

Waikato health sector workforce development plan

Ruth Ross,
Human Resource Consultant
Flora McCarthy,
General Manager Human Resources

2009/2019



Waikato District Health Board

This plan was led and prepared by:

- Ruth Ross, Human resources consultant and project manager, workforce planning and development;
- Fiona McCarthy, General Manager Human Resources

Acknowledgement and thanks to the members of the workforce stakeholder group and the expert reference panel, as well as those who develop and publish the report.

A full list of acknowledgements is provided in Appendix C.

Published by: Waikato District Health Board Human Resources Service

September 2009

© Waikato District Health Board 2009.

Contents

Contents	3
Foreword.....	7
Executive summary	9
Background	9
Process and outcome.....	9
Links to other workforce plans.....	9
Six strategic areas recommended for action	9
Summary of strategic objectives and key implementation tasks	10
1. Care and support workforce	10
2. Waikato DHB as corporate citizen	10
3. Māori health workforce	11
4. Pacific health workforce.....	11
5. Business and employment models	11
6. Health careers	11
1. Care and support workforce.....	13
Care and support workforce key points	13
Care and support workforce approach.....	13
Care and support role and function.....	13
Care and support outcomes	14
Care and support workforce links / flow on	14
Representative stakeholder working group.....	14
Care and support phased action plan and costs.....	15
2. DHB corporate citizen	18
DHB corporate citizen key points.....	18
DHB corporate citizen approach.....	18
DHB corporate citizen outcome	18
DHB corporate citizen links / flow on	19
Representative stakeholder group.....	19
DHB corporate citizen phased action plan and costs.....	20
3. Maori health workforce	23
Maori health workforce key points	23
Maori health workforce approach.....	23
Maori health workforce outcome.....	23
Health career links / flow on.....	23
Representative stakeholder group.....	23
Maori health workforce phased action plan and costs	24

4. Pacific health workforce	25
Pacific health workforce key point.....	25
Pacific health workforce approach.....	25
5. Business and employment models	26
Business and employment models key points	26
Business and employment models approach	26
Business and employment models outcome	26
Business and employment models links / flow on.....	26
Representative stakeholder group.....	26
Business and employment models phased action plan and costs.....	27
6. Health careers	29
Health careers key points	29
Health careers approach	29
Health careers outcome.....	29
Health careers links / flow on.....	29
Representative stakeholder group.....	29
Health careers phased action plan and costs	30
Implementation	34
Assumptions.....	34
Total costs.....	35
Workforce planning process	36
1. Waikato DHB workforce development plan 2008/2010	36
Summary of Waikato DHB workforce data	36
Summary of strategic workforce projects.....	36
2. Waikato DHB sector workforce development plan 2009/2019	37
Appendix A: Stakeholder planning information	41
Community demographics.....	41
Waikato DHB	41
Deprivation.....	42
Ministerial priorities 2009 / 2010.....	44
Waikato DHB priorities	44
Health indicators	44
Chronic disease.....	44
Social determinants	45
Ageing population.....	46
Maori health workforce development	46
Density	47
Provider survey	49

Survey key points	49
Census information about health workforce	51
Waikato Primary Health General Practice workforce information.....	51
Health of Older People Workforce Incentives Project	52
Background	52
Workforce for older people - key messages	52
Recommendations.....	52
Summary	53
Future vision planning assumptions	54
Chronic disease	54
Social determinants	54
Ageing population	54
Workforce supply chain	54
Key points from expert panel member discussions / emails.....	54
Appendix B: National workforce plan priorities	57
Appendix C: Acknowledgements.....	59
Workforce stakeholder group.....	59
Expert reference panel	59
Information and production	59
References.....	60
Tables.....	61
Graphs	61

Foreword

The Waikato DHB plans and funds health and disability services across the Waikato district, and directly provides community based and secondary / tertiary hospital services through its provider arm, Health Waikato.

Providing health and disability services now and into the future depends on having a workforce that is well matched to the health needs of the community and appropriately skilled and located.

Waikato DHB has a responsibility to view the health workforce in its entirety – including the primary and private sector - because all contribute to the health and wellbeing of the Waikato population.

For this reason, the DHB has led the development of the sector-wide plan. Working with representatives from health sector and workforce organisations, and tapping into the pool of knowledge that exists, we believe the resulting plan will help make the vision of an integrated primary sector a reality.

We face a rapidly changing future and the knowledge that current health services won't stretch to meet all our needs. Our model of delivering services needs to change. Our priorities need to be agreed and well resourced.

The future model for the health in the community in the Waikato is about strengthening what people can do for themselves, supporting them to remain well, and making access health and social services easier for those who really need our help. It isn't about creating more dependency on the system.

As the largest health employer in the Waikato, the DHB has a role to find ways of sharing its resources - support services, training and education facilities, leadership and coordination – with others in the sector to make this implementation happen. This as a collaborative task and it will build on the relationships and processes that brought this sector-wide workforce plan to fruition.

We support the implementation of this plan.

Craig Climo

Chief Executive

Fiona McCarthy

General Manager Human Resources

Background

The DHB plans and funds health and disability services across the Waikato district for 340,000 people and provides tertiary health services for 840,000 across the Midland region.

Health care in all aspects of the health industry is delivered by a highly skilled and trained professionally regulated workforce that works alongside a large non regulated health and disability workforce. The delivery of health care would not occur without them.

As a general trend the health and disability workforce and the population it serves are getting older, and the ethnicity and age profile of populations in territorial local authorities is forecasted to change in a variety of ways over the next 20 years which will affect health need, and will ultimately affect the shape and structure of the health and disability workforce.

Taking action now to identify workforce priorities within the DHB and across the sector is essential to maintain adequate health services in the future.

Process and outcome

The DHB has already completed an internal workforce development plan for Health Waikato which contains five strategic objectives to be implemented over the next two to three years.

The next step was to develop a wider plan involving the whole primary and private health sector in the Waikato, and to look at a 10 year implementation horizon.

The Waikato DHB's chief executive commissioned a stakeholder group to develop recommendations.

This process was informed by a survey of health provider organisations in November and December 2008, as well as a review of a wide range of plans, reports, census data and other relevant information. (See Appendix A for details.) An expert panel provided insights and advice. (See Appendix C for membership.)

The result is this report which

- collates available information
- identifies six strategic areas
- outlines the key points and objectives for each of them
- and sets out recommended implementation tasks phased over the next 10 years to achieve these objectives.

The plan focuses on

- local initiatives to deliver local solutions to local issues
- steadily building sector and workforce capability across the district, taking account of forecasted changes to patterns of Waikato populations and the workforce.

This plan does not address workforce issues for the disability sector other than where it overlaps with the health workforce.

Links to other workforce plans

There are a number of national workforce plans including the District Health Boards of New Zealand (DHBNZ) future workforce plan (see Appendix B for an overview), which cover distinct areas of the health workforce, such as public health, mental health and Maori health.

The Waikato sector plan needs to align with these, but there are initiatives and different ways of working that must be driven locally.

Six strategic areas recommended for action

The six areas are: the care and support workforce; the Waikato DHB as corporate citizen; the Māori health workforce; the Pacific health workforce; alternative business and employment models; and health careers.

These areas are summarised below, and described more fully in the body of this report – including tables showing recommended phased activities and estimated costs.

We will have information in the next two years about which of the planned initiatives will be more useful and likely to succeed. At this point (2011) the plan will be reviewed and updated.

The cost of implementing the entire plan each year is approximately \$420,000.

Summary of strategic objectives and key implementation tasks

1. Care and support workforce

To develop a care and support workforce that is knowledgeable and used effectively across the sector.

Implementation tasks phased over 10 years

- Identify the current workforce and the potential market need.
- Increase the number to meet future need.
- Use the workforce effectively by developing a referral process across the secondary and primary parts of the health sector.
- Check alignment of training to current and future needs, identifying gaps and developing solutions.
- Establish a process to maintain professional standards, support, mentoring and ongoing education for care and support workers.

If the strategic objective for the care and support workforce is met, what are the potential positive outcomes?

- Improved care and support aspect of patient / client journey aligned around the patient/client.
- Increased health knowledge within communities.
- Increased credible and effective role models within communities.
- Workforce hedged against potentially declining GP and practice nurse workforce (split care and support work from planning and treating, and monitoring and care).
- Increased rehabilitation in the community.
- Reduced readmissions.
- Improved self sufficiency.

2. Waikato DHB as corporate citizen

To share readily scalable Waikato DHB resources with other funded health and disability providers in the Waikato DHB district.

Implementation tasks phased over 10 years

- Share learning opportunities such as training programmes, library access, and business and leadership development.
- Share workforce development information to keep stakeholder groups informed and engaged.
- Work collaboratively to promote the health sector to prospective employees.
- Investigating potential for DHB recruitment facilities to be used for primary/private sector recruitment.
- Lead the rebranding and marketing of aged care as a sector-wide initiative.

If the strategic objective for the DHB as a corporate citizen is met, what are the potential positive outcomes?

- Reduced duplication of effort.
- Using DHB scalability to reduce marginal costs across the sector for defined functions / consumables.
- Increased information and knowledge share across the whole of the sector.

3. Māori health workforce

To address the development of the Māori health workforce in the Waikato.

Implementation tasks phased over 10 years

- Increase the numbers of Maori in the health workforce in the future.
- Facilitate retention of Maori in the health workforce.
- Support the spread of knowledge about tikanga.

If the strategic objectives for the Māori workforce are met, what are the potential positive outcomes?

- Increased awareness and practice of tikanga.
- Potentially reduced turnover.
- Increased sense of 'fit' for Māori entering the Waikato health workforce.
- Increased numbers of Māori entering the Waikato health workforce.

4. Pacific health workforce

- Support implementation of the Pacific health workforce development plan (currently being prepared by the Waikato DHB).

5. Business and employment models

To review and develop alternative business and employment models for the health and disability sector into the future.

Implementation tasks phased over 10 years

- Identify employment, business and funding models that may better meet future needs.
- Support national projects that reduce overall labour costs and sustain a more flexible and reliable supply of labour.
- Investigate training funding models that can support employment needs.

If the strategic objective for business and employment models is met, what are the potential positive outcomes?

- Sustainable business and employment models developed for the Waikato DHB district.

6. Health careers

To increase the attractiveness of health careers for New Zealanders; to encourage localised provision of health and disability training and education where practicable; and to support initiatives to expand opportunities for learning.

Implementation tasks phased over 10 years

- Get more kids experiencing health as a possible career.
- Support organisations working with local secondary schools to introduce some health science into their school curriculum, using ways that engage young people.
- Work with schools and other health providers to support them to pick up the Gateway programme; and the Waikato DHB to leverage off its own Gateway experiences.
- Increase the scope of experiences in all parts of the sector for new graduates so they get the broadest view of potential health sector work.
- Support a health generalist approach, especially in rural areas.
- Encourage provision of space for trainees in DHB and provider facilities.
- Work with tertiary training providers to ensure they produce graduates that are fit for purpose in about the right numbers.
- Work with iwi to make sure that workforce projects support the aspirations of Māori and to influence scholarship decisions favourably towards health careers.

If the strategic objectives for health careers are met, what are the potential positive outcomes?

- Increased number local kids interested in health for a career.
- Increased number of young people taking up health careers.

1. Care and support workforce

The strategic objective for the care and support workforce:

- To develop a care and support workforce that is knowledgeable and is used effectively across the sector.

Care and support workforce key points

The care and support workforce has the potential to undertake an expanding variety of roles in local communities and in health facilities, including providing cohesion for people with stable chronic disease across the sector.

A knowledgeable, skilled and experienced care and support workforce, which is dispersed across the district, provides the opportunity to reshape how other health workforces (particularly those that are forecasted to become scarcer) will operate in the future.

Increasing the knowledge base of the care and support workforce will have positive flow on health effects in their family / whanau.

Care and support workforce approach

The programme brings together and builds on the workforce initiatives that are already underway for this group locally – with local providers. Activities will be cross checked with those occurring nationally to ensure alignment where necessary.

The idea is to build this workforce into the health system to operate in its own right and to support the work of others where appropriate. In addition the plan will establish a process for those working outside of institutions to be able to access information and support without creating another regulated health profession.

This workforce needs to be able to hit the ground running and be able to perform all aspects of the care and support role effectively soon afterward. Knowledge and skills need to be transferable across a variety of roles that this workforce performs.

Most of this workforce operates in the primary sector with comparatively few employed by the DHB. The aim is to gradually increase the trained care and support workforce keeping in mind density for each territorial local authority (TLA) to get spread. The plan will monitor labour market changes and be in a position to respond to referral patterns and scope changes, as the workforce is seen as increasingly credible and useful.

Care and support role and function

The general functions and roles of the care and support workforce:

- Is a non regulated, non technical, non paramedic health and disability care and support workforce.
- Has broad local networks and that practices across all settings (community, home, hospital, residential) and may provide personal care; lifestyle support, coaching, role modelling to build self sufficiency; monitoring individual care plans and recommending review; assisting with access to health and social services for medically stable people.
- Roles include:
 - Home based care and support.
 - Health care assistants – within secondary services and within the allied workforce in the primary sector.
 - Aged care residential and retirement facilities (traditional and eden¹ philosophy, “Green House”² aged care facilities, kaumatua).
 - Whanau Ora and Healthright workers.
 - Community health workers.
 - Housekeepers in residential accommodation for people with disabilities.
 - Volunteers supporting people with chronic disease.

¹ Elder-centred care that places the maximum possible decision making authority in the hands of the elders or those closest to them.

² Purpose-built house shared by 10 or fewer residents needing aged residential care based on similar philosophies.

Care and support outcomes

If the strategic objective for the care and support workforce is met, what are the potential positive outcomes?

- Improved care and support aspect of patient / client journey aligned around the patient/ client.
- Increased health knowledge within communities.
- Increased credible and effective role models within communities.
- Workforce hedged against potentially declining GP and practice nurse workforce (split care and support work from planning and treating, and monitoring and care).
- Increased rehabilitation in the community.
- Reduced readmissions.
- Improved self sufficiency.

Care and support workforce links / flow on

The main linkages with other aspects of the workforce plan and pieces of work are listed below.

- Links with business and employment models and health careers project.
- Assumes access to information – decision support, client, community services, changes to practice.
- Requires significant change in roles and demarcation of functions over time – not overnight. These changes will be easier if the care and support workforce are properly trained and competent.
- Required to implement the AT&R bed report June 2008.

Representative stakeholder working group

Representatives from the following stakeholder groups will be involved with the implementation of this strategic objective:

NZ Institute of Rural Health, iwi, aged care providers, primary health organisations (PHO), DHB medicine specialty, DHB Older Persons and Rehabilitation Services, non government organisations employing community health workers.

