore recommended that the Queensland

Government lobby the Commonwealth Government to provide access to the Medicare Benefit Schedule and the Pharmaceutical Benefits Scheme for nurse practitioners, in recognition that these roles are taking on functions traditionally performed by doctors. This would increase the likelihood that nurse practitioners can work in community settings and offer affordable care.<sup>106</sup>

Under mutual recognition, qualified nurse practitioners from New South Wales could already move to Queensland to practice. Given the potential to employ these nurse practitioners now and in anticipation of Queensland graduates entering the workforce from 2008, it is recommended that Queensland Health work with the Queensland Nursing Council to ensure appropriate registration and endorsement systems are established. Queensland Health will similarly need to establish credentialing and clinical privileging systems for the nurse practitioner role.

### **Redesigning work practices to increase efficiency**

District visits highlighted the administrative burden imposed on nurses in managing workforce information and rostering systems. As with doctors, there was a consistent view expressed by nurses that these systems could be far more efficient and that management of some of these systems might be more appropriately performed by administrative support officers.

Opportunities to redesign work practice have been identified to increase efficiency and availability of clinicians to provide clinical care which include:

- Systematic implementation of outcome based clinical pathways into the health care work environment. This is based on the finding that a major Brisbane hospital which successfully improved clinical care and reduced the paperwork done by nurses by 44 percent, thereby freeing up clinicians' time.
- Devolution of non-clinical tasks to non-clinical categories of staff - for example creation of roster clerks to manage nursing rosters (supervised by nurses able to ensure appropriate skill mix) and answer telephones.
- Negotiating opportunities at the local level to introduce flexible hours of work to increase productivity. For example, negotiation of four day weeks based on 4x10 hour shifts could be used as a basis to increase theatre hours and surgical throughput each day and increase activity after hours and on weekends subject to availability and interest of nurses.

### **Development of country service register and incentive package**

Nurses expressed interest in performing short term rural and remote service on a rotational basis. This goodwill should be used to assist smaller districts through establishment of a register of clinicians, including nurses, willing to undertake rotations and concurrent development of an incentive package to make the rotations attractive (refer to discussion under initiatives for doctors for further detail on the proposed register and incentive package).

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<sup>106</sup> Nurse practitioners are distinct from practice nurses, who already work in some general practices under the supervision of doctors. In contrast, nurse practitioners are able to practise independently within their scope of practice.

**10.7 Recommendations to maximise the value of the nursing workforce**

The Queensland Government should seek from the Commonwealth:

- Access to the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme for community based nurse practitioners, in recognition that these roles are taking on functions traditionally performed by doctors

Queensland Health should:

- Undertake urgent assessment with clinical networks and area health services of the size and nature of the potential nurse practitioner workforce
- Begin immediate negotiations with universities to ensure relevant course content for nurse practitioner master degrees
- Work with the Queensland Nursing Council to ensure appropriate registration and endorsement systems are established

Area health services should:

- Be resourced to facilitate local, team based development and implementation of advanced nursing and nurse practitioner roles in areas of workforce or service pressures and managed through clinical networks where feasible
- Facilitate and resource districts to devolve non-clinical tasks to non-clinical categories of staff including provision of roster clerks, and support for advanced nurses with less time for non-clinical work
- Establish a register of clinicians – including nurses– willing to undertake country service rotations and design a country service incentive package

Districts should:

- Negotiate opportunities to introduce flexible hours of work to increase productivity subject to staff availability and interest

Clinical networks should:

- Lead implementation of outcome based clinical pathways to improve care and streamline work practices

**10.5.4 Improving nursing education and training**

Nursing education has undergone fundamental changes over the last twenty years, the most significant of which has been the introduction of university based degree programs for registered nurses and the move away from traditional hospital based education models. There are now a number of tertiary institutions providing nursing education across the State. Nursing enrolment numbers have averaged around 1400 per annum over the last five years and will need to continue to increase in line with the State's growing and ageing population and to offset the impacts of increasing part-time work and high wastage rates from the profession.

It is therefore critical that Queensland Health develops effective mechanisms for ongoing engagement with the tertiary sector. The long lead times associated with the expansion of student numbers and the introduction of new courses (the first post-graduate degree nurse practitioner courses in Queensland are set to commence in 2006) demonstrate the importance of coordinated strategic planning between the State's public health services and the tertiary sector. This needs to be underpinned by robust workforce projections and identification of specific areas of skills shortages.

Health 2020, Queensland Health's Directions Statement, sets out the need to develop flexible workforce models and make better use of our existing workforce. The potential

for changes to work practices and skills mix is greatest with the nursing profession given they make up the bulk of the health workforce. Enrolled nurses and assistants in nursing are not being sufficiently utilised to meet Queensland Health's workforce needs particularly in the context of overall nursing shortages. Queensland Health needs to pursue an expanded role for the VET sector to increase the number of enrolled nurses, assistants in nursing and other health workers.

Concerns were expressed to the review that nursing graduates are often not "work ready" and have not received sufficient practical and hands-on clinical experience as part of their health education programs. There are also concerns that the move away from hospital based training has resulted in student nurses having unrealistic expectations regarding the nature and demands of health work leading to further losses from the younger workforce entrants.

**Best Practice Example**

There are recent examples of best practice collaborative approaches between the universities and Queensland Health which attempt to better integrate service delivery and academic needs.

The University of Queensland and Queensland Health have recently collaborated to develop a new undergraduate nursing program which integrates classroom and clinical learning. The program incorporates increased clinical practical hours (1320) in total and is aimed at improving the "work readiness" of nursing students. The program commenced in 2004 with two pilots at the Princess Alexandra and West Moreton Health Service Districts with 60 students increasing to 130 in 2005. Student nurses spend considerable amounts of their time on the hospital campus and attend lectures on site. Most of their last year is spent working in a clinical environment.

