

**Health Workforce
New Zealand
Annual Report to the
Minister of Health**

1 July 2015 to 30 June 2016

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Foreword from the Health Workforce New Zealand Board Executive Chair

The committed and highly skilled practitioners who make up New Zealand's health workforce are fundamental to the successful delivery of the New Zealand Health Strategy. Health Workforce New Zealand has focused its attention over 2015/16 on a range of cross-sectoral projects that will improve workforce planning, enable sound investment in workforce development and build the agility and sustainability of the health workforce over the medium to longer term. Highlights have included:

- our new forecasting model
- a strategic review of funding for vocational training
- improving workforce data
- supporting innovation and workforce flexibility by removing legislative barriers.

Workforce forecasting is a critical element in ensuring we have the health workforce New Zealand needs and expects. A major initiative over the year has been the development of a sophisticated and dynamic workforce forecasting model that takes account of specialty-specific workforce demographics, retirement patterns, immigration trends and other factors. We have demonstrated and tested this model with health responsible authorities, colleges, professional bodies and other key stakeholders, and have presented it at international forums to great success. The model is used to identify vulnerable occupations and specialties and to inform investment decisions. Initially focused on medical specialties, it is already being rolled out to other health professions. The new model complements our existing approach to service forecasting, which is itself being refined.

Taking a more strategic approach to purchasing training and workforce development will be critical to achieving the kind of shifts we need to develop a future health workforce that is sufficient in number, accessible and sustainable. Funding must align with health sector priorities; to this end, we are reviewing our workforce development funding model in consultation with the sector.

New technologies and treatments, together with increasing demand for health services, have been drivers for adaptation and diversification across the health workforce. Many health professional groups now perform tasks that were previously the sole domain of medical practitioners. A number of key regulatory and legislative changes were introduced over 2015/16 to support innovative practices and maximise the use of health practitioners' skills. These have included registered nurse prescribing and the Health Practitioners (Replacement of Statutory References to Medical Practitioners) Bill, which will enable a range of health practitioners to undertake certain statutory functions currently only able to be carried out by doctors (such as issuing sickness certificates and taking blood samples to test blood alcohol levels of drivers). These amendments will make it easier for the public to access a range of health services, and will facilitate innovative and efficient practice.

The Health Workforce New Zealand workforce taskforces (Medical, Nursing, Midwifery, Allied Health, Kaiāwhina and Leadership) provide a valuable method for accessing expert advice across the sector, and promote cooperation in addressing workforce issues. Over the 2016/17 year, we will review the operation of the taskforces to ensure we are working as efficiently as we can and taking a collaborative, one-team approach.

Other priorities for the 2016/17 year are to refresh our workforce strategy, continue to build a robust information platform to support investment decisions, complete and embed the results of the workforce development funding review, and continue to strengthen our cross-sectoral relationships.

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Board Executive Chair, Health Workforce New Zealand

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Introduction

Health Workforce New Zealand's role

Health Workforce New Zealand (HWNZ) was set up in 2009 to provide national leadership on the development of the country's health and disability workforce. Its Board was established as a committee under section 11 of the New Zealand Public Health and Disability Act 2000. The HWNZ Board is supported by the Health Workforce New Zealand Business Unit within the Ministry of Health.

Health Workforce New Zealand¹ has a national focus across the broad scope of the health and disability workforce, including the clinical, non-clinical, private and non-government organisation (NGO) workforces.

The HWNZ Board provides advice to the Minister of Health and the Director-General of Health to help those offices rationalise workforce planning, education, training, development and purchasing within the health and disability services sector. The Board's Terms of Reference (see Appendix 2) set out the details of the purpose and key responsibilities of the HWNZ Board.

Health Workforce New Zealand aims to ensure that the health workforce is appropriately configured to meet current and future health needs, so New Zealanders can be confident that they will receive the best health care possible.²

The focus of HWNZ aligns with, but is not restricted to, the Ministry of Health's Statement of Intent. In particular, HWNZ contributes to strengthening the health and disability workforce.³ This priority is further reflected in the New Zealand Health Strategy and its companion Roadmap of Actions 2016.

Workforce taskforces

Health Workforce New Zealand facilitates work with and through stakeholders to build a sustainable workforce. To identify and develop mutually owned solutions to the challenges our sector faces, HWNZ has developed a taskforce and a work programme for each of six key workforces – doctors, nurses, midwives, allied health workers, non-regulated workers (kaiāwhina)⁴ and leaders.

Each taskforce comprises a governance group and a working group. Both groups are made up of representatives drawn from across the health sector, including the HWNZ Board and Business Unit, the wider Ministry, district health boards (DHBs), unions and education/training providers.

The governance groups provide advice on the strategic direction of their respective taskforces and oversight of the work programmes.

The working groups implement defined programmes of work to improve professional development, recruitment and retention.

1 In many instances, the HWNZ Board and the HWNZ Business Unit work together. Therefore, the term 'HWNZ' in this report often refers to the Board and the Business Unit collectively.

2 For more detailed information about the role of HWNZ, see Ministry of Health. 2014. The Role of Health Workforce New Zealand. URL: www.health.govt.nz/publication/role-health-workforce-new-zealand (accessed 17 January 2017).

3 Ministry of Health. 2015. *Statement of Intent 2015 to 2019*. Wellington: Ministry of Health, pages 17–18 and 28–29.

4 'Kaiāwhina' refers to workers in the health and disability sector who are not regulated under the Health Practitioners Competence Assurance Act 2003 and who work as aged or disabled carers in residential facilities; as support workers for older, disabled or injured people living in their own homes; in drug and alcohol addiction support roles; and in health-related corporate and administrative positions.

Cross-taskforce collaboration and oversight are key to the effectiveness of the taskforces to build a sustainable health and disability workforce. Health Workforce New Zealand recognises that the impact of changes to models of care and particular workforces spreads widely across a range of workforces.

This report is structured around the taskforces. It includes an outline of each taskforce: its composition, its work programme and how it contributes to government priorities. Certain key areas of work underpin the work programmes of all the taskforces, including workforce data and intelligence and investment priorities.