Care and support phased action plan and costs

Action	0-24 months	Cost PA	2-5 years	Cost PA	6+ years	Cost PA
<p>1. Establish workforce</p> <p>Develop the potential labour force and locate it within communities.</p> <p>Use the DHB AT&R bed review implementation to increase the number of trained, knowledgeable care and support positions in communities and allow them to naturally move into other related local roles.</p>	<p>Identify potential roles within communities such as Whanau Ora and Maori community health workers</p> <p>Identify current and potential labour market for roles and phasing of any implementation</p> <p>Identify patient / client pathways and where care and support workforce roles could add value and which occupations perform functions now (all sectors)</p> <p>Construct rehab care and support workforce pathway Identify care and support workforce skill requirements, numbers required + numbers of allied health workforce required</p>	<p>\$22,000 x2 Salary</p> <p>\$22,000 x2 Salary</p>	<p>Assess current numbers and potential market need</p> <p>Map what current activities could be done by care and support workforce Map effect on occupations currently doing work</p> <p>Phased establishment of DHB positions (potential to relocate to integrated family care teams when established), implement in-house training, implement referral pathways</p>	<p>\$43,000 x3 Salary</p> <p>\$57,000 (yr3) Salary</p>	<p>Inform numbers and skill sets required for the labour market and advise PTE providers</p> <p>Facilitate establishment of similar roles in local communities</p> <p>Maintain</p>	<p>\$43,000 x 5 Salary</p>
<p>2. Effective use</p> <p>Develop a referral process to the care and support workforce roles within the overall sector - secondary and primary.</p>	<p>Map potential referral pathways (all sectors) to components of the care and support role to support patients / clients within the community and within DHB</p> <p>Identify if there is potential for care and support roles to add value to the patient journey of patients that are receiving</p>	<p>\$22,000 x2 Salary</p> <p>\$29,000 x2 Salary</p>	<p>Liaise with providers re referral potential</p> <p>Incentivise referral</p> <p>Identify practical flows for referrals, skill set, resourcing</p> <p>Facilitate implementation of process change.</p> <p>Establish within a specialty then gradually increase scope across other specialties</p>	<p>\$43,000 x 3 Salary</p> <p>\$57,000 x 3 Salary</p>	<p>Trouble shoot issues</p> <p>Maintain</p> <p>Maintain</p>	<p>\$22,000 x 5 Salary</p>

Action	0-24 months	Cost PA	2-5 years	Cost PA	6+ years	Cost PA
	secondary services when they return to their communities to support self care (Flinders model of chronic care)					
3. Training Make sure that what is being taught meets current and near future needs. Establish a local method of training that can increase the numbers outside of people already in care and support employment. Training must be right for target client group and take into account a range of requirements e.g. of aged, Maori, DHB etc.	Identify current ITO curriculum Identify potential training providers across district Identify current costs of training and funding sources	\$4,000 x2 Salary	Assess if matches potential roles + emerging models Identify any gaps, changes required Negotiate with ITO / local tertiary providers if outside of current unit standards Development of curriculum changes if required for longer term	\$14,000 (yr3) Salary \$14,000 (yr3) Salary	Facilitate access to training on the job and outside of employment. Maintain	\$7,000 x5 Salary
4. Mentoring / standards / support / ongoing education Establish a process to maintain standards, provide support for care and support workers, and ongoing education outside of the employment relationship.	Identify current and potential employers Identify how professional standards are maintained. Identify any gaps and consider next step Identify potential education options outside of current employment arrangements to enable the care and support workforce to keep broadening the span of their role	\$7,000 x2 Salary	Implementation	\$14,000 x 3 Salary	Maintain	\$14,000 x5 Salary

Note: some aspects of this programme in each period need to be done before others so careful sequencing will be required to ensure success.

Approximate costs

Costs	0-12 mths	1-2 yrs	2-3 yrs	3-4 yrs	4-5 yrs	5-6 yrs	6-7 yrs	7-8 yrs	8-9 yrs	9-10 yrs
Salary	\$106,000	\$106,000	\$242,000	\$157,000	\$157,000	\$86,000	\$86,000	\$86,000	\$86,000	\$86,000
Other	0	0	0	0	0	0	0	0	0	0
Total	\$106,000	\$106,000	\$242,000	\$157,000	\$157,000	\$86,000	\$86,000	\$86,000	\$86,000	\$86,000

Salary costs are based on \$93,000 per annum (\$44.58 per hour) and are based on actual time required to complete the activities per annum. Total costs are as at 2009 and are not inflation adjusted. Costs are rounded to whole thousands.

2. DHB corporate citizen

The strategic objective for the DHB as a corporate citizen:

- To share readily scalable DHB resources with other funded health and disability providers in the Waikato district. Scalable resources are those that can be increased with marginal cost.

DHB corporate citizen key points

The Waikato DHB is a large health provider which can scale up some of its corporate services for other health and disability service providers to use.

The DHB has a shared responsibility with other health providers for the health and disability sector workforce.

The DHB already has a substantial investment in leadership development which could be accessed by other providers on a more regular basis.

There are a number of services and resources that are available to providers now. The DHB reports mixed uptake.

DHB corporate citizen approach

By taking a whole-of-sector approach, the overall health spend could be reduced where economies of scale are possible. Opportunities exist for the DHB to:

- market access to Waikato DHB's internal education and training offerings
- market access to Waikato DHB's library to service providers and care and support training providers
- review education and training offerings and provider needs, and realign if necessary
- review if access to the Waikato DHB's library is increasing from primary sector
- promote non DHB health and disability roles at career fairs and expos
- review the DHB's and other providers' recruitment processes and identify changes that would enable primary / private health and disability providers³ to use the DHB's recruitment service – including immigration, draft business case and process flows
- ensure any e-recruitment models are scalable for primary / private sector
- provide primary / private providers with information from the DHB's workforce plan implementation.

The Waikato DHB will schedule and host forums for aged care providers and will work with aged care providers to re-brand the sector.

Other initiatives may involve setting up a business mentoring programme and increasing access to information and educational opportunities.

DHB corporate citizen outcome

If the strategic objective for the DHB as a corporate citizen is met, what are the potential positive outcomes?

- Reduced duplication of effort.
- Using DHB scalability to reduce marginal costs across the sector for defined functions / consumables.
- Increased information and knowledge share across the whole of the sector.

³ The Waikato DHB acknowledges the important role of other providers, regardless of their funding models, which supports the delivery of health and disability services to communities, and believes that actively reducing overheads across all providers will ultimately reduce the price of delivering services.

DHB corporate citizen links / flow on

The main linkages with other aspects of the workforce plan and other requirements are listed below.

- Waikato DHB information systems, IT licensing requirements (library)
- Health careers, business and employment models projects

Representative stakeholder group

Representatives from the following stakeholder groups will be involved with the implementation of this strategic objective:

DHB Information Services, DHB Learning and Development, aged care providers, pharmacies, non government organisations, primary health organisations (PHOs)

DHB corporate citizen phased action plan and costs

Action	0-24 months	Costs PA	2-5 years	Costs PA	6+ years	Costs PA
<p>1. Learning and development</p> <p>Develop a suite of learning options for people in the primary / private sector (outside of their current health professional clinical medical education) targeted at owner / managers and future leaders.</p>	<p>Review internal training programmes</p> <p>Complete needs assessment in primary / private sector</p> <p>Market current programmes</p> <p>Audit current library access from primary / private sector</p> <p>Undertake needs analysis of primary / private providers re business training needs</p>	<p>\$22,000 x2 Salary</p>	<p>Realign DHB programmes to meet wider provider need.</p> <p>Assemble information together re training programmes and publicise</p> <p>Maintain</p> <p>Market library access to other providers</p> <p>Learning programmes to include various models to help learning stick such as chat groups, mentoring etc (cost up for decision)</p>	<p>\$14,000 (yr3) Salary</p> <p>\$2,000 x3 Salary</p> <p>\$7,000 (yr3) Salary</p> <p>\$2,000 x3 Salary</p> <p>Plus \$20k IT + \$10k production x3</p>	<p>Maintain and review</p> <p>Maintain</p> <p>Maintain</p> <p>Maintain</p> <p>Maintain</p>	<p>\$2,000 x5 Salary</p> <p>\$2,000 x5 Salary</p> <p>\$2,000 x5 Salary</p>
<p>2. Workforce information</p> <p>Set up a virtual place where information about workforce and generated by the workforce plan implementation team and representative stakeholder groups can be accessed, and where others can provide input</p>	<p>Set up a workforce website for the DHB that includes DHB plans, progress reports (from internal and external plans), links to other sites, chat room to engage providers and prospective employees</p> <p>Provide links for other local health providers to promote their facilities locally (may be linked nationally depending on embedding of HealthCareers brand)</p>	<p>\$11,000 x2 Salary</p>	<p>Maintain</p>	<p>\$4,000 x3 Salary</p>	<p>Maintain</p>	<p>\$4,000 x5 Salary</p>

Action	0-24 months	Costs PA	2-5 years	Costs PA	6+ years	Costs PA
<p>3. Promote sector</p> <p>Build on what is already happening to promote all aspects of the sector to prospective employees</p>	<p>Undertake needs analysis in each sector re need</p> <p>Identify key hard-to-get roles</p> <p>Identify specific providers with vested interest and hard to fill roles</p>	\$7,000 x2 Salary	<p>Develop low cost material for use at expos and fairs across the sector</p> <p>Use and update material</p> <p>Include specific providers at expos and fairs</p>	\$7,000 x3 Salary Plus \$20k production x3	Maintain	\$7,000 x5 Salary
<p>4. Recruitment machine</p> <p>Reduce costs of recruitment and increase effectiveness by taking a whole of sector approach and providing access to the DHB recruitment facilities to other providers (would need to recover marginal costs).</p>	<p>Undertake needs analysis of primary / private sector re which would like support with the recruitment process</p> <p>If they want support, then draft a business case including development of standardised recruitment forms and process, full marketing, website access, assistance with immigration for work permit renewals</p> <p>Review DHB recruitment machine to identify where it is most scalable</p>	\$14,000 x2 Salary	Implementation scaled depending on cost and need	\$7,000 x3 Salary (partial user pays)	Maintain	\$7,000 x5 Salary (partial user pays)
<p>5. Aged care</p> <p>Realign perceptions of the health workforce about the aged care sector</p>	<p>Identify key elements of aged care services</p> <p>Identify interested parties in aged care sector and involve in development of</p>		Implement marketing plan scaled depending on cost and marginal cost recovery from sector		Maintain	

Action	0-24 months	Costs PA	2-5 years	Costs PA	6+ years	Costs PA
	marketing concepts. Develop marketing plan for sector that includes strong workforce and service component Approach sector for partial sponsorship Cost marketing plan for decision making Host x2 forums in consultation with Planning and Funding where the providers set the agenda	\$17,000 x2 Plus \$15k production x2)	Host x4 forums depending on need	\$14,000 x3		\$14,000 x5

Approximate costs

Costs	0-12 mths	1-2 yrs	2-3 yrs	3-4 yrs	4-5 yrs	5-6 yrs	6-7 yrs	7-8 yrs	8-9 yrs	9-10 yrs
Salary	\$72,000	\$72,000	\$57,000	\$43,000	\$43,000	\$38,000	38,000	38,000	38,000	38,000
Other	\$15,000	\$15,000	\$50,000	\$30,000	\$30,000	\$30,000	\$30,000	\$30,000	\$30,000	\$20,000
Total	\$86,538.17	\$87,000.00	\$107,000.00	\$73,000.00	\$73,000.00	\$68,000.00	\$68,000.00	\$68,000.00	\$68,000.00	\$58,000.00

Salary costs are based on \$93,000 per annum (\$44.58 per hour) and are based on actual time required to complete the activities per annum. Total costs are as at 2009 and are not inflation adjusted. Costs are rounded to whole thousands.

3. Maori health workforce

The strategic objectives for the Maori health workforce:

- To increase the numbers of Maori in the health workforce in the future.
- To facilitate retention of Maori in the health workforce.
- To support the spread of knowledge about tikanga.

Maori health workforce key points

The numbers of young Maori in areas of the Waikato are increasing and are a potential labour force.

The DHB needs to increase the Maori health workforce in the future.

Maori health workforce approach

All the sector workforce strategic objectives outlined in this report include elements that will support the strategic objectives for Maori health workforce development.

However there are some approaches that are specific for Maori health workforce, such as encouraging implementation of findings of the *Rauringa Rauapa* report at a local level relating to:

- strengthening cultural competence
- establishing Maori health workers cultural supervision programme.

Maori health workforce outcome

If the strategic objectives for the Māori workforce are met, what are the potential positive outcomes?

- Increased awareness and practice of tikanga
- Potentially reduced turnover
- Increased sense of 'fit' for Māori entering the Waikato health workforce
- Increased numbers of Māori entering the Waikato health workforce

Health career links / flow on

All programmes in this plan contain elements of Maori health workforce development.

Representative stakeholder group

Representatives from the following stakeholder groups will be involved with the implementation of this strategic objective:

Iwi, DHB workforce, DHB Te Puna Oranga

Maori health workforce phased action plan and costs

Action	0-24 months		2-5 years		6+ years	
Cultural competence To strengthen cultural competency across the health workforce.	<p>Identify components for a programme to increase cultural competence</p> <p>Identify organisations wishing to participate in such a programme</p> <p>Draft business case with costing for decision</p> <p>Identify components of cultural supervision programme</p> <p>Identify potential need</p> <p>Develop potential business model to deliver cultural supervision and test the market</p>		<p>Implementation depends on costs and need</p> <p>Facilitate implementation depending on cost and need</p>		<p>Maintain</p>	<p>\$18,000 x2</p> <p>\$2,000 x3 Plus \$20k costs x3</p> <p>\$2,000 x5 Plus \$20k costs x4)</p>

Approximate costs

Costs	0-12 mths	1-2 yrs	2-3 yrs	3-4 yrs	4-5 yrs	5-6 yrs	6-7 yrs	7-8 yrs	8-9 yrs	9-10 yrs
Salary	\$18,000	\$18,000	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000	\$2,000
Other	0	0	\$20,000	\$20,000	\$20,000	\$20,000	\$20,000	\$20,000	\$20,000	\$20,000
Total			\$22,000.00	\$22,000.00	\$22,000.00	\$22,000.00	\$22,000.00	\$22,000.00	\$22,000.00	\$22,000.00

Salary costs are based on \$93,000 per annum (\$44.58 per hour) and are based on actual time required to complete the activities per annum. Total costs are as at 2009 and are not inflation adjusted. Costs are rounded to whole thousands.

4. Pacific health workforce

The strategic objective for the Pacific health workforce:

- To support implementation of the Pacific health workforce development plan.

