Echuca Regional Health

Workforce Plan
2024 – 2027

Echuca Regional Health

Contents

This plan was developed by Executive Director People, Culture and Safety, Director Education Training and Research and the Human Resource Manager.

JULY 2024

Executive Summary

The *Echuca Regional Health Strategic Plan 2024-27* clearly defines our people as a priority, with the aspiration that; **We are a dynamic, diverse and highly skilled workforce. We are continuously learning so we improve. We are inclusive.** The ERH Workforce Plan will support the achievement of this aspiration along with the successful growth of services as outlined within the *ERH Clinical Services Plan 2023-2033*.

The purpose of this plan is to align our workforce to future health service needs and determine what actions are required to create access to, and mobilise a workforce, while continuing to build an inclusive, supportive and values-based culture. Using a risk-based approach, the plan works to identify high demand, low supply roles as well as key enablers to plan for other future workforce changes.

The healthcare industry worldwide is currently facing significant workforce supply shortages. This challenge has been coupled with the pandemic and its ongoing disruption to operations, and impact on workload and workforce burnout. Locally we have seen the frequency and severity of natural disasters, and this has further strained resources and workforce wellbeing. Our region has experienced unprecedented population growth, is an aging population and as result, ERH's demand for service and patient complexity has increased.

A key focus for the Victorian Department of Health is to provide; right care, right time, right place. Achievement of this will have direct benefits for rural and regional communities and will require a strong and sustainable workforce. A combination of local training and career pathways, introduction of new models of care that enable advanced-scope of practice and introduction of new technologies will all be enablers to ensure our community have access to the care they need.

As ERH continues to build a strong learning culture that encourages adaptability and innovation, there are significant opportunities to adopt successful education and workforce models that create value for individuals, our organisation and the overarching healthcare industry. Expanding partnerships and creating a vision for a Regional Education hub will further strengthen our workforce development.

Extensive analysis of data, research documents and consultation has been undertaken to inform this important plan. The Workforce plan recommends a roadmap based on the pillars of attract and retain, our enablers, contemporary models of care and growing our learning culture. This plan will underpin the overarching *ERH strategic plan 2024-2027*.

Department of Health Priority Areas

The Department of Health workforce strategy aim is to build a modern, sustainable and engaged healthcare workforce that meets the needs of all Victorians. They have identified five focus areas over the next 10 years which include;

1. **Increase supply of priority roles**
2. **Strengthen rural and regional workforces**
3. **Improve employee experience**
4. **Build future roles and capabilities**
5. **Leverage digital, data and technology**

Strategic Alignment

This plan supports the achievement of the *ERH Strategic Plan 2024-2027* and acknowledges the identified ERH strategic risks.

Our Vision

Everyone in our community is healthy and lives well.

Our Purpose

Supporting everyone to be healthy and live well.

Our Values

Collaboration, Accountability, Respect and Excellence.

Our Priorities

- **Our People**

  We are dynamic, diverse and highly skilled workforce. We are continuously learning so we improve. We are safe and inclusive.

- **Our Service**

  We provide a safe, calm and connected experience for our community, delivering contemporary models of care, as close to home as possible.

- **Our Community**

  We empower our community to make healthy choices and live a connected, diverse and culturally rich life with equity of access to care. We listen, we advocate, we respond.

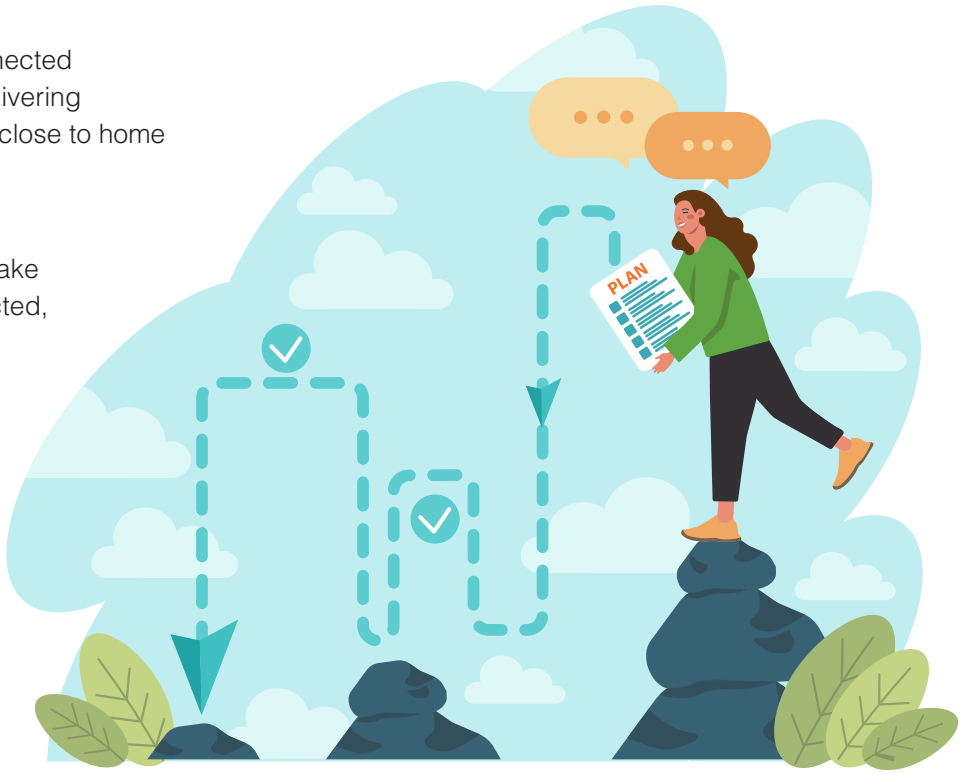
- **Our Future**

  We will be leaders in service provision, workforce development and wellbeing, digital health, sustainability, education and research.

Strategic Risks

This plan has been developed to ensure risk mitigation for the following strategic risks:

- Workforce capability and/or capacity does not meet ERH requirements and fails to respond to planned growth.
- Significant workplace incident resulting in a life altering injury or fatality of a worker.
- ERH does not develop or maintain a positive workplace culture.
- ERH does not meet the Corporate Social Responsibility expectations of community, workforce and/or potential partners.



Developing our Plan

This plan was developed using the following objectives:

Workforce Strategy

OBJECTIVES

Workforce Analysis	ERH's Existing Plans & Strategies	Environmental Scanning	Value Chains	Actions
Collect historical and current workforce data Compare data from different time periods Identify demographic trends locally and nationally Staff consultations and theme based findings	Identify existing plans and strategies ERH has developed and implemented Clinical Service Plan 2023-2033 Recruitment Strategy Health & Wellbeing Strategy OH&S Strategy	Assess the external environment influences on healthcare workforce by using the Social Technology, Economic, Environment & Political (STEEP) framework. Use the Strengths, Weaknesses, Opportunities & Threat (SWOT) framework to assess ERH internal influences on workforce	Identify value chains and key stakeholders that influence our current and future workforce Assess and discover current and future models of care.	Develop actions for high risk, high demand, low supply roles List key priorities for each division Recommend risk mitigation strategies and leverage on innovative workforce models

This plan builds on the foundations established by the 10-year Victorian Health Workforce Strategy and is a key enabler of the *ERH Strategic Plan 2024-27* and the *ERH Clinical Services Plan 2023-2033.*

Developing our Plan

This work also complements existing people initiatives including:

- CARE Values
- Leadership Capability Framework
- Recruitment and Retention Strategy
- Health and Wellbeing Strategy
- Occupational Health and Safety Strategy
- Learning and Development Strategy
- Performance, Development and Succession Planning Framework

The project team undertook development of this plan by using the *Victorian Public Sector Strategic workforce planning methodology* which enabled wide ranging collaboration and detailed information and data analysis with clear directions to design and build the future workforce for ERH. The following provides insights into each of the three phases of the workforce planning process.

Discover (and Analyse)

Discovery was conducted to understand our internal and external environment. Specifically, we undertook the following activities *(Appendix 1 + 2).*

- 15 staff focus group collaboration sessions
- 1:1 consultation with key managers and Executives
- Online survey containing closed and open-ended questions distributed to Executives and Directors
- Review and analysis of key internal and external strategies and plans
- Internal workforce data analysis (historical, current and predicted).

Design (and Forecast)

The design phase considered the information collated during discovery to help determine the skills, the source, the shape of the future workforce. To assist in synthesising this information we took a risk-based approach to identify our key priorities and our priority roles.

Build (Strategies and Actions)

To ensure targeted and meaningful outcomes, key actions and measures have been identified for each of the four workforce groups outlined below. It will be important to remain agile to factor in any unplanned changes that may occur locally or with a broader context.

Evaluate

To ensure continuous monitoring and evaluation, a 12-month plan will be developed with monitoring assessment occurring at the 6 and 12 month mark. Following the 12-month review, the workforce plan will be reviewed in line with annual planning processes.