While taskforces based on workforce type are convenient mechanisms for breaking HWNZ's strategic direction into a manageable structure, building a sustainable workforce for the future relies on cross-workforce planning. This report includes two case studies to illustrate this concept in action.

The New Zealand Health Strategy

The taskforce structure supports the New Zealand Health Strategy and the Roadmap of Actions 2016, both of which are based on the overarching goal that all New Zealanders live well, stay well and get well.

Health Workforce New Zealand's role in achieving the Health Strategy's other goals is to provide oversight in building a sustainable health and disability workforce that has the right number of suitably qualified health professionals to meet New Zealand's future needs. This oversight involves ensuring that:

- participants in the sector work together, sharing innovation and good practice, and support each other
- professions' roles are clear and widely understood
- the sector sees improvements in sector leadership, cohesion, flexibility, diversity and sustainability.⁵

In 2016/17, HWNZ will review the role of the taskforces and their respective work programmes to ensure continued alignment with the Health Strategy. It will also review the Workforce Service Forecasts⁶ it commissioned in 2010/11, to assess their continued applicability to health service and workforce needs. Those Forecasts looked at particular service areas (eg, mental health, eye health and aged care) that encompass a range of workforces across the medical, nursing, midwifery, allied health and kaiāwhina workforces. The aim was to consider workforce planning from a broader perspective, and challenge the silo approach to workforce planning.

⁵ Ministry of Health. 2016. *Roadmap of Actions*. Wellington: Ministry of Health, Action 24.

⁶ See Ministry of Health. Workforce Service Forecasts. URL: www.health.govt.nz/our-work/health-workforce/workforce-service-forecasts (accessed 17 January 2017).

2015/16 priorities

The HWNZ Board's Terms of Reference (see Appendix 2) set out its purpose and functions, and the Board reviews them as required. Each year, the HWNZ Board and the Business Unit agree a work programme with the Minister of Health. To date, the work programme has aligned with the Government's priorities and the Ministry of Health's Statement of Intent. From the 2016/17 year, it has also aligned with the New Zealand Health Strategy.

The overarching aim for HWNZ is to build a sustainable workforce for the future across the medical, nursing, midwifery, allied health, science and technical, and kaiāwhina sectors. Sitting within this overarching aim are the needs to:

- improve workforce recruitment, retention and distribution
- improve data and intelligence to more accurately project workforce supply and demand
- increase workforce collaboration, leadership and regional approaches to improve productivity and economies of scale.

For each of the years 2014 and 2015, HWNZ published *The Health of the Health Workforce*. This document aims to provide a snapshot of the health workforce at that time, and some future projections, to assist health professionals in making career decisions and employers making workforce decisions. At the time of writing this report, HWNZ is preparing *The Health of the Health Workforce 2016*, and expects to publish it in 2017.

The workforce taskforces

Each of the six workforce taskforce's work programmes for 2015/16 reflected themes common across the health and disability workforces:

- Recruitment and retention
- Training
- Data and intelligence
- Promoting, and removing barriers to, innovation.

Health Workforce New Zealand's work programmes across the health professions incorporate a strategic approach to future funding decisions. Health Workforce New Zealand has a budget of approximately \$173 million a year to fund postgraduate training and education programmes to develop the workforce.⁷ The majority of this funding goes to medical training (64 percent), followed by nursing (10 percent). Approximately \$4.5 million (2.7 percent) is allocated to a small number of allied health professions. This includes:

- anaesthetic technicians (allocated the largest share of this funding, at \$1.9 million)
- cardiopulmonary technicians
- physiology technicians
- ultrasonographers
- radiotherapists
- pharmacy interns
- medical laboratory scientists

⁷ This funding contributes towards the costs incurred by DHBs and other training providers in providing training. It does not cover the total costs of training.

- cervical cytologists
- psychology interns.

The allocation of funding is largely the result of historic ad hoc decisions. It does not reflect a strategic approach to meeting government, Ministry of Health and HWNZ priorities in the current environment. Health Workforce New Zealand is considering how best to improve this situation. This work will continue in 2016/17.

The Medical Specialty Workforce Forecasting Model

Historically, one of the key challenges to successfully building a sustainable health and disability workforce has been the lack and/or inconsistency of workforce data and, therefore, the lack of an ability to reasonably forecast future workforce needs.

To this end, HWNZ has developed the Medical Speciality Workforce Forecasting Model, which aims to:

- provide evidence for prioritisation for workforce investment
- plan training volumes in collaboration with medical colleges
- assist DHBs in their regional workforce planning
- assist the Office of the Chief Economist in long-term health expenditure planning
- identify the future age distribution of health professionals
- inform government health initiatives such as elective surgical planning and screening programmes.

The Forecasting Model focuses on the supply side, and needs to be considered alongside other factors, such as the trend towards primary and community care.

Health Workforce New Zealand anticipates that analysis arising from the Forecasting Model will contribute to more efficient planning for individual health workforces. Additional information and analysis provided by the Council of Medical Colleges; nursing organisations; allied health, science and technical groups; and kaiāwhina workforces will further refine this process.

The Office of the Chief Nurse has already adapted the Forecasting Model as a working tool, and HWNZ anticipates that governing bodies for all other regulated health professions will do similarly.

Introduction to the Forecasting Model

For each specialty workforce, the Forecasting Model uses data on differential entry age distributions, age-specific exit rates and specialists' working patterns over a lifetime to produce finely tuned, dynamic forecasting. For each specialty workforce, the Forecasting Model is able to predict:

- age distribution in full-time equivalents (FTEs: 'full-time' is 40 hours per week), as well as head counts for future years
- downstream effects of various training numbers
- 'ideal' numbers of trainees
- levels of training investment required (subject to economic conditions and broader health strategy).