Pacific health workforce key point

The Waikato DHB is developing a Pacific health workforce plan. Implementation will be confluent with the DHB's other workforce plans.

Pacific health workforce approach

The Pacific health workforce plan is being developed and will be completed early in 2010. Activities required to implement the plan may be incorporated into the DHB's sector workforce development plan or implementation will be confluent.

5. Business and employment models

The strategic objective for business and employment models:

- To review and develop alternative business and employment models for the health and disability sector into the future.

Business and employment models key points

The distribution of the population in the Waikato will impact on how health providers function in the future.

Funding models impact on the distribution and functions of health providers, which in turn impacts on the health workforce.

Employment models need to enable flexible use of increasingly scarce health professionals in the future.

Business and employment models approach

Current ways of operating may not be the best fit for some future needs. The plan's aim is to develop, cost and partner implementation of a series of business and employment models as alternatives to the current ways of operating that take into account:

- rurality
- changing demographics and rating base over time
- devolution of some secondary care components
- legal requirements
- training models
- exit strategies for some providers
- facilities for training and internships.

Implementation of this plan would also support the national RMO locums project, expand it across other groups, and propose that it also covers the primary / private sector.

Business and employment models outcome

If the strategic objective for business and employment models is met, what are the potential positive outcomes?

- Sustainable business and employment models developed for the Waikato DHB district.

Business and employment models links / flow on

The main linkages to other aspects of the workforce plan and requirements:

- Ministry and DHB's planning and funding models.
- Legal and company requirements.
- Links with care and support project roles and demarcation of functions.

Representative stakeholder group

Representatives from the following stakeholder groups will be involved with the implementation of this strategic objective:

Primary health organisations (PHO), DHB Planning and Funding Division, aged care providers, pharmacies, allied health services (private), DHB Rural and Community Services, iwi.

Business and employment models phased action plan and costs

Action	0-24 months		2-5 years		6+ years	
<p>Business and employment models</p> <p>Establish feasible, sustainable alternative business and employment model options</p>	<p>Describe current business and employment models – all sectors</p> <p>Identify other models that are being used internationally and opportunities within current models to make incremental improvements</p> <p>Identify potential employment models within NZ framework</p> <p>Identify opportunities for partnerships</p> <p>Review list of secondary procedures which are transferring to primary providers and the proposed phasing</p> <p>Identify skill set needed, if available locally, and devolution required</p> <p>Establish process (different depending on what) – identify funding and time requirements</p>	<p>\$29,000 x2</p> <p>Plus \$30k for specialist legal advice</p> <p>\$22,000 x2</p>	<p>Develop theoretical comprehensive business and employment models</p> <p>Identify transitional requirements</p> <p>Publish work on DHB workforce website</p> <p>Review funding models relating to new business and employment models</p> <p>Inform planning and funding decision making</p> <p>Support implementation</p> <p>Ongoing - phased</p>	<p>\$45,000 x3</p> <p>\$22,000 x3</p>	<p>Continue to implement models</p> <p>Ongoing - phased</p>	<p>\$45,000 x5</p> <p>\$21,461.54 x5</p>
<p>2. Locums projects</p> <p>Get in behind national projects that reduce overall labour costs and</p>	<p>Understand current project</p>					

Action	0-24 months		2-5 years		6+ years	
that firm up reliability of labour supply of flexible resources.	<p>Review timeframes</p> <p>Seek to review Terms of Reference to include primary / private representatives</p> <p>Inject DHB resource if required</p>	\$7,000 x2	Move into business model project	\$7,000 x3	Implement model	\$7,000 x5
<p>3. Training funding models</p> <p>Establish options for sustainable potential training funding models that link training and local employment.</p>	<p>Investigate models to off set training costs with bonding to employment within the district</p> <p>Investigate models to offer training positions within the primary / private sector but where the trainee is employed centrally.</p> <p>Develop business cases. Decision influences next step</p>	\$14,000 x2	Implementation may occur	\$14,000 x3	Maintain	\$14,000 x5

Approximate costs

Costs	0-12 mths	1-2 yrs	2-3 yrs	3-4 yrs	4-5 yrs	5-6 yrs	6-7 yrs	7-8 yrs	8-9 yrs	9-10 yrs
Salary	\$72,000	\$72,000	\$88,000	\$88,000	\$88,000	\$88,000	\$88,000	\$88,000	\$88,000	\$88,000
Other	\$15,000	\$15,000	0	0	0	0				
Total	\$87,000.00	\$87,000.00	\$88,000	\$88,000	\$88,000	\$88,000	\$88,000	\$88,000	\$88,000	\$88,000

Salary costs are based on \$93,000 per annum (\$44.58 per hour) and are based on actual time required to complete the activities per annum. Total costs are as at 2009 and are not inflation adjusted. Costs are rounded to whole thousands.

6. Health careers

The strategic objectives for health careers:

- To increase the attractiveness of health careers for New Zealanders.
- To encourage localised provision of health and disability training and education where practicable and support initiatives to expand opportunities for learning.

Health careers key points

The process of engaging young people in a health career has positive flow on effects on their family / whanau.

There will be increasing competition from a variety of industries to recruit from an increasingly smaller population of young people in the future. The health sector must increase its proficiency at attracting young people to health careers now in order to compete in the future.

Health careers approach

The sector needs to take a 'grow your own' approach to attract young people to a health career because this also has benefits for increasing the knowledge of health within their community of influence. This approach includes:

- transferring DHB's own workforce programme findings on attracting young people to health careers
- using findings of the *Rauringa Raupa* report to increase numbers of Maori youth entering health careers
- working with kohanga reo and kura kaupapa
- increasing Gateway and support Gateway in primary / private sector
- increasing skills simulation – and widen scope to primary / private sector
- taking a whole of sector approach with Nursing Entry to Practice Programme (NETP)
- working with secondary education sector and ensuring careers counsellors have a working knowledge of requirements and rewards of health careers.

The plan supports a generalist approach in nursing, care and support, allied, primary medical, general medical, paediatrics, and surgical particularly for rural areas.

It looks to take a sector wide view and include primary / private sector needs on matters such as discussions with tertiary education providers, provision of training facilities, working with iwi to support their health funding prioritisation, and scholarships and bonding.

Health careers outcome

If the strategic objectives for health careers are met, what are the potential positive outcomes?

- Increased number local youth trying out health for a career.
- Increase number of young people taking up health careers.

Health careers links / flow on

The main linkages with other aspects of the workforce plan and requirements:

- Links with care and support project.
- Links with business and employment models project.
- Links with DHBNZ workforce plan projects.

Representative stakeholder group

Representatives from the following stakeholder groups will be involved with the implementation of this strategic objective:

NZ Institute of Rural Health, DHB Recruitment Service, kura kaupapa representative, tertiary education providers, secondary schools representative, iwi.

Health careers phased action plan and costs

Action	0-24 months		2-5 years		6+ years	
<p>1. Increase participation</p> <p>Get more kids having an experience of health as a career</p> <p>Support organisations working with local secondary schools to introduce some health science in their school curriculum – using ways that engage young people</p>	<p>Identify current activities – Work Choice Day, Rural Institute, PHO, expos, skills simulation, Whakapiki Ake – by location</p> <p>Identify localities not covered (particularly low decile) and use local networks to decide what is the best approach to take to introduce concept of a health career – expand to include careers in primary / private sector</p> <p>Develop / acquire materials</p> <p>Produce, test, market to secondary schools</p> <p>At the same time market to school counsellors the academic requirements for kids for health professional careers and alternative professions</p>	<p>\$11,000 x2</p> <p>\$14,000 x2</p>	<p>Maintain</p> <p>Maintain – enhance post business case if costs are going to increase</p> <p>Develop business case for costs and resources, for decision</p> <p>Maintain</p>	<p>\$14,000 x3</p> <p>\$14,000 x3 Plus \$30k production x3</p>	<p>Maintain</p> <p>Maintain</p>	<p>\$14,000 x5</p> <p>\$14,000 x5 Plus \$30k production x5</p>
<p>2. Gateway</p> <p>Work with schools and other health providers to support them to pick up Gateway – DHB to leverage off its own experiences</p>	<p>Review Gateway schools to see if kids are having a health sector work experience</p> <p>Target schools in areas where this isn't happening</p> <p>Work with local providers to develop concepts for</p>					

Action	0-24 months		2-5 years		6+ years	
	<p>how this could work for them</p> <p>Support them through their first two intakes</p>	\$22,000 x2	Ongoing	\$7,000 x3	Ongoing	\$7,000 x5
<p>3. New Entrant to Practice (NETP) programmes</p> <p>Increase the scope of experiences in all parts of the sector for new grads so that they get the broadest view of work potential possible</p>	<p>Complete business model for current Clinical Training Agency (CTA) funding / training time, to account for reduced productivity from novice to competent and assessment</p> <p>Review the competency assessment process – all sectors (could require establishment of process in some areas which could take time)</p> <p>Identify potential employment model to allow graduates to:</p> <p>be supernumerary for a period of time; and rotate between placements</p> <p>Develop package of options</p> <p>Market with Ministry of Health</p>	\$29,000 x2	<p>Offer to providers as alternative</p> <p>Maintain</p>	\$14,000 x3	Maintain and review costings	\$14,000 x5
<p>4. Generalists</p> <p>Support generalist approach particularly in</p>	<p>Influence DHB consultants with positions</p>		Maintain		Maintain	

Action	0-24 months		2-5 years		6+ years	
rural areas	<p>in colleges to lobby for retention of generalist approaches in some professions</p> <p>Support scholarships for kids undertaking generalist health training and those within chronic disease areas</p>	<p>\$29,000 x2</p> <p>Plus \$15k marketing and events x2</p>	Maintain	<p>\$14,000 x3</p> <p>Plus \$10k marketing and events x3</p>	Maintain	<p>\$14,000 x5</p> <p>Plus \$10k marketing and events x5</p>
5. Training facilities						
Encourage provision of space for trainees to use	<p>Draft paper to DHB's executive regarding principle to include training facilities in all DHB owned facilities</p> <p>Review funding mechanisms for OPEX for other providers and see if can incentivise having training space set aside</p>	<p>\$3,000 x2</p>	Maintain		Maintain	
6. Tertiary education providers						
Work with tertiary training providers to ensure they produce graduates that are fit for purpose in about the right numbers	<p>Complete health section on regional facilitation plan</p> <p>Identify tertiary partners: Universities of Waikato & Auckland, Wintec, AUT, PHO, aged care, private, dental, allied, care and support workforce primary training enterprise</p> <p>Host meetings as required with partners re: intake numbers, curriculum, trainee posts required, internships, emerging</p>	<p>\$2,000 x2</p>	Maintain	<p>\$4,000 x3</p>	Maintain	<p>\$4,000 x5</p>

Action	0-24 months		2-5 years		6+ years	
	professions					
7. Iwi re health careers funding Work together with Iwi to make sure that workforce projects support aspirations of Maori and to influence scholarship decisions favourably towards health careers	Identify partners: Iwi, DHB Te Puna Oranga, and DHB workforce Host meetings re: workforce plan implementation in general, workforce data, tertiary education providers meeting, care and support workforce kaumatua group	\$4,000 x2	Maintain	\$4,000 x3	Maintain	\$4,000 x5

Approximate costs

Costs	0-12 mths	1-2 yrs	2-3 yrs	3-4 yrs	4-5 yrs	5-6 yrs	6-7 yrs	7-8 yrs	8-9 yrs	9-10 yrs
Salary	\$114,000	\$114,000	\$71,000	\$71,000	\$71,000	\$71,000	\$71,000	\$71,000	\$71,000	\$71,000
Other	\$15,000	\$15,000	\$40,000	\$40,000	\$40,000	\$40,000	\$40,000	\$40,000	\$40,000	\$40,000
Total	\$15,114,000	\$15,114,000	\$111,000.00	\$111,000.00	\$111,000.00	\$111,000.00	\$111,000.00	\$111,000.00	\$111,000.00	\$111,000.00

Salary costs are based on \$93,000 per annum (\$44.58 per hour) and are based on actual time required to complete the activities per annum. Total costs are as at 2009 and are not inflation adjusted. Costs are rounded to whole thousands.

Assumptions

The assumptions that underpin implementation are listed below.

- Overall management of the plan is the responsibility of the chief executive of Waikato DHB and is delegated to the Human Resources general manager at Waikato DHB. While a variety of stakeholder groups will be involved in various aspects of the plan, they do not have the responsibility for implementation of the overall plan.
- Implementation will occur over the next 10 years to give time for changes within the sector to occur, although most of the scoping work will be completed concurrently within 24 months. This is so that the potential efficacy of programme approaches and any unforeseen costs can be reconsidered before full implementation begins.
- The timeframes assume adequate resourcing initially and throughout the project. If this isn't the case timeframes will be adjusted to fit the resource available.
- The project will not duplicate activities in the DHBNZ workforce plan.
- The timing of implementation of the DHBNZ workforce plan objectives for the care and support workforce will impact on the Waikato DHB's sector plan relating to this workforce. There are no other critical dependencies from a timing perspective but the Waikato DHB's sector workforce development plan relies on activities in the DHBNZ workforce plan happening.
- The approach to implementation will be to review literature to see what others have done, identify key stakeholders to work alongside, implement and evaluate pilots (where appropriate), cost up implementation and refer to the project sponsor for decision before proceeding to implement. This approach is to limit likelihood of cost creep and continuing with initiatives that are not likely to succeed.
- Communication about implementation will occur on the DHB's website so that interested parties can be kept updated and involved.
- There will need to be considerable involvement by other providers to implement aspects of the plan that affect them. Stakeholders need to be included in the development of the implementation products and models to increase the likelihood that outputs will be useful and accepted.
- The costs of implementation of some aspects of the plan could be shared across providers where they stand to benefit directly.
- The stakeholder groups will be used to test ideas before implementation begins. Implementation will focus on delivering a series of products that can be adopted and implemented by providers; these products will include objectives, methodologies, inputs, and outputs of pilots and models. There will be other parts of the plan where the DHB will lead implementation within the sector.
- It is envisaged that acceptance of some approaches and products will take a long time because of the current business, workforce, and funding model.
- The DHB will build capacity in existing workforces and will not take the lead to develop new ones. The latter will be done via the DHBNZ workforce plan.
- The DHB will not necessarily employ the people implementing some of these programmes where implementation is more appropriately done from within other organisations, but it will retain oversight.
- Every line in the phased implementation plan and costs has been priced and included in the overall cost for each piece of work. Some pieces of work are not priced because it is assumed that they will be completed in unavoidable down time across implementation of the whole plan.

Total costs

The total costs for the phased implementation plan are in the tables below. The total cost of the project per annum is approximately \$420,000.