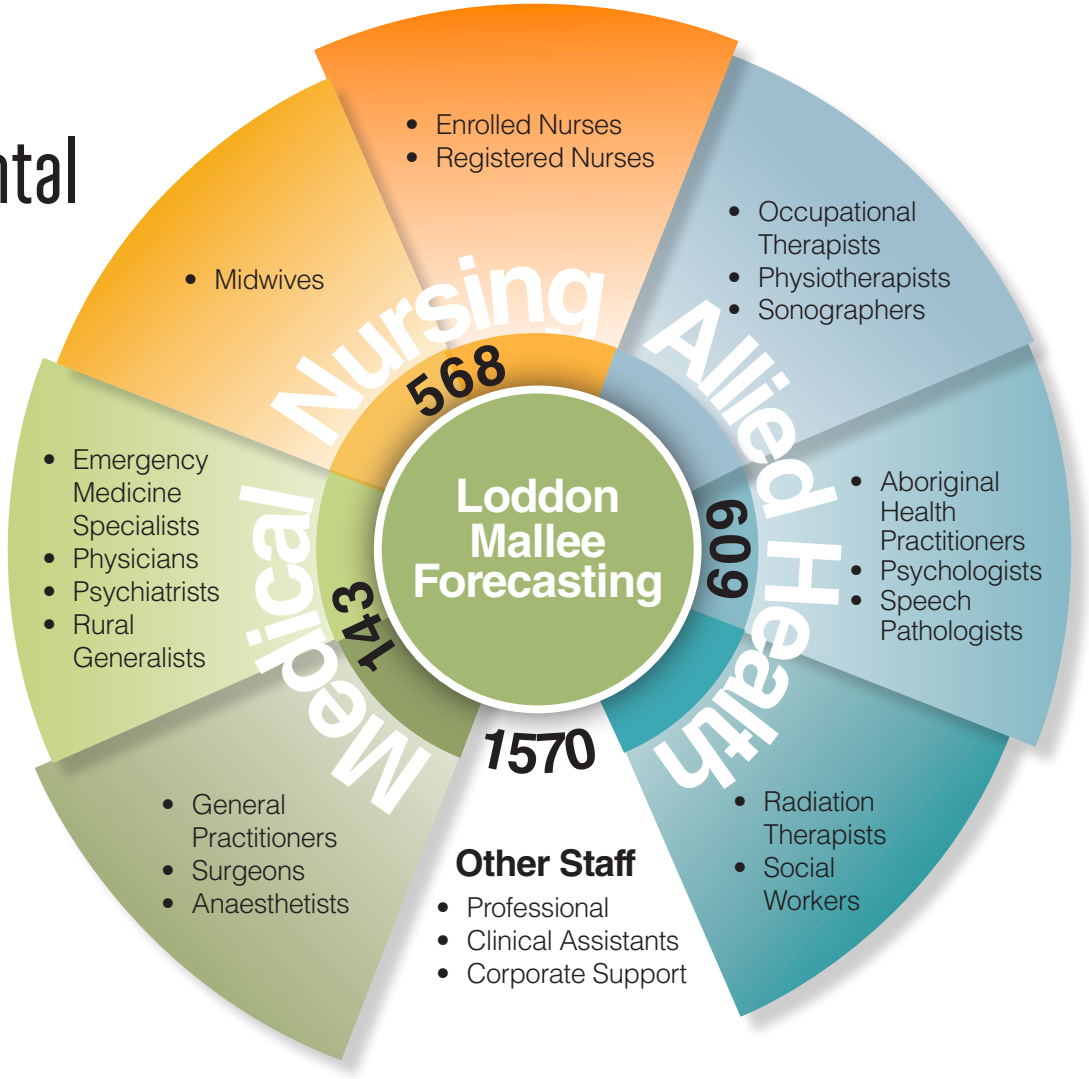
Discovery

External Environmental Themes

Figure 1

VICTORIAN SKILLS AUTHORITY - LODDON MALLEE FORECASTING

Pending healthcare reform outcomes will drive the need for broader collaboration with opportunity to streamline and centralise systems and processes, workforce efficiencies, flexibility and greater shared learning opportunities. While it is anticipated these changes will affect the entire health service, it is most likely to provide a greater impact on Corporate Services.



As described in the Department of Health Strategic Workforce Strategy, Victoria's Health workforce needs have grown by 33% which is at a rate faster than general population. It is predicted an additional 60,000 jobs will be required between 2023-26 which reinforces the health workforce market will remain highly competitive. The predicted increase is deemed to be occurring largely as a result of; population growth, ageing population and a rise in chronic disease.

Similarly, our region has experienced unprecedent population growth directly impacting service capacity. Interestingly, we have a higher than Victorian average characterised by poorer health status and outcomes, our population is older, and we have above average percentage of the population identifying as Aboriginal and or Torres Strait Islanders. The median weekly household income is lower than reported for Victoria and the education level is lower compared to the rest of regional Victoria.

This demographic snapshot provides insight into key influencing factors having a direct effect on the patient complexity. The complexity is predicted to increase and therefore the workforce plan must plan for this.

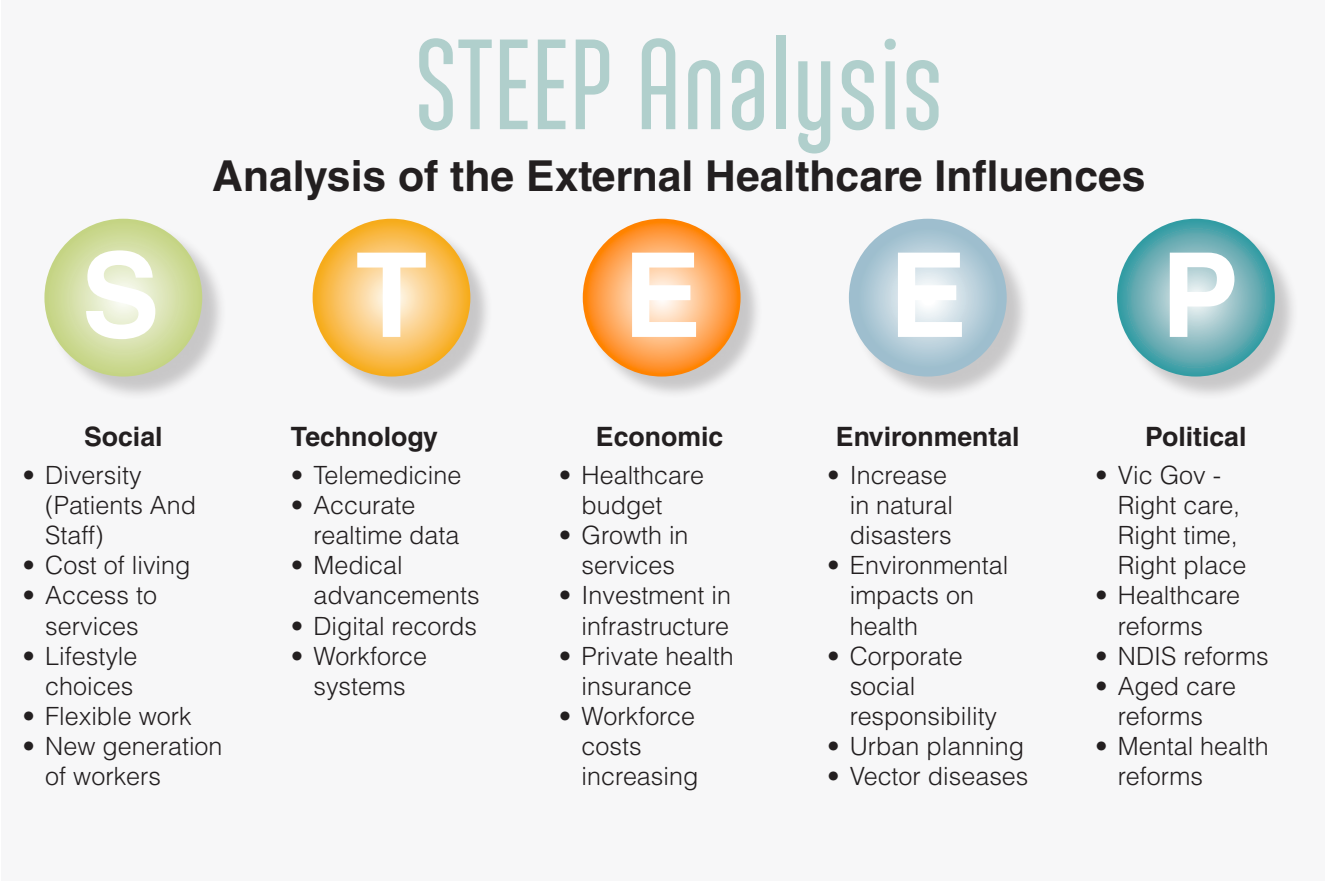
The Department of Health notes the introduction of new technologies and models of care will require today's health care workers to be supported to develop new skills and to fulfil new and different roles. Partnerships with universities and education providers to influence change and build strong and reliable regional pathways within this sector will be critical to keep up with the demand for a post graduate workforce. This is further evidenced by the insights provided by the Victorian Skills Authority, forecasting the Loddon Mallee will need:

- Allied Health – 609
- Nurses – 568
- Medical – 143
- Other staff (professional, clinical assistant, corporate support) – 1570

STEEP Analysis

Our staff also provided the insights regarding the external environment through the use of a STEEP analysis.

Figure 2 Internal Environment Themes



Internal Environmental Themes

We are seeing a significant shift in expectations of the workforce with the traditional 'employment contract' between the employer and staff member now being commonly referred to as a 'lifestyle contract'. Staff are more regularly demanding better work life balance, flexible work options, supported and welcoming environments and ethical employers that demonstrate a commitment to their corporate social responsibilities.

Through data analysis we can demonstrate this shift in terms of FTE v's headcount and the ways in which employment contracts are preferred. We also note staff enjoy the flexibility however are also seeking security, we have been able to improve this result as seen in *Figure 4* on page 10.

Workforce diversity has also experienced a shift with the available data identifying up to 12 different nationalities and a small increase in our First Nations staff from 2019. This will be an important focus area as we continue to develop our cultural safety knowledge and practices, implement the Aboriginal Employment Plan (AEP) and improve our diversity, equity and inclusion at ERH.

Finally, we acknowledge 36% of our workforce are over 50yrs of age who are likely to have begun or planned their transition to retirement upon the completion of the Clinical Services Plan. Preparation should be undertaken to secure and pass on their wealth of knowledge and experience while also welcoming a new generation with expectations of an environment that provides readily available digital platforms and tools, dedicated consideration of their phycological wellbeing and fast-tracked career advancements.

Workforce Flexibility

The data confirms, since 2019 our FTE has decreased by 3.5% yet the headcount has increased by 17.4%.

Headcount and FTE Profile

	2019	2020	2021	2022	2023
Headcount	824	845	915	999	998
FTE	603	616	511	526	582

Figure 3

Our workforce employment type has remained stable with information confirming full-time employment is the least attractive for our industry.

Workforce Employment Type

	2019	2020	2021	2022	2023
Full Time	15.9%	14.79%	14.86%	13.92%	17.33%
Part Time	65.53%	68.05%	66.45%	61.56%	65.83%
Casual	18.57%	17.16%	18.69%	24.52%	16.84%

Figure 4

Job Security

Job security is important to staff. To retain staff, we have reduced the use of short-term contracts by 10% since 2019.

Contract Type

	2019	2020	2021	2022	2023
Ongoing	77.91%	78.22%	83.93%	87.29%	87.78%
Fixed Term	22.09%	21.78%	16.07%	12.71%	12.22%

Figure 5

Nursing and Corporate Services demonstrate they have a large portion of their workforce in the 51-64yr category. Planning for potential impacts such as loss of corporate and industry knowledge will be important.

Age Profile

	16-30yrs	31-50yrs	51-64yrs	65yrs +
Medical	23	51	16	3
Nursing	100	195	127	10
Allied Health	38	67	23	4
Corporate Services	58	113	122	22

Figure 6

Consultation Themes

Between February to April 2024, Echuca Regional Health undertook extensive consultation with a broad range of internal stakeholders to inform the 2024-27 Strategic Workforce Plan. There were 15 sessions facilitated with leaders of services, functions and teams across the organisation. Each of the ERH Executives participated in an individual collaboration discussion to share their perspectives on workforce planning.

A consistent approach to obtaining and recording feedback was taken, with questions aligned to the Victorian Public Sector Commission's (VPSC) Workforce Planning toolkit 'Discovery and Design' phases. Broad, open-ended questions were posed, to undertake an internal and external environmental scan regarding impacts on workforce needs for the future. Participants also explored questions about potential sources of the ERH workforce for the future.

