Australian Government
Department of Health

Rural Workforce Agency (RWA)

Health Workforce Needs Assessment Reporting Template

This template must be used to submit the RWA, Health Workforce Needs Assessment report to the Department of Health (the department) by **28 February 2018**.

Rural Workforce Agency Victoria

When submitting this Health Workforce Needs Assessment Report to the Department of Health, the RWA must ensure that all internal clearances have been obtained and the Report has been endorsed by the Health Workforce Stakeholder Group.

Instructions for using this template

Overview

The Rural Health Workforce Support Activity (the Program) will run over three years from 1 July 2017 to 30 June 2020. The objective of the Rural Health Workforce Support Activity is to contribute to addressing health workforce shortages and maldistribution in regional, rural and remote Australia. The expected outcomes of the program are on meeting current and future community health workforce needs through workforce planning. This is done by:

- Identification of needs and undertaking activities in three priority areas:
    - **Access** – improving access and continuity of access to essential primary health care;
    - **Quality of access** – building health workforce capability; and
    - **Future planning** – growing the sustainability of the health workforce.
- Collaboration with relevant stakeholders such as Primary Health Networks and Aboriginal and Torres Strait Islander peak bodies, through establishing formal jurisdictional Health Workforce Stakeholder Groups (HWSG).
- Delivery of programs, including the Rural Locum Relief Program and Five Year Overseas Trained Doctors Scheme.
- National representation of rural workforce agencies and their interested, administered through sub-contracting arrangements to Rural Health Workforce Australia.

This template is provided to assist Rural Workforce Agencies (RWAs) to fulfil their reporting requirements for the Health Workforce Needs Assessment (HWNA).

It is a requirement that the HWNA is approved by the appropriate delegate of the RWA and endorsed by the HWSG prior to being submitted to the department.

The information provided by RWAs in this report may be used by the department to inform program and policy development.

Reporting

The Needs Assessment report template consists of the following:

Section 1 – Narrative

Section 2 – Outcomes of the Health Workforce Needs Assessment

Section 3 – Health Workforce Programs – Priority Activities

Section 4 – Health Workforce Programs – Other Activities

Section 5 – Eligible Health Professions

Section 6 – Health Workforce Stakeholder Group

Section 7 – Endorsement

Section 8 – Checklist

RWA reports must be in a Word document and provide the information as specified in Sections 1-8.

Limited supplementary information may be provided in separate attachments if necessary. Attachments should not be used as a substitute for completing the necessary information as required in Sections 1-8.

Submission Process

The Health Workforce Needs Assessment report must be lodged to the Department via email: HealthWorkforceGrants@health.gov.au on or before **28 February 2018**.

Reporting Period

This Health Workforce Needs Assessment report will cover the period of 1 July 2018 to 30 June 2019 and will be reviewed and updated as needed.

Section 1 – Narrative

This section provides RWAs with the opportunity to provide brief narratives on the process and key issues relating to the Health Workforce Needs Assessment.

Rural Workforce Agency (500-1000 words):

– in this section the RWA can provide background on the organisation, services provided, communities assisted etc.

Rural Workforce Agency, Victoria Limited (RWAV) vision is improved health for all in rural, regional and Aboriginal communities. RWAV's mission is to develop and deliver solutions to enhance rural, regional and Aboriginal communities' access to health workforce. RWAV has for the last 20 years delivered a comprehensive range of health workforce programs and services in rural and regional Victoria through funding from both the Commonwealth and Victorian governments. In doing so, RWAV has established and maintained collaborative working arrangements and networks with all key health workforce stakeholders in rural and regional Victoria.

Needs Assessment process and issues (500-1000 words)

– in this section the RWA can provide a summary of the process undertaken; expand on any issues that may not be fully captured in the reporting tables; and identify areas where further developmental work may be required (expand this field as necessary).

This needs assessment looks at need/problem/gap identification through to options and opportunities using an evidence based and consultative approach that then informs the choice of strategic actions around access, quality and sustainability of a health workforce for Victoria.

The approach is based on the principals that social determinants influence health outcomes. For the first year, the HWNA will focus predominately on General Practitioners, and remote area nurses (RAN). In successive years, this will be expanded to include allied health professionals and other key general practice staff.

The approach for determining 'hot spots' was based on 5 key steps:

- Categorise town based on health need using SEIFA IRSAD scores and remoteness
- Determine GP to population ratios
- Prioritise vulnerable populations e.g. aged <5 or >65/Aboriginal & Torres Strait Islander status
- Profile hotspots regions based on GP demographics and practice numbers
- Analysis of Potentially Preventable Hospitalisations

In determining the data sources, a number of factors influenced the selection, being:

- Readily available demographic data related to health status, social determinants and health conditions
- Data sets that are possible to set suitable base lines for future needs
- The potential for time series data to be developed and maintained

- Agreed definitions and suitable integrity.