Term	Care and support			DHB corporate citizen		
	Salary	Other	Total	Salary	Other	Total
0-12 mths	\$106,000.00	0	\$106,000.00	\$72,000.00	\$15,000	\$87,000.00
1-2 yrs	\$106,000.00	0	\$106,000.00	\$72,000.00	\$15,000	\$87,000.00
2-3 yrs	\$242,000.00	0	\$242,000.00	\$57,000.00	\$50,000	\$107,000.00
3-4 yrs	\$157,000.00	0	\$157,000.00	\$43,000.00	\$30,000	\$73,000.00
4-5 yrs	\$157,000.00	0	\$157,000.00	\$43,000.00	\$30,000	\$73,000.00
5-6 yrs	\$86,000.00	0	\$86,000.00	\$38,000.00	\$30,000	\$68,000.00
6-7 yrs	\$86,000.00	0	\$86,000.00	\$38,000.00	\$30,000	\$68,000.00
7-8 yrs	\$86,000.00	0	\$86,000.00	\$38,000.00	\$30,000	\$68,000.00
8-9 yrs	\$86,000.00	0	\$86,000.00	\$38,000.00	\$30,000	\$68,000.00
9-10 yrs	\$86,000.00	0	\$86,000.00	\$38,000.00	\$20,000	\$58,000.00
Total	\$1,198,000.00	\$0.00	\$1,198,000.00	\$477,000.00	\$280,000.00	\$757,000.00

Term	Business and employment models			Health careers		
	Salary	Other	Total	Salary	Other	Total
0-12 mths	\$72,000.00	\$15,000.00	\$87,000.00	\$114,000.00	\$15,000.00	\$129,000.00
1-2 yrs	\$72,000.00	\$15,000.00	\$87,000.00	\$114,000.00	\$15,000.00	\$129,000.00
2-3 yrs	\$88,000.00	0	\$88,000.00	\$71,000.00	\$40,000.00	\$111,000.00
3-4 yrs	\$88,000.00	0	\$88,000.00	\$71,000.00	\$40,000.00	\$111,000.00
4-5 yrs	\$88,000.00	0	\$88,000.00	\$71,000.00	\$40,000.00	\$111,000.00
5-6 yrs	\$88,000.00	0	\$88,000.00	\$71,000.00	\$40,000.00	\$111,000.00
6-7 yrs	\$88,000.00	0	\$88,000.00	\$71,000.00	\$40,000.00	\$111,000.00
7-8 yrs	\$88,000.00	0	\$88,000.00	\$71,000.00	\$40,000.00	\$111,000.00
8-9 yrs	\$88,000.00	0	\$88,000.00	\$71,000.00	\$40,000.00	\$111,000.00
9-10 yrs	\$88,000.00	0	\$88,000.00	\$71,000.00	\$40,000.00	\$111,000.00
Total	\$848,000.00	\$30,000.00	\$878,000.00	\$796,000.00	\$350,000.00	\$1,146,000.00

Term	Maori health workforce			Total Per annum		
	Salary	Other	Total	Salary	Other	Total
0-12 mths	\$18,000.00	0	\$18,000.00	\$382,000.00	\$45,000.00	\$427,000.00
1-2 yrs	\$18,000.00	0	\$18,000.00	\$382,000.00	\$45,000.00	\$427,000.00
2-3 yrs	\$2,000.00	\$20,000	\$22,000.00	\$460,000.00	\$110,000.00	\$570,000.00
3-4 yrs	\$2,000.00	\$20,000	\$22,000.00	\$361,000.00	\$90,000.00	\$451,000.00
4-5 yrs	\$2,000.00	\$20,000	\$22,000.00	\$361,000.00	\$90,000.00	\$451,000.00
5-6 yrs	\$2,000.00	\$20,000	\$22,000.00	\$285,000.00	\$90,000.00	\$375,000.00
6-7 yrs	\$2,000.00	\$20,000	\$22,000.00	\$285,000.00	\$90,000.00	\$375,000.00
7-8 yrs	\$2,000.00	\$20,000	\$22,000.00	\$285,000.00	\$90,000.00	\$375,000.00
8-9 yrs	\$2,000.00	\$20,000	\$22,000.00	\$285,000.00	\$90,000.00	\$375,000.00
9-10 yrs	\$2,000.00	\$20,000	\$22,000.00	\$285,000.00	\$80,000.00	\$365,000.00
Total	\$52,000.00	\$160,000.00	\$212,000.00	\$3,371,000.00	\$820,000.00	\$4,191,000.00

Workforce planning process

The planning process is designed to establish the DHBs workforce plan priorities for the next two to 10 years. There are two parts:

1. Up to two years for the workforce employed within the DHB.
2. Up to ten years for the workforce across the sector.

Separating the internal DHB planning process from the sector wide planning process enables appropriate focus on each part. It also allows the DHB to start implementing its shorter term internal workforce development plan without delay.

The Waikato DHB has completed and is implementing a workforce development plan for its own workforce.

1. Waikato DHB workforce development plan 2008/2010

The planning process within the DHB has been completed and approved for with implementation.

Implementation of these programmes has already begun. The methodology and results of implementation will be available to other health providers in the Waikato.

The methods and outcomes of a variety of activities will be transferable to other health providers.

A brief summary of the information that was reviewed by the stakeholder group together with a summary of workforce projects is below.

The full document *Waikato DHB workforce development plan: a plan for community and hospital services provided by the Waikato DHB 2008/2010* is available on the waikatodhb.govt.nz website in the About Us/Workforce Development area.

Summary of Waikato DHB workforce data

The Waikato DHB workforce data is summarised below.

- Turnover stable at 15% per annum for last eight years (699 staff in 2008).
- Transfers within the DHB average 7.5% per annum.
- Administrative and elementary roles take the least time to fill. Allied health, nursing, midwifery, technical and medical positions take longer to fill.
- Workforce numbers are steadily increasing.
- Increasing proportion of workforce is over 46 years (70% of workforce in some areas).
- Waikato DHB has a 60 year age span across all generations.
- Ethnic mix is becoming more diverse.
- Length of service is increasing.
- Older staff have less turnover than younger staff.
- Turnover varies across ethnicities.

Summary of strategic workforce projects

Below is a list of projects.

Retention

- Implement a series of activities to improve retention of the DHB's workforce.
- Leadership and management development and practise.
- Healthy workplaces.
- Professional and personal development.
- Collaboration and working in teams.

Recruitment

- Streamline internal recruitment processes.
- Forecast internal workforce needed in high volume / high impact roles over time and implement strategies to reduce delay from exit to fill.
- Implement strategies to contribute to the supply of the overall health workforce.
- Implement attraction strategies for high volume / high impact roles and across generations.

Ageing workforce

- Implement range of strategies for an ageing workforce.

Working more effectively

- Ensure the workforce is structured and resourced for optimum productivity (includes model of care).

- Reduce non-core work in high impact roles
- Structure work efficiently for high impact roles
- Reduce work process variation

Planning integration

- Service and workforce planning will be integrated to become business as usual

Source:

Waikato District Health Board. 2009. *Waikato DHB workforce development plan: A plan for community and hospital services provided by the Waikato District Health Board, 2008/2010*. Hamilton: Waikato DHB.

2. Waikato DHB sector workforce development plan 2009/2019

The DHB's board and chief executive commissioned a stakeholder group to develop recommendations for the primary health and disability workforce for the next five to ten years, for them to consider.

The stakeholder group (see Appendix D for membership) reviewed drivers of health resource consumption, priorities, other plans, and available information about the primary sector health workforce. There is no regular comprehensive information source about the primary health workforce so information came from other reports, census data, the expert reference panel, the phone directory, and the results of the DHB's provider survey that was carried out in November / December 2008. Information that was provided to the stakeholder group is abridged in Appendix A.

There are already a number of national workforce plans which cover distinct areas of the health workforce. For example public health, mental health, Maori health, health screening, and many more. The combined district health boards of New Zealand (DHBNZ) in consultation with the Ministry of Health have released the review of the DHBNZ's current workforce plan which includes 10 action priorities for the next six years. This plan is titled: *Our health workforce today and the future*, April 2009.

It is not the intention to replicate the work that is happening nationally but there are issues that require initiatives and different ways of working to be driven locally.

The Waikato DHB sector workforce plan will align with national plans but focus on the local needs and initiatives.

The Waikato District Health Board District Strategic Plan 2006-2015, which was due for review in October 2008, was approved by the board for another two years to enable a regional plan to be developed. The current strategic health priorities are supported by this workforce plan. The Waikato District Health Board District Annual Plan 2009/2010 has been submitted to government and includes provision for workforce planning and implementing outcomes.

The stakeholder group reviewed an early draft of this plan. Feedback regarding the general direction was generally favourable. However feedback from the stakeholder representative for the disability sector indicated that the plan did not address needs of the disability sector and that the plan reflected the DHB's core focus on health and other DHB funded services.

The stakeholder group reviewed information and responded by determining the strategic priorities for recommendation to the chief executive. The key points are summarised below.

1. Care and support workforce

Care and support workforce information

Information considered by the stakeholder group:

- The population is ageing across the Waikato DHB.
- Older people have increased incidence of chronic disease.
- Maori make up 22 percent of Waikato DHB population.
- Maori have higher incidence of chronic disease.
- People can have more than one chronic disease yet the secondary and tertiary workforce increasingly sub-specialised.
- Sixty percent of Waikato DHB's population live outside Hamilton city.
- Life expectancy of Maori is resulting in increased Maori frail elderly population which will require appropriate models of care and workforce.
- Higher proportion of Waikato DHB population are classed as 9-10 deprivation compared with total New Zealand population.

- Some territorial local authorities (TLAs) are forecasted to have reducing populations overall but increasing numbers and proportion of 65 plus age group.
- Aged care residential accommodation is located in each TLA with more beds per 1000 aged 65 plus in Hamilton.
- The aged care sector reports difficulty attracting and retaining staff, and the need to re-brand itself as dynamic with exciting career opportunities.
- Providers have reported problems getting enough skilled registered staff particularly in rural settings, along with increasing labour costs.
- The potential labour market for health workers is limited by the need to have strong competencies in maths and science; those without these competencies currently have limited options for health careers.
- Strategy to increase care and support workforce is in the DHBNZ national workforce plan and is a recommendation in the draft disability sector workforce plan.
- The density of Healthright and Whanau Ora workforce across the Waikato DHB district is uneven and patchy. Refer to the density map definitions in Appendix C for definitions of these roles.
- Expert reference panel member feedback is that there is no 'system' as such but that there are local networks and relationships that support access to treatment and care.

What did the stakeholder group say?

The stakeholder group key priorities:

- Need to introduce a career pathway for the care and support workforce to make it a more attractive occupation.
- Need to determine who does what across disciplines to enable changes to the clinical and non clinical workforce mix. Health professionals need to do work that only they can do, and devolve work to others which they may or may not need to supervise.
- Service delivery models need to be cognisant of the workforce and the impact of changing demographics and deprivation across the district.
- Needs to be more integration across the sector of both information and workforce.
- Need to increase workforce options in the home based care and support sector to strengthen the workforce so it can deal with increasing demand.
- Need to realign workforce to be more resident centred and less task based in residential aged care sector.
- Increased scope for decision making to be vested in the care and support workforce (within parameters).
- In the future residential aged care sector, the care and support workforce will have less direction but more clinical oversight from other health professionals.

2. DHB corporate citizen

DHB corporate citizen information

Information considered by the stakeholder group:

- The survey completed by providers indicates that Waikato DHB could contribute by giving access to its own HR and legal/corporate services, increasing the number of skilled people in the labour market, supporting a business mentoring programme, and assisting with immigration.
- Waikato DHB is a large health employer with scalable systems and experience in recruiting staff from NZ and overseas.
- Waikato DHB is taking a whole of sector approach to workforce planning.
- Waikato DHB employs a number of key professions that transfer to employers across the sector.
- DHB employees in some professions earn more than their counterparts in the primary sector which causes labour market competition within the sector.
- Waikato DHB arranges and provides training and education which is generally scalable.
- Waikato DHB's library service is available for all health and disability employees to use to further their knowledge.
- Waikato DHB is implementing an internal workforce plan, and the processes and outcomes of it may be applicable and transferable to other providers.
- Provider survey indicates that 60 percent of recruitment is word of mouth. Most positions are filled within three months, but skilled and registered health professional positions take more than three months to fill.
- Providers would like the DHB to host regular forums where providers set the agenda. There is a need to rebrand the sector to realign old negative perceptions with new models and reality. (From the Health of Older People Workforce Incentives Project)

- Waikato DHB has ongoing relationships with tertiary education providers to meet local service needs.

What did the stakeholder group say?

The stakeholder group key priorities:

- Need to support the existing workforce, including development, so that they are retained in the profession.
- Need to integrate recruitment activity to reduce overall costs and increase potential candidates for jobs across the DHB and sector
- Need to put in place health and safety / practice supports for workforces to meet the demands of ageing workforce and population.

3. Maori health workforce

Maori health workforce information

Information considered by the stakeholder group:

- There is concordance between the ethnicity of the provider and patient / client which positively affects their outcomes.
- Maori have disproportionately higher incidence of chronic disease.
- Maori are hospitalised more frequently (1.4-2.5x).
- Hospitalisations of Maori are expected to increase while hospitalisations of others are expected to decrease.

What did the stakeholder group say?

The stakeholder group key priorities for the Maori workforce:

- Need to educate staff on different cultural values and how to be observant about possible ethnic and religious needs of other staff. (People tend to be on autopilot when they deal with people who are not of their race so often the ethnic or religious needs are unknown and therefore not observed.)

4. Pacific health workforce

Pacific health workforce approach

The Pacific health workforce plan is being developed and will be completed early in 2010. Activities required to implement the plan may be incorporated into the DHB's sector workforce development plan or implementation will be confluent.

5. Business and employment models

Business and employment models information

Information considered by the stakeholder group:

- Contractors are used in most sectors and are individually contracted by each provider.
- Age of GPs and practice nurses is increasing.
- Within 20 years 66 percent of GPs and 60 percent of practice nurses will be aged 65 years or more and many will already have retired.
- Most owner / managers in the primary / private sector have been in the health industry for more than six years.
- Most are required to be on call.
- Different age generations have different characteristics and want different things out of employment.
- Business and subsequently employment models in the primary / private health sector tend towards owner operated, with few alternatives.
- Population is ageing, and in some TLAs is forecasted to reduce in the next 10 -15 years.
- The survey completed by Waikato providers indicated that the DHB could facilitate a district-wide bonding programme, a DHB / primary job share scheme, realignment of funding models, and reduction in compliance costs.
- The Minister of Health expects devolution of some secondary care components to the primary sector.

What did the stakeholder group say?