The consultation sessions were built on the foundational knowledge of:

- Our Purpose: "Supporting everyone to be healthy and live well"
- Our Values: Collaboration, Accountability, Respect & Excellence
- ERH Clinical Services Plan 2023-2033
- ERH Strategic Plan 2024-2027

We would like to sincerely thank all those involved in contributing to the discovery phase of this plan. Your insights, knowledge and enthusiasm has resulted in a robust plan for the future (Appendix 2)

Flexible and Innovative Workforce

Participants reported flexibility with rostering and employment contracts such as one week on and one week off, fly in fly out workforce and the continued use of agency and locum were useful methods of supplementing the workforce. Using alternate workforce options such as retirees, volunteers and regional shared workforce models are other options for the future.

Attraction and Retention enablers

There is a growing appetite to be creative and flexible with our attraction approaches, utilising networks and social media as additional ways of advertising. Staff agreed the importance of implementing initiatives such as the flexible rostering project, shared credentialing platforms, regional talent pools and incorporating paid nursing student placements into a roster would all assist with retention and if shared, a way to promote working at ERH.

Organisational Structure and Job Design

Staff alluded to the growing burden of administration from increasing compliance requirements, inefficient technology and undertaking project work on top of business as usual activities. Highly trained clinicians report undertaking data-entry tasks due to the lack of administrative support in their teams. Concern regarding unsustainable job expectations is leading to workplace stress and dissatisfaction.

Leadership

Building leadership capability within our manager group will enhance employee experience, build confidence in adapting to fluctuating workforce pressures and align strategic thinking. In addition, increased manager capability will release pressure on other support services such as HR and OHS. Leadership support and pathways need to be visible with considered succession planning opportunities shared with future successors.

Learning

Education and training models require and organisation-wide focus and consistent approaches to developing priority workforces. Innovative approaches will need to be considered including entry level programs, corporate education for all staff, regional partnerships and enhancement of 'grow our own' training pathways and scholarships.

Ongoing learning is important to ERH as health continues to evolve with new technology and models of care. Specialised post graduate programs should be tailored and specific to our service models with computer literacy included in our foundational training as we introduce digital transformation. Our managers will need to be equipped to support and led change in order to embrace the significant changes we are predicting over the next three years.

Volunteers

A volunteer workforce is a significant part of the health industry and a welcomed addition to teams across all areas of ERH. Prior to the pandemic ERH had in excess of 100 volunteers. Over the past 12mths there has been a steady increase with 62 active volunteers now involved with service delivery which equates to approximately 250hrs of time per month on average. Expansion of this service over the next three years will not only provide better outcomes for patients but provide an avenue for our community to give back.

Our Priorities

Using workforce data, research documents and engaging in extensive consultation, an ERH workforce road map has been developed for each discipline based on four priority areas

1. Attract and Retain

- Implement discipline specific actions linked to the recruitment and retention strategy
- Leverage industry and discipline attract and retain initiatives
- Improve systems and processes

2. Improve our enablers

- Enhancement and introduction of ICT systems, tools and hardware
- Right People, right time, right place, right skills
- Organisational structure and job design to drive excellence
- Develop partnership to drive efficiencies and broaden skill sets

3. Models of Care/Ways of Working

- Introduction of contemporary models of care
- Develop the workforce to deliver new models of care

4. Learning Culture

- Expand clinical and non-clinical career and learning pathways
- Broaden corporate education offerings
- Develop manager and leadership learning pathways

Our Future Workforce

The information and recommendations provided are a culmination of consultation, research and analysis. Specific consideration has been undertaken for each discipline with key actions aligned to the four priority areas and identified priority roles.

Medical

Attracting and retaining experienced and skilled Registrars, Emergency Physicians, General Medicine Physicians, Surgeons, and Rural Generalists to work and live in rural and regional areas is a national issue. Medical shortages also exist at ERH.

Future medical workforce requires more innovative approaches to attract and retain to regional and rural areas. ERH has experienced growth driven by an aging population, increase in community demands for services closer to home, increasing complexity of presentations and neighbouring health services withdrawing from provisions of some services, often because of the difficulty of recruiting and retaining Doctors.

ERH medical workforce is made up both junior and senior medical workforce. The junior medical workforce comprises of Doctors in Training (DiT). These positions include locally appointed and rotators from metropolitan, (Northern Hospital and Austin Hospital) and major regional centres (Bendigo). ERH is also a member of the Victorian General Practitioner Rural Generalist program, which integrates training in primary care and procedural practice from internship through to postgraduate year five. During the consultation for the workforce plan a survey response describes the registrar positions as *important for supervision and operational efficiencies* to grow a workforce.

The senior medical workforce is made up of local General Practitioners (GP), Rural Generalists (RG), Visiting Medical Officers (VMO), Staff Specialists, Senior Medical Officers (SMO) and Specialists who visit on a regular basis under a fee for service agreement. The VMO group have admitting rights to ERH and continue to work across acute and community settings and provide highly valued services in anaesthesia, procedural work, obstetrics, paediatrics and emergency medicine. The decrease in the number of GP, RG's and VMO's in the region over the last three years has challenged the service and increased the demand on the existing rural generalist practitioners. There remains a mismatch between the supply and demand for rural generalist-based specialists. A combination of Rural Generalists and rurally based Specialists and Senior Medical Officer's is essential for clinical safety, supervision, and professional development.

The ERH medical workforce is experiencing a shortage across both the junior and senior workforce cohorts. This requires stabilisation at every level to support local self-sufficiency, safe, quality care and delivery of care closer to home that is of the highest of standard.

Government policy and initiatives such as the rural clinical schools program established under the Integrated Rural Training Pipeline (IRTP) initiative and the Stronger Rural Health strategy's Murray – Darling Medical School Network has positively influenced the number of funded rural university training places for medical students.

This strategy has been somewhat effective in increasing the supply of doctors working in rural Australia, but the ongoing maldistribution of medical students and medical practitioners to metropolitan areas compared to rural regions remains a contributing factor to undersupply.

One strength for the future workforce is a stronger collaboration with the University of Melbourne for medical students with a focus on the end-to-end training to promote ERH and our region as a prime location to train, work and live.

Pharmacy is currently operating with an all-time low workforce against EBA approved FTE.

The ability to attract and retain pharmacists at ERH is a consequence of the continuing national shortage of pharmacists. In regional areas this is compounded by the attraction of larger hospitals with their choice of specialties for the early career and career minded pharmacists and the competitiveness of salaries offered by community pharmacies.

ERH is operating with a reduced FTE of 5.3 pharmacists and 0.5 FTE technicians plus 1 FTE intern in spite of positions being extensively advertised throughout 2024. Outreach pharmacist services are temporarily on hold and the Partnered Pharmacist Medication Charting as well as ED pharmacist roles have also been put on hold.

An Advanced Practice Technician role has been established to assist with patient admissions and support the pharmacists in fulfilling their clinical role. This novel approach is being supported by Safer Care Victoria. Pharmacy has also become actively involved in local school's career evenings to increase public awareness of the opportunities now available for a career path as a hospital pharmacy technician.

ERH pharmacy will explore becoming an accredited site for a rural module within the Advanced Pharmacy Australia residency training program, either independently or initially with a Tertiary Hospital as another innovative approach.

Priority Roles

The vision is to stabilise, consolidate and grow the workforce using a sustainable approach across both the junior and senior medical workgroups. Each role plays an important part in safe, quality service delivery, however, because of the growth of the service and the demand for care closer to home the following roles have been prioritised.

- All Specialists
- Rural Generalists
- Training Registrars

Medical
Objectives and Actions

Acronym list
see page 46

Priority 1: Attract and retain

	Actions	Timelines	Success Indicators	Responsibilities
1	Engage in research to pilot new medical workforce models	2024-2027	- Improved attraction retention retention rate - Patient satisfaction - Staff satisfaction - Cost effectiveness and sustainability	EDMS
2	Collaborate with the colleges on different regional model programs	2026-2027	- The number of enrolment/recruited - Retention rate	EDMS CD DETR
3	Increase accredited training positions at ERH	2025-2027	- Increase accredited	EDMS
4	Provide financial support for professional development, training, and other regional incentives	2024-2026	- Increased retention rate of Doctors at ERH	EDMS Directors DETR
5	Develop a medical workforce forecasting plan to identify future medical roles and size	2025-2026	- Completion of a forecasting plan	EDMS

Priority 2: Improve our enablers

	Actions	Timelines	Success Indicators	Responsibilities
1	Strengthen Rural Generalist consolidation pathways	2024-2027	- Increase in the number of advanced skills competencies - Increase RG satisfaction	EDMS MWVM DETR VGRC
2	Identify, share, and collaborate on a Loddon Mallee Medical workforce data set	2026-2027	- Partnership and agreeance of data governance (collection and security) - User friendly platform for accessing and sharing data - Data being used to inform workforce planning and decision-making processes	EDPCS DWS
3	Be a key driver in transforming to a Digital Electronic Medical Record (EMR)	2024-2027	- Implemented EMR with established performance metrics being monitored - Staff/ job satisfaction - Improved patient satisfaction - Improved continuity of care	EDFCS DHIPR EDMS DETR

Medical

Objectives and Actions

Acronym list see page 46

Priority 2: Improve our enablers - continued

	Actions	Timelines	Success Indicators	Responsibilities
4.	Build partnerships and collaborate with local GP practices on ways to increase the number of Rural Generalist trainees and third year medical students at ERH and within the region	2024-2027	- An increase in the number of RG's in local GP practices - An increase in 3rd year medical students in local GP pracitces - Partnerships with practices that represent Aboriginal and or Torres Strait Islander medical care	EDMS CD UoMSD VRGC MHE DETR
5.	To become an accredited site to deliver a rural module within Advanced Pharmacy Australia Residency Training Program.	2025	- Undertake site credentialing with AdPha	DOP EDMS

Priority 3: Develop new models of care/Ways of working

	Actions	Timelines	Success Indicators	Responsibilities
1	Support the Nurse Practitioner Model of Care to enhance access to speciality Care in parallel with the increasing size and complexity of medical services	2024-2027	- Reduced wait times for appointments and emergency wait times - Positive patient testimonials and satisfaction score on surveys - Improved cost effectiveness associated with readmissions or ED presentations - The number of Nurse Practitioners (NP) credentialed and practicing - Number of new services supported by NP's	EDNM DON EDMS
2	Work with Department of Health and other stakeholders to consider models for virtual regional clinics support care coordination	2025-2027	- New and existing partnership development to pilot and or to pilot and or evaluate the implementation of a virtual model of care for specialist clinics	EDMS DHIPR EDFCS
3	Structure the medical workforce effectively to support medical leadership that encompasses a mix of GP/RG, VMO's, specialists, SMO's	2025-2027	- Improved access to care through reduced waiting times, LOS, NEAT targets, surgery wait lists - Staff satisfaction levels	EDMS