Queensland Health and the University have jointly developed a new program including the overall structure of the teaching program, the use of practice settings for clinical placements, the involvement of Queensland Health staff in the academic program and sharing of costs

Queensland Health has been working with the universities to establish agreed standards for clinical placements to ensure there is sufficient support for students. Queensland Health nursing staff provide direct supervision and training of students and in some cases undertake formal assessments of the performance of individual students. Many nursing staff reported they did not have the time to provide adequate supervision of university students on clinical placements and that insufficient resources were being made available to support this role.

Queensland Health needs to strengthen its relationships with the universities through adjunct and conjoint appointments and support a model which encourages the employment of clinical facilitators at the ward level. Queensland Health has recently negotiated with the universities to provide increased financial support to hospitals providing clinical staff to supervise students. However, additional resources are required and it is suggested that Queensland Health negotiate with the Commonwealth and the tertiary sector to increase funding in this area. This is particularly important in light of the review's recommendation to increase nursing student numbers.

It is imperative that nursing graduates have the appropriate level of supervision and gain enough practical experience to be able to practise safely and competently. Queensland Health has introduced transition to work programs for graduate nurses. However, the programs are not applied on a consistent basis across the Health Service Districts and need to be expanded.

## Ongoing training and professional development

Queensland Health has a responsibility to ensure nurses receive appropriate ongoing training and professional development during their careers once they become employees of the public hospital system.

Unlike doctors, nurses do not undertake further hospital based training to gain registration or to attain specialist qualifications. Instead, nurses acquire specialist qualifications through post-graduate study at university. Nursing groups argue they are disadvantaged because they have to meet the costs of ongoing education themselves whereas doctors are effectively subsidised by the State because their post-graduate education occurs in public hospitals under the specialist training programs rather than in the tertiary sector. Queensland Health could consider providing support in the form of scholarships or paid study leave for post-graduate qualifications in targeted areas including advanced practice roles.

The review received numerous reports from nursing staff about deficiencies with the current on the job training offered by Queensland Health. As noted in the interim report, access to training was variable across the State and particularly poor in rural and remote areas. Training was not targeted to service delivery needs and nurses considered they were not being treated equitably with other health profession groups.

One of the main complaints from nursing staff was that they could not be released for training as there were no staff available to backfill their positions. Clearly, there needs to be a balance between the employers' need to have sufficient staff coverage to meet patient needs, and the needs of staff for access to appropriate levels of training. However, to foster a learning culture, Queensland Health should ensure that sufficient backfill is made available for staff to undertake approved courses and training.

Most of the large hospitals employ nurse educators who are specifically charged with responsibility for providing clinical training and education support to nursing staff. Many educators complained of increasing workloads and a lack of recognition of the importance of their role in promoting safe and quality services. Queensland Health needs to ensure there are sufficient numbers of nursing educators available across the State to meet training needs and that they receive appropriate levels of support including administrative support.

### 10.8 Recommendations to improve nursing education and training

Queensland Health should:

- Adopt a strategic and proactive approach to influencing the direction of under-graduate nursing education to ensure it continues to meet service delivery needs and to adequately prepare graduates for entry to the workplace.
- Strengthen relationships with universities through adjunct or conjoint appointments and review the role of clinical facilitators at ward level to support nursing education.
- Negotiate with the Department of Employment and Training and the Commonwealth Government to increase funding for enrolled nurses, assistants in nursing and other certificate based health workers with a focus on also attracting these workers to rural and remote communities.
- Seek support from the Commonwealth and State governments to increase the level of funding available to support the clinical teaching and training of nursing students within the Queensland public health system given this is a shared area of responsibility
- Support nurses undertaking post-graduate study through scholarships and/or paid study leave

- Expand its transition to work programs so that new graduate nurses receive appropriate supervision and support.
- Establish an ongoing education and training program for nursing staff which is linked to service delivery needs, addresses identified skills gaps and supports advanced clinical practice roles.
- Review the number of nurse educators working in the system and provide adequate resourcing and support for them to undertake their roles.
- Ensure adequate backfilling of positions to allow clinicians to attend training and education programs.

## 10.6 Initiatives for allied health professionals

### 10.6.1 Relief for allied health professionals: immediate recruitment initiatives

#### Active recruitment locally, interstate and overseas

Based on the analysis in section 10.2.11, Queensland Health's most critical area of workforce shortage is arguably the allied health group. Allied health staff comprise a diverse group of professionals including physiotherapists, occupational therapists, speech therapists and pathologists, pharmacists, psychologists, dieticians, radiographers, podiatrists, social workers and optometrists. Queensland would need an additional 2,350 allied health staff to reach the national average of allied health professionals per head of population. On a workload basis, Queensland Health would need an additional 1,780 allied health staff to meet the national average workload ratios for public hospital inpatient services. This figure does not take account of outpatient or community services, settings where allied health professionals are also likely to work.

Expansion of the allied health workforce will require concerted recruitment efforts over a number of years and cooperative planning with universities and the Commonwealth Government in respect of student numbers and priority disciplines. Given the significant work required across the various allied health disciplines, it is recommended that allied health leadership positions be created in Area Health Services to drive workforce planning, recruitment and reform activities.

As a starting point, it is suggested that Queensland Health implement targeted as well as web-based marketing and recruitment campaigns locally, interstate and overseas to attract major allied health groups employed in the public health system such as physiotherapists and radiographers. Overseas campaigns could focus in particular on the United Kingdom and other countries with training equivalent to Australian standards. Other suggestions in this section aim to improve allied health recruitment, retention, career pathways and long term workforce planning.

#### Simplifying recruitment processes

In line with the suggestions for doctors and nurses, recruitment processes for allied health professionals could be simplified through:

- negotiation of a standing exemption under the advertising guidelines to increase flexibility in advertising

- devolving allied health recruitment to the facility level as far as possible
- clarification for line managers of the range of recruitment techniques that may be for recruitment

### **Increasing student places**

As for doctors and nurses, it would be prudent to develop recommended allied health student intakes in Queensland to enable the Queensland Government to seek from the Commonwealth Government an immediate increase in student places focussing particularly on formulas that reflect the true cost of training. Additionally, the Queensland Government could consider funding bonded allied health student places as it has done at the Griffith University medical school.