The stakeholder group key priorities:

- Need a new employment / functional model that will increase the flexibility of the workforce to work across various providers depending on demand.
- Need to increase the affordability of nurses.
- Need to increase generalist teams.
- Systems need to better use health professionals to do the work that only they can do and devolve the rest – with or without supervision.
- Need to stabilise the workforce and take action to manage turnover in some areas.
- Need to introduce sustainable employment models to increase flexibility and make better use of scarce resources across the sector.
- Need to introduce sustainable commercial models that provide options for health professionals to manage / lead within the sector without having to own and operate a business.
- Need to use technology to increase the flow of information.
- Need to review funding assumptions that drive funding formulas.
- Need a business model that preserves the integrity of individual providers.
- Need to have agreed relationships and referral patterns to enable service and resource planning to occur.
- Need to increase wages and improve conditions to attract and retain workforce.
- Need to increase the ability for people to earn an income whilst training, and for employers to get benefits from staff during their training period. Need to review the current scope of practice requirements for this to occur.
- Need to increase the scope of what is taught and assessed on the job to reduce down time.

6. Health careers

Health careers information

Information considered by the stakeholder group:

- A career in health offers a strong degree of security due to the future increasing demand for health workers.
- The number of 0-14 year olds across the DHB and within some TLAs in particular is declining so there will be fewer candidates for all careers which will lead to increased competition in the labour market.
- Young people from rural areas are more likely to return and practice rurally compared with young people from urban areas.
- There is concordance between the ethnicity of the provider and patient / client which positively affects health outcomes.
- The survey completed by Waikato providers indicated that the DHB could facilitate primary sector scholarships and a graduate programme that took a whole-of-sector approach rather than placing graduates with one provider in the sector.
- Maori make up a higher proportion of the population in the Waikato compared with NZ in total and have higher numbers of children.

What did the stakeholder group say?

The stakeholder group key priorities:

- Scopes of practice need to facilitate the expansion of the generalist workforce.
- Need to take a 'guerrilla marketing' approach to make it a more appealing career for younger people.
- Need to stabilise workforce and take action to manage workforce turnover.
- Need to put in place supports for workforces to meet the demands of ageing workforce and population.
- Need to increase influence over registration and training requirements for professions so that staff don't price themselves out of the market.
- Need to reduce the propensity to over-specialise and over-regulate the workforce without employer input because the employer designs the workforce needs and not the other way round.
- Need to increase the ability for people to earn an income whilst training and for employers to get benefits from staff during their training period. Need to review the current scope of practice requirements for this to occur.
- Need to increase the scope of what is taught and assessed on the job to reduce down time.

Appendix A: Stakeholder planning information

Community demographics

The total Waikato DHB population is forecasted to increase by 16% over 20 years.

The highest increase will be in the Asian, Pacific Island, and Maori populations.

Some TLAs will experience negative population growth in some or all ethnic groups (Waitomo, Ruapehu, South Waikato, Otorohanga, & Hauraki).

The percentage of Maori in Waikato DHB in 2006 is higher than in total NZ (21% / 15%).

The percentage of Pacific Islanders in the Waikato DHB is lower than in total NZ (2% / 6%).

The proportion of people aged 65+ is increasing over 20 years (12%-17%).

The proportion of population aged 65+ varies across TLAs.

Waikato DHB

Table 1: Population ethnicity projections and percentage growth from 2001-2021 (Waikato DHB)

Population ethnicity projections and percentage growth from 2001 - 2021 (Waikato DHB)					
Year	European / other	Maori	Pacific	Asian	total
1996	273200	70900	6800	6200	357100
2001	270200	72900	7600	9000	359700
2006	283600	76100	8700	14700	383100
2011	291000	82000	10100	18400	401500
2016	294600	88100	11600	22400	416700
2021	296200	93300	13300	26400	429200
Percentage growth from 2001 - 2021	9%	22%	43%	66%	16%

Source: Statistics New Zealand. 2009. www.stats.govt.nz (accessed in March 2009)

Table 2: Percentage population by ethnicity (Waikato DHB)

Percentage population by ethnicity (Waikato DHB)				
Year	European / other	Maori	Pacific	Asian
1996	77%	20%	2%	2%
2001	75%	20%	2%	3%
2006	74%	20%	2%	4%
2011	72%	20%	3%	5%
2016	71%	21%	3%	5%
2021	69%	22%	3%	6%

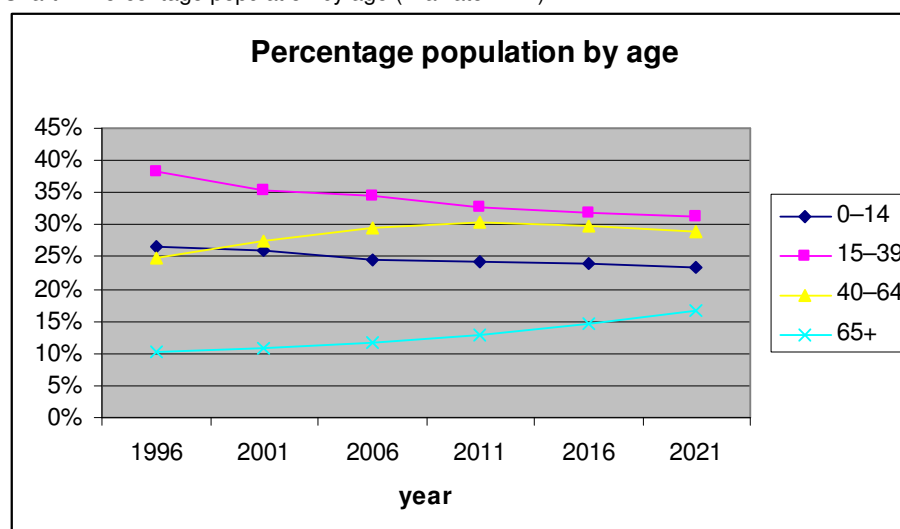
Table 3: Population age range projections and percentage growth from 2001 – 2021 (Waikato DHB)

Population age range projection & percentage growth from 2001 - 2021 (Waikato DHB)					
Year	0–14	15–39	40–64	65+	All ages
1996	95200	137100	88800	36100	357100
2001	94000	127500	99300	38700	359700
2006	93600	132000	112900	44800	383100
2011	97000	131700	121500	51400	401500
2016	99400	132600	123900	61200	416700
2021	100400	134200	123900	70900	429200
Percentage growth from 2001 - 2021	6%	5%	20%	45%	16%

Table 4: Percentage population (Waikato DHB)

Percentage population (Waikato DHB)				
Year	0–14	15–39	40–64	65+
1996	27%	38%	25%	10%
2001	26%	35%	28%	11%
2006	24%	34%	29%	12%
2011	24%	33%	30%	13%
2016	24%	32%	30%	15%
2021	23%	31%	29%	17%

Chart 1: Percentage population by age (Waikato DHB)



Compared with the total NZ Waikato DHB has a higher proportion of people with higher deprivation.

The TLAs with the highest proportion of people with most deprivation are Ruapehu, South Waikato, and Waitomo districts.

There are some clusters of people with high deprivation in more affluent TLAs.

Deprivation

This information was created from data from the 2006 Census of Population and Dwellings. The index describes the deprivation experienced by groups of people in small areas. Ten deprivation variables were used in the construction of the index are outlined in the table below.

Table 5: Deprivation variables

Dimension of deprivation	Variable description (in order of decreasing weight)
Income	People aged 18-64 receiving means tested benefit
Income	People living in households with income below an income threshold
Owned home	People not living in own home
Support	People aged less than 65 living in a single parent family
Employment	People aged 18-64 unemployed
Qualifications	People aged 18-64 without any qualifications
Living space	People living in households below a bedroom occupancy threshold
Communication	People with no access to a telephone
Transport	People with no access to a car

Source: Waikato DHB. 2008. *Waikato DHB Health Needs Assessment 2008*. Hamilton: Waikato DHB.

Table 6: Deprivation range by TLA (Waikato DHB)

Deprivation range by TLA	Deprivation range				
	1-2	3-4	5-6	7-8	9-10
Hamilton City	23,496	18,687	23,727	29,550	33,795
Hauraki District	207	2,469	4,239	4,824	5,457
Matamata-Piako District	3,237	9,459	6,759	7,368	3,675
Otorohanga District	705	1,830	2,589	2,229	1,713
Ruapehu District	168	1,188	1,056	2,604	3,666
South Waikato District	804	3,972	2,958	4,428	10,473
Thames-Coromandel District	528	3,894	9,306	8,052	4,164
Waikato District	10,407	9,198	7,275	5,226	11,868
Waipa District	11,334	11,781	8,847	7,395	3,156
Waitomo District	0	1,167	2,766	1,713	3,792
Total	50,886	63,645	69,522	73,389	81,759

Graph 2: Percentage population deprivation within each local authority

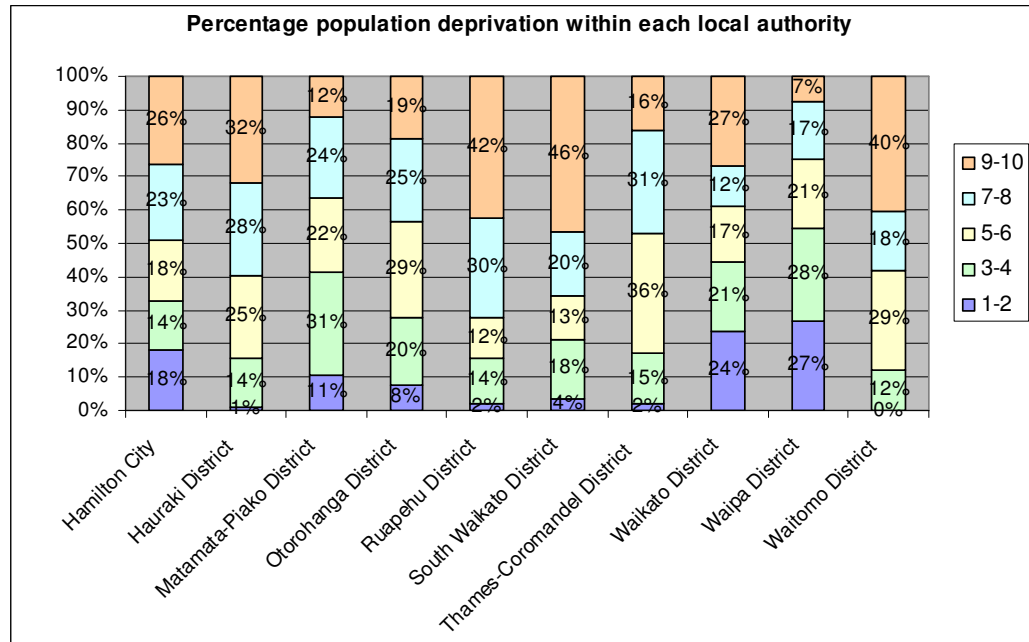
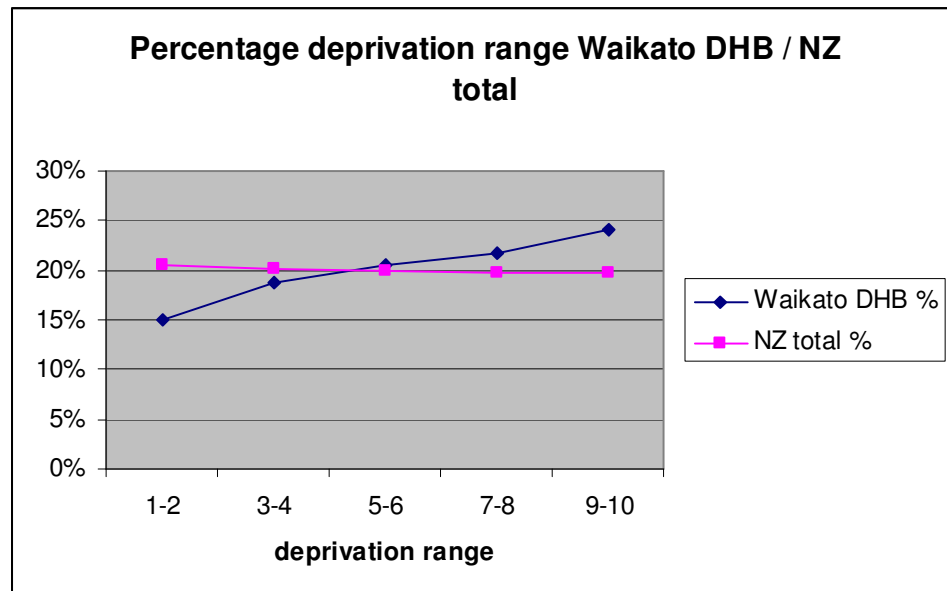


Table 7: Number and percentage deprivation range Waikato DHB / NZ total comparison

Deprivation range	Waikato DHB	NZ total	Waikato DHB %	NZ total %
1-2	50,886	825,516	15%	20%
3-4	63,645	811,002	19%	20%
5-6	69,522	801,993	20%	20%
7-8	73,389	791,499	22%	20%
9-10	81,759	798,135	24%	20%
total	339,201	4,028,145		

Graph 3: Percentage deprivation range Waikato DHB / NZ total



The minister has indicated priorities for health provision which will have impacts on workforce.

Ministerial priorities 2009 / 2010

The priorities from the minister of health are listed below.

- Shift secondary services to primary care settings via Primary Health Organisations
 - Medical and surgical specialist assessments
 - Medical and surgical specialist assessments
 - Primary care direct referral to diagnostic imaging
 - Primary care direct referral to procedure lists
 - Minor surgery
- Establishing multi disciplinary Integrated Family Health Centres
- Improve services and reduce waiting times:
 - Increase elective volumes
 - Improve emergency department waiting times
 - Improve cancer treatment waiting times
 - Reduce in patient bed days
 - Improve management of acute demand
 - transfer resources from back office into frontline services
- Improve workforce retention
 - Improve clinical staff retention
 - Foster clinical leadership
- Remain within budget
- Increase regional co-operation

Source: Office of Hon Tony Ryall, 19 February 2009
Ministry of Health, 9 March 2009

The Waikato DHB chief executive's priorities have been outlined which will impact on workforce.

Waikato DHB priorities

The priorities from the DHBs chief executive are listed below:

- Addressing chronic conditions (prevention, detection, self management, disease management, case management)
- Quality improvement within Health Waikato (DNA, satisfaction, Staph rates, acute readmissions, theatre productivity)
- Increasing elective services
- Implementing DHB internal workforce strategic priorities (ageing, working more effectively, attraction and recruitment, retention, integrated planning)
- Planning to strengthen rural services
- Waikato Hospital building programme
- Increase regional collaboration – corporate
- Operate within budget

Source:

Waikato District Health Board. 2009. *Waikato DHB District Annual Plan; 2009/2010*. Hamilton: Waikato DHB.

