Community Services, Health and Education Training Council

HEALTH INDUSTRY WORKFORCE DEVELOPMENT PLAN

2015 UPDATE

FOREWORD

This 2015 Update of the Health Industry Workforce Development Plan (IWDP) for the Western Australian (WA) health industry has been prepared by the Community Services, Health and Education Training Council (CSH&E TC). The update is essentially a snapshot of the workforce development issues confronting the health industry in 2015. It builds on but does not repeat the far larger Health IWDPs documents that we produced by the CSH&E TC in both the 2013 and 2014. This 2015 Update summarises;

- current aspects of the health industry context that differ from the 2014 context;
- changes to governmental infrastructures and programs during the last year;
- minor amendments to the recommended priority actions, and
- new or changed health industry data.

To make these relatively minor changes the CSH&E TC relied on advice from its health sector industry advisory groups (IAGs) that have continued throughout the year to seek ways of addressing the recommended priority actions (RPAs) included in the 2013 and 2014 Health IWDPs.

The Health IWDPs were developed to seek ways of addressing the workforce planning and workforce development requirements of what is a large, complex and changing industry in both its state and national frameworks and from both from strategic and operational perspectives.

The health industry plays a crucial role in the life of every person in WA and helps to sustain and underpins all other economic and social activities within the state. This role is reflected in the increased commitment of state funding to WA's health services. Since 2008-09, WA Health's budget has increased from $4.8 billion to $8.1 billion in 2015-16, an increase of 71%.[1]

The Health industry workforce continues to suffer competition from other industries in respect to attraction, recruitment and retention of workers. As the state population increases and as anticipated demands for health services increase, labour and skill shortages in the Health industry will continue to mount.

I would like to acknowledge the contributions of members of the CSH&E TC's Board of Management and staff, and health industry stakeholders in updating this important document that will hopefully continue to serve as a useful tool to agencies across the WA private and public health sectors seeking to plan for, and develop, their workforces in these challenging and competitive times.

Geoff Jones

Chair

Community Services, Health and Education Training Council
August 2015

[1] www.ourstatebudget.wa.gov.au/15-16/

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Overview of the WA Health Industry

The importance of the health industry's services to the people of this state cannot be overstated. How the health workforce will continue to strive to meet the state's expectations depends in some large part, on effective workforce planning and workforce development within every health agency and across networks and sectors. The WA Government is committed to encouraging all industries to use workforce development processes to secure workforces in the anticipated period of expansion. The main purpose of this health industry workforce development plan (Health IWDP) is to help health services to attract, recruit, retain and develop skilled workers required to maintain levels of essential services.

Workforce planning for the health industry requires strategic engagement and coordination across governments, the tertiary education sector and industry bodies. Planning for the future and responding to changes in the policy settings for health is made more difficult by the lack of reliable, comparable and transparent training and workforce data. Main items in the data that is available include:

Economic, Social, Demographic, Environmental and Technological issues that impact on workforce development in the WA Health industry

A range of factors with complex aetiologies combine to impact on workforce planning and development in the health industry. These include:

- Attraction and retention continue to be major workforce issues for the health industry given the ageing workforce, likely increased retirements and continued growth of need for health services as the WA population grows, and the population ages.

- Within health services, there is a shift towards interdisciplinary practice to improve access to services that meet multiple client needs and goals (particularly in regional, rural and remote areas).

- wage gaps between the health industry as a whole and other industries, and between the government and non-government health sectors,

- government funding systems are varied and operating successfully within them creates additional time and costs for health services,

- reporting burdens on non-government agencies detract from their principal objective of service delivery,

- Complex and wide ranging workforce development issues related to attraction, retention, attrition, career changes, and impending retirements of the ageing workforce.

- The need for more ethnically and culturally balanced workforce in relation to Culturally and Linguistically Diverse (CaLD) / Migrant groups and Aboriginal people.

- The lack of skill development and training opportunities, especially in rural and remote areas, also problems relating to access to quality training delivery, especially in regional and rural areas.

- The lack of accurate and current data on the health workforce for workforce planning purposes.

- The increasing pace of technological development (eHealth technologies) and the upskilling implications for the health workforce.

Clinical Placements – Access to quality clinical placements has been a perennial difficulty with all health related training and education, particularly in the VET sector where there is restricted funding available to both seek and support placements. The WA Department of Health recently published results of its research in 'Clinical Placement Activity 2011 – 2014.[2] The results indicate the scale of the placement required with 2000 plus establishments providing placements across WA, 4.29million hours spent on placement in 2014, a 17% increase in placements from 2011-2014 but some of the increase could be due to improved reporting, nursing and medicine staff accounted for 63% of all placements with 67% in the public sector and 30% in the private sector, and 56% in hospital settings. Some 10% of placements occurred outside the metropolitan area. Some 98% of all clinical placement activity is generated by the 5 WA universities. It should be noted that there is no reference in the results of VET Enrolled Nursing training generated clinical placements. What is known is that VET providers experience difficulty in securing placements because of the pressure created by the Universities. Using Health Workforce Australia funding, the Health Department has a project to introduce a 'Clinical Placement Management System" (CPMS) which will provide 'visability' of all WA Health Clinical placement opportunities to health and education stakeholders. It is hoped that this will lead to better informed planning and management of clinical placements. There will be a similar CPMS system for the Dental and Oral Health sector. The WA Health update indicates that anticipates completion of the 'User Acceptance Testing by 31 Dec 2015 in readiness for the first semester in 2016.

- The impact of the opening of the Fiona Stanley Hospital on workforce issues – The impact of the opening of the Fiona Stanley Hospital on workforce issues – Fiona Stanley Hospital (FSH) opened on 4 October 2014 in a four phased sequence which was completed on 16 February 2015. Overall, FSH staff have managed to transition successfully from other institutions and are progressively forming into a cohesive team. Areas with strong medical and nursing leadership have been able to implement new, adapted models of care for their patients. However, some units have not transitioned easily to the new hospital and there are persisting tensions regarding workforce levels and models of care. These concerns were most noticeable within the Maternity Services. The Allied Health Services team have implemented a hospital-wide model of care with the allied health clinicians responsible to the Director, Allied Health Services. This has ensured strong leadership and is a well-resourced department.

  It was reported by many of the clinical staff interviewed that clerical staff within the hospital had initially found IT systems difficult to negotiate, and were unprepared for the nuances of clinical practice where some doctors were credentialed differently and performed completely different roles to others. This initially led to patients being booked to inappropriate clinics. As clerical staff becomes more experienced in their new roles, this should not continue to be an issue. In the meantime, the hospital should ensure that systems are in place to provide appropriate orientation and support to clerical staff and therefore, minimise clerical booking errors.

The Industry Sections covered in the 2015 Health IWDP Update

The CSH&E TC is mandated to cover the 'Health Care and Social Assistance' Industry which is designated as Division Q of the Australian & New Zealand Standard Industry Classification (ANZSIC).

[2] Clinical Placement Activity in WA 2011-2014 Department of Health Government of Western Australia, Aug 2015.