Further, for each specialty workforce, the Forecasting Model:

- considers specialty-specific dynamic movements (allowing dynamic manipulation of data) affected by factors such as feminisation, ageing, entering/exiting the workforce, training volumes, immigration and returning to the workforce
- assesses vulnerability by forecasting the age profile of the future workforce in one to ten years' time, and considers:
 - FTEs
 - head count
 - the ratio of specialists in FTE and the head count of specialists per 100,000 population

- allows forecasting of the number of specialists required for each of the ten years from the base year 2014 and 2023, in terms of:
 - FTE and head count per 100,000 overall population
 - the 60+ age group
 - the age distribution of paediatric specialists (those providing services for people under age 19 years).

Validation of the Forecasting Model

Health Workforce New Zealand has tested and validated the methodology, formulas and input parameters of the Forecasting Model with a large group of stakeholders within the Ministry of Health and across the medical sector. These stakeholders discussed and acknowledged the model's technical limitations, but broadly supported its assumptions.

Health Workforce New Zealand is sharing the Forecasting Model and the data it produces with the medical colleges, and continues to improve and review it. Appendix 3 provides more information about the Forecasting Model's characteristics and the data sources it uses.

Use of the Forecasting Model to date

Over 2015/16, HWNZ used the Forecasting Model to identify vulnerable medical specialties in terms of the sector's ability to meet demand within the current models of health care. The identified vulnerable specialties could be the focus of increased investment, to address areas of current and projected shortages, reduce service maldistribution and increase the sector's capacity and capability to meet the expectations reflected in the new Health Strategy.

A projected increase in demand from the 60+ age group is making some specialties particularly vulnerable; these specialties include gastroenterology (in particular, within the bowel screening programme), dermatology and plastic and reconstructive surgery (in particular, for skin lesions and skin cancer), orthopaedics (in particular, hip and knee replacements), ophthalmology (in particular, cataract surgery) and radiation oncology.

Health Workforce New Zealand plans to extend the model to identify vulnerable workforces outside medicine. It continues to work with the sector to ensure consistent collection and collation of workforce data across workforces.

The Forecasting Model will help HWNZ take a wider view of the health workforce, and the flow-on effects of changes in one workforce, model of care or technology on related health workforces.

The Medical Workforce Taskforce

Introduction

The Medical Workforce Taskforce was established in 2013. Its key focus is on ensuring that:

- there is a sustainable medical workforce in all roles from postgraduate year 1 (PGY1)⁸ roles to specialty roles
- medical graduates trained in New Zealand have an opportunity to successfully progress their career through to vocational training.

Both the governance group and the working group of the Medical Workforce Taskforce are chaired by the Chair of the HWNZ Board. Membership of both includes HWNZ Business Unit and Ministry staff, and representatives from the Medical Council of New Zealand, the Royal New Zealand College of General Practitioners, the Council of Medical Colleges, DHBs, the Pasifika GP network, deans of the medical schools, the New Zealand Resident Doctors' Association, the Association of Salaried Medical Specialists, the New Zealand Medical Students' Association and the New Zealand Medical Association's Doctors-in-Training Council.

The Medical Workforce Taskforce Programme

The Medical Workforce Taskforce Programme includes a number of work streams, in which the taskforce has continued to achieve significant results in 2015/16. This section deals with each work stream in turn.

Pipeline modelling

The Medical Workforce Taskforce makes use of the Forecasting Model outlined in the previous section of this report to model the medical pipeline to identify choke points and gaps in medical workforce supply and demand.

Data collection and reporting

The Medical Workforce Taskforce carries out twice-yearly surveys of DHB resident medical officers⁹ (RMOs) and senior medical officers¹⁰ (SMOs) to inform workforce planning and funding. The survey is increasing in value as DHBs become accustomed to providing the necessary information.

The September 2015 survey showed a large reduction in numbers of postgraduate year 3 (PGY3) and postgraduate year 3+ (PGY3+) positions, and a marked decrease in the number of international medical graduates, clearly indicating that there is more opportunity for movement through the medical pipeline for New Zealand citizens and permanent residents trained in New Zealand. The next stage of the surveys will include capture of data to identify the impact on SMOs of training RMOs.

8 'PGY1' refers to the first year after a medical student graduates from university. A medical graduate must complete a PGY1 programme as part of their training.

9 Resident medical officers refers to doctors from their last year of undergraduate training to completion of vocational (specialist) training.

10 Senior medical officers refers to doctors who have completed vocational (specialist) training.

Postgraduate year 1 placements

The Taskforce continues to work with DHBs to find placements for all eligible medical graduates. It continues to give priority to new medical graduates who are New Zealand citizens and permanent residents, or Australian residents. In November 2015, there were 423 medical graduates, an increase of 29 from November 2014.

Community-based clinical attachments

Community-based clinical attachments are 13-week assignments prevocational trainees must complete in order to meet the Medical Council of New Zealand's registration criteria. The attachments take place in community settings (including urgent care services, hospices, community mental health services and other community-based services, as well as general practice). The roles focus on caring for patients and managing their illness within the context of the patient's family and community.

Community-based attachments are being phased in. As at April 2016, 25 percent of prevocational trainees were undertaking a community-based clinical attachment. The Medical Council requires 100 percent compliance by November 2020.

Because this initiative represents a significant work programme, HWNZ has established a separate governance structure for it, in collaboration with the Medical Council of New Zealand and the Royal New Zealand College of General Practitioners.

Career information and guidance

The Medical Taskforce is committed to supporting medical graduates to make appropriate career choices and find employment in New Zealand. HWNZ It recently collaborated with the Council of Medical Colleges and separate medical colleges to bring together and publish all the information that graduate doctors need, in the form of a set of career information specialty factsheets. Some 50 factsheets are published on the Kiwi Health Jobs website (www.kiwihealthjobs.com/rmo/factsheets); these are updated as new information becomes available.

In 2016/17, a focus for HWNZ will be to explore funding model options that allow training funding to:

- align with the priorities of the Health Strategy
- be based on accurate workforce data and intelligence
- encourage national, regional and local workforce planning.

Currently, the largest proportion of HWNZ funding is spent on medical vocational training. Changes to the funding model will, therefore, have a particular impact on medical vocational training.