Medical

Objectives and Actions

Acronym list see page 46

Priority 3: Develop new models of care/Ways of working - continued

	Actions	Timelines	Success Indicators	Responsibilities
4	To create a formal credentialing program at ERH for Partnered Pharmacist Medication Charting	Ongoing 2025	- Have each eligible pharmacist (Grade 2 pharmacist with a minimum of 2 years general experience) complete PPMC credentialing - Established a permanent PPMC role in the Emergency Department	DOP DOEM EDMS
5	To encourage and support more technicians to undertake Advanced Practice training to assist and further support pharmacists in patient care areas	Jan 2025 2025	- Current technicians to participate in external training via RMH (ERH accepted as a trial/research site) - Establish an Advanced Practice Technician Pathway, in line with EPAs from other health services	DOP Grade 4 Technician EDMS

Priority 4: Learning culture

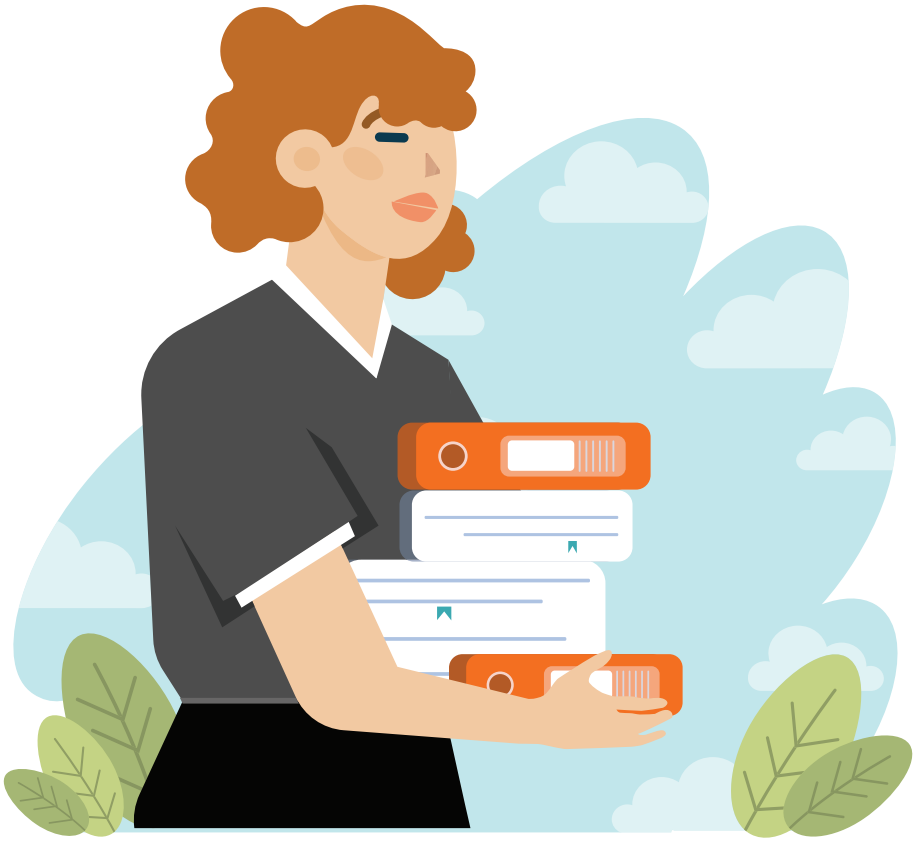
	Actions	Timeline	Success Indicators	Responsibilities
1	Increase medical student placements	2025-2027	- Increase in the number of student days at ERH	DETR EDMS UoMSD HE
2	Aim for an End-to-End Medical Training Hub at Echuca 2030	2025-2027	- Appointment of Sub Dean - Appointment of Clinical Nurse Educators - MD2 curriculum delivery - MD1 curriculum discussion plan (aim 2030) - SLA completed between ERH and UoM	DETR EDMS EDPCS
3	Develop and market a leadership, career and corporate package program targeting the registrar cohort that includes 2hrs paid above EBA to attend and complete the program	2026-2027	- Increase in pool of registrars to rotate to ERH from parent hospital - >50% participation in professional development program - Increase in return to ERH once training completed as specialists - Improved Registrar satisfaction (surveyed) - Improvement in leadership competencies identified through feedback and end of term.	DETR EDMS EDPCS

Medical
Objectives and Actions

Acronym list see page 46

Priority 4: Learning culture - continued

	Actions	Timelines	Success Indicators	Responsibilities
4	Investigate ways to incorporate a Master of Research into the clinical trial portfolio as part of a medical position	2026-2027	- Approval of the Masters of Research program by both ERH and the relevant academic body	DETR EDMS
5	Enable a flexible learning and development model	2024-2027	- Strengthen the LMS to support regional programs, eLearning and other blended learnings that includes RPL	DETR EDMS DWS ICTM



Nursing and Midwifery
(Inpatient and Community)

The recent pandemic and the already existing shortage of nurse and midwives globally, is further compounded in rural and regional areas by an ageing workforce, aged care reforms and burnout, causing a significant workforce shortage. Nurses and midwives are the largest healthcare profession in Victoria, and demand continues to outgrow the supply.

Since 2019, ERH Nursing FTE has had a 7.7% decrease yet, specialist nursing has increased by 17%. A theme from the consultation report provides an example of the demand for more senior skills which is currently depleting the supply of general registered nurses. *"The number of Clinical Nurse Specialists (CNS) working on the acute wards has reduced in recent years, due to Registered Nurses (RNs) stepping directly into ANUM vacancies rather than taking the traditional pathway via the CNS role".* This was further supported by all nursing leaders who completed the Nursing Workforce Strategy survey predicting Registered Nurses to be the biggest supply gap in the next 5 years.

In contrast to national and state trends ERH has a remarkably low vacancy rate for midwives compared to the rest of Victoria and a robust Enrolled Nurse pathway, ensuring a continuous supply of skilled Midwives and Enrolled Nurse professionals. This strong foundation, positions ERH well to maintain high standards of maternal and neonatal care, expand our services to meet growing community needs, and support the professional development of our nursing staff.

The Nurse practitioners care model at ERH is underutilised. 72% of nursing leaders who completed the workforce survey identified ERH will need 30% more Nurse Practitioner FTE in the next three years. Currently, Nurse Practitioner roles exist in oncology and community drug and alcohol. Nurse Practitioner candidate positions have been selected for diabetes, cardiac, respiratory and palliative care. There is real opportunity to build Nurse Practitioner capacity in areas where there are part time medical specialists in the region.

With the increase in life expectancy and the new aged care reform for mandatory 24/7 Registered Nurses onsite, aged care providers are struggling to recruit and retain RN's. Even though ERH's aged care facility 'Glanville' met all the Aged Care Quality and Safety assessment standards, and the staff were found to be highly capable and competent, agency staff continue to support the workforce gap of Registered Nurses.

Priority Roles

- Nurse Practitioner
- Aged Care Registered Nurses
- Registered Nurses
- Enrolled Nurses (Community)

Nursing and Midwifery
Objectives and Actions

Acronym list see page 46

Priority 1: Attract and retain

	Actions	Timelines	Success Indicators	Responsibilities
1	In collaboration with universities investigate and facilitate an increase in student placement	2024-2025	- Increase in student numbers - Student conversion to graduates	DETR
2	Explore and implement expansion of graduate employment models including registered nurses & midwives and enrolled nurses	2025-2026 employment 2025-2026	- New graduate modules implemented	DETR EDNM NUMs
3	Optimising roster practices to meet care delivery needs, support wellbeing and improve job satisfaction	2024-2027 practices	- Improved rostering - Staff feedback	EDNM
4	First Nations Nursing and Midwifery traineeships/cadetships	2025-2027	- Increased access to First Nations	EDPCS HRM WDM
5	International recruitment supported onboarding and training program	2024-2025	- International candidates supported upon arrival	EDPCS DETR NUMs

Priority 2: Improve our enablers

	Actions	Timelines	Success Indicators	Responsibilities
1	Visibility and access to relevant workforce data including performance dashboards to monitor compliance	2025-2026	- Improved compliance Managers able to make informed decisions	EDPCS/HRM
2	Improved onboarding process, integrated between relevant departments by new staff feedback	2025-2026	- Streamlined and efficient onboarding process confirmed	EDPCS/HRM
3	Improved manager tools to drive efficiencies	2025-2026	- Managers' report improved access to managers tools	EDPCS/HRM
4	System and process enhancement (business operations) to enable right people, right time, right skills, right place	2024-2026	- Systems and processes are improved evidenced by feedback and efficiencies	EDFCS/EDPCS

Nursing and Midwifery
Objectives and Actions

Acronym list see page 46

Priority 3: Develop new models of care/ways of working

	Actions	Timelines	Success Indicators	Responsibilities
1	Partner with Universities to pilot new workforce models		- New workforce models implemented as appropriate	EDNM DETR
2	Increase Nurse practitioners and identify key areas for growth for example Nurse Practitioner generalist	2024-2027	- Number of Nurse Practitioners models introduced	EDNM
3	Develop and implement enhanced Pool employment model and grow program to meet workforce needs	2026-2027	- Improved Pool employment model evidenced by feedback	DON DETR NPM
4	Develop an attractive Aged Care Innovative Stream with leadership focus and professional development incentives	2026-2027	- Increase in top tier aged care candidates - Number of positions filled	DON ACQM GC

Priority 4: Learning culture

	Actions	Timelines	Success Indicators	Responsibilities
1	Enhance secondary school relationships and explore pathways and employment models	2024-2025	- Increase in interest and participation	DETR
2	Explore and implement a clinical nurse educator program to coordinate and provide supervision to international students	2024-2025	- Program developed and implemented	DETR
3	Develop a career pathway for CNE to provide medical student support for medical curriculum	2024-2027	- Career pathway developed	DETR SD
4	Establish supervision programs to support CNC and Research roles	2026-2027	- Supervision programs developed	DETR RHAN
5	Develop a supported EN to RN transition program that compliments existing DH scholarships	2024-2027	- Program developed with increase in EN converting to RN's	EDNM DETR
6	Complete a training needs analysis for the Nursing division	2025-2027	- Training Needs Analysis (TNA) report	DETR NUMs
7	Leverage from the strengths within our existing learning and development models including graduate and postgraduate programs and adapt accordingly	2024-2027	- Number of graduate and post graduate positions in underserved areas Staff and manager satisfaction	DETR NUMs DON

Allied Health

Rural and regional communities are grappling with the chronic shortages and high turnover of Allied Health professionals. The National Disability Insurance Scheme (NDIS) policy reform has seen Allied Health professionals leave the public system for the private fee for service model attracting greater financial rewards. Allied health has been acknowledged by the National Primary Health Network strategy as key group to improve rural/regional health outcomes, access, integration, safety, quality and cost efficiencies across the healthcare system.