ANZSIC's Division Q (Health Care and Social Assistance) includes four ANZSIC Subdivisions (denoted by two digits), which are as follows:

- Subdivision 84 – Hospitals
- Subdivision 85 – Other Medical & Health Services
- Subdivision 86 – Residential Care service

Both subdivisions 84 and 85 contain a number of '*Groups*' (that are denoted by three digits in ANZSIC) and '*Classes*' (that are denoted by four digits in ANZSIC).

(Please note that the other two subdivisions of Division Q - Subdivisions 86 and 87 - are the main focus in the 2014 Community Services IWDP)

Please see Appendix A in the 2014 Health IWDP for further details of the various ANZSIC categories.

For the majority of VET covered health occupations there are qualifications in the **Health Training Package** from Certificate II to Advanced Diploma levels. The Health Training Package is now designated with the HLT prefix with no identifying year.

Size of the Health workforce
The 2011 Census figures indicate the WA health Industry grew from 55,693 in 2006 to 69,328 in 2011, an increase of 24.5%.

The areas with the largest growth were:

- Ambulance Services 53.93% to 1,131
- Specialist Medical Services 47.1% to 3,136
- Pathology & Diagnostic Services 44.7% to 3,271, and
- Other Allied Health Services 42.5% to 5,682.

Even the largest sector, i.e. Hospitals, grew 20.7% from 28,893 to 34,876. Increases of more than 13.9% (for 'General Practice Medical Services' to 7,288) occurred in every sector except 'Medical and Other Health Care Services, nfd', which showed a decrease of – 46.3% to 2,407 in 2011 from 4,485 in 2006. The reasons for this decrease, against an overall increase of 24.5% are not known. One possibility is that in the 2006 Census workers who identified themselves in this 'Not further defined' (NFD category) were now in 2011 able to identify a more specific health sector. In this case, the 'medical and other health services' sector would have been reallocated to other sectors in the five year period between the two censuses.

The Health industry employs 10% of the total Australian workforce. It is projected that 229,400 new jobs will be created in the community services and health industry between 2013 and 2018 (Australian Government Department of Employment 2014a).[3] Combined with the Community Services and Care industry it has the largest WA workforce given recent reductions in the construction industry. The recent growth is predicted to continue as the state's population grows and the demands for health services increase concomitantly.

Relative to all industries, the workforce in the health industry is older (average 42.8 years compared to average 39 years) and mostly female (78% compared to average 45%). Employment in the Community Services and Health industry has grown by 3.8% each year over the last ten years, compared to 2% across all industries (Australian Bureau of Statistics, 2014b). As a result, our industry now employs 1.4 million workers, which is more than any

[3] 2015 Environmental Scan, Community Services and Health Industry Skills Council

other industry, and accounts for 12% of the total Australian workforce (Australian Government Department of Employment, 2014a).[4]

It is projected that 229,400 new jobs will be created in the Community Services and Health industry between 2013 and 2018 (Australian Government Department of Employment, 2014a). Ten occupational groups specific to health and community services are predicted to have the largest actual growth between 2013 and 2018. These projections suggest particularly strong growth in VET-qualified occupations such as aged care and disability support workers (classified as Aged and Disabled Carers).[5]

Overall, Division Q (Health Care and Social Assistance subdivisions) increased by 54% (41,891) in the period between the 2006 and 2011 Censuses. Although in WA workforces of other industries grew by larger percentages (for example, mining by 93%, and electricity, gas and water by 81%), these increases were from much smaller initial bases, and of course are now in decline given the current economic downturn. In 2011 Health Care and Social Assistance, which is comparatively stable in terms of overall size, had WA's largest workforce. This is not expected to have changed in 2015.

Labour Force data

Labour Force Survey results showed that there had been a decrease in employment in the State in the month of June 2015, accompanied by a lower rate of labour market participation. As a result, the State's unemployment rate in June increased (at 5.5%).

During June 2015, the State's unemployment rate of 5.5% was the lowest of all the states, and a full percentage point below the national unemployment rate of 6.0% in June. The State's current rate of 5.5% is however higher than the 5.0% rate recorded for the State a year prior (i.e. for June 2014). The estimated number of unemployed people in the state rose to a total of 80,200 persons in June.

WA's labour force participation rate was 68.6% in June 2015, (down from 68.7% in May). This equates to decrease in number of people participating in the State's labour force. The State's participation rate was below the national rate of 64.8%.

In annual average terms, the State's youth unemployment rate averaged 17.2% over the past year, equating to some 5,500 unemployed youth who were looking for a full time job over the year. This rate was lower than the national rate of 26.8%.

Reductions in the resources and mining sectors in 2013 and 2014 thus far appear to have reduced the 'crowding out' pressure on the health industry. The predicted growth in the need for Health services to 2016 could mean such pressures will return if the health industry does actually expand to meet the anticipated increased demands for health services from the growing population.

The Health IWDP aims to provide a framework by which the WA health industry can develop workforce and training initiatives to enable its workforce to remain viable and productive. In particular, the plan identifies strategies to help the industry respond to the anticipated increasing demand for skills, labour and other workforce challenges.

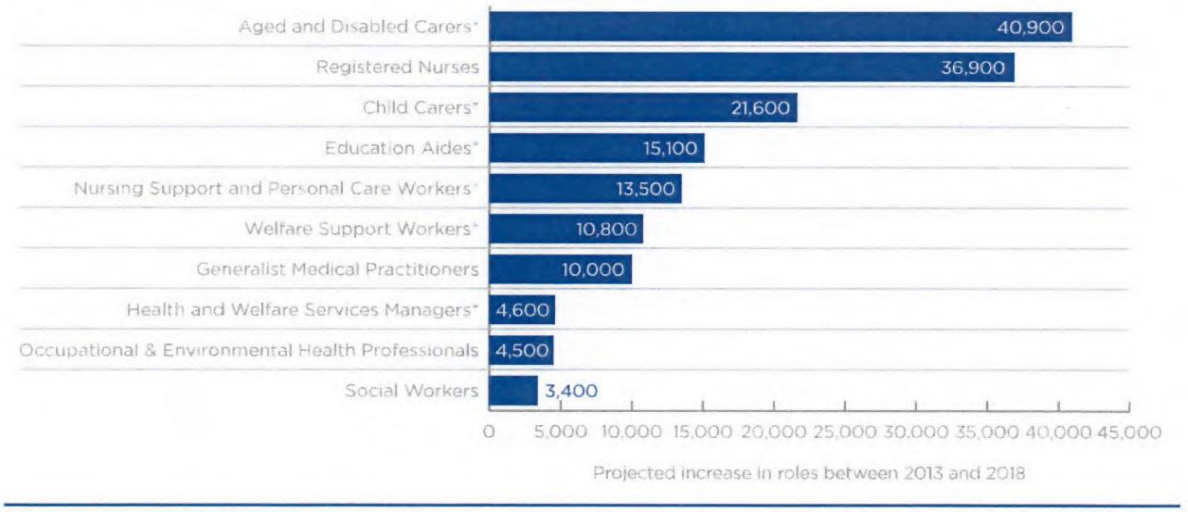
The retention of existing workers will need to be addressed by providing support for mid-career skills development. There is also a need for leadership skill to implement workforce change.