The most common aggregation for the demographic data for the Needs Assessment is Statistical Area 2 (SA2). The 2016 geographic standard is the most recent. SA2 generally represents population sizes between 9,000 and 25,000. Although SA2s span much larger areas in some jurisdictions, this area level is most consistent for aggregation nationally.

Age standardised rates (ASR) and proportions, rather than absolute numbers, have been used to enable areas across Victoria to be ranked comparatively and compared over time.
To identify 'hotspots' or areas of high need, this assessment examines rates or proportions of health outcomes, according to medical disciplines or specialties, that are persistently above the state or national average for a period of at least two years. This provides an indication of whether the prevalence of a specific health outcome is intermittent or by chance, or due to an ongoing or persistent issue in the community. Where longitudinal data is not available (e.g. Aboriginal and Torres Strait Islander health), the degree above or below the state or national rate was used to identify areas in need.

As our data capture methods and collaboration with research and community organisations develops, specific data for more contextual and relational needs will develop. RWAV will continue to develop our overall data picture by including qualitative data through our knowledge management initiatives.

Additional Data Needs and Gaps (approximately 400 words)
– in this section the RWA can outline any issues experienced in obtaining and using data for the needs assessment. In particular, the RWA can outline any gaps in the data available, and identify any additional data required. (Expand field as necessary).

Where geographical areas changed from 2011 to 2016 some measures can be overstated as population data refers to 2016 statistical areas that have been redefined. In one case, Irymple SA2s was truncated 3-ways from 2011 causing a population subset to be greater than the total population. This can be managed with knowledge of the anomalies.

Creating a workforce profile capturing GPs and GP Registrars was difficult as the Registered Training Organisations (RTOs) in Victoria will only provide de-identified GP Registrar data to RWAV thereby not enabling us to reconcile this Registrar data with our GP workforce data.

In the next HWNA, there may be issues in accessing allied health workforce data especially from self-regulated professions to effectively identify the current workforce and inform future workforce planning.

Additional comments or feedback (approximately 500 words)

– in this section the RWA can provide any other comments or feedback on the needs assessment process, including any suggestions that may improve the Health Workforce Needs Assessment process, outputs, or outcomes in future (expand field as necessary).

The Health Workforce Needs Assessment Framework provides a useful benchmark for national comparisons for identifying hotspots in a uniform way across RWAs. Where the framework can't provide town level data, RWAV staff and stakeholders have been able to inform more precisely where hotspots are.

For future Needs Assessments we will look at the GP Practice level incorporating allied health and Practice Nurses and then include those allied health professionals who operate their own practice to better inform a multi-disciplinary approach to providing a health workforce.

Section 2 – Outcomes of the Health Workforce Needs Assessment

This section summarises the findings of the Health Workforce Needs Assessment (HWNA) in the table below.

Additional rows may be added as required.

Outcomes of the Health Workforce Needs Assessment		
Priority Area / Identified Need	Key Issue	Description of Evidence
Priority Area 1: Access		
Population	26 of the 153 SA2 areas have populations with more than 25% aged 65 and above • Paynesville – 38.2% • Queenscliff – 35.6%	SA2 data can be downloaded for each jurisdiction via the link below: http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3235.02016?OpenDocument
	33 SA2 areas have populations with more than 30% being vulnerable (<5 and >65) • Queenscliff – 41.4% • Paynesville – 40.8%	
	40 SA2 areas in Victoria are classified as Extreme in terms of SEIFA and remoteness. 19 of these are based in the Murray PHN.	IRSAD scores for SA2 can be exported via the link below: http://stat.data.abs.gov.au/Index.aspx?DataSetCode=SEIFA_SSC# *Australian Government Department of Health. DoctorConnect.*

Outcomes of the Health Workforce Needs Assessment		
		Source: *http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/downloads*
	12 SA2 areas had population growth over 30% from 2008 to 2016. Two were in the lowest three deciles in the SEIFA IRSAD rank. • Drouin – 45% pop. growth (3rd decile)	SA2 data can be downloaded for each jurisdiction via the link below: http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3235.02016?OpenDocument
	29 SA2 areas had Indigenous populations greater than 2% • Maiden Gully – 7.5% • Robinvale – 7.3%	
GP Population	26 SA2 areas had more than 65% of GPs aged over 55. Of those, 12 areas with only one or two GPs were aged over 55, four had GPs over 65. • Robinvale – 50% (1) • Merbein – 50% (1) • Ballarat – North – 100% (1) • Otway – 100% (1)	RWAV – ChilliDB
	Regarding GP vacancies, 80.8% positions have been vacant for six months or more. 43 positions in Murray (81.1%) and 25 in Western Victoria (89.3%).	
Priority Area 2: Quality		