Ethnicity, deprivation, access, and age impact on the health of individuals.

Health indicators

Concordance of practitioner and patient ethnicity improves patient outcomes.

Chronic disease

Studies indicate that health is affected by the following economic and social determinants of health:
-Knowledge and skills
-Cultural identity
-Leisure and recreation
-Physical environment
-Paid work
-Economic standard of

- World Health Organisation estimates in 2005 globally 60% all deaths are attributable to chronic disease and that this will rise by 17% by 2015.
- Centre for Disease Control attributes 75% of all health care costs in US to chronic disease
- Ministry of Health NZ in 1999 attributes 80% of deaths to chronic disease
- Ratio of mortality rates in low income groups higher than in high income groups
- Diabetes incidence in New Zealand 2001 person with diabetes hospital costs are 2.5x greater than someone without it
- Ministry of Health NZ 2006 links cardiovascular disease, chronic lung disease and cancer to socioeconomic status
- Centre for Disease Control 2000 links incidence of diabetes in women to educational attainment and low income (2x mods likely)
- Maori with cardiovascular disease die 3x rate of non Maori with the disease
- Diabetes 3x more common in Maori adults and they suffer more complications such as renal failure and amputations
- Maori are hospitalised more frequently (1.4-2.5x)
- Pacific people have approximately 50% excess risk of avoidable mortality
- By 2011 the prevalence of diabetes for Pacific people is projected to increase by 146% compared with 58% for European New Zealanders

living
-Civil and political
rights
-Safety
-Social connectedness
-Access to health care

- Chronic disease affects Asians differently than other groups
- Centre for Disease Control paper indicates that reducing obesity and increasing exercise can reduce impact of chronic disease and reduce likelihood of introducing co-morbidities

Ministry of Social
Development. 2008.
*The Social Report
2008*. Wellington:
Ministry of Social
Development.

Source:

World Health Organisation. 2002. *The World Health Report 2002; Reducing Risks, Promoting Healthy Life*. Geneva: World Health Organisation.

Centre for Disease Control and Health Promotion. 2009. *The Power of Prevention: Chronic disease...the public health challenge of the 21st century*. USA: Department of Health and Human Services.

Ministry of Health. 1999. *Our Health Our Future: Hauora Pakari, Koiora Roa – the Health of New Zealanders 1999*. Wellington: Ministry of Health.

National Health Committee. 2007. *Meeting the needs of people with chronic conditions: Hapai te whanau mo ake ake tonu*. Wellington: National Advisory Committee on Health and Disability.

Public Health Advisory Committee. 2004. *The Health of Peoples and Communities. A way forward: public policy and economic determinants of health*. Wellington. Public Health Advisory Committee.

Social determinants

From World Health Organisation

- Life expectancy reduces depending on work type (UK professional women 83 yrs, UK unskilled women 77yrs)
- Retarded growth in infancy associated with increased cardiovascular, respiratory, pancreatic and kidney development and function
- Low birth weight associated with increased prevalence of diabetes in men
- Peer group and higher education associated with increased incidence of healthier habits
- Poverty correlates with increased incidence of cardiovascular disease
- Degree of control over work affects incidence of coronary disease (less control = more disease)
- Social integration has a positive affect on wellbeing
- Most economically deprived have highest incidence of dependency on alcohol, nicotine and drugs
- Economic circumstances impacts on access to good quality food

Source:

World Health Organisation. 2002. *The World Health Report 2002; Reducing Risks, Promoting Healthy Life*. Geneva: World Health Organisation.

World Health Organisation. 2008. *Closing the gap in a generation: health equity through action on the social determinants of health*. Geneva: World Health Organisation.

From Public Health Advisory Committee & National Health Committee

- Unemployment and low education relate to poor health outcomes
- Deprivation levels of the small geographical areas in which people live is a predictor of variation in health status
- Higher income groups have lowest death rates
- Estimated that one in three children in NZ live in poverty
- People from the unskilled occupational group have increased incidence of mental health problems, oral health problems, accidental death, poisonings and violence, and chronic disease.
- Childhood social and economic gradient effects health in adulthood
- Literacy level is strong indicator of education attainment. Low education and literacy levels are linked with poverty, malnutrition, ill health and high infant mortality plus smoking, alcohol abuse, lack of exercise and unhealthy eating.

Source:

National Health Committee. 2007. *Meeting the needs of people with chronic conditions: Hapai te whanau mo ake ake tonu*. Wellington: National Advisory Committee on Health and Disability.

Public Health Advisory Committee. 2004. *The Health of Peoples and Communities. A way forward: public policy and economic determinants of health*. Wellington. Public Health Advisory Committee.

From Rauringa Raupa, Taupua Waiora Centre

- International evidence that ethnic concordance between health professionals and their patients leads to improved health outcomes for patients.
- Practitioners from ethnic minorities are 5x more likely to provide health care to poor and under served patients, and to practice in under served areas.(pg 16, 17)

Source:

Ratima, M., Brown, R., Garrett, N., Wikaire, E., Ngawati, R., Aspin, C., Potaka, U. 2007. *Rauringa Raupa; Recruitment and retention of Maori in the health and disability workforce*. Auckland: AUT University.

Ageing population

- Between 2001-2021 proportion of population aged 65 + will change from 11.9% to 17.6%.
- By 2051 65+ will be 25.4% population
- 65+ has 3-5x costs of younger population
- 54% over 65+ had a disability
- Maori have a reduced life expectancy than non Maori
- Hospitalisations of older Maori and Pacific peoples are higher than others and expected to increase while others are expected to decrease
- Requirement for labour will increase as population ages – demand will increase between 2.5 – 4.3 times the rate of increase of the population as a whole

Source:

NZIER. 2004. *Ageing New Zealand and Health and Disability Services; demand projections and workforce implications, 2001-2021 – discussion document*. Wellington: Ministry of Health.

National Health Committee. 2007. *Meeting the needs of people with chronic conditions: Hapai te whanau mo ake ake tonu*. Wellington: National Advisory Committee on Health and Disability.

Health outcomes are improved if there is a concordance between the health professional and the patients' ethnicity.

Maori have higher incidence of chronic disease, and increased incidence of complications arising from chronic disease, and shorter life expectancy.

The Ministry of Health commissioned Taupua Waiora within AUT University in January 2007 to provide a Maori health workforce plan.

Te Puna Oranga (Waikato DHBs Maori health unit) has developed a workforce plan based on strategies in Rauringa Raupa.

Maori health workforce development

Key recommendations from Rauringa Raupa, Recruitment and Retention of Maori in the health and disability workforce (duplication removed). Implementation is across tertiary education commission, ministries (various), DHBs, and education providers.

Leadership and collaboration

- Establishment of body to provide national leadership for Maori workforce development
- Ministers of health, education, and tertiary education require ministries to collaborate to align policies
- Work with education providers to strengthen students preparedness for a health career
- Promote relevance of science and health careers
- Provide support for Maori health professional bodies

Monitoring and research

- Report and monitor workforce participation, schools
- Prioritise research into Maori health needs
- Facilitate organisations that support Maori

Policy

- Implement policy to more comprehensively address issues regarding implementation of Maori health workforce development
- Engage Maori within workforce development strategic planning

Funding

- Engage Maori within Maori workforce development funding decisions
- Map funding decisions with tool to assess if will improve equity
- Provide funding
- Revise curriculum for responsiveness and relevance of health programmes for Maori

Technical and cultural competence

- Recognise that Maori health workers have dual technical and cultural competence
- Support and resource technical and competency training for Maori health professionals
- Develop guidelines and competency standards that will address Maori priorities for workforce development
- Provide cultural supervision
- Incorporate dual competency learning outcomes into tertiary education
- Recruit Maori teaching and research staff
- Describe explicit cultural competencies that are required

Recruitment and retention

- Apply successful models for Maori recruitment and retention
- Collaborate with education sector to initiate project to improve Maori engagement in science and access to accurate and targeted quality health career information
- Increase use of Maori health profession role models
- Promote scholarship programmes

- Clarify / develop Maori health professional pathways
- Pilot workforce development interventions with Maori
- Introduce healthy work environments
- Market health careers for primary, secondary and tertiary students that includes practical experiences
- Introduce preceptorship programmes for Maori in the workforce
- Review criteria to enable more Maori students to participate in health training
- Develop outreach programmes in schools with high Maori roles and promote health careers
- Increase access for Maori to bridging programmes and foundation courses
- Strengthen learning support for Maori within the health workforce
- Introduce positive role models
- Advocate for Maori training leadership positions

Source:

Ratima, M., Brown, R., Garrett, N., Wikaire, E., Ngawati, R., Aspin, C., Potaka, U. 2007. *Rauringa Raupa; Recruitment and retention of Maori in the health and disability workforce*. Auckland: AUT University.

Density

Information about where private primary providers are located is presented because it shows the location of the components of the system. It does not include any DHB provider services.

A copy of the map which shows the location of providers and lists their roles is at the back of this document.

The distribution of providers across the Waikato DHB district in relation to the population as at 2011 is variable depending on the professional group.

Table 8: Provider density per 1000 population by TLA (1)

Provider	Population base	Waipa Number	Waipa Density (2011) / 1000	Waitomo Number	Waitomo Density (2011) / 1000 total	Ruapehu Number	Ruapehu Density (2011) / 1000 total	Sth Waikato Number	Waikato Density (2011) / 1000 total	Otorohanga Number	Otorohanga Density (2011) / 1000 total	Hamilton Number	Hamilton Density / 1000 total
GP	all	27.00	0.56	8.00	0.75	5.00	0.32	13.00	0.49	3.00	0.30	131.00	0.82
Physio practices	all	5.00	0.10	2.00	0.19			1.00	0.04	1.00	0.10	31.00	0.19
Pharmacies	all	7.00	0.15	2.00	0.19	1.00	0.06	5.00	0.18	2.00	0.20	34.00	0.21
LMC	births	14.00	3.78	4.00	4.00	1.00	0.59	3.00	1.11	2.00	2.50	60.00	4.08
Aged care beds	65+	289.00	39.59	46.00	38.33	64.00	42.67	128.00	37.65	25.00	22.73	989.00	62.59
Podiatrist	all	2.00	0.04									5.00	0.03
Health right RN	all	1.30	0.03					2.00	0.08			1.00	0.01
Health right	all	0.00	0.00	0.10	0.01	1.00	0.06	2.00	0.08			5.70	0.04
Mobile disease state	all	0.66	0.01	0.50	0.05					0.50	0.05	0.32	0.00
CHW	all	0.66	0.01			0.25	0.02					2.66	0.02
CRP	all	1.66	0.03									1.66	0.01
Dietitian practices	all											2.00	0.01
OT practices	all											2.00	0.01
Psychology practices	all											22.00	0.14
Kaiawhina	all											0.50	0.00

Table 9: Provider density per 1000 population by TLA (2)

Provider	Population base	Matamata Number	Matamata Density (2011) / 1000 total	Waikato Number	Waikato Density (2011) / 1000 total	Hauraki Number	Hauraki Density (2011) / 1000 total	TCDC Number	TCDC Density (2011) / 1000 total	Number Waikato DHB	Density (2011) /1000
GP	all	15.00	0.46	18.00	0.35	13.00	0.68	18.00	0.61	251.00	0.63
Physio practices	all	3.00	0.09	4.00	0.08	3.00	0.16	8.00	0.27	58.00	0.14
Pharmacies	all	3.00	0.09	6.00	0.11	4.00	0.21	11.00	0.37	75.00	1.77
LMC	births	7.00	2.80	12.00	2.55	3.00	2.14	9.00	0.31	115.00	3.28
Aged care (beds)	65+	208.00	37.82	169.00	30.73	158.00	43.89	311.00	48.59	2387.00	46.44
Podiatrist	all	1.00	0.03					2.00	0.07	10.00	0.02
Health right RN	all									4.30	0.01
Health right	all									8.80	0.02
Mobile disease state	all	0.50	0.02	2.76	0.05	0.50	0.03	0.50	0.02	6.24	0.02
CHW	all			8.33	0.16	0.50	0.03	0.50	0.02	12.90	0.03
CRP	all			0.83	0.02					4.15	0.01
Dietitian practices	all									2.00	0.00
OT practices	all									2.00	0.00
Psychology practices	all									22.00	0.05
Kaiawhina	all									0.50	0.00

The Waikato DHB distributed a survey to private health providers and primary providers funded by the DHB.

The voluntary sector was not surveyed.

The providers are evenly split between urban and rural, as was the response rate.

Providers are faced with a number of issues.

They have identified areas where the DHB can provide assistance.

Provider survey

The Waikato DHB has surveyed providers about their workforce, supply and demand now and in the future, and where they think the DHB could assist. The results will be used to inform the DHBs sector wide workforce plan along with other information.

The survey was distributed to all providers that receive funding from the district health boards planning and funding service which includes aged care providers, some dental practices, Maori providers, Pacific Island providers, mental health providers, pharmacies, NGOs, PHOs, and other agencies. In addition physiotherapist practices, Dietitians, psychologists, occupational therapists, lead maternity carers and podiatrists were surveyed using addresses from the phone book. GPs were not surveyed because there is already information available about them from Pinnacle Practice Network. Finally, the implication of using the list of providers that are funded locally is that some of the nationally funded groups were not surveyed.

The survey did not include volunteer agencies because of timeframes for the report, vastness and changeability of providers, and because only some of them employ staff – most are staffed by volunteers.

Survey key points

Survey sent to 566 providers and 135 were completed (24% response rate, 95% confidence responses representative within 7% of what the rest would have answered if they had responded to the survey).

47% rural, 53% urban providers – 50% responses rural, 50% responses urban

The survey was divided into a section about employees, a section about owner / managers, and a section about the future. Feedback about current workforce issues and what the DHB could do to assist was also included.