[4] CSHISC EScan 2015, page 11.
[5] CSHISC EScan 2015, page 12.

The number of health workers aged 55 years and over was 15,334, which equates to 21.4% of the total health workforce. The number for those who are 50 years and over is 25,244, which equates to 35%. These figures confirm that the rates of retirement from the health workforce will continue to increase and create labour shortages over the next 15 years. Indeed, 2,315 workers (3.2%) were already over the retirement age of 65 years, and a further 5,086 (or 7.1%) in the 60 to 64 age bracket. This means that 10.3% of the current workforce was already over 60 years at the 2011 ABS Census. The implications are clear: massive recruitment efforts are required to attract younger people into the industry to counteract the impact of the inevitable retirements and to respond to the need to grow the workforce to meet the increased needs for services from the growing and ageing population.

Projected growth in selected health and community service specific occupational groups, 2013 – 2018

Figure 2: **Projected growth in selected health and community service specific occupational groups, 2013 – 2018**

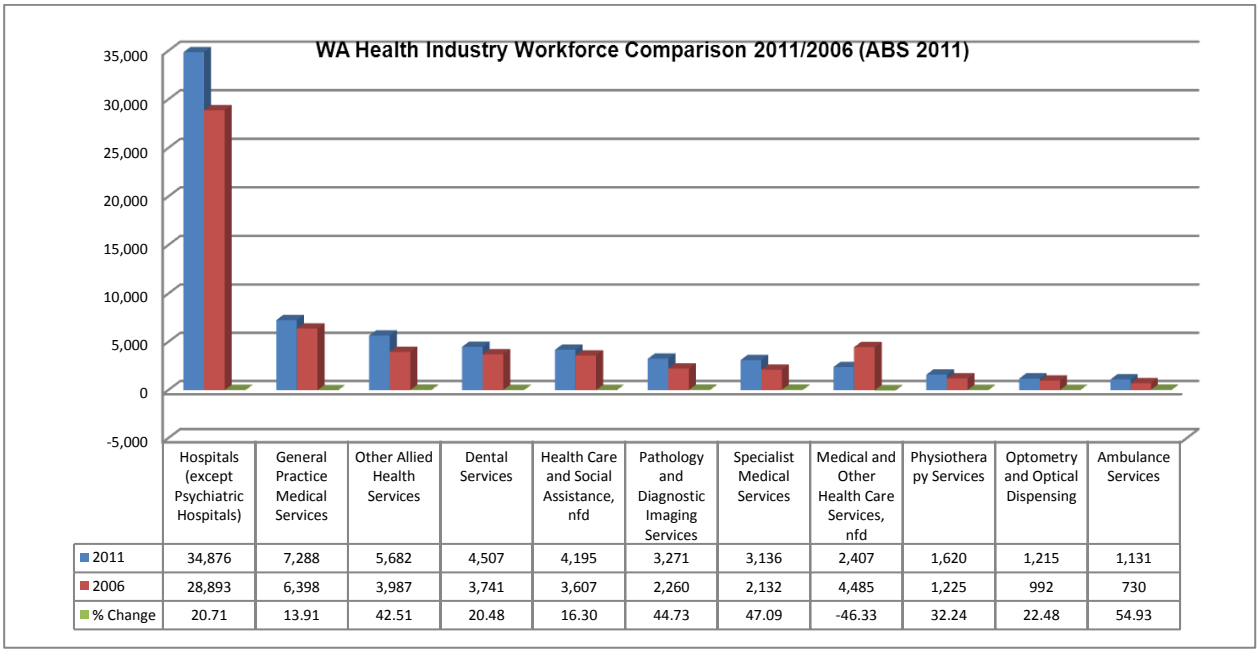


Source: Australian Government Department of Employment (2014a). Occupational projections, (projected change) to Nov 2018

Notes:

1. *indicates groups that include occupations aligned to VET qualifications.
2. Data presented is based on projections rounded to the nearest hundred.

Chart 1: Western Australian Health Industry Workforce Comparison 2011/2006



	Hospitals (except Psychiatric Hospitals)	General Practice Medical Services	Other Allied Health Services	Dental Services	Health Care and Social Assistance, nfd	Pathology and Diagnostic Imaging Services	Specialist Medical Services	Medical and Other Health Care Services, nfd	Physiotherapy Services	Optometry and Optical Dispensing	Ambulance Services
2011	34,876	7,288	5,682	4,507	4,195	3,271	3,136	2,407	1,620	1,215	1,131
2006	28,893	6,398	3,987	3,741	3,607	2,260	2,132	4,485	1,225	992	730
% Change	20.71	13.91	42.51	20.48	16.30	44.73	47.09	-46.33	32.24	22.48	54.93

Government policies impacting on the Health industry's workforce
The Australian Health Practitioner Regulation Agency (AHPRA) is the organisation responsible for the implementation of the National Registration and Accreditation Scheme across Australia.

AHPRA's operations are governed by the Health Practitioner Regulation National Law Act 2009. Under this law, National Health Practitioner Boards are regulated by nationally consistent legislation for each of the following 10 health professions - Chiropractic, Dental, Medical, Psychology, Pharmacy, Nursing and Midwifery, Physiotherapy, Osteopathy, Podiatry, and Optometry). On 1 July 2012, Chinese Medicine Practitioners, Medical Radiation Practitioners, Occupational Therapists, and Aboriginal and Torres Strait Islander Health Practitioners joined the National Registration and Accreditation Scheme.

The Boards have the power to register students - estimated at 100,000 and will work directly with education providers to do this. The CSH&E TC has links with the WA office of AHPRA in respect to Enrolled Nurse registration. An AHPRA representative sits on the CSH&E TC's Enrolled Nurses IAG. Discussions have covered a number of areas, but of particular interest to the EN IAG have been the new Accreditation and Registration processes, and issues related to clinical placements and overseas qualified Enrolled Nurses.

The health workforce split between the metropolitan and regional areas

The overall WA health industry workforce total is 69,328. Of these approximately 78% work in the metropolitan area and 22% in the WA regions.

The contrast between the full-time and part-time workforce statewide is 56% full-time and 43% part-time. The metropolitan and regional full-time to part-time figures are similar, i.e. 56% to 43%, except for a few small decimal places. There are 5,964 part-time workers in the WA regions. The part-time workforce creates particular difficulties for workforce planning and training delivery purposes even in the metropolitan area but these difficulties are exacerbated in the regions.