In 2023, Allied Health's FTE was down 22% compared to 2019. This therefore requires targeted focused action in the workforce strategy. Staff also highlighted through collaboration sessions, the important role Allied Health Assistants (AHA) have in supporting Allied Health professionals to work to their full scope. Student numbers have also grown across most departments; however, the student number targets are well below in consideration of the available supervision available in each department. The report refers to the tension between clinical demands, training, supervision and limited allocated education support that impacts the ability to expand student numbers as a model to build workforce capacity.

The analysed results from the workforce strategy survey, the strategic workforce consultancy report and other data sources support that the allied health professional group poses one of the biggest risks if we don't plan to address the shortage of workforce in this discipline. ERH has not been able to attract a permanent Podiatrist either through attractive recruitment strategies or student pipelines and Speech Pathologists positions remain hard to fill.

Priority Roles

- Speech Pathologists
- Podiatrists
- Mental Health Practitioners
- Dentists
- Occupational Therapists
- Physiotherapists

Allied Health
Objectives and Actions

Acronym list see page 46

Priority 1: Attract and retain

	Actions	Timelines	Success Indicators	Responsibilities
1	Develop an allied health graduate program	2024	- Annual graduate program built into workforce profile	DAH/DETR
2	Investigate options for a community partnership dual workforce model	2024	- Increase availability of workforce	EDCS
3	Strengthen regional partnership opportunities to build skills and access career pathways	2024	- Increased opportunities for staff to develop and progress careers	DAH
4	Improve collaboration between departments of shared internal resourcing requirements	2024	- Increased opportunities for candidates and access to job variety	Hiring Managers

Priority 2: Improve our enablers

	Actions	Timelines	Success Indicators	Responsibilities
1	Visibility and access to relevant workforce data	2025	- Managers can make informed decisions - Increased accountability for managers	EDPCS/HRM
2	Refresh regional craft group community of practice partnerships	2024	- Supported regional networks established	EDCS/DAH

Priority 3: Develop new models of care/ways of working

	Actions	Timelines	Success Indicators	Responsibilities
1	Introduce Allied Health Rural Generalist/ Transdisciplinary Key Worker model	2025	- Model is introduced successfully	EDCS/DAH
2	Participate as a key partner in the Latrobe University NAP Nexus program (pilot)		- Program is adopted and forms part of workforce profile	DAH
3	Seek opportunities to introduce extended scope of practice models	2024	- New models are introduced - Staff satisfaction is improved	DAH

Allied Health
Objectives and Actions

Acronym list see page 46

Priority 4: Learning culture

	Actions	Timelines	Success Indicators	Responsibilities
1	Partner with Universities to provide continuing accredited professional development	2025-	Number of ERH staff enrolling in post-graduate courses	DETR/EDCS/DAH
2	Invest in supervision and developing programs for mentorship considering regional opportunities	2024-	Accessible supervision offered to all Allied Health staff - Grade 2-4 Allied Health staff are equipped to provide supervision	DAH
3	Investigate opportunity to introduce an Allied Health Assistant Diploma program at ERH (based on the EN GoTafe/ERH model)	2025	- Implementation of an annual AHA Diploma at ERH	DETR
4	Collaborate with Universities with intention to increasing student placements at ERH in respect to the priority roles	2025	- Increase in students aligned to priority roles	DETR
5	Conduct a review to determine feasibility of expanding research opportunities for AH at ERH	2026	- Future research determined	DETR
6	Plan for an increased capacity to deliver onsite Allied Health Education. This may involve internal and external resources and partnerships	2025	- Strengthened Allied Health professional development framework	DETR

Corporate Support
(Clinical Assistants, Professional and Corporate support)

With our workforce numbers increasing as we support flexible work options, coupled with an expansion of our clinical services and infrastructure to meet the rising healthcare demand, it is imperative to recognise the relationship between clinical and non-clinical workforce, considering the impacts and resources required from Corporate Support Services in order to maintain sustainable operations.

The Department of Health note challenges within this area of the health sector workforce, noting the most concerning being Health Information Management across the state due to the lack of students enrolling year on year and the long-term nature of this pipeline of future workforce. While ERH aligns with the Departments view, we also reflect on many other areas in which we are experiencing sustained challenges and risks to business continuity. Long term succession plans for key and critical roles is also becoming increasingly challenging due to lean teams and vacancies within the corporate areas of the organisation.

Workforce attraction continues to be a challenge as non-clinical health roles struggle to remain competitive in the market along with an ageing workforce in which we need to plan for. Additionally, looming Health Service Reform initiatives highlight proactive resource allocation and cost reductions with the emphasis on non-clinical areas. It is essential to strategically address and plan to safeguard essential support services while also seeking opportunities to explore and initiate regional partnerships that will result in shared services.

Further, digital transformation is identified by the DH as a key strategy to enhance patient care and streamline operations along with ERH outlining digital transformation as a key priority in the strategic plan 2024-27. While ERH has initiated preliminary integration phases with various programs and software solutions future regional partnership opportunity should be considered in light of the pending health service reforms.

Priority Roles

Corporate Support
- Food services
- Security
- Cleaners

Professional Support
- Information Technology
- Health Information Management
- Human Resources
- Finance

Clinical Assistants
- Instrument technicians
- Theatre technicians

Corporate Support
Objectives and Actions

Acronym list see page 46

Priority 1: Attract and Retain quality staff

	Actions	Timelines	Success Indicators	Responsibilities
1	Expansion of work experience program promotion for corporate support roles and careers	2025	- Corporate support roles are strongly Represented - Increased number of school leaver candidates during recruitment	EDPCS
2	Establish a Corporate Services entry level pathway program that provides opportunity to experience a range of corporate support roles	2026	- Strong pool of applicants to participate - Increased staff retention and satisfaction - Staff seek further career opportunities	EDPCS
3	Earn while you learn corporate services program (targeted to Uni students/gap year)	2026	- Increased pool of strong applicants to support peak times	EDPCS

Priority 2: Improve our enablers

	Actions	Timelines	Success Indicators	Responsibilities
1	Active engagement in the implementation of digital transformation within Victorian regional health sector.	2024-27	- Implementation of new systems - Efficiencies created - Increased pool of workforce due to remote opportunities	EDFCS/EDPCS
2	Access to ICT hardware for non-office-based roles ie; cleaners	2025	- Greater compliance with our ICT workforce systems	EDFCS

Priority 3: Develop new models of care/ways of working

	Actions	Timelines	Success Indicators	Responsibilities
1	Identification and active engagement in partnering opportunities for ERH (regional/community)	2024-27	- Partnerships have provided sustainable and accessible solutions	EDFCS/EDPCS

Corporate Support
Objectives and Actions

Acronym list see page 46

Priority 4: Learning culture

	Actions	Timelines	Success Indicators	Responsibilities
1	Develop a Corporate training framework suited to organisational needs	2025	- Visibility of training and career pathways available - Increased learning opportunities provided	EDPCS
2	Corporate Support Team Development Days (locally/regionally)	2025	- Increased staff engagement - Regional collaboration and networking increased	EDPCS


References
and
Resources

References and Resources

Echuca Regional Health Strategic Plan 2019-2024. E. Printers. https://erh.org.au/wp-content/uploads/2020/03/ERH_StrategicReport_2019_DOWNLOAD.pdf (no longer available)

Donald Cant Watts Corke. (2023). *Echuca Regional Health Clinical Service Plan 2023-20233. E. Printers*

Doleman, G., Duffield, C., Li, I. W., & Watts, R. (2022). Employment of the Australian graduate nursing workforce: A retrospective analysis. *Collegian, 29(2), 228-235.* https://doi.org/10.1016/j.colegn.2021.12.002

Echuca Regional Health - Strategic Plan 2024-2027. Approved link on website

Garcia-Perez, A., Cegarra-Navarro, J. G., Bedford, D., Thomas, M., & Wakabayashi, S. (2019). *Critical Capabilities and Competencies for Knowledge Organizations. Emerald Publishing Limited.* http://ebookcentral.proquest.com/lib/think/detail.action?docID=5963799

Hubbard, G., Rice, J., Galvin, P. (2016). *Strategic Management.* Pearson. https://doi.org/https://bookshelf.vitalsource.com/reader/books/9781488620317/epubcfi/6/2[%3Bvnd.vst.idref%3Dcover]! /4/2%4053:89

Kotter, J. P. (2012). *Leading change.* Harvard Business Review Press. http://bvbr.bibbvb.de:8991/F?func=service&doc_library=BVB01&local_base=BVB01&doc_number=027084950&line_number=0001&func_code=DB_RECORDS&service_type=MEDIA http://catalogue.londonmet.ac.uk/record=b1794930~S1

Ramsden, R., Colbran, R., Linehan, T., Edwards, M., Varinli, H., Ripper, C., Kerr, A., Harvey, A., Naden, P., McLachlan, S., & Rodwell, S. (2020). Partnering to address rural health workforce challenges in Western NSW: Managing Community Care [Rural health workforce challenges]. *Journal of Integrated Care, 28(2),* 145-160. https://doi.org/http://dx.doi.org/10.1108/JICA-06-2019-0026

Ray, P. K., Nakashima, N., Ahmed, A., Ro, S.-C., & Soshino, Y. (2020). *Mobile Technologies for Delivering Healthcare in Remote, Rural or Developing Regions.* Institution of Engineering & Technology. http://ebookcentral.proquest.com/lib/think/detail.action?docID=635598

Senge, P. M. (2006). *The fifth discipline: the art and practice of the learning organization* (Rev. and updated). Doubleday/Currency. http://catdir.loc.gov/catdir/enhancements/fy0703/2006281125-s.html

Skinner, T. C., Semmens, L., Versace, V., Bish, M., & Skinner, I. K. (2022). Does undertaking rural placements add to place of origin as a predictor of where health graduates work? *Australian Journal of Rural Health.* https://doi.org/10.1111/ajr.12864

Victoria, Department of Health. (2022). *Victorian Health Workforce.* Department of Health Victoria. Retrieved 25 April 2024 from https://www.health.vic.gov.au/health-workforce

Appendix

Appendix 1: Project Milestones

Appendix 2 – Consultation Report

Strategic Workforce Planning Consultation Report

A summary of the Consultation process and feedback received from internal stakeholders.