The Nursing Workforce Taskforce

Introduction

The Nursing Taskforce works with the Office of the Chief Nurse (OCN) within the Ministry of Health and the National Nursing Organisations Group (NNO Group) on initiatives to support the development of the nursing workforce.

The Nursing Taskforce's Governance Group is chaired by the NNO Group Chair. Membership consists of DHB chief executive officers (CEOs), DHB directors of nursing, primary health organisation CEOs, the New Zealand Aged Care Association CEO, Pacific nurses, representatives from Te Rūnanga o Toa Rangatira National Māori PHO Coalition representatives and a consumer representative.

The Nursing Workforce Programme

The NNO Group submitted a report to HWNZ in June 2014 that analysed a range of concerns about the nursing workforce and its sustainability. That report informed the development of the current Nursing Workforce Programme, which essentially facilitates coordination across agencies and addresses identified priorities. The Nursing Workforce Programme is designed to achieve particular short-term, medium-term and long-term objectives.

The Nursing Workforce Programme's work streams can be grouped into three broad categories:

- Workforce data
- Recruitment and retention
- Workforce planning and development.

This section discusses each in turn.

Workforce data

The Ministry of Health uses the Forecasting Model, and specifically aims to improve the workforce intelligence the model relies on, including in terms of data quality, completeness and accessibility.

Recruitment and retention

Over 1,500 nursing students graduate in New Zealand each year. The Nursing Taskforce aims to retain these nursing graduates in the New Zealand workforce.

New graduates need to find employment, and want to be able to see a career path for themselves. Nursing workforce stakeholders, including HWNZ, are working to improve the matching of nursing FTE positions to population need, including through estimating both the total number of nurses needed and the locations in which they are needed (in terms of specialty/service area as well as geographical location).

Retaining experienced nurses is key to building a sustainable nursing workforce. In collaboration with the sector, HWNZ is working to maximise the use of nursing knowledge and skills across the three nursing scopes of practice (Registered Nurse, Enrolled Nurse and Nurse Practitioner).

Workforce planning and development

Effective workforce planning requires an alignment of education and employment plans. Key nursing workforce stakeholders, including HWNZ, the Nursing Council of New Zealand and tertiary education providers, are working to achieve this alignment.

New Zealand needs a nursing workforce that reflects its population. The Nursing Taskforce aims for the percentage of the nursing workforce that identifies as Māori to match the percentage of Māori in the population by 2028 (this will require an additional 10,209 Māori nurses by that date). The Nursing Taskforce considers the next steps in achieving this aim should be strategic discussions to establish partnership and engagement opportunities between iwi, education providers and employers.

The Nursing Workforce work programme aims to shift the distribution of the nursing workforce by improving the capability of aged care, primary care and community services to deliver models of care. The future nursing workforce has a critical part to play in new and emerging models of care.

In 2015/16, HWNZ achieved legislative changes to enable more effective and efficient use of our existing workforce, as follows.

- The Health Practitioners (Replacement of Statutory References to Medical Practitioners) Bill will allow certain functions to be carried out by qualified health practitioners other than doctors. This will lead to better use of our existing health workforces, and more cost-effective and convenient processes for patients and their families. The nursing workforce will be one of the workforces most affected by the change.
- Designated nurse prescribing refers to a legislative mandate for nurses to prescribe certain medicines they have not previously been allowed to prescribe. This will make best use of the knowledge and skills of nurses, and contribute to addressing the demands of an aging population. International evidence suggests the benefits of extended nurse prescribing include improved access to treatment, enhanced care, more effective use of medical staff's time, strengthened inter-professional working practices and increased professional satisfaction for nurses.

Nursing leaders have shown interest in the development of the nurses performing endoscopies postgraduate training programme and the revised nurse practitioner training programme. These training programmes reflect the strategic direction of a sustainable workforce that extends roles and scopes of practice using the existing workforce to meet future needs.

Following feedback from members, the Nursing Taskforce intends to focus in the future on models of care, investments in postgraduate nursing and aligning priorities with the Health Strategy.

Case Study: Nurses performing endoscopies

The nurses performing endoscopies project, led by HWNZ and the Ministry of Health, is designed to increase health workforce capacity and capability in anticipation of the increased colonoscopy volumes the national bowel screening programme will generate.

The key focus of the project is on the development of nursing knowledge and skills within gastroenterology so that nurses can undertake a wider range of tasks in specialised clinics dealing with conditions such as inflammatory bowel disease, hepatitis, dyspepsia and rectal bleeding. The project focuses on nurses performing endoscopies, but allows for expansion of nurses' roles beyond this.

Colonoscopy is an endoscopy of the large bowel (colon). It requires a high level of endoscopy skills. Nurses in the training programme will develop skills to perform diagnostic colonoscopies, along with gastroscopies and flexible sigmoidoscopies. Where nurses are able to perform such procedures, gastroenterologists will be freed up to perform more complex procedures; this will improve service delivery.

The nurses performing endoscopies training programme was developed by representatives from a range of organisations, including the Ministry of Health, national nursing organisations, DHBs, the New Zealand Society of Gastroenterology, the Royal Australasian College of Surgeons, the New Zealand Society of Anaesthetists, private providers and the National Endoscopy Quality Improvement Programme.

The University of Auckland is delivering the training programme. It is a postgraduate programme consisting of two specialised papers and a practicum.

To enter the programme, a nurse must have a Postgraduate Diploma in Nursing and at least five years' FTE clinical experience as a registered nurse. At least three of the five years must have included specialist clinical experience working in gastroenterology or a related specialty.

An important principle of the project is that safety is paramount. Endoscopy training for nurses, gastroenterologists and general surgeons alike is subject to identical standards, and there is common governance of the training available to all three professions.

Four nurses from three DHBs made up the first cohort of the nurses performing endoscopies training programme. Their training started in the first semester of 2016, and was fully supported by their respective DHBs.

The Midwifery Workforce Taskforce

Introduction

The Midwifery Taskforce is comprised of representatives from HWNZ and the wider Ministry of Health, the midwifery profession, the midwifery education sector, employers, the Midwifery Council of New Zealand, the wider health workforce and consumers.