Total Potentially preventable hospitalisations (PPHs)	13 of the 25 SA3 areas in Victoria had **Total** Age-standardised rate of PPH per 100,000 above the three rural PHN average in 2015/16 (2,718). Seven of those were in the Murray PHN.
	• Murray River – Swan Hill (3,540)
	  ○ Largest towns
	  ▪ Swan Hill – pop. 9,894
	  ▪ Kerang – pop. 3,872
		Australian Institute of Health and Welfare. (2017). Healthy Communities: Potentially preventable hospitalisations in 2015-16. AIHW: Sydney
		
		Source: http://www.myhealthycommunities.gov.a

Outcomes of the Health Workforce Needs Assessment		

	• Latrobe Valley (3,408)
	  ○ Largest towns
	  ▪ Traralgon – pop. 25,485
	  ▪ Moe – Newborough – pop. 16,734
	  ▪ Morwell – pop. 13,771
	• Campaspe (3,165)
	  ○ Largest towns
	  ▪ Echuca – pop. 12,906
	  ▪ Kyabram – pop. 7,321
	
	13 SA3 areas had increases in **Total** Age-standardised rate of PPH per 100,000 over the statewide average of 7.8% from 2014/15 to 2015/16.
	• Wodonga – Alpine (20.9%)
	  ○ Largest towns
	  ▪ Wodonga – pop. 38,559
	• Mildura (20.1%)
	  ○ Largest towns
	  ▪ Mildura – pop. 32,738
	• Latrobe Valley (15.7%)
		u/our-reports/potentially-preventable-hospitalisations-update/july-2017
		
		Duckett, S. and K. Griffiths, 2016, Perils of place: identifying hotspots of health inequalities, Grattan Institute
		
		https://grattan.edu.au/wp-content/uploads/2016/07/874-Perils-of-Place.pdf

Chronic	Nine of the 25 SA3 areas in Victoria had **Chronic** Age-standardised rate of PPH per 100,000 above the three rural PHN average (1,332) in 2015/16. 11 of those were in the Murray PHN. • Latrobe Valley (1,935) • Campaspe (1,849) • Murray River – Swan Hill (1,667)	

Outcomes of the Health Workforce Needs Assessment		

	12 SA3 areas had increases in Total Age-standardised rate of **Chronic** PPH per 100,000 over the three rural PHN average (10.2%) from 2014/15 to 2015/16.
	• Baw Baw (36.5%)
	  ○ Largest towns
	  ▪ Warragul – pop. 14,276
	• Latrobe Valley (32.1%)
	• Campaspe (22.7%)	

Ear, Nose and Throat	Nine of the 25 SA3 areas in Victoria had **ENT** Age-standardised rate of PPH per 100,000 above the three rural PHN average (175) in 2015/16. Five in Murray PHN.
	• Wangaratta – Benalla (246)
	  ○ Largest towns
	  ▪ Wangaratta – pop. 18,891
	  ▪ Benalla – pop. 9,298
	• Moira (224)
	  ○ Largest towns
	  ▪ Cobram – pop. 6,018
	  ▪ Numurkah – pop. 4,768
	• Shepparton (222)
	  ○ Largest towns
	  ▪ Shepparton – pop. 50,198
	
	Nine SA3 areas had increases in Total Age-standardised rate of **ENT** PPH per 100,000 over the three rural PHN average (10.9%) from 2014/15 to 2015/16.	

Outcomes of the Health Workforce Needs Assessment		

	• Heathcote – Castlemaine – Kyneton (78.6%)
	  ○ Largest towns
	  ▪ Shepparton – pop. 50,198
	• Moira (72.3%)
	• Gippsland – South West (54.0%)
	  ○ Largest towns
	  ▪ Inverloch – pop. 5,519
	  ▪ Leongatha – pop. 5,119
	
	A 2016 Grattan Institute report 'Peril of Place' highlighted high priority places with long term ENT rates.*
	• St Arnaud
	• Swan Hill
	• Buloke
	• Nhill Region
	*at least 50 per cent above the state average, for one or more ACSCs, every year for the decade 2004-05 to 2013-14.	