Compiled by: Jackie Austin

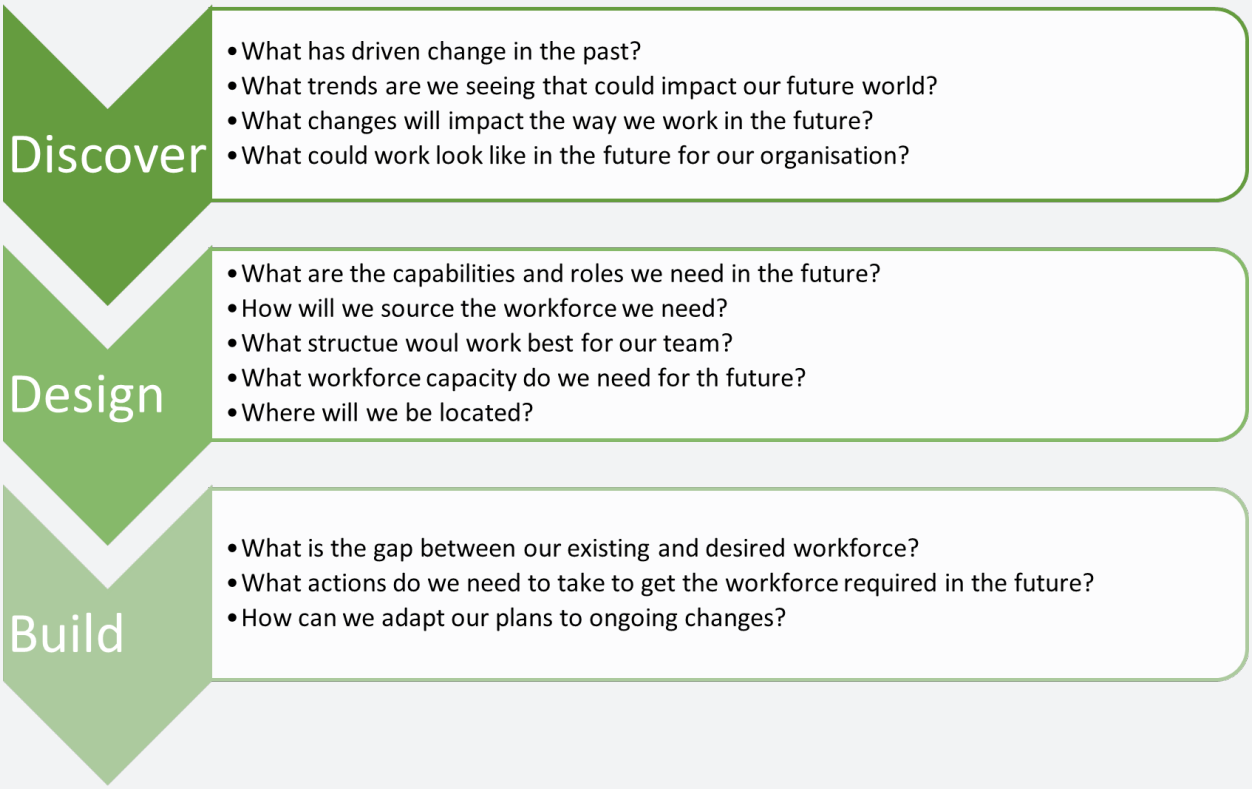
29 April 2024

Contents

Background and Methodology

Between February to April 2024, ERH undertook extensive consultation with a broad range of internal stakeholders to inform the 2024-27 Strategic Workforce Plan.

A consistent approach to obtaining and recording feedback was taken, with questions aligned to the Victorian Public Sector Commission's (VPSC) Workforce Planning toolkit 'Discovery and Design' phases. Broad, open-ended questions were posed, to undertake an internal and external environmental scan regarding impacts on workforce needs for the future. Participants also explored questions about potential sources of the ERH workforce for the future.



Underpinning the collaboration workshops was the knowledge of the foundations of the workforce plan:

1. ERH's Purpose: "Supporting everyone to be healthy and live well"
2. ERH's Values: Collaboration, Accountability, Respect & Excellence
3. ERH's Clinical Services Plan 2023 – 2033
4. ERH's Strategic Plan 2024-2027

There were approximately 15 discussions facilitated by Jackie Austin with leaders of services, functions and teams across the organisation. Each of the ERH Executives participated in an individual collaboration discussion to share their perspectives on workforce planning.

Discover Stage

Environmental Scan

A 'STEEP' analysis guided exploration of the impacts of Social, Technological, Environmental, Economic and Political/Legal factors which will impact the organisation and workforce in coming years.

Social

All participants pointed to the social and generational differences in approach to resilience, loyalty and expectations of employers to play a role in supporting their psychosocial safety and wellbeing. Young workers entering their careers at ERH are more empowered to ask for what they want and many have expectations of advancing in their careers at a rapid rate.

More staff than ever before are valuing work-life balance over income, with many younger workers electing to work less hours than in the past. In addition, there is an expectation amongst working parents, that flexibility will be supported and many express the desire for their employer to support in some way with childcare.

ERH's catchment population is growing, patients are presenting to the health service sicker, and requiring higher acuity treatment. People stay home longer as they get older, and the lack of GP availability locally, means they come into ERH's Emergency Department more unwell with more complex issues that haven't been addressed – requiring highly skilled and adaptable clinical staff to support their health needs.

The aftermath of the Covid-19 pandemic and local flooding have led to increased mental health challenges in the community, in both patient presentations and workers. Clinicians report an increased burden of chronic disease, including younger patients in their 30s presenting with conditions with lifelong impacts.

Long-term ERH team members described the organisation as having a core of committed, local employees who 'aren't going anywhere' which is of benefit to continuity of service and care to the community. The effectiveness of this cohort, and opportunities to attract and retain others, is reliant on a healthy internal organisational culture. Participants in consultation highlighted the importance of trust in leadership and transparency from leadership to support a values-based culture.

Technological

Feedback emphasised that internally, technology presents a hurdle to efficient work, notably stemming from inadequate integration of systems. Clinicians have concerns about safety of patient care due to delays in logins, accessing medications etc. Managers point to the psychological impact of technology on staff, as it is a 'pebble in their shoes' every day. Concerns were raised that the use of hybrid systems without integration creates both clinical and non-clinical risks.

Technology is a positive engagement factor for some sectors of the workforce, with greater access to specialists via Telecare, VST, VICCTU as well as Teams providing the opportunity for inter-health service connections and learning. The RCP community patient record is reported to save many hours of clinician time, which the ERH team hope to see enhanced even further over time. The quality of ERH's technology creates issues, it is not currently reliable and creates issues for middle managers who become system trouble-shooters on top of their existing workloads.

Views on the shift towards Electronic Medical Records (EMRs) varied, with the majority stating that a more digitised future is a positive one. However, some noted that the introduction of a sub-standard EMR would be worse than having no EMR at all, with the creation of greater clinical risks and administrative burden.

It was noted that online training opportunities open up a world of learning at people's fingertips and the ERH workforce has access to more education options than ever before.

Environmental

Most participants spoke to the crucial role of disaster planning for known environmental impacts which will continue to arise in the coming decade, include heatwaves, floods, disease and fires.

Many highlighted the impact of neighbouring health services who are no longer delivering the level of care they once were, so more patients are coming to ERH for services. One senior leader stated, “We’re doing more of their work than ever”

The impact of climate anxiety since the recent natural disasters was noted by a number of leaders, with examples of staff leaving work early when bad weather is forecast, for fear of impact to their property.

Economic

Tight financial constraints in the public health system make it challenging to be innovative and flexible. Many participants spoke of the innovations and workforce they would like to see in the future, while also stating that they did not think it realistic that these things would materialise, due to budget constraints.

Increased cost of living challenges mean that people in the broader community are working more hours and appointments for early interventions for preventative healthcare are being delayed as a result. Stress levels for existing staff are increasing with financial pressures and accommodation challenges.

An increase in student poverty is evidenced by a decrease in regular placements across a variety of professions. In addition, unsustainable accommodation prices in the community make it challenging to attract new people to the region, and public transport from metro and regional centres is not timely or reliable.

Political / Legal

ERH’s partnerships with neighbouring health services significantly impact on workforce capacity in both the clinical and corporate areas. Participants spoke of the decreasing ability or willingness of smaller health services to provide care to patients of a certain complexity level, which increases ERH’s activity levels.

Changes in national disability policy have a direct impact on ERH’s NDIS services, as well as creating workforce challenges with Allied Health Professionals (AHPs) drawn to private, for-profit work outside of ERH. During recent years, more than six AHPs have left ERH to take up private NDIS work. Currently, a number of long-term ERH AHPs work part-time to allow them to engage in a mix of private NDIS work as well.

In the Corporate areas, providing services such as Health Information, Payroll and Supply to other health services, impacts on the capacity of already stretched teams to fulfill their roles locally and maintain a degree of satisfaction and fulfillment in their work.

Capabilities and Roles for the Future

Stakeholders bought a variety of perspectives about the capabilities and roles that will be needed to meet future demands. Based on the information gathered through this discussion, participants were asked to consider where skill and capability gaps are likely to exist in the short and long term.

A theme across all professional groups was the importance of having **training and supervision skills built into the work area to support development and growth of the existing workforce.** Investing in these skills, as well as formal qualifications such as Certificate IV in Training & Assessment, leadership and specialist trainers in focus areas such as paediatrics and critical care, will be critical to this growth. Taking a structured approach to 'layering' supervision, training and education skills will support a controlled and incremental approach to upskilling existing staff.

Participants in consultation pointed to the importance of empowering ERH managers to be managers and **leaders** who attract, engage and support a healthy, vibrant and learning culture in their teams.

A key element of the 2024-2027 ERH Strategic Plan is to, "Build research capability to ensure our region continues to advance care provision, including clinical trials." In order to achieve this objective, ERH needs to focus on building Research Governance skillsets in clinical and non-clinical roles. Junior Medical Officers (JMOs) will need to access research projects and clinical trials to build this capability over time.

Grant-writing and partnership skills will be pertinent for future growth of the health service as the Victorian Government shifts to a more structured partnership approach. Investing in these skillsets will ensure that ERH is in a position to capitalise on opportunities that arise as a result of significant system changes. In addition, Service Development and Business Management capability specific to Cancer and Aged Care services could tap into extensive resources valuable to ERH.

Data now plays a more prominent role than ever at ERH, and the skills to work with this will be essential into the future. Capabilities around managing big data, cleaning and structuring data, telling a story with data will benefit ERH during a time of growth.

A focus on delivering care closer to home, means that more and more services are being delivered outside the health service every month. Hospital In The Home (HITH) demand continues to rise, and the workforce models to support this need to evolve with the expanding services. Versatility is required to provide health care services in the home, and over time, more ERH staff will be required to work in this way.

Profession and Service-specific information

Medical Workforce

There is consensus that medical workforce supply will not meet demand in the short to medium term, and the continued use of locums will be business as usual for a period of time. During this time, there is also consensus that a focus on Rural Generalist pathways is critical to build the regional medical workforce of the future. ERH is working closely with industry bodies to lobby for improvements including:

- Introduction of a program from Year 2 to Year 4 flowing into an Internship at ERH
- Changes to curriculum to allow local medical students to study specialities closer to home, rather than having to travel to Bendigo or Melbourne for specialist placements that could be undertaken at ERH.
- Department of Health to recognise General Practitioners (GPs) in the 24/7 staffing model required to upgrade to a Paediatric Unit Nursery under the capability framework.