The Midwifery Workforce Programme

In 2015/16, the Midwifery Taskforce was in the process of developing its work programme. The work programme will span the next two to three years. The Midwifery Taskforce may establish working groups to implement defined programmes of work within the programme, and will invite representatives from the wider health workforce as appropriate. The work programme will support:

- workforce planning for future midwifery service provision
- investment planning that supports workforce needs
- the use of regional workforce development hubs, which can implement strategic goals for the midwifery workforce
- using workforce and population data to determine the need for educating midwives at undergraduate and postgraduate levels
- improving the distribution of the workforce geographically, and between core and lead maternity carer midwives¹¹
- identifying opportunities to install trust and confidence in the midwifery workforce and midwifery practice, by promulgating evidence in relation to safety and the success of maternity services
- making the best use of the available workforce.

In the 2016/17 year, the Midwifery Taskforce has become the Midwifery Advisory Group. The Group will review its role and priorities, ensuring they align with the Health Strategy and focus on building a sustainable workforce across urban and rural centres.

¹¹ Lead maternity carers are midwives or specialist doctors who coordinate a woman's maternity care. Core maternity carers are midwives who are based in a hospital or birthing centre.

The Allied Health, Science and Technical Workforce Taskforce

Introduction

The Allied Health, Science and Technical Workforce Taskforce was established in 2014. Both its Governance Group and its Working Group are chaired by the Chair of the HWNZ Board. Membership of both includes HWNZ Business Unit and Ministry of Health staff, along with representatives from education providers, responsible authorities, allied health professional organisations, unions and ACC.

There are over 40 allied health, science and technical professions working in New Zealand. This diverse group of professions includes:

- some professions regulated under the Health Practitioners Competence Assurance Act 2003 (the HPCA Act) (eg physiotherapists and psychologists), and some not regulated under this Act (eg renal technicians and audiologist)
- professions employed in the public and private health sectors, and self-employed practitioners
- professions that are small in number and, therefore, more vulnerable to workforce changes (eg perfusionists and medical physicists).

The Allied Health, Science and Technical Workforce Work Programme

The three allied health work programme work streams are:

- recruitment and retention
- education and training
- data, intelligence and information.

These work streams reflect the range of issues that affect our ability to ensure a sustainable allied health workforce for the future. Such issues include, but are not limited to:

- a lack of awareness among the public of the number and range of allied health professions
- unclear entry, education and career pathways
- a lack of alignment between student intake numbers and future supply and demand projections
- a lack of coordination between education programmes and the competencies and skills workplaces actually require
- a lack of clinical training opportunities and training funding that is based on historic decisions
- a need to incorporate new and emerging professions and technology in the education model and in service delivery.

In 2015/16, the Allied Health, Science and Technical Taskforce's work programme included the following activities and achievements.

Recruitment and retention

The Allied Health Taskforce worked to address:

- current shortages in sonography
- the vulnerability of the medical physicist workforce

- improved access to hearing testing and hearing aid fitting, through development of a scope of practice for audiometrists, in conjunction with audiometrists and audiologists
- improved access to early glaucoma diagnosis through promoting improved cooperation between optometrists and ophthalmologists.

It focused separately on laboratory pathology, which has particular importance for bowel screening, in early 2016.

In 2015/16, the Allied Health Taskforce also considered ways to raise the profiles of allied health careers.

Education and training

The Allied Health Taskforce undertook work to specifically support allied health workforces to ensure that practitioners are qualified and available/capable to support the health system of the future.

Data, intelligence and information

The Allied Health Taskforce worked to improve the quality and consistency of data collection and analysis, initially working with the 13 responsible authorities established under the HPCA Act to do so.

In 2016/17, the Allied Health Taskforce will continue its work within the three work streams, to maximise the contribution of allied health professions to implementing the Health Strategy.

The Kaiāwhina Workforce Taskforce

Introduction

Membership of the Kaiāwhina Taskforce comprises representatives from the Ministry of Health (including staff from the HWNZ Business Unit, Disability Support Services, Primary Care, Health of Older People, Mental Health Service Improvement, the Office of the Chief Nurse, the Chief Advisor – Pacific Health and the Chief Advisor – Māori) and from ACC, DHBs, community organisations, care providers, education providers, professional organisations and unions.

Health Workforce New Zealand works closely with Careerforce, the industry training organisation responsible for setting qualification standards and arranging training for the kaiāwhina workforce.

The kaiāwhina workforce consists of more than 60,000 people (according to the 2013 Census). Of those, 68 percent are support workers in the home and community support services sector. Compared to the overall New Zealand workforce, the kaiāwhina workforce is generally female dominated and ethnically diverse, and has lower levels of qualifications.

The Kaiāwhina Workforce Programme

Demand for the kaiāwhina workforce is expected to rise, as the population grows and ages and as models of care move closer to home. Models of care increasingly focus on carers and support workers, so that the system can make more efficient use of the clinical workforce. Such models envisage health care assistants undertaking tasks that free up doctors and nurses to concentrate on treating patients and work closely with other health professionals.

In late 2013, HWNZ and Careerforce agreed to collaborate to develop a 20-year vision for:

A Kaiāwhina workforce that adds value to the health and wellbeing of New Zealanders by being competent, adaptable and an integral part of service provision.

With HWNZ's support and expertise, along with input from key stakeholders from across the health and disability sectors, Careerforce produced a five-year workforce action plan (the Kaiāwhina Action Plan).

The Kaiāwhina Action Plan is based on the following principles.

- The relationship between kaiāwhina and consumers, families and whānau is based on trust and transparency.
- Consumer choice is supported through systems that are enabling.
- Services support consumers, families and whānau to develop self-management skills.
- The kaiāwhina workforce understands and recognises the impact of stigma and discrimination on the consumers they work with and their families and whānau, including self-stigma.
- Diversity and the cultural values and beliefs of consumers and their families and whānau are respected.

In mid-2015, Careerforce and HWNZ began implementing the Kaiāwhina Action Plan.