Employees

- 53% staff aged more than 46 years (except dental assistants, pharmacy assistants, physiotherapy practices, and psychology practices)
- 70% NZ European, 18% Maori (more Maori in mental health)
- 41% work full time (higher in dental, and pharmacy)
- 80% positions filled within 3 months (except nursing, midwifery, physiotherapy, community health workers, and psychology)
- 60% recruitment via word of mouth, 23% local newspaper, 10% internet
- 84% live within 30kms of workplace (except lead maternity carers)
- 26% replacement positions last 12 months
- 19% in new positions in last 12 months (lower in aged care 7% and pharmacy 8%)
- 10% moved to another health provider in last 12 months
- 2% moved to another health provider in last 12 months had scholarship
- 12% positions filled by contractors (higher aged care and dental)
- Core competencies missing
 - Professional – local knowledge, some aspects of specific knowledge, experience
 - Technical – experience, industry knowledge
 - Unregulated, non technical – personal care, infection control, interaction skills, experience, industry specific knowledge
 - Corporate – research, management and business, interaction skills, industry specific knowledge
- Impediments to training
 - Professionals – cost, time, travel, access to broadband, accommodation, distance, replacement staff, motivation, limited spaces available on some training, and getting access to specialised knowledge
 - Technical – cost, distance, and time
 - Unregulated, non technical – availability, suitability, cost, distance, lack of a qualification, language skills, finding replacement staff, time, and motivation
 - Corporate – cost, time, motivation, and replacement staff

Owner manager

- 79% NZ European, 5% UK, 3% Maori
- 68% in current role for 6 or more years
- 90% been in the health industry for 6 or more years (exception LMC)

- 89% live within 30kms of workplace
- 94% have tertiary qualification, 82% are qualified health professionals
- 76% completed undergraduate qualification in NZ
- 91% of health professionals have current practicing certificate
- 42% had 3-4 weeks holiday which was the mean with even distribution around the rest
- 61% required to be on call
- 66% required to be on call all the time (most aged care, dental, LMC, pharmacies – least psychologists, physiotherapists, podiatrists, mental health), 55% called often, 81% worked the next day
- 80% did not have unmet training needs
- Mediums used to update knowledge (ranked left to right)
 - Networks, conferences, websites, journals (#1 professional, #4 sector)

Future

- 63% thought core competencies would change
- 57% intended to change number of staff in organisation over next 10 years
- 55 respondents – increase average 34%, 3 respondents – decrease average 45%
- 84% thought it would not get easier to attract and retain staff (Nov / Dec 2008)
- 81% would not employ different staff mix

Current workforce issues

- Availability of qualified staff (all sectors)
- Increased funding for wages and training
- Disparity between DHB remuneration rates and other providers
- Availability of locums
- Workforce mobility
- Low pay rates for aides
- Complexity of employment rules
- Difficulty attracting staff to rural areas
- Strong market competition for qualified staff
- Owner / managers difficulty getting away from business to take leave and attend training
- Limited back up and relief cover for owner / managers
- Primary secondary interface and staff for LMCs
- Owner / managers difficulty balancing on call component with home life
- Compliance requirements are time consuming
- Dealing with staff issues
- Increased travel time and costs working in rural areas
- Different generational expectations

DHB could do to support

- Provide access to DHB training at reasonable prices
- Advertise for staff
- Provide free job list website
- Assist with immigration department policy
- Align contracts with actual service delivery
- Fully fund contracts and move to a business model
- DHB community to collaborate with primary sector providers
- Increase DHB knowledge of and support for community sector
- Co-ordinate graduate / work experience programme across rural, public, and private providers (nursing, allied, pharmacy, and corporate)
- Establish a job share scheme across private and public sector
- Structure training so that it is more accessible to rural areas
- Fund rural locums (all sectors)
- Assist with HR and legal issues
- Increase funding for remuneration and training
- Increase the supply of qualified staff (all sectors)
- Fund for pay parity with DHBs
- Rationalise purchase units and reduce competition (mental health)
- Reduce compliance and reporting costs, establish one audit system
- Provide scholarships and bonding within the district
- Allocate funding to the private sector and refer patients (secondary and community services)
- Assist with overseas recruitment
- Set up business mentor programme for owners / managers
- Employ more core midwives in Waikato Hospital for LMC handover and to enable breaks during long deliveries
- Provide free access to medical library and journals
- Provide or fund relief cover for managers / owners (aged care, pharmacy)

- Re-establish pharmacy technician training in the district

According to census data, of the occupational groups employed in the DHB, the DHB employs 63% the health workforce.

Census information about health workforce

Census data from the 'health professionals' category for the Waikato district health board area was compared with the number of staff known to be employed in the DHB in 2006. The census data is taken from the household dwellings data set and the occupation stated by the householder at the time.

Table 10: Percentage Waikato DHB employees for ANSCO health professional census category (2006)

Percentage DHB employees for ANSCO health professional census category in Waikato DHB (2006)			
title	DHB staff	census	Percentage DHB staff
Dietitians	18	33	55%
MRT / RT	148	159	93%
Health Protection	10	36	28%
Pharmacy	28	273	10%
Health Promoters	35	105	33%
Occupational Therapists	67	129	52%
Physiotherapists	62	186	33%
Podiatrist	2	12	17%
Audiologists	6	12	50%
Speech Therapists	6	39	15%
Registrar	185	267	69%
SMO	277	240	115%
Hospital Midwife	103	207	50%
Nurses	1928	2844	68%
total	2875	4542	63%

Not all categories of DHB employees are included in the data set. For example, social workers, laboratory, psychologists, vision hearing technicians, attendants, and administration.

The DHB does not employ a number of people engaged in the health workforce in the community such as osteopaths, acupuncturists, and chiropractors.

Source: Statistics New Zealand. 2009. www.stats.govt.nz (accessed in April 2009)

The mean age of GPs and Practice Nurses is increasing.

Waikato Primary Health General Practice workforce information

Within 20 years 66% of GPs and 60% of Practice Nurses will be aged 65 years and many will have already retired.

Forecasting general 23-25% increased GP consultations as population ethnicity changes over 20 years (38% - 51% increase for Maori and Pacific Island consultations).

Forecasting general 18% increase to GP consultations due to age profile of population.

Forecasting that by 2026 2/3rds current GPs and 3/5ths current practice nurses will be 65 years or more (many will have already retired)

In 2006 mean age of GPs are 48.6 years and practice nurses are 48.8. (DHB rural SMO 52, all SMO 48.4, DHB rural nurse 48.6, all nurse 44)

Estimated increase in GP consultations by 2026 is 23-25% equates to 47-51% additional GPs to maintain current service levels, plus 134 that will retire within the 20 years minus the current workforce means that in 20 years 181 – 185 additional GPs will be needed. In addition, 197 additional practice nurses will be needed.

Source:

Pinnacle Group Limited. 2007. *The General Practice Workforce in the midland PHO network 2006. Workforce Analysis Vol 1*. Hamilton: Pinnacle Group Limited.

Pinnacle Group Limited. 2007. *Impact of projected population changes on workload and workforce of midland PHO network Vol 2*. Hamilton: Pinnacle Group Limited.

The DHBs Planning and Funding division has commissioned a report into the aged care workforce.

Compared to OECD countries, NZ has a relatively young population with only 11.5 percent of people 65 and over. The proportion of older New Zealanders is projected to grow steadily to about 13% by 2010 and then much more rapidly (to 22% by 2031 and 35% by 2051. The proportion of those over 65 years of age who are non European will have increased by 242%, the proportion of these who are of Maori and Pacific ethnicity is increasing. This further enhances the stress on the workforce requirements as these groups are disproportionately adversely affected by chronic health conditions.

Source: Ministry of Health. 2006. Health workforce development – an overview. Wellington: Ministry of Health.

Health of Older People Workforce Incentives Project

A report about the workforce engaged in the aged care sector was commissioned by the Planning and Funding division of the Waikato DHB. The report provides some useful information for future workforce planning for this sector. The background, summary, and recommendations sections are extracted below. A number of recommendations from the report that relate to a workforce are included in the DHBs sector workforce plan.

Background

The drivers of change for the sector in New Zealand and the Waikato are:

- The general population of New Zealand (NZ) and therefore the workforce is ageing.
- Many of our current workers will be retiring and there will be a smaller population of younger workers to replace them.
- More complex health needs, including an increase in chronic illnesses, are developing as a result of ageing population.
- The ethnic make-up of New Zealand's population is changing, with an increase in Maori, Pacific and Asian populations.
- Growing consumer choice, lifestyle factors, and technological developments are changing the way services are provided.
- Health service recipients and consumers are more aware and better informed than ever before.
- Technology is changing the way we work, the way we live and the way care and interventions are delivered.
- NZ Institute of Economic Research suggests the NZ shortfall will be between 40 and 70 thousand health and disability workers over the next 20 years

With this in mind, in order to have a chance of ensuring a sustainable supply of practitioners and caregivers, strategies will have to include:

- recruiting and training more resources
- effective use of available resources
- developing new roles
- refining existing roles to meet future needs
- giving consideration to new funding /contracting frameworks.

Workforce for older people - key messages

- The industry has bad press and a poor image
- There are too many discrepancies in pay, expectations and audit requirements between DHBs and the aged care industry sector monitoring authorities
- The Registered Nurse (RN) workforce is thin on the ground and could be used more efficiently
- Payment differentials between DHB and other employers continue to be an issue for nurse retention
- Governance and leadership education is required
- The cost of training staff is a barrier for employers and staff
- A nationally recognised career pathway for "caregivers" is required
- There is room for greater collaboration between providers in this sector on a wide range of areas
- Structured collaboration and communication would be welcomed within the wider stakeholder group

Recommendations

It became apparent that there were six topic areas that were common across all participants. The solutions proposed are related to these topic areas and have Waikato DHB, regional and even national application.

Media, PR and Communication - "re brand the aged care sector"

- Develop a Waikato DHB wide, positive campaign in conjunction with the DHB Comms team and with sector input to positively promote ageing, aged care and the availability of work in this sector.

Career and Training – "more effective and innovative use of scarce resources"

- Secondment opportunities across DHB and residential facilities
- Support for career path through contract changes
- regional training budget for residential sector
- Establish a specialist gerontology nursing position for rural communities to help train carers, provide supervision and advocate at a community and clinical level for kaumatua care.
- Establish a pool of Registered Nurses (RNs) affiliated or employed by the DHB who could be allocated to service delivery (community and residential) within an enrolled population or specific geographic boundary.
- Provide access to e-learning opportunities

- The providers are willing to share compliance training and material electronically. A small grant or seed funding to support this could speed implementation.

Promote the Ministry of Social Development developed career pathways as a multi sector initiative – “take a regional approach”

- Develop a regional training approach with joint funding of initiatives (e.g. training opportunities) between DHB and Ministry of Social Development.
- Train and employ kaumatua to deliver programmes and services.
- Top slice existing contracts to construct a regional budget with economies of scale.

Governance and Management – “strengthen thinking about leadership, governance and business”

- Places on DHB management and governance courses to be available to rest home providers and owners (free or reduced cost)
- Management secondment opportunities across DHB and residential facilities.

Sector Integration and Collaboration – “we are all on the same team”

- More structured, facilitated workshops for providers and intersectoral partners to produce solutions and share information provided by a lead agency.
- Joint funding of initiatives (e.g. training opportunities) between DHB and MSD
- Initiate and fund a kaumatua service providers’ network. This is a valuable low cost way of establishing collaboration between providers.

Ageing in place - “the right for the older members of our community to stay safe and supported in their own place, wherever that may be”

- Intersectoral support for people to stay at home and if desired to be cared for by their family/whānau.
- Train and employ kaumatua to deliver programmes and services

Summary

Consciously raising the public’s perception of working in the eldercare sector would have multiple effects on this workforce throughout the Waikato. There appears to be a misinformed public perception that work in the eldercare sector is only moderately skilled, unrewarding and suited toward people who are in the ‘twilight’ of their careers. Those who work in the sector lament this view and believe there is a significant opportunity for an orchestrated public relations campaign.

In addition stakeholders appear to be ready to work collaboratively and non-competitively to strengthen and enhance services by meeting to discuss and find solutions within a structured environment. It is recognised that there would be much to be gained by the DHB taking a lead in some of the initiatives as the DHB has infrastructure and valuable experience in areas such as learning and development, communications and regional initiatives. By the end of the data collection, the stakeholders appeared to see themselves more in the light of “shareholders” in the solution process.

The overriding issue for the residential sector seems to be availability of RNs; consequently there are some solutions which relate specifically to piloting new models of employment or deployment of these staff.

Maori participants would like the issue of earlier ageing characteristics to be recognised and also their desire to have kaumatua caring for kaumatua as paid employees rather than volunteers.

There are clearly some contract and funding framework issues which have been highlighted through the workshops and interviews.

The recommendations in the report do not cover dissatisfaction with contracts or funding however where the suggestions may require a different approach to funding those ideas have been included.

The sector clearly recognises the need to adopt new technology and is aware of the challenges ahead. One rest home has formally offered to trail a healthcare robot and several others would like to pursue the opportunity of developing material for managerial and compliance issues that could be shared among the sector electronically to save time and effort. This fits with the concept of creating and adding value and releasing time and /or resources for direct patient care.

Source:

Waikato District Health Board. 2009. *Health of Older People Workforce Incentives Report DRAFT March 2009*. Prepared for Fiona Murdoch, Agewise and Waikato DHB Version 1.7 050409, Report prepared by Bernadette Doube

The DHBs chief executive has approved a vision of the future primary health system so that workforce planning can occur to build towards the vision.

Future vision planning assumptions

The system and workforce are connected. As part of the process to plan the future health workforce the future health system has been described. The Waikato DHBs chief executive has signed off the planning assumptions outlined below.

The overarching assumption is that all people regardless of their disability, age, where they live, or their ethnicity will have equitable access to the primary sector of the future.

While environment, socioeconomic status, access, ethnicity, ageing, and behaviour combine and each factor potentiates the effect of the other on the health status of the individual, they are separated into four chunks to make the planning process more manageable.

Chronic disease

The sector workforce plan assumes:

- current health systems and processes will be connected around the patient
- people will be able to access routine individual health screening in their community (primary sector)
- clinical information will pass between clinical professionals to support patient care and increase knowledge
- people are encouraged to make choices that are less likely to increase ill health and disability
- people with chronic diseases are supported to self manage where appropriate or have their care managed or co-ordinated across providers and sectors depending on need
- communities support improving health status
- people can access clinical services if they need to

Social determinants

The workforce plan assumes:

- people are encouraged to make personal choices that are more likely to lead to improved health status
- people with dependents make choices that support their good health status
- living environments are conducive to good health
- communities support good health
- external environments are conducive to good health
- people are enabled to participate in the economy
- people can access clinical and social services if they need to
- clinical and social services collaborate to facilitate access and effectiveness

Ageing population

The workforce plan assumes:

- current health systems and processes will be connected around the patient
- people are encouraged to make choices that are less likely to increase ill health and disability
- people are supported to retain their independence and self sufficiency where possible
- communities enable people to retain their independence
- people can access clinical, home based support, and long term care services if they need to

Workforce supply chain

The workforce plan assumes:

- adequate supply of health and disability workforce across the sector is necessary and is a shared responsibility
- competence of the health and disability workforce is essential to quality of services

An expert reference panel have commented about what needs to change in order to achieve the vision.