Advanced skills are needed, and at least 1.2 FTE of Paediatricians are required to 'grow our own' paediatrics model via an incremental approach. In order to attract Paediatricians to this model, a fractional approach will be most sustainable and recruitable; with the option for specialists to take on a portfolio and build their skills on the job. A mixed model of Paediatricians and GPs is seen as ideal, to ensure GPs have the opportunity to maintain paediatric skills, while having the support of fractional Paediatricians.

Visiting Medial Officers (VMOs) will remain a crucial element of the ERH medical workforce and fostering these relationships and career pathways must remain a priority. VMOs combined with a fractional workforce require a robust handover system to ensure clinical safety.

Attraction strategies to secure a portion of the scare medical workforce available include:

- Consideration of a model with Fellows on a 6-month position, becoming the key contact for the Region. This will require partnership with Bendigo Health on regional staffing models.
- Access the 17% of the medical workforce who are career medical officers who have not gained their fellowship, known as 'The Lost Tribe'. They are a big proportion of the locum workforce. Targeting these workers with attractive EBA contracts including Continuing Medical Education (CME), portfolio work and a title for their CV.
- Recognition of the importance of the Rural Generalist workforce pathways, include advanced skills roles and synergise with Nurse Practitioner (NP) roles in ED through medical budget.
- Put Medical Officers through the Australian College of Rural & Remote Medicine (ACRRM) program and put them on Year 3 contracts to make it attractive to work at ERH.

ERH's surgical cases have increased in complexity and number over time, however Surgical Senior Medical Officer (SMO) hours are still limited to four hours per day on weekends, consider increasing this to support increasing work.

Pharmacy Graduates have reduced by 60% over the past 20 years, this is another challenging workforce to source. The Pharmacy workforce model needs to evolve to support expanding services including Paediatrics and surgical services. Recognising and adopting the advanced scope for Pharmacy Technicians will play a key role, as will embedding specialist Pharmacist roles in the ED, Theatre and wards.

Nursing Workforce

Enabling strong Nurse Leaders is key to maintaining and strengthening a core workforce. The Emergency Department (ED) example of upskilling and empowering a group of Associate Nurse Unit Managers (ANUMs) over the past four years, is a pathway that will provide more nurses who are strong people leaders over time. Conscious effort and structured pathways will support this.

There was a general consensus that the number of Clinical Nurse Specialists (CNS) working on the acute wards has reduced in recent years, due to Registered Nurses (RNs stepping directly into ANUM vacancies rather than taking the traditional pathway via the CNS role.

A desire to replicate the Maternity Ward model of Clinical Nurse Education (CNE) across other acute wards was highlighted, with suggestions that this could improve staff attraction, retention and engagement as well as enhancing clinical skills.

Maternity and Paediatric services - One objective of the Clinical Services Plan (CSP) is to expand and uplift Maternity services to provide neonatal and paediatric services. It was noted that for Registered Nurses in training, paediatric placement opportunities are scarce. To achieve this, there are very specific staffing requirements including:

- Paediatric trained nurses
- Midwives upskilled to support paediatric patients
- Paediatric educators who could work across Theatres, Emergency Department and Paediatric Unit to continually build skills in the workforce

Nurse Practitioner models - A variety of views exist on the value of Nurse Practitioner models in different speciality areas. Priority areas for Nurse Practitioners based on consultation include:

- Aged Care
- Anaesthetics
- Oncology
- Community services – HITH, Residential In-Reach, Respiratory, Cardiac. Support existing NP models in Diabetes, AOD and Palliative care.
- Surgical specialities such as dental, paediatric ear, nose and throat.
- Emergency Department – There is scope to introduce a Nurse Practitioner model to support the Fast-tracking of Triage level 4 and 5 (T4 & T5) patients through the Emergency Department. Views vary on the likelihood of NP candidates finding this option attractive, in a health service of ERH's size, this may result in the NPs 'sacrificing' work with more complex T2 and T3 patients.

Perioperative Services – including specialised roles such as Theatre Liaison, Central Sterilising Supply Department (CSSD) etc, are currently 'in crisis' due to workforce shortages and lack of sustainability in the current model and continued tension between ERH versus surgeon priorities.

Expanded CSSD services will require additional Full Time Equivalent (FTE) staff working extended hours. The effectiveness of a multi-skilled CSSD/Theatre Technician role has proved valuable over time and will be the ideal model as the service grows. CSSD leadership via the Equipment Nurse has created a more responsive leadership structure and should be maintained as the service grows.

Subacute Services – including GEM@home and Transition Care Program (TCP) are currently Nurse-heavy and require more permanent Allied Health Professional (AHP) and Medical staff allocations to provide more innovative models of care. Geriatrician and neuropsychology support is a priority for TCP care, and is also an attraction and retention factor for Nursing staff who love learning from these specialists.

Community Nursing – increasing demand for HITH services requires evolving workforce models and an increased scope of practice across all areas including:

- Addition of an afternoon shift for Palliative care
- Nurse Practitioner model
- Separating out District Nursing Services (DNS) from HITH
- Diversifying DNS workforce to include Personal Care Workers (PCWs) and Enrolled Nurses as well as high-level Grade 4 RNs. There is currently no budget to expand the team, so introduction of these roles will occur when there is natural attrition in the team.

Cancer and Wellness Services – having evolved the service with new infrastructure, the workforce has out-grown their existing model and require consideration of appointing a Clinical Director to oversee Junior Medical Officers in Oncology and Haematology. The breadth of the service now requires a review of the nursing structure and inclusion of Allied Health Professionals (including Pharmacy) in the multi-disciplinary model. It was noted that *'A NUM is no longer enough, if we're to explore expanded models such as Chemo@ Home, business development skills and capacity are required."*

Residential Aged Care Services (RACS) – the Glanville Village team is facing increasing administration and compliance burdens with ongoing changes in the national system. There is a growing need for a core workforce to support residential and community Aged Care, however ERH's acute health services are more attractive to Nursing recruits to the health service.

The Residential In-Reach (RIR) model is highly valued in RACS, the team suggests that a multidisciplinary team (RIR Nurse, NP, Geriatrician and Pharmacist) could service a range of RACS in the area as a for-profit model.

Critical Care Services (including Emergency Department and HDU)

Enhanced Critical Care Services: A gap analysis is currently underway, led by the HDU Nursing team, to determine the staffing requirements to move from a 3-bed High Dependency Unit, to an Intensive-Care Unit, as per the Clinical Services Plan. This analysis will provide critical information to build a workforce roadmap to enhanced Critical Care services at ERH. Preliminary findings indicate that, at a minimum, requirements will include:

- Critical Care Liaison Nurse (potential to incorporate with After Hours Manager role)
- Outreach capability via a Clinical Support Nurse (CSN) or Clinical Nurse Specialist (CNS)
- 75% of HDU Nursing staff with a Critical Care certificate
- Access Nurses for patient flow, Education support
- Full-time Nurse Educator
- Full time Senior Medical Officer

Current experience shows that Internationally-trained Registered Nurses joining ERH in recent years are not Critical Care certified, however they come with significant experience to support a rapid progression to 'Nurse A' level in HDU.

Opportunities to 'grow our own' Critical Care workforce would be enhanced by developing a model with Bendigo Health, where ICU workers could rotate between health services to build skills and exposure.

An outcome from the TEC project showed that the trial of a Social Work Care Coordinator in ED has been a great innovation in service delivery, as are having a SMO and Nurse on Fastrack supporting patient flow through ED. Despite the TEC funding ending, these are the types of models that will support attraction, retention and wellbeing of staff.

In order for the Emergency Department to open to full capacity (an additional 3 cubicles) an additional Registered Nurse is required across all shifts. In order for the Short Stay Unit to flex up to 8 beds, an additional Registered Nurse is required across all shifts. Business cases have been submitted to this end. In addition, a Senior Medical appointment to the Short Stay Unit would increase the overnight medical workforce to three, rather than two, supporting more complex patient admissions.

Allied Health Professionals

Current Allied Health Professional (AHP) student numbers are not reflective of the significant growth in this workforce, which has doubled in number over the past five years with further room for growth. Barriers to supporting more students includes the minimal FTE allocated to AHP Education, currently at two days per fortnight.

Clinical demands create tension between training and supervision of students and junior workforce in Allied Health, where service impacts of the Acute wards in particular, often pull workforce away from training and supervision. Providing pathways for AHPs to develop from Grade 1 to more senior roles will make ERH an employer of choice.

A multi-disciplinary AHP Education Lead would have the ability to coordinate students and develop a structure for specialised AHP Educators to support this growing cohort of clinicians. The practice of drawing community AHPs into the Acute setting results in less preventative and maintenance healthcare, resulting in greater acute presentations.

AHPs described historic workforce practices which resulted in the loss of highly-skilled and specialised AHPs, due to the ERH mandate for AHPs to work across all areas. Participants recommended a more flexible approach for future, to attract AHPs to work in their areas of interest, such as Paediatrics.

"Workforce models are more innovative than ERH's budget modelling." Community Services participants indicated that current budget models restrict creativity in workforce (particularly AHP) attraction and retention.

There is an increasing role and need for an Allied Health Assistant (AHA) workforce to support the work of Allied Health Professionals, however a framework to support a sustainable model is essential.

Internationally-trained AHPs are not as simple to embed as Nurses. There is a significant level of input required to overcome the challenges of limited registration for AHPs trained internationally and the cost-benefit may not be in ERH's favour.

Support Services and Administration Workforce

Enhancing administrative support in skills and number, would increase the ability for clinicians to focus on working to the fullest scope of their clinical practice, rather than time being absorbed with administrative tasks such as Kronos, rostering, developing forms, writing meeting minutes and data entry.

Suggestions were made regarding the introduction of a central, multi-skilled ERH Administration pool which can be drawn upon for Departments requiring surge work, data entry support etc. There was also encouragement from participants to consider the option of remote administration support where appropriate, particularly for services such as Health Information. One senior nurse leader shared an experience of having no choice but to delegate data entry to a highly-paid Agency Registered Nurse, as they did not have access to an administration assistant to complete the work.

Person-dependency is a significant issue in corporate functions such as Payroll, Finance, Health Information and Procurement, where single roles or individuals are the keepers of much corporate knowledge. In some areas, periods of leave that can be taken are limited to work around payment deadlines, which creates a fatigue and burnout risk.

Corporate teams are not expanding at the same rate as clinical workforces and services, which creates additional load on the existing workforce. Some stated that, culturally there is a *"growing divide between clinical and non-clinical workforces."*

Health Information Services – highlighted that there were only six Health Information Manager (HIM) graduates in Victoria in 2023. Demand far exceeds supply, in a workforce that is highly amenable to automation, however that is unlikely to occur in the short-term. In the meantime, there is a current lack of capability in senior HIM which will remain a crucial requirement at ERH in the coming decade.

Corporate Services – covers a large and diverse workforce of entry-level positions. There is a gap in middle-management/team leader/supervisory capacity which needs to be addressed to sustainably grow and support this cohort of staff to operate safely and effectively.