As noted previously, many allied health professionals complained about not having sufficient time to supervise and mentor students and junior staff. In expanding allied health personnel in the system, it is suggested that Queensland Health target recruitment efforts on those staff with a willingness to engage in teaching allied health students in addition to their service delivery tasks.

#### **10.9 Recommendations to provide immediate relief for allied health professionals**

The Queensland Government should:

- seek from the Commonwealth an immediate increase in allied health student places and/or consider funding additional bonded places in Queensland tertiary institutions
- seek support for the State to immediately increase the employment of allied health personnel in Queensland's health system with an emphasis on a willingness to teach allied health students

Queensland Health should:

- implement a local and interstate campaign to position itself as an employer of choice for allied health staff with the aim of increasing staffing numbers by around 2,000 over the next three years
- increase flexibility in recruitment processes including advertising and selection processes and devolve recruitment responsibility to the facility level except where staff are being recruited across a number of facilities
- develop recommended student intakes in Queensland to inform negotiation with the Commonwealth
- create leadership positions in the Areas Health Services which focus on workforce planning and recruitment activities.

## **10.6.2 Retention measures for the allied health workforce**

### **Remuneration and Conditions**

It is important that staff perceive they are being paid justly and fairly. As noted previously, the review has concluded that it would be helpful for the enterprise bargaining process to be reviewed to address the lack of flexibility and complexity of current arrangements.

It is suggested that allied health awards be used to create clinical career pathways for advanced and extended practice roles and clinical leadership positions (see separate

section on advanced and extended roles). Given the need for urgent workforce reform, enterprise bargaining processes could be used to remove impediments to:

- extending the scope of practice for allied health professions
- outsourcing work, particularly in areas of acute workforce pressures and/or high demand
- negotiating flexible employment arrangements for allied health professionals including a four day week and a mix of public and private work
- creating temporary positions for training purposes eg temporary positions could be created for a cohort of allied health graduates to provide them paid work experience and skill development (as occurs for medical interns) until permanent opportunities arise for which the graduates would be able to apply more competitively.

### **Improving clinical career pathways**

The Clinical Advancement Scheme is recognised as a key strategy to retain and reward highly skilled allied health professionals seeking career advancement in clinical rather than managerial settings. The scheme enables eligible professionals at the PO3, PO4 or PO5 level to advance by one or more classifications – in effect, the scheme allows a significant promotion on the basis of outstanding clinical skills, research or education.

It is appropriate that applicants undergo an assessment process as would any professional applying for a promotion. It is also appropriate that the scheme rewards clinical excellence rather than years of service. Arrangements such as long service leave or the proposed retention bonus for clinicians in rural and remote settings (see Chapter 7) are more appropriate means of rewarding long service.

The program currently benefits only a small number of clinicians, with 20 advancements offered each year. Given the acute shortages in allied health professionals, it would be helpful for consideration to be given to increasing the scale and flexibility of the scheme to encourage more nominations and reward more clinicians. Suggestions include:

- increasing the number of advancements offered
- expanding the eligibility criteria to recognise priorities suggested by this review, including outstanding clinical leadership or mentoring skills
- establishing standing assessment panels in order to accept applications throughout the year rather than in one annual intake
- better marketing the scheme and providing practical assistance to prepare applications
- requiring supervisors and Area Health Service allied health leaders to support and encourage applications from outstanding clinicians rather than relying on clinicians to self-identify as candidates and incorporating this consideration into performance and development plans
- involving recognised allied health leaders in making the above changes to the scheme
- evaluating the changed scheme from a process perspective after 12 months' operation and in terms of impact after two years' operation.

Queensland Health is also at risk of losing other highly specialised professional staff who cannot easily be replaced because they are national and world leaders in their field. It is suggested that the scheme be expanded to include all professional groups on the professional officer pay scale:

- which have limited advancement opportunities offering continued professional practice (as opposed to managerial advancement) and
- whose work has direct impact on health outcomes or clinical practice eg epidemiologists, environmental health or public health professionals.

The limitation of the Clinical Advancement Scheme is that it is driven by individual initiative rather than workforce and service needs. It is therefore suggested that an additional recruitment and retention strategy be the creation of advanced allied health roles, as outlined below, in areas which would offer maximum benefit in alleviating workforce pressures and improving patient services. This would have twofold benefits in creating new clinical career pathways whilst also allowing Queensland Health to address workforce and service pressures. It would be helpful for a career structure to be created for such advanced roles, either rewarding staff through higher paypoints on the existing award or through creation of a new advanced practice award.

### **Other measures to support allied health staff**

Given the shortages being experienced with regards to allied health staff in Queensland Health, it is important that exiting staff feel valued and supported by their employer. There are a range of relatively simple measures which Queensland Health could implement to support its staff including:

- improving organisational culture to foster strong leadership and reconnect allied health staff to decision making, service planning and budget allocation;
- providing suitable amenities such as training and meeting rooms;
- providing appropriate induction programs and information about entitlements, including training and development, with access to entitlements monitored through individual performance and development plans;
- providing appropriate peer support and professional supervision particularly for allied health staff working in rural and remote areas;
- ensuring a safe working environment including access to appropriate parking and training in aggression management; and
- providing access to suitable travel and accommodation

#### **10.10 Recommendations to improve retention of the allied health workforce**

The Queensland Government should:

- Review the process for enterprise bargaining to address the lack of flexibility and complexity of current arrangements and remuneration levels
- Use enterprise bargaining to remove impediments to workforce reform including extending scope of practice, outsourcing work, negotiating flexible employment arrangements and creating temporary positions for training purposes

Queensland Health should:

- Enhance clinical career pathways for allied health professionals through creation of advanced and extended positions under a new award or additional paypoint in the existing award structure
- Increase the scale and flexibility of the Clinical Advancement Scheme as suggested in 10.6.2
- Implement strategies to improve organisational culture and foster strong leadership and

change management capacity within the department, discussed in chapter four.

- Provide allied health staff with timely, quality travel and accommodation services.

