Australian Health Ministers' Conference (AHMC)

Health Workforce Principal Committee

KPI Workshop (Attachment F)

Principle 1	**Australia should focus on achieving, at a minimum, national self sufficiency in health workforce supply, whilst acknowledging it is part of a global market.**
	% of workforce by discipline/by geographic distribution/professional speciality % of total workforce comprised Overseas and trained Health Professionals (HPs) % of total enrolments in programs who graduate % of graduates remaining in profession after 5 years Consistent definitions for KPIs and business rules across all states and territories No. of profession on Department of Employment and Workplace Relations' occupation list
	% of overseas recruits vs. % of emigration (immigration vs. emigration) AHIW labour force surveys – collected, collated and utilised in a timely fashion (unlike the present situation) Retention rates of new graduates
	% of Post Graduate Year (PGY) 1-3 that are local graduates (workforce) Unfilled positions /vacancies on an annual basis – also unfilled training places Drop-out rates
	Overseas recruits as a % of health workforce by category
	Overseas graduates registered as a % of total health workforce Number of vacancies > 3, 6, 12 months old Number of vacancies filled by overseas trained practitioners Rate of change (in number) of overseas trained graduates compared to rate of change in number of local graduates Note: measure all the above in: (a) rural, regional, metropolitan (b) public, private (c) by profession (d) collect data to measure number of adhoc hours worked as a % of total hours worked

Principle 2	**Distribution of the health workforce should optimise equitable access to health care for all Australians, and recognise the specific requirements of people and communities with greatest need.**
	FTE per 100,000 population for various disciplines according to ARIA classification (major city, remote etc) Waiting times for services (eg. To see a psychiatrist) or for elective surgery by geographic area – also GPs Medicare utilisation rates by geographic area ATSI health access measure – morbidity and mortality – measure various things – immunisation rates, ante natal care etc
	Age of workforce by profession, to support succession planning strategies – i.e. professionals preparing to leave workforce Appropriate population and needs based planning tools developed Appropriate population and needs based planning tools implemented % broad band connectivity Practising and non-practising ratios to guide development of accelerated re-entry programs Develop workforce modelling tool for all health professionals i.e. inclusive of allied health Extent to which incentive programs are equally provided to all health workers to meet health needs
	Number of patient presentations per Rural, Remote and Metropolitan Areas (RRMA) to General Practitioners (GPs) in communities of specific need – eg. Indigenous, Culturally and Linguistically Diverse (CALD) Compare birthing morbidity across RRMAs Numbers of women transported from their local area for birthing Compare renal morbidity and mortality by RRMA Compare immunisation rates by RRMA, by age cohorts and include Indigenous and CALD communities Compare via RRMA the numbers who need to travel outside their local area for oncology care/or palliation Compare via RRMA the numbers who need accommodation for aged care outside their local area

	What is equitable access? Able to receive the care you need at the time you need it at the prices you can afford? (not all services in all areas) Southern Metropolitan Region data Australian without access to Primary Health Care (+/quals) within 100km = accessible domain Australians without access to emergency surgery with 2 hours % training opportunities in communities with greater need – ATSI/Disability/Rural Workforce: pop ratios are measured in full time equivalent (FTE) annually with modalities – discipline, private/public, geographic % growth in areas of shortfall Service mapping to AHMAC standard with targeted strategies to need (rather than simply to RRMA) AHHMAC needs to determine an agreed minimum standard of access to affordable health care Is health care an essential services? Is choice essential?
	Following service need the time or duration for consumers to access the necessary service(s) required as a measure against agreed benchmarks Retention rates Number of unfilled vacancies Effective outcomes of health services to a community – life expectancy, morbidity, Quality of Life (QOL) variations in type of intervention Changes in health outcomes or access the health workers Time, distance and cost to access health services (reason for choice)
	Specific performance indicators can not be developed until specific actions are initiated. Notwithstanding that, performance indicators for Principle 2 should be mindful of: - rates of service/population - numbers of health workers/population - locations of training programs - registers of models of service delivery benchmarked on service access criteria - turnover/retention/churn rates and exit interview analysis

<table>
<tr><td rowspan="4">Principle 3</td><td>All health care environments regardless of role, function, size or location should be places in which people want to work and develop: where the workforce is valued and supported and operates in an environment of mutual collaboration.</td></tr>
<tr><td>Staff retention
- survey (standardised)
- larger organisations to do sampling
- results are benchmarked
Staff turnover
- longevity measure
Sick leave
- e.g. higher rates where greater constraints on job role/responsibility

Keys:
- flexible
- education and training
- feeling valued

Outcomes:
- hire more staff
- restructure work environment</td></tr>
<tr><td>Recruitment and retention and returns – vacancies
Absenteeism rates – Workers Compensation claiming for “stress”
Waiting lists for employment
Suicide rates in staff
Qualitative analysis of workforce
“mood” – corporate or organisational
Pay
Apply KPI’s to workforce
Exit interviews
Characteristics of positive workforce
- obtain agreed standard and measure against standard
Structured framework for Continuing Professional Development (CPD) and measured satisfaction in staff</td></tr>
<tr><td>Must be related to particular environment/settings
- staff satisfaction surveys
- consumer satisfaction surveys
Student application numbers
Staff absenteeism/stress leave
Length of time to fill vacant positions
Need for KPIs to be attached to a particular sector of jurisdiction to be meaningful</td></tr>
</table>

	Workforce participation as a percentage of registered graduates/practitioners but query effect of demographic factors – such as feminisation Graduate satisfaction by profession - satisfaction by profession (part of registration/re-registration process) “Organisational climate indices” (workplace satisfaction) (part of accreditation process?) Retention and supportive environment etc, as part of current organisational accreditation processes
	Turnover rate = vacancies/total workforce Average duration of employment of employees who leave Amount per capita spent on training and development Staff satisfaction/environment survey (expensive) Rate of unplanned absence