Volunteers

Community Services were enthusiastic about welcoming more volunteers to support their work in areas such as IPAC, Community Rehabilitation and NDIS services.

Design Stage

Source

Participants were asked to consider the Build, Bot, Buy, Borrow model used by the VPSC to explore sources for future workforce.

1. **Build** – ERH has had a long-term approach of 'Growing Our Own' workforce, however national workforce shortages mean that this is no longer enough.

   A decrease in availability of Nursing graduates overall, means that the Build model previously relied upon, will no longer provide the volume of staff required to meet the Safe Patient Care Act.

   There was consensus that Succession Planning for key roles is essential, and that leadership and Executive roles should be backfilled for leave greater than five days, to create leadership development and exposure opportunities.

   The Corporate workforce stated that traineeships and apprenticeships in their workforces makes sense on the surface, however the reality is that there is not capacity in the stretched workforce to provide adequate training and support, and with limited FTE there is a preference to hire staff who already have the skills and qualifications.

2. **Buy** – ERH is accessing more Agency and Locum staff than ever before, predominantly in the Medical and Nursing areas. The ability to buy skillsets in for Corporate departments is more limited, due to the specialisation and person-dependency of many roles such as Finance and Payroll.

   Corporate functions including Health Information coding and Security stated that there are options to engage contract services if needed.

   International Recruitment – there has been a mixed experience with recruitment of internationally trained Registered Nurses at ERH. All participants found the process time and energy-intensive. The ED has found it valuable, with six of seven new recruits on board and settling into the community. Aged Care has conducted over 40 interviews and only one candidate has started, and already indicated they'd like to move to a role in ERH's acute services.

3. **Bot** – there is consensus that automating work at ERH would be a positive move. There is significant frustration and fatigue with the use of systems which are outdated, not integrated and sometimes unreliable. One suggested area for immediate automation of work was the use of Artificial Intelligence (AI) to build training programs.

4. **Borrow** – there was some openness to sharing clinical resources regionally, however most stated that it would be unattractive for ERH staff to work at smaller health services. It was stated that shared protocols across health services would be an important precursor to shared staffing models.

   Partnership discussions revolved around the challenges of sharing workforces across health services when all services are already stretched. Some stated that Nursing rotations from ERH to neighbouring Small Rural Health Services (SRHS) could be useful for fatigue-relief and to keep patients at SRHS instead of transferring to ERH.

Objectives and Actions from consultation

Flexible and Innovative workforce

Participants in consultation highlighted that flexible and innovative workforce models across all disciplines are required for ERH to meet the needs of the community into the future. This includes actions such as:

1. Implement the Nursing Flexible Rostering Toolkit recommendations across ERH
2. Creativity with Medical contracts in terms of remuneration, hours, offering titles and portfolios
3. Provide the flexibility for people to work on what they're passionate about, for example:
   a. Medical Officers and Allied Health Professionals focusing on a specialisation
   b. No longer requiring Critical Care trained staff to work in HDU as well as ED
4. Flexibility in employment modes, e.g. working one week on, one week off
5. Develop more open-mindedness about the need for workers to live locally, reinforcing that having a partially FIFO workforce is ok
6. Remain open-minded to reasonable use of Agency and Locum staff as national workforce shortages impact. Continue to provide a positive experience for agency staff to remain an employer of choice
7. Consider regional workforce models for training and ongoing development of clinicians
8. Consider untapped workforce populations such as retirees seeking casual hours
9. Increased likelihood of natural disasters impacting the health service and workforce should be factored into workforce planning, including features such as robust casual banks, flexibility across organisations, partnerships and continually updated disaster planning toolkit
10. Ensure acute and community services collaborate effectively across the span of preventative, acute and step-down care models, making the best use of clinical skills at each stage
11. Explore flexibility in budgeting for AHPs, with the potential for uncapped FTE increases where there is a revenue stream to make it cost-neutral, such as fee-for-service models
12. Review the role of the Nurse Pool, staff are choosing to remain on Pool long-term for the variety of work, however FTE shortfalls exist for permanent roles
13. To support enhanced paediatric services, a basic operational enabler may include expanding the requirement for more ERH employees to maintain a current Working With Children Check to meet Child Safe standards

Attraction and Retention enablers

Attraction

1. Empower leaders to be creative and proactive with candidate searches, rather than "doing it the way it's always been done" and going through the motions of standard advertising
2. Promote the Flexible Roster project to enhance balance and satisfaction in the nursing workforce, consider expanding to other areas
3. Explore changes to Nursing placements to incorporate a 24/7 roster and payments for placements to reduce student poverty impacts and set more realistic expectations of what shift work looks like
4. Explore options to increase the availability of housing and accommodation for workers moving to the area
5. Consider the implementation of a regional pool of clinicians credentialled to work across a range of health services based on need
6. Shared credentialling across health services/regions to support flexibility, partnerships etc.
7. Consider employment opportunities locally for the spouses of Internationally-trained clinicians, potentially at ERH or other local organisations

Retention

1. Remove the “pebbles in shoes” to encourage people to stay engaged at ERH through:
    a. Streamline on & off boarding processes
    b. Community connector role critical to supporting new families into the community and ERH
    c. Make the use of IT more user-friendly and accessible. Improved technology experiences for staff could improve workflows, patient safety and workforce engagement and satisfaction
    d. Consider patient flow and patient load to make the work on some wards more attractive
    e. Lack of on-site pathology service on weekends makes it unattractive for RNs to work, due to lack of access to results to provide best care to patients
    f. Access to café services or vending machines would make after-hours work more enjoyable for shift workers
    g. Ensure basic ‘tools of the trade’ are available for staff to get the job done – laptops, iPads, medical equipment and workspaces.
2. Consider partnerships with childcare providers to ensure access for ERH parents returning to work (explore models used by other health services in the state). Consider options for priority places for health service staff at childcare services, pay by the 12 hours, offer flexible shifts around daycare placements.

Organisational structure and job design

All participants in consultation alluded to the growing burden of administration from increasing compliance requirements and inefficient technology. Highly trained clinicians report undertaking data-entry tasks due to the lack of administrative support in their teams.

1. Invest in Administration and ‘back office’ resources to allow clinicians to work to the fullest scope of their practice and undertake the duties that fulfill them in their roles:
    a. Consider ‘pool’ administration to support leave backfill, surge requirements etc
    b. Use automation where possible for administrative tasks like helpdesks, recruitment, screening candidates
2. Project and development roles are critical to ongoing workforce development, but appropriate supports are needed to ensure success. For example, when a leader takes on a major project, additional support with their “day job” is important to ensure that additional workload is not simply absorbed into an already full role
3. Consider the addition of a Key Selection Criteria for all Director and above roles, relating to digital literacy / telling a story with data
4. Continued focus on building and maintaining a Casual Nurse pool over time will support the taking of leave, prevention of fatigue and burnout
5. VMOs combined with a fractional workforce require a robust handover system to ensure clinical safety
6. Advocate via Department, Unions and other options to increase ERH’s levels under the Safe Patient Care Act (for ED), capability frameworks and Enterprise Agreements (e.g. Pharmacy)

Leadership

1. **Empowering managers to be leaders** – when managers become strong people leaders, the need for 'back office' business partners is lessened. For example, OHS or People & Culture provide subject matter experts (SMEs) to advise and guide, while managers execute the tasks of a people leader.
2. Ensure targeted support and pathways for staff who show potential and interest in growing into specific roles – this requires strong people leadership to identify talent and enact development plans.
3. Embed ownership for shared responsibilities – for example – safety is everyone's responsibility, not the OHS Manager.
4. **Budget models to support workforce planning** – a common theme in consultation was that the restrictive approach to Departmental budgeting, impedes flexibility in workforce planning
5. Backfilling leave is a valuable succession and development tool, creating a pipeline of ready-leaders

Education and Training

ERH's education and training models require an organisation-wide focus and consistent approaches to developing priority workforces. Consider implementing:

1. Innovative approaches to student placement to support impacts of student poverty – instead of 6-week placements, offer 1-2 days per week over a longer period – requires collaboration with education institutions.
2. Traineeships – take a uniform approach to appointing trainees to ongoing positions and paying above trainee rates while they are training in their first year.
3. Ensure appropriate training pathways are in place from the beginning to ensure success.
4. Consider opportunities such as VCAL, with appropriate supervision arrangements to ensure success.
5. Strengthen connections with local schools to promote pathways.
6. Consider the use of secondments from clinical to non-clinical roles for structured learning and development – for example, a NUM in a HR position for 6 months will take valuable people leadership skills back to their NUM role.
7. Continue to enhance the 'grow our own' model of Critical Care students to support an increasingly complex ED and HDU model and build the foundations for more complex care to meet the Clinical Service Plan objectives.
8. Allied Health Professional Educators must be expanded with a focus on building supervision into the AHP model to ensure an ongoing flow of students and future workforce.
9. Corporate Education has been highlighted as a gap, with budget the core barrier. An ERH-wide approach to education could include a part-time Safety & Wellbeing Trainer, Leadership & Diversity Educator etc. to increasing organisation-wide training in:
    a. Diversity and Inclusion – as the ERH workforce increases in diversity, a level of diversity and inclusion safety will be crucial to attraction and retention of staff.
    b. Aboriginal Cultural Safety – will be key to achieving ERH's strategic objective to "Honour and support First Nations people as the oldest living culture through building a culturally safe, respectful health service that is free from discrimination and racism."
    c. Leadership, service delivery, communication/ and project management skills
10. The future of health service partnerships may create a need for a more regional education model, with discipline-specific educators who can provide education to partner health services to ensure they have the skills to receive patients back safely.
11. Partnerships with metro health services as well as GV Health and Bendigo Health for staff rotations would be valuable. The headspace model for Year 2 rotations would be a great model to follow.

Abbreviations and Acronyms

ACQM – Age Care Quality Manager
CD – Clinical Directors
DETR – Director Education Training and Research
DWS - Director Workforce System
DHIPR – Director Health Informatic Performance Reporting
DON – Director of Nursing
DOEM – Director of Emergency Medicine
DOP – Director of Pharmacy
DAH – Director Allied Health
EDFCS – Executive Director Finance and Corporate Services
EDPCS – Executive Director People, Culture and Safety
EDMS/CMO – Executive Director Medical Services and Chief Medical Officer
EDNM/CNO – Executive Director Nursing and Midwifery/Chief Nursing Officer
EDCS – Executive Director Community Services
GC – Graduate Co-ordinator
HRM – Human Resource Manager
HE – Health Educator
ICTM – Information Communication Technology Manager
MWUM – Medical Workforce Unit Manager
MHE – Medical Health Educator
NUMs – Nurse Unit Managers
NPM – Nurse Pool Manager
RHAN – Rural Health Academic Network Co-ordinator
SD – Sub Dean
UoMSD – University of Melbourne Sub Dean
VGRC – Victorian Rural Generalist Co-ordinator
WFDM – Workforce Development Manager (Nursing)

Notes

Notes