Area health services should:

- Create peer support networks along professional groupings or streams of care to improve support for isolated allied health workers
- Ensure allied health staff have access to revised and better targeted and resourced aggression management training.

Districts should:

- Provide amenities such as meeting and training rooms where feasible and in consultation with allied health workers
- Provide all new allied health staff with an induction which includes information about entitlements, with access to entitlements supported and monitored through individual performance and development plans

### 10.6.3 Maximising the value of the allied health workforce

#### Redesigning work practices to increase efficiency

District visits highlighted the administrative burden imposed on allied health professionals and the potential for administrative support officers to increase availability of allied health professionals to perform clinical work.

As noted previously, opportunities to redesign work practice have been identified to increase efficiency and availability of clinicians to provide clinical care which include:

- Systematic implementation of outcome based clinical pathways into the health care work environment
- Devolution of non-clinical tasks to non-clinical categories of staff
- Negotiating opportunities at the local level to introduce flexible hours of work to increase productivity. For example, allied health workers in community health services running clinics out of hours to better meet patient needs.

#### Development of country service register and incentive package

As for doctors and nurses, it is suggested that each Area Health Service establish a register of allied health professionals interested in performing country service rotations and develop an incentive package to make the rotations attractive.

#### Role redesign

Nationally and internationally, workforce roles are being redesigned to better align skill level with task complexity and improve patient outcomes. This work falls into two broad categories:

- 1) *Advanced practice roles*, where clinicians use their skills to an advanced level. In this situation, clinicians work within the existing scope of practice for their profession.
- 2) *New or extended roles*, where clinicians may require additional training and competency assessment before performing new tasks and legislative change may be required eg to allow limited prescribing rights.

Such roles may enable independent, unsupervised practice by non medical staff (eg podiatric surgeons) or extended practice under medical supervision (eg surgical assistants). This section first highlights opportunities for advanced allied health roles and then explores opportunities for new or extended roles. In developing more advanced roles, Queensland Health will also need to consider increasing the use of assistant allied health positions to take on lower order tasks that may previously have been performed by allied health professionals.

As noted in section 10.5.3 in the discussion of advanced and new nursing roles, the review has deliberately not prescribed the nature of advanced and extended health workforce roles, nor the education and training requirements to develop them. Whilst there are some proven initiatives that can immediately be implemented more widely (outlined below), there are other new and extended allied health roles that require development and assessment at the local level. An incremental implementation approach is suggested in this section for development new and extended roles.

### ***1) Developing advanced practice roles – for immediate implementation***

Within the existing scope of practice of health professionals, there is an opportunity to better align skill level with task complexity and improve patient outcomes. Three examples are explored below. These examples are illustrative only and are by no means exhaustive.

It is essential that such reforms are driven by teams of doctors, nurses and allied health professionals, not people removed from front line clinical work. Under the proposed structural arrangements for Queensland Health, workforce reform has been devolved to Area Health Services. As a starting point, it is suggested that these positions be resourced to facilitate local, team based development and implementation of advanced practice roles in areas experiencing service pressures or workforce shortages. Where relevant, this work should be managed by clinical networks with local clinical champions to drive change.

#### *(i) Use of allied health professionals to reduce outpatient and elective surgery waiting times*

Modelled on an initiative in the United Kingdom, Queensland Health is trialling a “Fit for Surgery” program at Ipswich, Royal Brisbane and Townsville Hospitals at an approximate cost of \$250-\$300,000 per site. The program uses physiotherapists, occupational therapists, dieticians and psychologists to maximise the number of people who are “fit for surgery” on elective surgery waiting lists. The program also helps improve quality of life for those category three patients who are unlikely to receive surgical intervention or for whom alternative treatment may be preferable. The program aims to improve cardiovascular and musculoskeletal fitness, help people stop smoking and manage chronic pain and disability.

The Fit for Surgery initiative has been labelled as a trial not due to lack of an evidence base but due to limited funding, meaning it could only be implemented in three sites, which were badged as “trial” sites. Given that this initiative has been well tested in the United Kingdom and other Australian jurisdictions, this could immediately be rolled out more widely. This initiative does not require changes to the scope of the allied health professionals involved and could feasibly commence pending start up resources and recruitment of additional staff.

It would be prudent for this initiative to be complemented with boosted investment in, and integration with, community health services to provide post-operative support to patients and undertake preventative work in the community.

*(ii) Use of physiotherapists in accident and emergency department*

Consistent with advanced roles in the United Kingdom, there is scope for physiotherapists to provide first contact assessment and treatment to patients with musculoskeletal traumatic injuries in accident and emergency departments. Within their existing scope of practice, physiotherapists could undertake examinations, x-ray requests, referrals to specialists, immediate treatments and patient discharge. This role would better use the expertise and training of physiotherapists, shorten elective surgery waiting lists, reduce the time required by doctors or, in some cases, avoid or reduce the need for medical intervention.

Given the weight of evidence from the United Kingdom supporting the effectiveness of this role, it is suggested that Queensland Health immediately analyse facilities where the volume of presentations of musculoskeletal traumatic injuries could warrant a physiotherapist and resource districts to implement this initiative.

*(iii) Podiatric services including podiatric surgery*

Podiatrists could play a role in clinical networks planning service models for people with diabetes, given the link between diabetes and development of serious foot problems.

Additionally, a small number of appropriately qualified podiatrists could be used to perform below the knee surgery. Some podiatrists are already recognised by the Australian College of Podiatric Surgeons as being qualified to perform ankle and foot surgery and, recently, have been allowed access to private health insurance rebates by the Commonwealth Government. This is in line with existing practice in the United States and United Kingdom where appropriately qualified podiatrists perform below the knee surgery.

Use of such practitioners by Queensland Health could assist in reducing waiting lists for elective orthopaedic surgery. Practically, this could achieve only modest outcomes in the short term given estimates that as at 30 August 2005, only 300 of the 9,500 patients were on the orthopaedic waiting list were awaiting procedures commonly performed by podiatrists. Additionally, there are only three podiatrists registered in Queensland who are recognised by the Australian College of Podiatric Surgeons, with a further three understood to be training with the college.