In only two sectors the part-time workforce outnumbers the full-time workforce; these are:

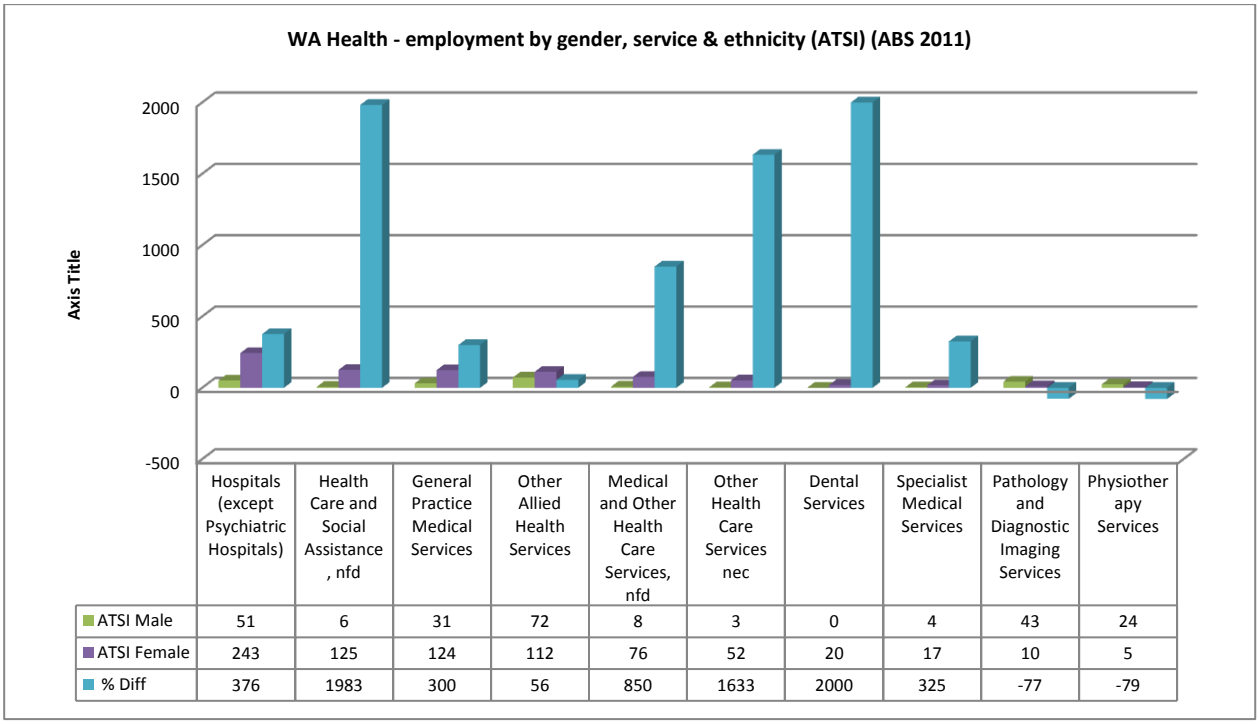
- General Practice Medical Services in the metropolitan area,
- Other Allied Health Services in both metropolitan and regional areas.

Challenges related to the geographical spread of WA health services
Health services are provided through a wide variety of sites across WA from large tertiary hospitals with large numbers of staff, to small community services and remote nursing posts, sometimes staffed by a single person. This vast geographical spread of the population in WA presents significant challenges for health service delivery and therefore similar challenges for workforce development and training. A number of Health IWDP recommendations relate directly to the issues associated with WA's unique geographic challenges and the problems associated with maintaining regional health service delivery, and attracting, retaining and training personnel for those services.

Aboriginal people in the WA Health workforce
In a total Health workforce of 68,163 only 1,026 (1.5%) are Aboriginal people. Of these, there are 242 males and 784 females. This participation rate is somewhat below the numbers of

health people in the general population and even below the proportions of Aboriginal people in some other industries.

Chart 2: Health—employment by gender, service and ethnicity (ATSI)



	Hospitals (except Psychiatric Hospitals)	Health Care and Social Assistance, nfd	General Practice Medical Services	Other Allied Health Services	Medical and Other Health Care Services, nfd	Other Health Care Services nec	Dental Services	Specialist Medical Services	Pathology and Diagnostic Imaging Services	Physiotherapy Services
ATSI Male	51	6	31	72	8	3	0	4	43	24
ATSI Female	243	125	124	112	76	52	20	17	10	5
% Diff	376	1983	300	56	850	1633	2000	325	-77	-79

Source: ABS 2012

Char 2 shows the number of people employed in WA Health by gender, service and ethnicity. The non-ATSI number of people employed in the health industry is 67,137 (including 14,536 males and 52,601 females) as compared to ATSI workforce in health, which is 1,026 (242 males and 784 females) in the above mentioned services. This chart indicates low participation rates of the ATSI workforce. The numbers and proportions of Aboriginal people in the health workforce are far below state averages and are especially problematic given the higher levels of health needs of Aboriginal people. Given that health industry, anyway, suffers from both labour and skills shortages, it is critical that increased efforts are made to attract greater numbers of Aboriginal people into the health workforce.

Substantive Equality

One of the major outcomes of the COAG Reform Agenda and the Substantive Equality Initiative has been an increase in Aboriginal employment. WA Health has established over 400 new Close the Gap and Indigenous Early Childhood Development positions, with 60% of these located in regional and remote areas. Over 60% of these positions are filled by Aboriginal people.[6]

Workforce development issues in the health Industry

Retirement rates

The increase in retirement rates from the health workforce is likely to further increase pressures caused by attrition of workers to other industries. At both individual agency and whole-of-system levels, there is an urgent need for a focus on prevention of labour and skills shortages related to the anticipated retirement of large numbers of the existing workforce.

[6] Annual Report 2011-12, Department of Health, Government of Western Australia, P 122.

Gender disparities
WA Health has developed a Workforce Retention Framework in recognition of the changing workforce profiles and the need to ensure critical skills and experience is available to deliver services and provide clinical training. Workforce in the health industry is older (average 42.8 years compared to average 39 years) and mostly female (78% compared to average 45%). The number of females working in the health industry is much higher than the number of males. The proportions are even higher in specific occupations such as Enrolled Nursing. From an overall total of 71,500, women make up 78% (55,780) and men 22% (15,720). The proportions in the regions are similar.

Ageing workforce
The number of health workers aged 55 years and over was 15,334, which equates to 21.4% of the total health workforce. The number for those who are 50 years and over is 25,244, which equates to 35%. Indeed, 2,315 workers (3.2%) were already over the retirement age of 65 years, and a further 5,086 (or 7.1%) in the 60 to 64 age bracket. This means that 10.3% of the current workforce was already over 60 years at the 2011 ABS Census.

Need for attraction and retention strategies
These figures confirm that the rates of retirement from the health workforce will continue to increase and create labour shortages over the next 15 years at a time when demand for health services is predicted to increase. The implications are clear: massive recruitment efforts are required to attract younger people into the industry to counteract the impact of the inevitable retirements and to respond to the need to grow the workforce to meet the increased needs for services from the growing and ageing population.

Both the WA State and Commonwealth Governments have committed to increasing training and employment opportunities for members of the participation target groups (women, CaLD, Aboriginal people, older men, people with a disability, youth and people in rural and remote locations). Given the current general high employment rates in WA, people in these participation groups constitute the only readily available source of additional workers to ease the health industry's labour supply problems.

A recent success story has been the tripling in the number of Aboriginal people working for WA Health. However, the participation rates still remain low if compared with the total Aboriginal population.

To address retirement and labour shortage issues the CSH&E TC will be:

- working with Health stakeholders to seek the development of strategies to respond to the challenge posed by the high and rapidly increasing proportion of older workers in the workforce who are nearing retirement age, and

- developing strategies to attract greater numbers of young people (university graduates, school leavers and VET qualified) to occupations in the health workforce.