In addition to this, Careerforce has taken a number of steps to further the training and career development of kaiāwhina, including the following initiatives:

- Vocational training programmes in social and community services for Year 12 and 13 secondary school students to complete as part of their NCEA qualification
- Apprenticeship programmes in the areas of primary care, brain injury rehabilitation support, community health work, mental health and addiction support and social services
- New Zealand Qualifications Authority Health and Wellbeing qualifications, which provide pathways through which school leavers, informal carers and employees can pursue a career in the regulated health workforce.

Case Study: Aged care

The kaiāwhina workforce in aged care has been a key focus of HWNZ for 2015/16. Experts recognise that the kaiāwhina workforce will need to play an increasing role in the health and disability sector in the future. Kaiāwhina workers are often the people who spend the most contact time with residents in aged care facilities and those receiving care at home. Demand for the kaiāwhina workforce is expected to increase as New Zealand's population increases and ages, and models of care move closer to home.

A broad range of non-regulated and regulated workers comprise the health of older people workforce. The workforce is spread across home, community and hospital settings, and includes both specialist and generalist services.

Actions 4.1 and 4.2 of the Kaiāwhina Action Plan relate directly to workforce development issues identified in the Health of Older People Strategy. Those actions cover assessing the roles and contribution of kaiāwhina in terms of future workforce planning and models of care.

The Leadership Taskforce

Introduction

The Leadership Taskforce aims to ensure consistency in developing health leaders across the DHBs and the wider health sector. Its main work occurs within the Leadership Domains Project undertaken jointly by the DHB National General Managers Human Resources Group (the GMsHR Group), DHB Shared Services and HWNZ.

The project envisages five leadership domains:

- Be a values leader.
- Engage others.
- Develop coalitions.
- Lead care.
- Mobilise system improvement.

The domains can be mapped to and complement leadership frameworks already in place in DHBs, and applied directly where there are no such frameworks.

The domains have been endorsed by the DHBs' Chief Executives Group, Chief Operating Officers, Chief Medical Officers, Directors of Nursing and Directors of Allied Health.

Piloting the domains

Waitemata and Waikato DHBs piloted the domains in 2015, to test their applicability within the health setting and their ability to complement existing frameworks and methodologies. The pilots confirmed support for the domains, the need for a leadership strategy at national and organisational levels, the importance of local context when applying the domains, and the fact that roll-out of the domains will require high-level sponsorship, and executive and clinical support.

Leadership frameworks

Effective leadership in the health sector requires collaboration and consistency across agencies.

At a high level, health leadership frameworks should consider:

- capacity and capability building in the health sector
- consistency in leadership development across the health sector
- development of the agility to adapt and change to meet future needs
- development of cultures focused on safety and continuous improvement.

The One Leadership Team Framework

Health Workforce New Zealand and representatives from the GMsHR Group met with Ministry of Health leaders to develop a high-level multi-disciplinary framework entitled 'One Leadership Team Working Together' (the Leadership Framework).

In 2015/16, formal guidelines were developed for roll-out of the Leadership Framework across DHBs (using the outcomes from the pilot sites). Roll-out of the Leadership Framework across the 20 DHBs is under way.

Phase 2 of this project will focus on identifying and assessing existing best practice leadership programmes, to develop a suite of programmes/tools to support leadership development.

The domains will also be tested as part of the 2016/17 DHB annual planning process. The GMsHR Group will seek DHB feedback to ensure consistent leadership development across DHBs.

The Health Quality & Safety Commission New Zealand

The Health & Quality Safety Commission New Zealand (HQSC) is developing a framework to develop and support capability and leadership in quality improvement and patient safety, to ensure that the delivery of health care is consistent with HQSC's overarching framework. The HQSC has invited the GMsHR Group to work with it on the leadership section of this framework as appropriate. The framework was finalised in the early part of 2016.



Finance

The HWNZ Board is an advisory board, and does not hold financial delegation for HWNZ's budget, which sits within the Ministry of Health's budget. This report therefore does not present financial information.

Appendix 1: Health Workforce New Zealand Board Members 2015/16

In 2015/16, the HWNZ Board comprised:

- Professor Des Gorman (Executive Chair)
- Helen Pocknall (Deputy Chair)
- Gloria Crossley
- David Kerr
- Sally Webb
- Tim Wilkinson
- Andrew Wong.

A list of current HWNZ Board members and their profiles are available on Health Workforce New Zealand's website <http://healthworkforce.health.govt.nz/about-us/board-members>

Appendix 2: Health Workforce New Zealand Board Terms of Reference

Released May 2014¹²

Preamble

1. The Minister of Health established the Clinical Training Agency Board as a Committee under section 11 of the New Zealand Public Health and Disability Act 2000. The name of the Clinical Training Board was expanded to Health Workforce New Zealand (HWNZ) to reflect its national focus and that the health and disability workforce is broad in scope and includes clinical, non-clinical, private and NGO workforces.
2. The role of HWNZ is to provide advice to both the Minister of Health and the Director-General of Health to oversee and drive the rationalisation of workforce planning, education, training, development and purchasing within the health and disability services sector. It will be accountable to the Minister of Health (the Minister).
3. The establishment of HWNZ in this form was an interim measure to drive immediate change while advice on the best arrangements and location of the health and disability services workforce policy, planning and purchasing is developed.
4. Cabinet decisions arising from the recommendations of an independent Ministerial Review Group (MRG) have led to the establishment of a National Health Board (NHB), also a section 11 Committee.
5. The NHB is responsible for bringing together service planning and funding as well as the capital and IT investment needed to deliver the capacity required to deliver that service into the future. Workforce planning is integral to that process.
6. These Terms of Reference were revised to reflect the scope of the NHB advice and to ensure consistency and a coherent work plan between the NHB and the associated Boards responsible for capital and IT.
7. Cabinet has further considered the long term structure of the national health workforce functions and agreed to retain HWNZ as a section 11 Committee and establish a branded health workforce unit in the National Health Board business unit (NHBBU) of the Ministry, to be known as the Health Workforce New Zealand Business Unit (HWNZBU).
8. These Terms of Reference have been agreed to by the Minister (TBC) and replace those agreed to in October 2009. They have been amended to reflect Cabinet's decision on HWNZ's long term structure and finalise HWNZ's alignment with the legislative parameters of Section 11 Committees.