As noted in Queensland Health's submission to the Bundaberg Commission of Inquiry, the key impediments to the use of surgical podiatrists are the cost of training, which is self funded, and the limited numbers of orthopaedic surgeons or anaesthetists willing to work with podiatric surgeons. Nonetheless, Queensland Health could explore opportunities either for direct employment of surgical podiatrists or outsourcing less complicated foot and ankle surgical cases to appropriately qualified podiatrists. Queensland Health could also consider offering funding support for podiatrists currently employed by Queensland Health to undertake training with the Australian College of Podiatric Surgeons, thereby increasing the pool of qualified surgical podiatrists.

## **2) *New and extended roles for nurses and allied health professionals – for incremental implementation***

This section outlines opportunities to extend the scope of practice for allied health professionals to create new health workforce roles. Such reforms, unless managed well, may meet with resistance and will require clear communication strategies to assure the community that new and extended roles will be implemented with an overriding interest in ensuring patient safety and quality of care.

Given that these reforms involve new workforce roles, an incremental approach to implementation has been recommended by key stakeholders including universities. The suggested implementation approach is allocation of a pool of money to the workforce reform function within area health services to facilitate local, team based trials of new or extended roles. Where relevant, this work should involve clinical networks to build clinician support for the roles. Localised pilots have been successful in trialling and building support for the nurse practitioner role in Queensland Health.

Under this approach, area health services would work with districts and clinical networks to identify new workforce roles that could support service priorities. For example, clinicians in a regional centre experiencing difficulty providing local radiology services might develop an initiative to train a radiographer to read plain films. In establishing this new role, the centre would need to develop suitable training and credentialing arrangements and may require legislative reform to support the new role. Subject to a positive evaluation, resources would be made available to support wider implementation of the roles through area health services or clinical networks.

In trialling new roles, it will be important that all three Area Health Services work together to minimise cost duplication and role variation that may arise if the same role is trialled in a number of different sites. Close links will also be required with the corporate office workforce planning unit and to facilitate enabling policy such as changed legislation.

The three examples outlined below are illustrative only and by no means exhaustive. It will be important for Queensland Health to consider other opportunities for new workforce roles where they support service requirements and offer relief in areas of workforce shortage. Examples may include paramedic primary care practitioners in rural areas (discussed in chapter seven), prescribing and immunisation roles for pharmacists, and new roles to manage care for people with chronic diseases.

### *(i) optometrists in outpatient clinics*

Optometrists tend to work in private practice settings, with only three currently employed in the public health system on a sessional basis. Private optometry services have minimal waiting times and are financially accessible due to availability of Medicare rebates. Some optometrists are employed by ophthalmologists in private practice to provide initial patient assessments and free up the ophthalmologist's time for complex interventions.

Optometrists' scope of practice has recently been extended in Queensland through introduction of therapeutics legislation enabling limited prescribing rights for optometrists who complete appropriate training (although the list of approved drugs is still to be finalised). This creates the potential for optometrists to diagnose and treat many urgent and non-urgent conditions and decrease waiting lists.

There is scope for public outpatient clinics to use optometry services by diverting patients to privately practising optometrists and/or engaging optometrists to provide direct patient services, triage and diagnostic services. Equally, it would be possible in accident and emergency settings to divert patients to private optometrists (particularly those who are therapeutically qualified), use optometrists for on call arrangements to assist with triaging or directly employ optometrists for service provision to patients presenting with ophthalmic conditions.

Given the extensive ophthalmology outpatient and elective surgery waiting lists, it is recommended that these possibilities be immediately investigated. Additionally, it would be prudent for Queensland Health to analyse presentations to emergency departments to identify whether use of optometry services may ease pressure and consider implementing some or all of the above options.

*(ii) radiographers reading plain films*

The National Health Service in the United Kingdom has successfully trained radiographers to read plain films to alleviate pressures arising from radiologist shortages. There is a clear body of evidence demonstrating that appropriate trained radiographers can perform this role safely and accurately. Immediate trialling of this is suggested in districts with capacity for supervision and training to ensure safety and quality.

*(iii) surgical/ physician assistants or clinical associates*

In the United States of America, surgical and physician assistant roles are well developed and work in team based settings under medical supervision (as opposed to independent practice). Practice in these professions requires training in a nationally accredited course and passing a national certification examination. As their title suggests, surgical assistants assist surgeons in theatre and perform less complex aspects of surgical procedures to free up the time of highly skilled surgeons. Physician assistants practice under supervision of a physician and can conduct physical exams, diagnose and treat illnesses, order and interpret tests, counsel on preventive health care, assist in surgery, and in virtually all states can write prescriptions. Opportunities to trial and develop these roles in Queensland should be explored through clinical networks.

**10.11 Recommendations to maximise the value of the allied health workforce**

Area Health Services should:

- Be resourced to facilitate local, team based development and implementation of advanced and extended allied health roles in areas of workforce or service pressures and managed through clinical networks where feasible
- Be resourced immediately to implement alternative models of care using allied health professionals to reduce pressure in outpatient clinics and accident and emergency departments, as discussed in 10.6.3
- Facilitate and resource districts to devolve non-clinical tasks to non-clinical categories of staff including support for advanced allied health professionals with less time for non-clinical work
- Establish a register of clinicians – including allied health workers– willing to undertake country service rotations and design a country service incentive package

Districts should:

- Negotiate opportunities to introduce flexible hours of work to increase productivity subject to staff availability and interest eg community health services running clinics out of business hours

Clinical networks should:

- Lead implementation of outcome based clinical pathways to improve care and streamline work practices

#### 10.6.4 Improving allied health education and training

The allied health workforce is made up of a diverse range of professions including physiotherapists, occupational therapists, speech therapists and pathologists, pharmacists, psychologists, dieticians, radiographers, podiatrists, social workers and optometrists. Each of these groups is a product of a profession specific undergraduate program for which there are generally more applicants than places and academic entry standards remain high.