Demand and supply disparities
Recent anecdotal reports indicate that an expansion of services in an increasingly constrained fiscal environment requires a much greater emphasis on workforce productivity. To meet increased service demand our industry will need to continue to develop and implement strategies that attract new workers, retain existing workers and establish new ways of working in a more productive way. There is also a particular need for more efficient use of new and existing roles to meet the demand for health and community services in rural and remote areas.

There is a continued need to develop skills that support our workforce to respond to the changing needs of clients, policy developments and the training needs of the current workforce. For example:

- The increased emphasis on home and community delivered services, client-focused and consumer-directed models of care and support is likely to lead to an increased demand for workers with a broader base of skills and the further blurring of boundaries between traditional sectors
- Strong leadership and management skills will be necessary to manage the organisational, cultural and financial implications of consumer-directed services
- As the client-base becomes increasingly diverse, there is more emphasis on employers providing working environments that are 'culturally safe' for workers and clients, as well as workforce development to equip workers with the required skills and cultural competencies
- Overseas workers may need to be provided with additional support to develop the cultural competency, English language literacy and related communication skills they need to do an effective job.

Streamlining of Training Package
The Community Services and Health Industry Skills Council (CS&HISC) completed extensive national consultations for the review and streamlining of the Health Training Package (HLT).

The new Australian Industry and Skills Committee (AISC) endorsed the 28 qualifications and 164 units of competency on 27 July 2015.

The new qualifications reflect the changing needs of industry and the structure and design of most units has been modified. Key changes include:

- Simplified and streamlined content to make it less complex and easier to interpret, through use of concise descriptions and plain language
- Unnecessary or duplicated detail removed
- Content segmented into fit-for-purpose categories, including separating performance standards and requirements from supporting information
- More work placement hours as key component of some qualifications

Transition to the new revised (2015) qualifications and 'teach out' of the HLT2008 and HLT2012 qualifications must be completed by 6th August 2016. This will create cost and time pressures on the public and private RTOs who deliver HLT qualifications to the health industry.

The new qualifications endorsed in July 2015 include:

- Complementary & Alternative Health, including: Aromatherapy, Ayurveda, Kinesiology, Massage, Reflexology, Shiatsu & Oriental Therapies and Traditional Chinese Medicine Remedial Massage

- Direct Client Care and Support including: Allied Health Assistance and Health Services Assistance

- Technicians and Health Support Services, including: Anaesthetic Technology, Audiometry, Cardiac Technology, Health Administration, Hospital/Health Services Pharmacy Support, Medical Practicing Assisting, Operating Theatre Technology, Pathology and Sterilisation Services

- Cross Sector units, including: Health professional support, anatomy and physiology, infection prevention and control, oral health and work health and safety.

The endorsed qualifications can be accessed on the National Register (www.training.gov.au).

By December 2015, the streamlining of the remaining health qualifications will be completed, including: Ambulance, Nursing, Oral and Dental Health, Public Health (Population Health and Indigenous Environment) and Health Support Services.

Other significant changes in the July 2015 Health Training Package include:

- mandatory work placements (e.g. 80hrs, 120 hours, 240 hours)
- pre-requisites and Entry requirements have been removed, except in regulated areas such as Nursing and Dental Prosthetics
- workplace assessment is mandatory for relevant units
- enhanced simulated assessment and scenarios for relevant units such as child protection, mandatory reporting
- cultural diversity and inclusion are core in all qualifications
- new performance evidence describes volume and frequency of assessment e.g. interacted with at least five families from a diverse range of backgrounds; provided care to at least three children with varying needs across a range of ages
- assessor requirements over and above the AQTF/NVR requirements in some units

New and Emerging Skills
Stakeholders highlight several emerging roles, including case manager, care coordinator, therapy assistant, personal carer, direct care worker, diversional therapist, formal visitor, end-of-life consultant and e-health trainer. Stakeholders also suggest that current workers will need additional skills in dealing with dementia, alcohol and other drug issues and chronic mental health, as well as literacy, numeracy and customer service skills. The ageing workforce is also increasingly multicultural, and it has been suggested that a more multicultural workforce is ideal. Aged care may evolve into aged services, reflecting the emergence of new models of working, point-of-care interventions and the development of more services relating to consumer-directed care support, transport and home maintenance. Relating specifically to the delivery of VET, some stakeholders expressed concern that there was more material included in the content of training programs and that these were being delivered in less time, and that this may dilute effectiveness. They noted that fast-tracking students did not facilitate job-readiness.[7]

Increased demand for services and changes in the funding and service delivery environment are driving demand for different roles and specific skills. To compete in a care and support market, service providers will need to invest in workforce development activities that support the attraction, recruitment, retention of, and ongoing learning of, appropriately skilled workers.

Skills in Demand and Emerging Roles
The changes due to service expansion, new quality standards and changes to the way services are funded and delivered are driving demand for specific skills as well as roles. Industry stakeholders have identified the following key trends:

- increased scope of support worker roles
- emerging demand for care coordination roles
- demand for workers to develop existing skills and acquire new ones (in some cases leading to the development of advanced care roles)
- increased demand for skills in business management and administration
- greater emphasis on technological knowledge and skills. [8]

New or redeveloped work roles are likely to include:

[7] CS&H (Community Services & Health Industry Skills Council, 2012)ISC 2015 Environmental Scan, page 20
[8] CS&H ISC 2012 Environmental Scan

- Mental Health: mental health peer worker, health assistant, care consultant and consumer consultant,
- Disability: consumer facilitators, that is, positions to support service purchasing decisions and rights, communication, service/case coordination and management,
- Aged Care: roles focusing on wellness and rehabilitation, and
- Indigenous services: Certificate IV (practice stream) for registered Aboriginal and Torres Strait Islander health practitioners, and higher Health Care workers and community services workers[9]

VET in Schools (VETiS) update
To meet the growing recruitment requirements of the industry there is an urgent need to increase VET in Schools programs to encourage health career choices by students.

The CSH&E TC has liaised with health stakeholders to seek further development of an embedded health qualification based on the Certificate II - Health Service Support as a VET industry specific course. This course provides 2 units towards WACE. This should act as a recruitment incentive to attract more young people into the industry. The CSH&E TC will monitor its developments and encourage schools to gather destination statistics on students entering the health industry.

The DTWD has published a VETiS Register (July 2015) in which industry advice is provided on the suitability of qualifications for delivery in VETiS programs.

Recently, initiatives have been developed to improve employment opportunities for Aboriginal people in the health industry in response to state and national workforce priorities. These include:

- the use of VETiS as a pathway into further VET and tertiary qualification streams,
- a cadetship program that provides employment opportunities for students nearing the completion of undergraduate study, and
- employment in areas including nursing, primary health care work and pathology.