¹² The Terms of Reference released in 2014 were in place for most of the 2015/16 year. At the time of writing this report, HWNZ is reviewing the Terms of Reference, to align with changes within the Ministry of Health.

Health Workforce New Zealand

9. There is an urgent need for a simpler, more unified and responsive approach to workforce issues that is driven by the future needs of the sector and which enables changing roles and practices to deliver improved models of care and service delivery.
10. In particular, the Minister acknowledges that:
 - there is a need for greater clarity and coordination in respect of the roles and responsibilities of the various stakeholders at the national, regional, and local level. This may result in significant change in current work programmes of the Ministry of Health and allied agencies (for example, the mental health workforce centres and DHBNZ Future Workforce programme)
 - there is also a need for greater clarity in respect of roles and responsibilities for public and private employers, teaching and training organisations, registration and accreditation bodies, professional colleges, societies, and unions
 - there is an urgent need for much greater flexibility and responsiveness in the nature and deployability of the health workforce in respect to roles and scopes of practice and to address the current workforce shortages and meet future workforce demand
 - the education and training sector needs to be more responsive to changing workforce priorities, new and emerging models of care and service configurations, and these should drive consequential competencies and learning outcomes and the curriculum of education and training organisations
 - the funding for training needs to be better coordinated across programmes and providers to ensure cross-sector and across educational continuum views
 - recruitment, retention and the distribution of the health workforce requires better coordination and a more integrated approach
 - there is an urgent need for a more cohesive and collective leadership of clinicians and managers, and a focus on developing the essential domains of professional leadership such as skills in communication and conflict resolution, clinical governance, and management
 - there is a pressing need for high-quality information on the workforce, including current quantitative realities, and modelling demand (linkages back to service requirements) and supply (linkages back to teaching and training capacity. The Health Workforce Information Programme (HWIP) needs to be supported to become a national and across-sector resource.

Key tasks

11. HWNZ will be responsible for:
 - advising the Minister and Director-General of Health on all aspects of workforce policy, education, training and development, planning, and purchasing for the health and disability services sector
 - advising the Minister and Director-General of Health on the actions necessary to consolidate and focus the various health workforce work programmes, including the significant work programme being conducted by District Health Boards New Zealand and the Ministry of Health, and the realignment of public funding allocated to workforce
 - the oversight of planning, development and implementation of the national health workforce annual plan which includes assessing future workforce needs, the oversight of planning and funding of post-graduate training, and which enables a more unified approach to health workforce education, training, recruitment and development

- ensuring appropriate, timely and effective linkages with Government agencies (Tertiary Education Commission, Ministry of Education, and Te Puni Kokiri) and sector representatives (clinical leaders, health academics, health regulators, employer representatives, and training providers)
 - working with the various professional groups to influence work practices and making recommendations to the Minister for changes to scopes of practice and workforce innovations
 - advising the Minister on the optimal implementation process for the training and workforce related recommendations arising from the Ministerial Review Group (MRG), the Medical Training Board, the Committee on Strategic Oversight for Nursing Education, and the Resident Medical Officer and Senior Medical Officer Commissions
 - advising the Minister and the Director-General of Health on the implementation of key Government workforce priorities.
12. HWNZ will develop an Annual Plan to be agreed by the Minister of Health. HWNZ will review its Plan and Terms of Reference annually.
 13. In undertaking the above functions, HWNZ will take into account the Government’s priorities and health targets.

Accountability

14. HWNZ is accountable to the Minister of Health for the quality and timeliness of its advice and reports through the HWNZ Chair.

Relationship between the NHBBU and HWNZ

15. HWNZBU has been established in the NHBBU to provide administrative and planning support to HWNZ and to implement projects and initiatives as agreed.
16. The NHBBU National Director and ultimately the Director-General of Health are accountable for the performance of the HWNZBU.
17. The National Director will appoint a Director for the HWNZBU after first consulting with the chair of HWNZ on the appointment. The Director will be responsible for the performance of functions and powers delegated by the National Director and set out in a delegation instrument agreed between the Director-General of Health, National Director and the Director.
18. The Director-General of Health will require the Director to seek advice from HWNZ in the performance of delegated powers and functions.
19. The Director-General of Health will give due regard to the advice provided by HWNZ.

Relationship with other government agencies

20. HWNZ will have the ability via the National Director to request advice from other government agencies on issues related to its work programme.

Membership

21. HWNZ, including the Chair and Deputy Chair, will be appointed by Ministerial letter.
22. Collectively HWNZ will have the following expertise and attributes:
 - Knowledge of and expertise in undergraduate, postgraduate, clinical and vocational educational and training programmes for the health and disability sector both in New Zealand and overseas
 - Knowledge of New Zealand’s current health and disability services delivery in both hospital and community settings

- An understanding of health and disability services delivery needs to meet future demands reflecting New Zealand’s ageing population and ethnic mix
 - An ability to think creatively to provide solutions that are not constrained by traditional health and disability sector professional boundaries or current service delivery models.
23. HWNZ will comprise eight members including the Chair and the Deputy Chair (if a Deputy Chair is appointed). The Minister may from time to time alter or reconstitute HWNZ, discharge or reappointment any member or appoint new members in response to any changes to the key tasks that are being addressed.
 24. Any member of HWNZ may tender their resignation at any time by advising the Minister in writing.
 25. At any time, the Minister may remove a member or the Chair or the Deputy Chair of HWNZ from that office by notice in writing stating the date from which that decision is effective. The Minister shall have the discretion to consult with the Chair before removing a member from office.
 26. Any member of HWNZ may at any time be removed from office by the Minister of Health for inability to perform the functions of office, bankruptcy, neglect of duty, or misconduct, proved to the satisfaction of the Minister.
 27. HWNZ may draw on external expertise as required and may appoint expert advisors to assist in making deliberations after first discussing financial implications with the Director-General of Health. These expert advisors are not HWNZ members and have no voting rights.
 28. The Director-General of Health shall have a standing invitation to attend HWNZ meetings and to contribute to deliberations, but is not a member of the HWNZ and has no voting rights.