While there are concerns with shortages of particular groups such as pharmacists, the overall local supply of allied health professional staff has been improved with the expansion of programs in regional universities over recent years. Student numbers will need to continue to increase in line with increasing demands. The numerous different faculties and institutions involved in allied health professional education present particular challenges in terms of Queensland Health's ability to undertake long term planning for its allied health professional workforce. Professional associations also play a role in determining the number of practice hours to be completed by students and provide professional development opportunities. It is vital that Queensland Health engages effectively with external stakeholders to develop a coordinated and strategic approach across the various professional groups.

Concerns have been raised about the adequacy of undergraduate education programs in preparing allied health professional students for the workplace as have been previously canvassed in regard to nursing education. While it is generally considered the current courses provide a good foundation of overall general knowledge, they are not seen as being sufficiently focussed on preparing students to meet the specific service needs of employers.

##### **Clinical placements**

There is considerable variability in the approach to clinical placements for allied health staff across the organisation. Many allied health staff complained that increasing workloads limited the time available to provide adequate supervision and there were differing views about the perceived benefits of making resources available for the clinical placements of graduates. Universities have put in place a number of different arrangements to support students including joint appointments of academic staff, and training support for clinical staff to undertake clinical supervision.<sup>107</sup>

Allied health professionals have been particularly affected by changes to Commonwealth funding arrangements with respect to universities. Prior to 2000, universities employed their own staff to train physiotherapy students in Queensland Health facilities. This workload now falls on clinicians who are already busy coping with patients and has been compounded by increasing student numbers in recent years. Queensland Health needs to come to similar arrangements for allied health professional staff with universities as has occurred with medical and nursing clinical placements. In relation to Commonwealth funding to universities, special attention needs to be given to a realistic funding formula that reflects the high retention in most of these programs and adequate funds for quality clinical placements. Queensland Health needs to ensure that the teaching and support environment is appropriate for quality training and academic quality.

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<sup>107</sup> Queensland Health, Summary Report, Director-General's Allied Health Recruitment and Retention Taskforce 1999-2000.

## Ongoing training and development

Allied health staff work across a variety of settings in Queensland Health including community, rehabilitation and acute hospital inpatient settings. Training programs for these groups need to be organised around the different demands of these service areas.

Because allied health staff make up a relatively small proportion of the workforce and often work as individuals with little peer support, it is important they have training programs tailored to individual needs. However, many staff report difficulties in accessing professional development programs and post-graduate education opportunities.

A number of allied health staff complained they had to finance their own professional development without any assistance from Queensland Health. They also reported having limited opportunities to attend courses and training programs as there were insufficient staff to provide cover in their absence.

Many young allied health professional graduates are likely to fill rural and remote vacancies as a means of gaining entry level employment. Their needs for sufficient support and access to professional development are particularly high and should be given priority. This has been partially recognised with the provision of a special professional development incentive package for rural and remote allied health employees. However, similar problems arise with covering staff absences to enable staff to take advantage of these opportunities. Some staff were also unaware of their entitlements.

### 10.12 Recommendations to improve education and training for allied health workers

Queensland Health should

- Facilitate better linkages with external agencies including the tertiary sector and professional associations to develop a long term education, training and professional development program for allied health staff.
- Ensure the provision of clinical placements for allied health students is coordinated and able to cope with continued increases in student numbers.
- Negotiate with the State and Commonwealth to address the issue of an adequate teaching and support environment during clinical placements, and funding models that reflect student retention and clinical placement costs.
- Consider expanded peer support programs for young allied health professionals working in rural and remote areas and ensure they have access to professional development opportunities.
- Identify areas of skills shortages amongst its allied health professional staff and consider providing financial subsidies in targeted areas of post-graduate study.

## 10.7 Addressing organisational and cross-disciplinary education and training issues

To date, educational institutions have tended to structure their health education programs around the traditional professional boundaries of medicine, nursing and the allied health professions. However, in the context of significant workforce shortages, there is a growing need for new types of health workers who are multi-skilled and can work across various clinical settings. Queensland Health needs to engage effectively with educational institutions and other partners to look at ways of fast tracking health education and developing multi-disciplinary approaches in order to address workforce and skills

shortages. This includes pursuing a greater role for the Vocational Education and Training (VET) sector to expand the pool of available health workers in the short term.

While there have been attempts to increase the focus on education and training in response to particular professions or in the context of specific workforce pressures, it is clear there is no organised or strategic approach to professional development across the agency. Training programs are organised and delivered at various levels throughout the organisation and access to, and availability, varies depending on the location of services and the commitment of the clinical and administrative leadership.

Health service needs should guide the direction and scope of education and training programs within Queensland Health. Priorities should include the clinical practices and activities carried out frequently in team settings. Although there are networks of training coordinators throughout Queensland Health, these positions often focus on clinical training within streams, rather than the team environments which deliver holistic patient care and services.

In more remote settings, there are rural health training units which operate to deliver a range of clinical and non clinical training. These units provide valuable education and training for staff in rural settings, but are not presently part of a broader statewide education teaching and training strategy. This strategy would include focus on clinical training in team settings to ensure service needs are addressed and patient outcomes improved. The education and training systems established would include curricula based education and competency based training in the workplace and in other settings. Adult education approaches, simulation environments and multi disciplinary settings would be defining features.

### **The Skills Development Centre**

The Skills Development Centre was established to provide a teaching Centre of Excellence for the enhancement of clinical competence and skill on a commercial fee for service basis.

The Centre has been effectively designed and delivered, but its development has been constrained by the service approach. Frequently there is no funding to engage sufficient educators or trainers or to backfill the positions of participants who attend.

It is imperative that the Skills Development Centre be adequately funded to reach its potential. It should be conceived as the hub of a decentralised network of education, teaching and training programs. The Skills Development Centre should be able to make a significant contribution to the reform program within Queensland Health by advancing clinical training in team settings not only in Brisbane but throughout the State.

Contracted external resources should be used to help develop its service capability to deliver programs within South-East Queensland as well as other State centres.

It should also progressively increase its own capacity to educate, teach and train, and do this in conjunction with the three Area Health Services to ensure appropriate attention is provided to needs in centres outside South-East Queensland.