Apprenticeships and Traineeships
The CSH&E TC will continue its efforts to better promote traineeships to the health industry, especially in the occupations where there has been under utilisation of traineeships. These efforts include collation and analysis of the relevant statistics, identification of new enrolment targets, development and circulation of appropriate promotional materials, liaison with the DTWD's Apprenticeship Office, Australian Apprenticeship Support Network (AASNs)[10] and Group Training Organisations (GTOs), Workforce Development Centre and the Aboriginal Workforce Development Centres. The aim is to remove underperforming traineeships, establish new traineeships in areas of acknowledged need and overall better promoting of traineeships to the health industry. The views of the health industry on current and future traineeship requirements will be collated and provided to the DTWD and STB staff.

The CSH&E TC will liaise with health stakeholders and service providers to seek resources and opportunities for delivery of training to existing workforces. Traineeships remain an under-utilised funding program within the health industry and the CSH&E TC will continue to promote their increased usage in 2015-2016.

[9] CS&H ISC 2012 Environmental Scan
[10] Four AASNs commenced operation in WA from 1st July 2015. These are AMA Services (WA) Pty Ltd, Chambers Apprenticeship Support Australia Pty Limited CCI, MEGT Australia, & The BUSY Group Ltd.

Higher Education Pathways
The CSH&E TC makes reference to health occupations that are subject to Higher Education (HE) qualifications, in the following areas:

- where strong articulation pathways exist between an occupation that is covered at both VET and HE levels (e.g. Enrolled Nurse to Registered Nurse)

- in respect to advice given to DTWD for the SPOL and WA Skilled Migrant Occupations List (WASMOL), which include both VET and HE covered occupations, and

- where professional associations (those that cover HE qualified professionals) are involved in the CSH&E TC's IAGs and provide advice on the VET-covered occupations that they manage.

Summary of Health industry workforce development issues to be addressed in the PRAs of this 2015 Update

The following important Health industry issues are assigned 'bullet points' for the purposes of adding emphasis and later extracting the issues for further attention.

Workforce development issues

In the Health industry (as with the Community Services and Education industries) skill shortages continue to impact negatively on the quality of delivery of their essential services delivery. Although these shortages have common causes there are dimensions that are specific to each industry. For all three industries these skill shortage pressures are likely to increase as the WA population increases, their workforces' age, the proportion of older people in the general population increases, and the need and demand increases for the community, health and education services.

Increasing proportion of Aboriginal people in the three workforces

The numbers and proportions of Aboriginal people in the workforces of all three industries are far below state averages and are especially problematic given the higher levels of need of Aboriginal people for health, community and education services.

It is critical that increased efforts are made to attract greater numbers of Aboriginal people into the three workforces.

The decreasing number of volunteers in the community services, health and education industries

Increased competition for volunteers due to relatively low unemployment and decreased rates of voluntarism (the average age of volunteers in the three industries is 53 years, compared to the average age of all volunteers in all industries of 44 years).

The need for culturally sensitive services

People from CaLD backgrounds are underrepresented in the workforces of the three industries. This impacts on the cultural sensitivity of the services provided by the three industries. The need to increase cultural awareness and sensitivity of the community services workforce in respect to both fellow workers and clients

Regional and rural—skills development and training

There is an urgent need to address the workforce related challenges of providing community services, health and education services to the 33% of the WA population who live in the WA regions.

Concerns about quality of training delivery

The quality of VET training delivery remains a major critical concern for all three industries.

Mental Health sector

There is a lack of trained and qualified staff in the Mental Health sector at a time when both Government and non-Government sectors are planning a general expansion of mental health services including a range of new types of mental health service.

Unavailability of adequate data

Lack of adequate workforce planning data on the numbers of people employed in the health workforce, numbers required and attrition rates across the public and private health sectors and in the aged care sector.

Strategies to address workforce development issues

How recommendations (RPAs) of the 2015 Update Health IWDP will be addressed
The WA health industry is undergoing a range of major funding, structural, policy and program changes that have important implications for the health workforce, and therefore this 2015 Update of the Health IWDP. These changes have been assessed in the process of updating the 2014 Health IWDP. It is a constantly moving agenda and the CSH&E TC will make efforts to monitor further changes and update the recommendations, should this be required.

The recommendations of the 2014 Health IWDP had implications for a range of stakeholders, including the WA Health Department and other relevant State Government departments. The steps towards addressing or implementing the recommendations involved the CSH&E TC liaising with other health agencies and key stakeholders in both the private and public health sectors to facilitate joint action.

In seeking to continue to address the Health IWDP recommendations the CSH&E TC's role will be:

- Maintaining and increasing as appropriate the membership base of its health sector specific IAGs,
- aligning work plans of the health sector specific IAGs and CSH&E TC to the DTWD workforce planning framework and timelines,
- increasing the flow of workforce development information to the health industry by improving links with the agencies and networks represented by members of the Board of Management, and encouraging promotion of workforce issues through their newsletters and internal consultation processes,
- increasing communications with health sectors and the regions through email, web, meetings, and phone conferences,
- enhancing links with the national Community Services & Health Industry Skills Council (CS&H ISC) and relaying information to the WA health sectors on its national projects and issues, and
- promoting greater utilisation and recognition of VET qualifications in non-degree related occupations to support health service delivery.

The CSH&E TC will promote the Health IWDPs and encourage stakeholders at all levels to use the plan to help develop workforce development strategies for their own agencies.

Further to this, the CSH&E TC will continue to liaise with the DTWD to seek ways of implementing Health IWDP RPAs and to seek public funding for those requiring training delivery. The CSH&E TC will also act as a conduit between the DTWD and the industry's peaks, networks and agencies to encourage the implementation of the Health IWDP and report on progress and updates.

Explanation of the tables below
The framework used in the following tables is as follows:

- Skilling WA Strategic Goals
- Issue – shared across the three industries or specific to the industry
- Strategy to address the issue

- Recommended Priority Action (RPA) to seek to address the strategy
- Steps to achieve the RPA

Each table is headed by one of the five Strategic goals of Skilling WA. In the row below is a summary of the issues that needs to be addressed. (n.b. there are six shared issues and two specific issues for each of the three industries covered by the CSH&E TC. In the next row is the strategy designed to address the shared or industry specific issue. In the next row is the RPA designed to address the strategy. In the final row are number of Steps that the TC or industry will endeavor to follow in order to address the issue.

Skilling WA: Strategic goal 1 **Increase participation in the workforce particularly among the under-employed and disengaged, mature-aged workers, Aboriginal and Torres Strait Islanders and other under-represented groups**
Shared Issue 1. In the community services, health and education industries labour and skill shortages continue to impact negatively on the quality of the delivery of essential services. Although these shortages share common causes there are different dimensions that are specific to each industry. For all three industries these labour and skill shortage pressures are likely to rise over the next ten years. This will be primarily due to predicted increases to the WA population, increasing numbers and proportions of older people, and increased demand for the services provided by the three industries.
Strategy 1 Support sectors in all three industries to address skill and labour shortages by evaluating, improving and promoting current and new policies and programs to further increase employment and training opportunities for people in the various access groups (i.e. people with a disability; young people 16-24; women returning to workforce; people from CaLD backgrounds; mature men; and people with a mental illness; disability; and young people. (please see below for specific recommendations in relation to Aboriginal people)
Shared Recommended Priority Actions RPA 1 The CSH&E TC will liaise with government departments and non-government peaks in the community services, health and education industries to identify workforce planning and development responses, policies and projects designed support their capacity to deliver their essential services and reduce labour and skill shortages.
Steps The CSH&E TC will work with the health industry to: **Step 1.1** Encourage increases in workforce participation rates of people from the access groups. (i.e. people with a disability; young people 16-24; women returning to workforce; people from CaLD backgrounds; mature men; and people with a mental illness; disability; and young people.) **Step 1.2** Encourage consideration of EEO policies in relation to people from the above access groups in all aspects of workforce planning and development in the three industries.