Principle 4	**Cohesive action is required among the health, education, vocational training and regulatory sectors to promote an Australian health workforce that is knowledgeable, skilled, competent, engaged in life long learning and distributed to optimise equitable health outcomes.**
	Student intake match service workforce requirements Implementation of national registration and national accreditation of education and training for health care professionals Accreditation conditions are being monitored and met Retention and attrition levels of health care professional students
	Presence of mechanisms of engagement Collaborative structures Shared responsibility arrangements Extent of standing/continuous education programs/CPD
	% of health care workers engaged in research (surrogate for quality care) % of consumers undertaking clinical trials or addressing the evidence base % or number of health workforce engaged in vocational training % of workforce involved or engaged in assessment of performance of clinical skills Clinical academics in rural and remote environments Accreditation requirements for collaborative ventures including outcomes
	Developing broader "shared" competencies (behaviours) (non-clinical) and community expectations CPD program – continuing (regular) assessment against specific competencies * % of time dedicated to education and training Number of pay positions that achieve a minimum standard of uninterrupted teaching time % of domestic medical graduates accessing intern positions (measures capacity of system) Evidence based outcomes
	Development of a shared CPD model linked to client need is implemented Regular forums to allow relevant stakeholder views and priorities to inform policy development processes

<table>
<tr><td rowspan="6">Principle 5</td><td>To make optimal use of workforce skills and ensure best health outcomes, it is recognised that a complementary realignment of exiting workforce roles or the creation of new roles may be necessary. Any workplace redesign will address health needs, the provision of sustainable quality care and the required competencies to meet service needs.</td></tr>
<tr><td>Effective feedback and monitoring systems in place and in use
Formal, structured framework, responsibilities and reporting accountabilities in place and in use
Systematic evaluation of workplace redesign (core group of indicators for pilots/implementation)
Evidence or changed industrial/insurance frameworks to facilitate new models of workforce design
(? Count and track) support / non graduate staff
Evolutionary process – already in the middle of redesign</td></tr>
<tr><td>No KPIs
Framework development of new roles
- be clear about outcomes
- utilise existing professionals – up-skill/retrain, evolution of the roles</td></tr>
<tr><td>Quality and safety evidenced through innovative programs
Access – time to care and type of provider
Economic analysis of new innovation
The aetiology of adverse events – clinical indemnity
- audit, core reporting</td></tr>
<tr><td>Any evaluation of workforce roles must be related to particular sectors and environments
Competencies established – examined on entry to workforce, recertified periodically
Evidence of changed industrial agreements
Establishment of uni courses
Number of new models and evaluations of new services/roles</td></tr>
<tr><td>Number of new job roles/pay scales
Number of changes to legislation
Number of new qualifications
Number of roles that are realigned and/or expanded
Number of new job titles/positions
Need to define what constitutes “new”
Timeframe for the benchmark/target needs to be limited</td></tr>
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Principle 6	**Health workforce policy and planning should be population and consumer focused, linked to broader health care and health systems planning and informed by the best available evidence.**
	Development of new services need to be in response to demonstrated gaps in health care provision Conduct a regular national survey of patient/consumer satisfaction with access to health services
	Number of diabetics with access to eg. Podiatry services, vision screening, endocrinology by Local Government Area (LGA) Numbers of dialysis units in NT relative to number of renal patients in NT who need dialysis or by LGA Number of pre-schoolers who receive a vision screening eye examination by LGA % of newborns who receive a hearing test by LGA Number of visits by children to maternal and infant welfare as a function of local government area * everything is dependence on the patient being prepared to use the services if they are there.
	% of jurisdictions with a workforce plan that reflects population health needs % of workforce policy decisions/plans reflecting robust workforce data % of workforce policy decisions/plans which reflect evidence based practice % of workforce policy decisions/plans which encourage innovative workplace models that improve quality/efficiency and effectiveness % of workforce policy decisions/plans which reflect outcomes of measurement of consumer priorities and preferences % of workforce policy decisions/plans which plan for regional variances in morbidity/mortality and population need

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Principle 7	**Australian health workforce policy development and planning will be most effective when undertaken collaboratively involving all stakeholders. It is recognised that this will require: cohesion among stakeholders; stakeholder commitment to the NHWSF; a nationally consistent approach; best use of resources to respond to NHWSF strategies; and a monitoring, evaluation and reporting progress.**
	For all policies developed, have an implementation plan and measured outcome Every plan (implementation) has a corresponding evaluation plan and process NHWSF 100% - update, consistency Inter-professional uptakes
	(Recognising that identified stakeholders influence the collaborative outcome) All stakeholders identified and kept on website database so gaps may be identified Communication strategy clearly defined including consultation Opportunities for input by special needs groups (who may need targeting) and consumers Decision making structure agreed (ministerial ? consumers ?) Decision made using agreed quality framework (where cost effectiveness is not the only value) Policy outcomes will be monitored with 3 yearly evaluation and response to shortcomings identified
	Level of multidisciplinary participation Level of consumer participation % of workforce plans accessible (refers to transparency and availability)
	% of multi-professional collaboration/input into development of workforce policy Note – inter-professional NOT multi-disciplinary The number of evidence based policies Implementation of a program to support the reporting, monitoring, evaluation progress % of inter-professional clinical placements – maximise use of courses Level of trained clinical educations/preceptors with additional competencies to support inter-professional learning (IPL) & clinical placements Policy to support IPL (at tertiary level – qualifying training) i.e. NOT optional