The Herston Centre would ideally operate on a two shift a day basis six days a week to make full and best use of its excellent medical and surgical simulation environment. This

environment has relevance for a very broad range of clinical teaching and training settings from undergraduates through to postgraduate specialists and clinical leaders.

The Centre has been capably managed to date but would now benefit from a greater level of clinical leadership in keeping with reform themes. It would be appropriate for a specialist medical practitioner with necessary adult education and teaching experience to lead the Centre and oversee the development of clinical curricula and clinical skills education development and training programs. The Centre should link closely with tertiary educational bodies across all health disciplines and to the Medical Colleges. It is instructive to note that the University and Skills Centre have already jointly engaged staff. It might also be appropriate to appoint on a three yearly basis an eminent clinician as patron and chair of an advisory group of clinicians, educators and trainers drawn from the clinical networks who might best advise on priorities and needs to help shape the future programs to be offered throughout the State by the Centre.

Additionally, the Centre will continue to require senior managerial, commercial and entrepreneurial skills to ensure clinical programs are delivered effectively and innovation and commercial partnerships continue to develop.

### **Funding for training**

As noted previously, there is considerable variability in access to training across Queensland Health. Some training and study leave are included in award entitlements while others are less formalised and dictated by local District arrangements. For instance, senior medical officers have access to 13 weeks study leave and travel every 5 years and conference leave of 1 week each year. Radiation therapists receive a development allowance as an award entitlement and there is a professional development incentive package for rural and remote allied health employees.

All health employees have access to study and research assistance as does the rest of the Queensland public sector. However, Queensland Health offers more limited assistance than other agencies. For example, employees can apply for study leave but cannot claim an employer contribution towards HECS costs. Expanded assistance could offer a means of Queensland Health supporting staff to move into more advanced clinical roles. For example, HECS subsidy could be used as an incentive for an enrolled nurse to undertake tertiary study and become a registered nurse.

The 2003-04 Measured Quality Report highlighted disparities between districts in expenditure on professional development and education. While these figures should be treated with some caution, they provide an indication of inequities for staff in different districts. The cost of paid training and study leave per FTE varied markedly from the State median of \$461, ranging from approximately \$200 in some hospitals to over \$1000. The cost per FTE of education courses and conferences similarly varied from the median of \$198, ranging from below \$100 in some hospitals to over \$400 in others.

As noted earlier, the majority of the cost burden of meeting education and training costs currently falls on Queensland Health. However, the benefits of that training are enjoyed much more broadly by the private sector and by individual practitioners who leave the public sector to work in the private sector.

### 10.13 Recommendations to address organisational and multi-disciplinary education and training issues

Queensland Health should establish a central coordination point for training and education in the organisation to facilitate better linkages with external agencies. The central coordinating area would be responsible for training and education across all health professional groups and would be charged with:

- establishing the overall strategic direction for training and skills development across the State based on future service needs;
- providing input into curriculum development to ensure sufficient levels of practical experience are incorporated in under-graduate health education programs;
- examining the feasibility of fast-tracking health professional education to meet workforce shortages;
- exploring opportunities to train multi-skilled health workers in the VET sector with a range of competencies to provide a more flexible and adaptable workforce; and
- expanding transition to work programs so that health professional graduates receive sufficient supervision when first entering the workplace.

Queensland Health should refocus the operation of the Skills Development Centre and staff and resource the Centre to enable it to operate on an expanded basis to promote skills enhancement and training for clinical staff across the State. A clinical director should be appointed and increased resourcing be provided so the Centre can operate as the training hub for staff across the State at least six days a week.

Queensland Health should foster a learning culture across the organisation by:

- designing in-hospital training programs which are linked to service needs and provided equitably across professional groups;
- providing standard entitlements to ongoing training and professional development;
- expanding assistance under the Study and Research Assistance Scheme to include subsidisation of HECS costs
- streamlining approval processes for study leave and professional development attendance.

Queensland should review the level of funding available for education and training across the organisation and seek increased support for teaching clinical students from the Commonwealth.

Districts should receive dedicated budgets to support education and training and these should be linked to student and staffing numbers.

## 10.8 Planning for the future

It is essential that comprehensive workforce planning underpin all of the above initiatives. Submissions to the review recommend a 10 year planning horizon as it is difficult to anticipate new technologies and treatments beyond this timeframe.

To this end, it is recommended that Queensland Health ensure the workforce planning unit in corporate office includes the following roles:

- 10 year modelling of future workforce needs reflecting projected demographic changes, service planning and models of care and taking account of emerging technology and treatment methods

- Planning for adequate workforce supply across disciplines, in partnership with universities, the vocational education and training sector, medical colleges, professional bodies and the Commonwealth Government
- Monitoring and analysis of key workforce trends including: regular staff satisfaction surveys and exit interviews; long term vacancies by district and discipline; turnover and absenteeism trends; attrition rates; identification of OTDs by district and classification/specialty; and targeted research to improve understanding of nurse wastage rates, factors that would attract former nurses back into the workforce, and longitudinal tracking of a cohort of graduate health professionals to track their career choices and distribution in terms of geographic location and public/private sector
- Working through national forums including AMWAC and AHWAC to undertake more robust, future focused workforce planning including modelling of alternative workforce roles and streams of care and improved data collection for allied health professions.

It would be helpful for the work of this unit to be overseen by a clear governance structure with representation from corporate office, area health services, district representatives and external stakeholders. Whilst this unit would drive high level workforce modelling and planning, area health services will also have a workforce reform function to undertake more detailed local planning and redesign of workforce roles, in alignment with service needs and the Service Capability Framework.

#### **10.14 Recommendation to improve workforce planning**

Queensland Health should ensure the Central Office workforce planning unit undertakes the specific roles outlined in section 10.8, to be overseen by a governance structure comprising corporate office, area health services, district representatives and representatives of external stakeholders such as universities, the Commonwealth Government, professional and regulatory bodies.