Step 1.3
Liaise with government departments and peaks that focus on each of the disengaged groups to share information on programs designed to encourage workforce engagement in occupations in the three industries.

Step 1.4
Provide practical support to RTOs and employers seeking to develop workforce development policies appropriate to increasing employment rates for people from disengaged groups.

Step 1.5
Liaise with the Department for Local Government & Communities and youth organisations to further assist with the development of Youth Mentoring programs in WA.

Step 1.6
Work with the schools sector and the three industries to better promote their occupations to school students and increase VETiS and School-Based Traineeship (SBT) programs linked to the three industries.

Step 1.7
Endeavour to monitor participation rates of people from disengaged groups across all industries to provide cross-industry comparisons.

Shared Issue 2.
The numbers and proportions of Aboriginal people in the workforces of all three industries are far below state averages and are especially problematic given the higher levels of need of Aboriginal people for health, community and education services.

It is critical that increased efforts are made to attract greater numbers of Aboriginal people into the three workforces.

Strategy 2
Support sectors in the three industries to increase their employment of Aboriginal people especially in those regions where there are higher proportions of Aboriginal people in the population than indicated by the state averages.

Shared Recommended Priority Actions RPA 2
The CSH&E TC will liaise with the peaks and agencies in the three industries to promote initiatives to increase recruitment of Aboriginal people in the three workforces.

Steps
The CSH&E TC will work with the health industry to:

Step 2.1
Liaise with Aboriginal organisations, peaks and agencies to encourage increases in training and employment opportunities for Aboriginal workers across the three industries.

Step 2.2
Undertake further work to collate successful recruitment strategies. This will include work to:

- identify best practice materials and gaps,

- develop appropriate resources (brochures, flyers) to address known gaps,
- promote these materials across the three industries, and
- continue monitoring the participation rates of the Aboriginal people in the workforces of the three industries.

Shared Issue 3.
Increased competition for volunteers due to relatively low unemployment and decreased rates of voluntarism (the average age of volunteers in the three industries is 53 years, compared to the average age of all volunteers in all industries of 44 years).

Strategy 3
Investigate and promote good practice examples of recruitment and retention strategies for volunteers in the three industries.

Shared RPA 3
The CSH&E TC will liaise with stakeholders to identify recruitment and support models for volunteers in the three industries

Steps
The CSH&E TC will work with the health industry to:

Step 3.1
Identify typical volunteer recruitment pathways.

Step 3.2
Collate sources of data on volunteers in the health industry.

Step 3.3
Identify strategies that have been successful in attracting and retaining volunteers in the three industries.

Skilling WA: Strategic goal 2
Supplement the Western Australian workforce with skilled migrants to fill employment vacancies unable to be filled by the local workforce and address those factors which support a growing population

Shared Issue 4.
Increasing numbers of people from CaLD backgrounds are employed in the workforces of the three industries. There is a need to increase training in cultural awareness and cultural competence to create culturally harmonious workforces and to bolster the provision of culturally sensitive services to the clients of the three industries.

Strategy 4
Increase migrant and CaLD links across the three industries to monitor and respond to issues related to cultural awareness and sensitivity.

Shared RPA 4
The CSH&E TC will liaise with the Migrant & CaLD sectors to seek the development of strategies for increasing recruitment of CaLD people into the workforces of the three industries.

Steps
The CSH&E TC will work with the health industry to:

Step 4.1
Liaise with stakeholders across the health sectors to identify strategies to address the workforce planning and development issues related to the Office of Multicultural Interests' (OMI) report findings on the need for improved cultural sensitivity and awareness.

Step 4.2
Promote through the CSH&E TC's IAGs increased uptake of Professional Development (PD) in developing cultural competence.

Step 4.3
Work with the Overseas Qualification Unit (OQU) to support the expansion and improvement to recognition services provided by the OQU.

Skilling WA: Strategic goal 3
Attract workers with the right skills to the Western Australian workforce and retain them by offering access to rewarding employment and a diverse and vibrant community and environment to live in.

Shared Issue 5.
There is an urgent need to address the workforce related challenges of providing community services, health and education services to the 33% of the WA population who live in the WA regions.

Strategy 5
Support sectors in the three industries to meet the workforce challenges related to providing services in the three industries to the WA regional population.

Shared RPA 5
The CSH&E TC will liaise with the DTWD Regional IWDP processes and with its own regional IAGs to seek ways of encouraging the recruitment of people to work in the three industries in regional areas.

Steps
The CSH&E TC will work with the health industry to:

Step 5.1
Analyse each of the regional WDPs to extract, collate and synchronise recommendations that relate to services in the respective regions.

Step 5.2
Amalgamate the recommendations of the CSH&E IWDPs with those of the regional WDPs.

Step 5.3
Monitor developments and programs in the regions designed to address the combined regional recommendations for the services provided by the three industries in the respective regions.

Step 5.4
Identify ways of improving workforce planning and development for the three industries in the respective regions.

Step 5.5
Seek ways of improving and expanding the delivery of flexible training opportunities to match the realities of workers and potential workers in the three industries in the WA regions.

Skilling WA: Strategic Goal 4
Provide flexible, responsive and innovative education and training, which enables people to develop and utilise the skills necessary for them to realise their potential and contribute to Western Australia's prosperity.

Shared Issue 6.
The quality of VET training delivery remains a major critical concern for all three industries.

Strategy 6
Work with state and national government agencies, the Industry Skills Councils (ISCs), industry and the VET sector to seek improvements to the quality of training delivery available to the three industries.

Shared RPA 6
The CSH&E TC will continue to liaise with the state and national bodies responsible for maintaining and improving the quality of VET training delivery for the three industries.

Steps
The CSH&E TC will work with the health industry to:

Step 6.1
Identify ways of increasing the availability and use of Information and Communications Technology (ICT) to improve the delivery of VET training for the three industries.

Step 6.2
Identify ways of increasing the use of state and national WELL and Language Literacy and Numeracy (LL&N) programs to support workers in the health, community services and education industries in their training activities.

Step 6.3
Promote the use of the VET Workforce Capability Framework (i.e. developed by IBSA 2013) to all RTOs servicing the three industries.

Step 6.4
Promote increased use of the TAE10 LL&N unit to all RTOs servicing the three industries.

Step 6.5
Promote and support implementation of the Foundation Skills Training Package in WA to all RTOs servicing the three industries.

Step 6.6
Encourage through its IAGs the uptake of PD for all RTO personnel servicing the three industries, especially in ICT.