Duties

29. Through their letters of appointment, members of HWNZ will be advised of the term of their appointment and will be given a copy of these Terms of Reference.
30. Members of HWNZ are expected to act in good faith, with reasonable care, and with honesty and integrity when exercising their powers or performing their duties on behalf of the HWNZ duties.
31. Members attend meetings and undertake HWNZ activities as independent persons responsible to HWNZ. Members are appointed for their knowledge and expertise, not as representatives of professional organisations and groups. HWNZ should not, therefore, assume that a particular group’s interests have been taken into account because a member is associated with a particular group.

Liability

32. A member of HWNZ, in accordance with section 90(4) of the NZPHDA:
 - is not liable for any legal liability as a result of an act or omission of the Ministry of Health
 - is not liable to the Ministry of Health or the Crown for any act or omission done or omitted in their capacity as a member of HWNZ if they have acted in good faith, and with reasonable care, in pursuance of the role specified for HWNZ in this Terms of Reference.

Disclosure of interest

33. Any HWNZ member who has an interest in a transaction which is not limited to advising on contracts but includes exercising all tasks under these Terms of Reference must, as soon as practicable after the relevant facts have come to the member’s knowledge, disclose the nature of the interest to HWNZ. For the purposes of this clause, section 6(2) of the NZPHDA will apply.
34. Disclosure under this section must be recorded in the minutes of the next meeting of HWNZ and entered in the separate Conflicts of Interests register.

35. A member of HWNZ who makes a disclosure under this obligation, after that disclosure must not:
 - subject to paragraph 36, take part in any deliberation, discussion or decision of HWNZ relating to the transaction
 - be included in the quorum required for any such deliberation or decision.
36. However, a member of HWNZ who makes a disclosure under paragraph 33 may take part in any deliberation or discussion (but not decision) of HWNZ relating to that transaction provided:
 - a majority of the other members of HWNZ and the Chair wish the member to do so and
 - wherever and in whatever form such permission is given, this action must be reported via the minutes.
37. In such a case, HWNZ must record in its minutes:
 - the permission and the majority’s reason for giving it
 - what a member said in any deliberation or discussion relating to the transaction concerned.
38. Every member of HWNZ must ensure that:
 - the statement completed by the member is incorporated in the Conflicts of Interests register, and
 - any relevant change in the member’s circumstances affecting a matter disclosed in that statement is also entered in the Conflicts of Interests register as soon as practicable after the change occurs.
39. Failure to comply with these requirements, however, does not affect the validity of any action taken, or arrangement, or agreement, or contract made by the Ministry of Health subsequent to the resolutions made by HWNZ.

Media and communications

40. HWNZ will develop a media and communications strategy.
41. Media statements about HWNZ recommendations will be directed to the Chair. The Chair will provide the Minister of Health or the Minister’s office with advance notice of any media statements.

Confidentiality

42. All HWNZ meetings will be held ‘in committee’, and minutes of proceedings will not be circulated outside HWNZ membership or the Ministry of Health. It is expected that official reports to the Minister of Health will be released into the Public Domain once the Minister of Health has agreed. HWNZ’s proceedings and advice are covered by the Official Information Act 1982.

Appendix 3: The Medical Specialty Workforce Forecasting Model

This appendix sets out key facts about the Medical Specialty Workforce Forecasting Model, in terms of its characteristics and data sources.

Characteristics of the model

Exit rate

For each year, the exit rate is applied to the current workforce and the number of new specialists expected to join the workforce with various age distributions. Specific exit rates for each age group and specialty are used to account for the different characteristics in each specialty.

The exit rates were calculated from annual practising certificate (APC) renewals for 2010–2015 and by comparing each year's APC status for each doctor. This allows for doctors returning, and those without an APC, to be counted in the new entry/re-entry categories. This may appear to result in an inflated number, but re-entry and exit numbers cancel each other out. One limitation is the inability to calculate the permanent exit numbers, as we do not know whether a doctor will return to the workforce.

Generation characteristics

The ageing of the population, lifestyle changes and the possibility that some of the current specialty workforce care for aged patients is reflected in the model through the effects on exit rates and FTE/head count (HC) ratios.

The model purposely uses five-year age bands, with no separation of gender, to avoid skewing the model by particular cohorts with small sample sizes. The model assumes that the number of doctors is evenly distributed within each five-year age group except for the age group of 25–29, which has very few specialists.

Full-time equivalent and head count ratio

The ratio of FTE per HC is used for each age group and specialty, to reflect different patterns of working over a lifespan. Therefore, the model accounts for doctors who reduce their hours when they are of child-bearing age, and a tendency for doctors in older age groups to reduce their hours.

The feminisation of the workforce is reflected in the model through its effect on exit rates and FTE/HC ratios.

One limitation of the model is that the current exit rate and FTE/HC used for each age group may not accurately reflect future generational characteristics. For example, the workforce in the current 30- to 35-year age group may not work the same number of hours in 20 years' time as the current 50- to 54-year age group.

Age distribution of new and re-entering specialists

The model uses the various entry age group distributions, new and re-entering numbers for each specialty to produce an accurate representation of the group. Again, the base entry age for each specialty is based on APC renewals for 2010–2015. This includes those specialists new to New Zealand, and those re-entering the workforce after a break. The model can also take different entry age distribution and new and re-entering numbers for future years. This group also includes newly trained specialists.

Data sources

Two key sources were used in this model:

- The age profile, HC, and FTE of SMOs, and FTE/HC ratio by age group for each specialty, sourced from the Medical Council of New Zealand's 2014 workforce survey combined with the Medical Council's registration dataset, unless provided by corresponding colleges
- Registrar numbers, sourced from the RMO survey, unless provided by corresponding colleges.