## **10.9 The way forward - relationships between Queensland Health and educational organisations**

The development of teaching health systems in Queensland and in most western countries has been dependent on the joint development and integration of health service delivery (hospitals, teaching hospitals) with the university sector. This co-development has resulted in a culture of teaching, research, critical analysis, peer review and openness. These have been the hallmarks of health developments in Anglo-American countries and have been characterised as a 'Teaching Health or Learning System'. One system is enmeshed with the other.

As noted previously, Queensland Health provides the teaching, training, educational and developmental environment for universities to educate the clinical workforce. This is a long standing practice. These organisations have not been provided with adequate funding to ensure teaching and training effectiveness for clinical placements in any discipline. Fragmented funding arrangements provide a very modest level of training. The Commonwealth and State Government have long held differing views on their respective funding responsibilities. Observations throughout the State's hospitals reveal a

totally inadequate level of educational, teaching, training and research support compared with what would be regarded as satisfactory, acceptable or safe.

The Review saw repeated instances where doctor, nurse and allied health professional education training was breaking down in work pressured environments, where conflicting objectives and differences of viewpoint about funding abound. In keeping with many of the fragmented and dysfunctional arrangements in the health system, differing Commonwealth and State funding responsibilities and capabilities are inexorably linked in this issue. There has been an on-going argument for over thirty years concerning where responsibility lies for funding clinical placements. In the 1975 Medibank arrangements, the Commonwealth agreed to meet 50% of the net operating costs of State public hospitals. It was inferred that most of the costs of the clinical component of medical training would be assigned to the States' public hospital systems, and so it remains.

Extensive consultation with the education sector has confirmed that these institutions lack of funding to adequately teach and train in clinical settings. In the context of the impending health workforce crisis, the Commonwealth in 2004 acted to provide a contribution towards the practicum component of the training of nurses, formalised in 2005 by designating Nursing and Education (teacher education) as areas of National Priority within the new *Higher Education Support Act*. The issue of funding for the clinical component of training remains unresolved in relation to Allied Health and Dentistry. Notwithstanding this, the amount allocated by the Commonwealth per student seems quite inadequate (some \$1080 for medicine and \$659 for nursing) to provide significant input into the true costs of quality clinical training. Universities are also faced with funding levels that underestimate the true costs of teaching in the clinical health disciplines in the modern clinical environment. For example, universities receive funding for only 75 % of students from one year into the subsequent year, on a compounding basis over four years, (i.e. an initial intake of 10 EFT students into the first year of a program is only funded in the fourth year of the degree for 4.219 EFT students, regardless of actual retention)

A suggested way forward would require meaningful consideration, discussion planning and action along the following lines:-

- Responsibility for undergraduate education and training programs in the health sector has been divided between State and Commonwealth jurisdictions. Significant energy has been spent on blame shifting in relation to this issue. At a time of dire clinical workforce shortage in Australia, a measure of commitment to our future workforce would be to properly fund undergraduate training including essential periods spent in public health systems. This should include teaching and supervision time, the resourcing of necessary program coordinators and the real costs of teaching, training and educational infrastructure, including a reflection of the real student retention rates which approach 90 % in most disciplines.
- The State Government should ensure that the necessary human resources and associated physical infrastructure are provided to ensure effective service delivery whilst accommodating essential teaching and training responsibilities. In a vibrant teaching health system, teaching and research provides the intellectual stimulus to sustain high quality health care. It is unacceptable that staff already overly stretched with workload, should have the additional burden of teaching and training with no compensation or backfilling support.

Infrastructure includes contribution to training rooms and facilities, necessary access to practical application and procedural classes requiring particular equipment and technology and most importantly, the time of senior professionals who can ensure the junior workforce is properly trained and able to deal with the increasing challenges of this sector.

The State should develop a comprehensive training plan across all clinical domains including the opportunity for more team based and group practical training in the workplace, and should engage the Commonwealth in discussions to ensure the best way forward. The cost of this initiative will be significant, but if it is not properly funded, the inevitable consequence will be the breakdown of teaching and training capability, increasing difficulty in attracting and retaining appropriately qualified staff, escalating threats to patient safety and quality, and a deterioration of the health system at a time when greater strength and capacity to handle enormous future challenges is paramount.

Australia surely has an obligation to educate and train its future workforce adequately. Differences of viewpoints about funding do not address problems. The following may provide a way forward.

#### **Recommendation 10.15**

Queensland Health needs to explore the following range of jointly funded initiatives or initiatives funded in innovative ways:

- In recognition of the national importance of medical workforce training, the Commonwealth Government be approached to accept responsibility for funding all training posts for doctors (registrars within the public hospital system) and for the funding of dedicated teaching time and/or new positions for specialists, teaching VMOs, as well as trainees (registrars, senior health officers and interns).
- The support infrastructure, medical equipment, practical sessions etc. must be properly planned and funded across the continuum of nursing, allied health and medical training with adequate human resources to support training and service continuity. The investment is significant. International experience suggests that these costs may be approximately 20% of total recurrent costs.
- Networking of teaching and training across hospital and sector boundaries to ensure consistency and access to comprehensive training. For example, trainee specialists accessing learning opportunities in the private sector and private hospital based specialists providing teaching support for specialist trainees in the public sector.
- Unilateral recognition for trained health professional graduates (including medical graduates) with qualifications from countries with similar training requirements and standards, e.g. the United Kingdom, Ireland, Canada and New Zealand.
- Supernumerary preceptor positions and a network of facilities throughout the State to cope with student nursing places and undergraduate allied health workforce placements.
- Pilot programs for new types of health practitioners and new models of care including clinical associates' positions such as physician's assistants and nurse practitioners etc.
- Use simulation, telehealth and teleeducation linkages to enhance integration of clinical placement and academic teaching models with service provision, in a strong Area Health teaching network.
- Integrated models of vocational and university education and training to deliver mainstream health professional qualifications in the more remote parts of the State.
- To ensure Area Health Services are resourced to provide a decentralised Skills Centre network which provides for the clinical needs of health professionals and trainee health professionals in that Area Health Service. Each Area Health Service Skills Centre network would be resourced to provide equitable access to basic clinical skills training and team based training.