Step 6.7
Provide opportunities for RTO personnel (e.g. trainers, assessors, and lecturers, etc.) servicing the health industry to be more aware of vital quality delivery issues including: validation, moderation, AQTF compliance, risk units, sources of funding and Training Package developments.

Step 6.8
Investigate and publish relevant PD through the CSH&E TC's website, newsletter and IAG

meetings.

Health Specific Issue 7.
Lack of trained and qualified staff in the mental health sector at a time when government and non-government sectors are planning to introduce a range of new service types and general expansion of mental health services. A key challenge is the attraction and retention of sufficient numbers of quality trained and qualified mental health personnel to maintain the service delivery required to meet WA's future mental health needs. There is also a lack of clarity about the roles, responsibilities and competencies of mental health workers employed within the health and community services industries.

Strategy 7
Work with the mental health sector to develop training and recruitment programs to meet the current shortfall of the mental health workforce in both metropolitan and rural and remote areas.

Health specific RPA 7
The CSH&E TC will liaise with the Mental Health Commission of WA (MHC) and the WA Association of Mental Health (WAAMH) to seek ways to address barriers to employment and training and to encourage mental health agencies to adopt workforce planning and development programs.

Steps
The CSH&E TC will work with the health industry to

Step 7.1
Liaise with key stakeholders to better identify and codify the occupations in demand for the mental health sector

Step 7.2
Promote the use of mental health and mental health peer worker traineeships targeting existing and new workers in metropolitan and regional areas

Step 7.3
Identify and/or seek the development of training delivery resources for the new mental health peer work traineeship

Step 7.4
Encourage mental health agencies to adopt workforce planning and development approaches and programs, and

Step 7.5
Clarify roles, responsibilities and competencies of mental health workers given recent developments at the state and national levels within the sector, and seek to have the occupation included in ANZSCO.

Skilling WA: Strategic Goal 5
Plan and coordinate a strategic State Government response to workforce development issues in Western Australia

Health Specific Issue 8.
Lack of adequate workforce planning data on the numbers of Enrolled Nurses employed, numbers required and attrition rates across the public and private health sectors and in the aged care sector. Also the numbers of Enrolled Nurses in the training pipeline on an annual basis.

Strategy 8
Work with the enrolled nurses sector to improve the collection of data on number of Enrolled Nurses in the workforce and data on the delivery of enrolled nursing qualifications.

Health specific RPA H 8
The CSH&E TC will undertake two research projects. The first will seek to identify workforce statistics for Enrolled Nurses in the private health sector, and aged care sector. The research be combined with WA Health EN survey results establish combined workforce figures for Enrolled Nurses in the state. In the second project the TC will survey current EN students to identify post-graduation job intentions.

Steps
The CSH&E TC will work with the health industry to

Step 8.1
Liaise with Nursing & Midwifery Office and key stakeholders and Enrolled Nurse IAG to collect data on overall numbers of Enrolled Nurses in the workforce.

Step 8.2
Clarify the numbers of Enrolled Nurses in the WA training pipeline.

Step 8.3
Access and analyse training delivery statistics regarding Enrolled Nurses' enrolments and completions.

Step 8.4
Survey Enrolled Nurses in training to identify post-graduation work intentions.

Step 8.5
Compare datasets and analyse the results.
Identify graduation rates and attrition rates.

Step 8.6
Report findings of the survey.

Appendix A:

STATE PRIORITY OCCUPATION LIST (SPOL 2015)
The State Priority Occupation List (SPOL) is used to help guide purchasing of publicly-funded training in Western Australia through the State Training Plan and Future Skills WA. It is also used for migration purposes, such as informing the development of the *Western Australian Skilled Migration Occupation List* (WASMOL), used to guide State Sponsored migration where jobs cannot be easily filled.

The list and background evidence will also form the basis for any labour market submissions the DTWD is asked to make to other agencies (both at a Commonwealth and State level) over the course of 2015-16, if and when required.

In addition, SPOL is used to inform workforce development planning in the State and is used as a key source of labour market evidence in a number of policy areas.

As in previous years by far the largest numbers of entries in the SPOL in all categories are Health occupations. The totals of Health occupations in each category are as follows:

In the overall total of 265 occupations in the SPOL 2014 across all industries, 86 or **32%** are in the Health industry, and a total of 106 (or **40%**) are from the CSH&E industries combined

An occupation listed on the SPOL may be assigned to one of five separate categories:

- **State Priority 1**
- **State Priority 2A**
- **State Priority 2B**
- **State Priority 3**
- **Other identified occupation**

Explanation of the Priority categories

State Priority 1
These are the highest priority occupations. They will generally be of the highest skill level (critical occupations), statistically ranked very highly and experiencing unmet demand.

State Priority 2A
These are at the second highest level of priority. They will be of the highest skill level and statistically ranked very highly meaning that it is desirable to maintain supply in these occupations, despite there being little evidence of unmet demand.

State Priority 2B
These are at the second highest level of priority. They are not necessarily occupations of the highest skill levels, but they will be statistically ranked very highly and they are experiencing unmet demand.

Priority 3

These are the third tier and represent industry or regional-level priority occupations. They tend to be either occupations experiencing unmet demand or highly-skilled occupations. Statistically, they will be ranked at a lower level than State priorities.

Other Identified Occupation
The 2015 release sees the recognition of this category for the first time. This category refers to occupations where issues have been identified through consultations undertaken across various industries or regions; however at the current time there is not enough evidence to support the existence of widespread unmet demand or other, non-market factors which would see their elevation to a priority status.

These occupations are being closely monitored by DTWD for any evidence which may see them elevated to a priority status in the future.

Not identified as a priority

These occupations do not currently have any issues identified relating to the labour market, higher education, VET or migration in Western Australia.

Occupations on SPOL in 2015

Overall, the occupations analysed for SPOL 2015 cover around half of the number of employed persons in Western Australia, with around 38% employed in State priority or priority occupations.

Table 1: Number of Occupations by SPOL Priority (2013 – 2015)

Priority Status	**2013**	**2014**	**2015**
State Priority 1	93	47	23
State Priority 2A	61	116	155
State Priority 2B	43	18	7
Priority 3	103	84	57
Total SPOL Occupations	**300**	**265**	**242**
Other Identified Occupation	-	-	76
Not a priority	441	479	426
Total ANZSCO (6 Digit)	**741**	**744**	**744**

Table 2: SPOL Priority (2015) by Industry

SPOL 2015					
Industry	**Priority 1**	**Priority 2A**	**Priority 2B**	**Priority 3**	**Other**
Health	19	61	2	3	6
Community Services	1	8	-	4	2
Education & Training	-	7	-	1	-
Totals	20	76	2	8	8

Table 3: SPOL Priority (2015) by Training Council share

SPOL 2015			
Priority	State	CS, H & E	CS, H & E %
1	23	20	**87**
2A	155	76	**49**
2B	7	2	**29**
3	57	8	**14**
Other	76	8	**10**
Totals	**318**	**114**	**36**

The full State Priority Occupations List is available on the Department of Training and Workforce Development website
http://www.dtwd.wa.gov.au/workforceplanninganddevelopment/occupationlists/spol/Pages/spol.aspx