Key points from expert panel member discussions / emails

The above assumptions, about how the system would be in the future, were used to drive comment from the expert panel about:

- a) if any assumptions were missing
 - b) if the assumptions are achievable within the current primary health systems and structures
 - c) if not achievable, in general terms, what needs to change
 - d) the general impact on the current workforce
- a) Missing assumptions are that:
- We are not tied to the historical funding models that tend to create silos across the sector
 - Social isolation is an issue
 - A range of health professionals are needed to meet needs of the patient (as per Primary health strategy)

- Choices are limited by poverty
 - The Treaty of Waitangi and how the government and DHB will act to address health inequalities
 - There is cultural safety and competence across the system and across all providers
- b) Current health system will not deliver because:
- It is designed around specific disease states and many people have more than one disease
 - Care is delivered around specific disease states
 - Clinician training is increasingly specialised
 - It is not a whole system and the parts are not integrated
 - It is not integrated around the patient
 - Patient care across specialties, providers and sectors is not co-ordinated
 - Funding models designed to continue current system and strengthen status quo
 - Funding models are reported to be inflexible and are variable
 - It lacks required levels of cultural and community development competence for information and required behavioural change to stick
 - Not designed to respond to increased demand caused by unfavourable demographics and increased chronic disease
 - Multiple agencies have input into the same clients without co-ordinating effort and resources
 - Funding is allocated within silos and does not encourage collaboration
 - It is based in treatment of illness and not on developing communities to prevent disease in the first place
 - Knowledge about services is not evenly known which leads to inequity of access
- c) The current system could be redesigned to improve delivery by:
- In the primary sector having a GP led team deliver treatment and care to the patient. The team would include allied health, nursing, HealthRight co-ordinators, physician assistants, and administration. The composition of the team would vary depending on location and need
 - Introducing a primary nursing model, which would combine the roles of the current community and GP practice nurses into one team on the basis of the patient rather than the setting where care is delivered.
 - Introducing an interdisciplinary team model what would work in concert to provide treatment and care for patients in the community. This would result in improved general skills over various settings and increased job satisfaction.
 - Socialising the use of decision support software so that it is a commonly used tool to improve consistency of treatment pathways, access diagnostics, access DHB booking systems, and access patient records.
 - Increasingly integrating primary and secondary systems to improve patient access, improve access of primary health professionals to secondary knowledge and support, increase scope of what is delivered in the community on a case by case basis.
 - Altering the funding model to provide capital funding, salaried primary sector positions, revolve around the patient, incentivise collaboration amongst providers
 - Clarifying roles to manage duplication and increasing demand
 - Influencing local and national government policy to put more resources and focus into developing communities, early intervention for kids with problems, strengthening the education in high deprivation areas and for Maori that prevent kids from attending school, increasing health promotion and disease prevention
 - Increasing input from families
 - Increasing knowledge of services that are already available
 - Introducing community development and cultural competencies across all health professionals to improve relevance of interaction for the patient and their family, and to assist them to access other providers
 - Introducing a qualification for people working in communities with patients and their families to support them to manage their chronic disease to increase knowledge, consistency and acceptance of worth of these positions by other health professionals
- d) The workforce could be impacted by:
- The need to increase the number of generalists to manage patients with multiple disease states
 - The change in culture of introduction of interdisciplinary teams which requires health professionals to work together to share the treatment and care of patients
 - The initial time needed to discuss issues in depth with patients and their families, and to assist them to access other services and the introduction of cultural and community development models
 - The initial time required to increase use of technology
 - Changing the primary nursing model so that the current nursing workforce has a broader skill set and scope of practice across all community settings
 - Sharing of access to secondary patient booking processes (FSA – follow-ups to be sequenced at time of FSA)
 - Increased collaboration across providers and agencies to reduce duplication of effort

- Increased use of certificated whanau ora workers within the interdisciplinary teams to assist patients along with their families, to manage chronic disease in their own environment
- Increased use of community health care workers to facilitate community based health promotion
- Introduction of physician assistants that would carry out low risk structured activities for patients under the supervision of the nurse and GP, and would also do additional administration work
- Increasing demand caused by ageing population (nursing, care and support, GP, allied)
- The recession and health being perceived as a 'safe' sector

Appendix B: National workforce plan priorities

The national health workforce plan for the combined district health boards has been published.

Waikato DHB will collaborate with others to implement the national plan.

Waikato DHBs own workforce plan will not duplicate work that is more effective if completed nationally.

The district health boards of New Zealand have reviewed their 2005 workforce plan and have published a revised development plan for the next six years titled, "Our health workforce; today and the future, April 2009". While activities are primarily focused within DHBs there are a number that take a whole of sector approach and others that the processes and outcomes would have direct application to the primary / private sector.

An overview of the action priorities is below.

1. Identify and respond to whole of sector workforce supply issues including development of new roles.

- Forecast and plan future national workforce supply needs for identified key workforces:
 - Medical
 - Nursing
 - Allied health and technical
 - Frontline support – care and support, corporate support.
- Develop new and expanded workforce roles.
- Brand the health and disability sector as the career destination of choice with key target audiences:
 - Youth
 - Current health workers
 - NZ labour market including non-practising health professionals
 - International labour market.
- Focus on workforce sustainability, productivity and retention.

2. Value health and disability workforces by fostering supportive environments and positive cultures.

- Develop proactive employment relations strategies that value people and support productivity.
- Promote initiatives focusing on development of healthy workplaces and developing and retaining health workers.
- Develop the cultural safety of health and disability workplaces.

3. Support development of clinical leadership working in partnership for improved retention, productivity, service quality and health outcomes.

- Strengthen engagement of clinical leaders and networks in workforce activity including partnership initiatives.
- Promote the sector's leadership development capability.
- Provide career pathway development opportunities for health professionals.

4. Grow and develop of the public health, primary health care, rural, and community workforce including NGO workforces.

- Develop relationships and co-ordination to support workforce development.
- Agree development priorities for public health, primary health, rural health, disability and community care and NGO workforces.
- Progress development of key public health, community, NGO, rural and primary health care workforces.
- Priority workforce groups identified:
 - General medical practitioners
 - Registered nurses in primary in primary health care and health of older people service particularly in rural areas
 - Nurse practitioners
 - Allied health and home based / whanau health workers.

5. Grow and develop the Maori health and disability workforce.

- Strengthen the existing Maori health and disability workforce.
- Address system and structural barriers.
- Building a future Maori health and disability workforce.
- Support the development of cultural competence within the health and disability workforce.

6. Grow and develop the Pacific health and disability workforce.

- Increase Pacific leadership capability in health and disability services.
- Increase participation of Pacific people in the health and disability workforce including the regulated health professionals.
- Improve Pacific workforce information.
- Identify strategies that increase the commitment of health and disability organisations to cultural governance.

7. Grow and develop a sustainable care and support workforce.

- Improve accuracy of workforce information on the care and support workforce.
- Implement a unified training framework for the care and support workforce.
- Focus on recruitment and retention to improve workforce supply.
(Note: this links to wider sector sourcing, the NZ Health and Disability Careers Framework, the Health Careers Brand, and healthy workplace initiatives.)
- Clarify relationships between care and support workforce and related workforces.

8. Align the workforce, including new roles, to address population health needs and service models (of prevention, early identification and intervention).

- Prioritise sector-wide workforce action to ensure it delivers, within available resources, to priorities based on population health needs and service models for prevention and early intervention.
- Align workforce planning to government priorities and ensure connected service and workforce planning mechanisms at local / regional and national levels.

9. Build a whole of system unified approach to workforce planning and development (including cross government activity).

- Consolidate a system-wide integrated and co-ordinated approach to workforce development and planning.
- Deliver trusted workforce information capability as platform for workforce decision support including workforce modelling and forecasting capability.

10. Ensure health and disability sector future service and workforce demand drives education content and delivery.

- Continue to develop system level funder relationships and co-ordinated action between the health and education sectors.
- Embed and integrate cross sector advice mechanisms.
- Maintain and develop local, regional and national relationships with education providers to maximise responsiveness to local service needs.
- Provide for post-entry continuing education for health practitioners and foster the ongoing development of a learning culture.

Source:

DHBNZ. 2009. *Future Workforce: Our health workforce today and the future*. Wellington: DHBNZ.

Appendix C: Acknowledgements

We acknowledge the work of the following people who contributed to the development of the plan.

Workforce stakeholder group

This group reviewed information and developed the strategic priorities on which this plan is based.

- Brett Paradine, General Manager Planning and Funding, Waikato DHB
- Jan Adams, Chief Operating Officer, Waikato DHB
- Linda Rademaker, GP Liaison, Waikato DHB
- Ian Vickers, Service Development Consultant, Waikato Primary Health
- Fiona McCarthy, General Manager Human Resources
- David Hall, CEO Resthaven
- Paul Bennett, Chief Executive, Braemar Hospital
- David Slone, Manager Hamilton Residential Trust
- Daryl Gatenby, Organiser, Public Service Association
- Glenda Raumati, General Manager, Nga Miro Health
- Mere Balzer (MNZM), General Manager, Te Runanga O Kirikiriroa
- John Macaskill-Smith, Chief Executive, Pinnacle General Practice Network
- Sue Hayward, Director of Nursing and Midwifery, Waikato DHB
- Tui Kaa, Industry Partnership Advisor, Ministry of Social Development
- Julie Dolan, Regional Labour Market Manager, Ministry of Social Development
- Robin Steed, Chief Executive, New Zealand Institute of Rural Health
- Elaine Elbe, Strategic Advisor Rehabilitation Service Delivery, Accident Compensation Corporation
- Grant O'Brien, Senior Project Manager, Waikato DHB (Rural Portfolio)
- Alan Grainer, Chief Information Officer, Waikato DHB
- Mary Anne Gill, Director Media and Communications, Waikato DHB

Expert reference panel

This group provided information that informed the plan.

- Linda Rademaker, GP Liaison, Waikato DHB
- Anne Morrison, PHIT Unit Manager, Population Health, Waikato DHB
- Dale Wilson, District Health Promoter, Population Health, Waikato DHB
- Trish Wright, HealthRight Project Leader, Waikato Primary Health
- Rawiri Blundell, Project Co-ordinator, Te Puna Oranga, Waikato DHB
- Deanne McManus-Emery, Social Development Manager, Ministry of Social Development
- Tui Kaa, Industry Partnership Advisor, Ministry of Social Development
- Lisa Mitchell, Acting Community Development Unit Manager, Hamilton City Council
- Hannah Banks, Neighbourhood Development Advisor, Hamilton City Council
- Brendon Gardner, Department of Labour, Labour Market Knowledge Manager
- Wayne Mclean, Chief Executive, Raukura Hauora O Tainui

Information and production

The following people contributed to developing and publishing of this report.

- Paul Keesing, Strategic Planner, Planning and Funding, Waikato DHB
- Andre Donnell, Clinical Audit Data Base Developer/Administrator, Quality and Risk, Waikato DHB
- Erena Kara, Project Manager, Te Puna Oranga, Waikato DHB
- Bernadette Doube, Bernadette Doube Consulting Ltd
- Dean Edwards, Information Analyst, Statistics NZ
- Beryl Pears, Senior Communications Consultant
- Tamara Miles, Graphic Designer, Viscom

References

Centre for Disease Control and Health Promotion. 2009. *The Power of Prevention: Chronic disease...the public health challenge of the 21st century*. USA: Department of Health and Human Services.

DHBNZ. 2009. *Future Workforce: Our health workforce today and the future*. Wellington: DHBNZ.

Ministry of Health. 1999. *Our Health Our Future: Hauora Pakari, Koiora Roa – the Health of New Zealanders 1999*. Wellington: Ministry of Health.

Ministry of Health. 2006. *Health workforce development – an overview*. Wellington: Ministry of Health.

Ministry of Social Development. 2008. *The Social Report 2008*. Wellington: Ministry of Social Development.

National Health Committee. 2007. *Meeting the needs of people with chronic conditions: Hapai te whanau mo ake ake tonu*. Wellington: National Advisory Committee on Health and Disability.

NZIER. 2004. *Ageing New Zealand and Health and Disability Services; demand projections and workforce implications, 2001-2021 – discussion document*. Wellington: Ministry of Health.

Pinnacle Group Limited. 2007. *The General Practice Workforce in the midland PHO network 2006. Workforce Analysis Vol 1*. Hamilton: Pinnacle Group Limited.

Pinnacle Group Limited. 2007. *Impact of projected population changes on workload and workforce of midland PHO network Vol 2*. Hamilton: Pinnacle Group Limited.

Public Health Advisory Committee. 2004. *The Health of Peoples and Communities. A way forward: public policy and economic determinants of health*. Wellington. Public Health Advisory Committee.

Ratima, M., Brown, R., Garrett, N., Wikaire, E., Ngawati, R., Aspin, C., Potaka, U. 2007. *Rauringa Raupa; Recruitment and retention of Maori in the health and disability workforce*. Auckland: AUT University.

Statistics New Zealand. 2009. www.stats.govt.nz (accessed in March 2009)

Waikato District Health Board. 2008. *Waikato DHB Health Needs Assessment 2008*. Hamilton: Waikato DHB.

Waikato District Health Board. 2009. *Health of Older People Workforce Incentives Report DRAFT March 2009*. Prepared for Fiona Murdoch, Agewise and Waikato DHB Version 1.7 050409, Report prepared by Bernadette Doube

Waikato District Health Board. 2009. *Waikato DHB workforce development plan: A plan for community and hospital services provided by the Waikato District Health Board, 2008/2010*. Hamilton: Waikato DHB.

Waikato District Health Board. 2009. *Waikato DHB District Annual Plan; 2009/2010*. Hamilton: Waikato DHB.

World Health Organisation. 2002. *The World Health Report 2002; Reducing Risks, Promoting Healthy Life*. Geneva: World Health Organisation.

World Health Organisation. 2008. *Closing the gap in a generation: health equity through action on the social determinants of health*. Geneva: World Health Organisation.

Tables

Table 1: Population ethnicity projections and percentage growth from 2001-2021 (Waikato DHB)	41
Table 2: Percentage population by ethnicity (Waikato DHB)	41
Table 3: Population age range projections and percentage growth from 2001 – 2021 (Waikato DHB)	41
Table 4: Percentage population (Waikato DHB)	41
Table 5: Deprivation variables	42
Table 6: Deprivation range by TLA (Waikato DHB)	42
Table 7: Number and percentage deprivation range Waikato DHB / NZ total comparison	43
Table 8: Provider density per 1000 population by TLA (1)	48
Table 9: Provider density per 1000 population by TLA (2)	48
Table 10: Percentage Waikato DHB employees for ANSCO health professional census category (2006)	51

Graphs

Chart 1: Percentage population by age (Waikato DHB)	42
Graph 2: Percentage population deprivation within each local authority	43
Graph 3: Percentage deprivation range Waikato DHB / NZ total	43