Mental health hospitalisations	11 of the 25 SA3 areas in Victoria had **Hospitalisations for any mental health conditions** age-standardised rate per **10,000** above the three rural PHN average (90.6) in 2015/16. Two in Murray PHN.
	• Latrobe Valley (134)
	• Gippsland – East (113)
	  ○ Largest towns
	  ▪ Bairnsdale – pop. 14,887
	  ▪ Lakes Entrance – pop. 4,810
		Australian Institute of Health and Welfare. (2017). Healthy Communities: Web update: Hospitalisations for mental health conditions and intentional self-harm in 2015–16. AIHW: Sydney https://www.myhealthycommunities.gov.au/our-reports/mental-health-and-intentional-self-harm/november-2017/web-update

Outcomes of the Health Workforce Needs Assessment		
	• Gippsland – South West (109) 14 SA3 areas had increases in Total Age-standardised rate of **Hospitalisations for any mental health conditions** PPH per 100,000 over the three rural PHN average (6.8%) from 2014/15 to 2015/16. • Barwon – West (41.8%) • Latrobe Valley (20.7%) • Creswick – Daylesford – Ballan (18.2%)	

Mental health hospitalisations for drug and alcohol use	12 of the 25 SA3 areas in Victoria had **Hospitalisations for any drug and alcohol use** age-standardised rate per **10,000** above the three rural PHN average (16.5) in 2015/16. Four in each Victorian PHN.
	• Gippsland – East (30)
	• Latrobe Valley (27)
	• Geelong (22)
	  ○ Largest towns
	  ▪ Lara – pop. 16,355
	
	10 SA3 areas had increases in Total Age-standardised rate of **Hospitalisations for any drug and alcohol use** PPH per 100,000 over the three rural PHN average (18.4%) from 2014/15 to 2015/16.
	• Baw Baw (87.5%)
	• Shepparton (83.3%)
	• Upper Goulburn Valley (63.6%)
	  ○ Largest towns
	  ▪ Kilmore – pop. 7,958	

Outcomes of the Health Workforce Needs Assessment		

Hospitalisations from intentional self-harm	11 of the 25 SA3 areas in Victoria had **Hospitalisations from intentional self-harm** age-standardised rate per **10,000** above the three rural PHN average (14.6) in 2015/16. Five in Murray PHN.
	• Grampians (25)
	  ○ Largest towns
	  ▪ Horsham – pop. 16,395
	  ▪ Ararat – pop. 8,297
	• Gippsland – East (23)
	• Wangaratta – Benalla (22)
	
	13 SA3 areas had increases in Total Age-standardised rate of **Hospitalisations from intentional self-harm** PPH per 100,000 over the three rural PHN average (12.5%) from 2014/15 to 2015/16.
	• Moira (54.5%)
	• Grampians (47.1%)
	• Surf Coast - Bellarine Peninsula (37.5%)
	  ○ Largest towns
	  ▪ Ocean Grove – pop. 14,165
	  ▪ Torquay – pop. 13,258	

Deaths from suicide and self-inflicted injuries	26 of the 84 PHAs in Victoria had annual ASR per 100,000 people aged 0-74 of **deaths from suicide and self-inflicted injuries** above the three rural PHN average (13.8) from 2010 to 2014. • Ararat Region (36.5) • Heathcote (26.5) • Bendigo Region – North (25.2)	*Public Health Information Development Unit (PHIDU). (2017). Social Health Atlas of Australia: Population Health Areas.* *http://www.phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-population-health-areas*

Outcomes of the Health Workforce Needs Assessment		

Eye health	12 of the 25 SA3 areas in Victoria had ASR per 100,000 people **aged 40 years and above of hospitalisations for cataract surgery** over the three rural PHN average (2,259) in 2014/15. Eight in Murray PHN.
	• Gippsland – East (3,015)
	• Loddon – Elmore (2,925)
	  ○ Largest towns
	  ▪ Loddon – pop. 7,516
	• Baw Baw (2,882)
		Australian Commission on safety and Quality in Health Care. (2017). The Second Australian Atlas of Healthcare Variation. Sydney: ACSQHC
		Source: https://www.safetyandquality.gov.au/atlas/atlas-2017/

Maternal and pediatric care	68 of the 153 SA2 areas had **fertility rates** above the three rural PHN average (2.26) in 2015. 13 areas in Gippsland and 35 in Murray. • Moira (3.22) • Rochester (3.10) • Mildura Region (2.97) The top SEIFA IRSAD state decile had an average fertility rate of 2.26 in Robinvale (2.74), Cobram (2.59) and Red Cliffs (2.46).	*Australian Bureau of Statistics. (2016). Births. Cat.no. 3301.0.*
	96 of the 153 SA2 areas had **rates of births per 1,000 females aged between 15-44** above the three rural PHN average (55.7) in 2015. • Robinvale (117.6) • Foster (86.9) • Gannawarra (86.7) The greatest increases from 2010 to 2015 where in	*Calculated from data retrieved from Australian Bureaus of Statistics: Births, Australia, 2015 and Estimated Resident Population, 2015*

Outcomes of the Health Workforce Needs Assessment		
	• White Hills – Ascot (1,000% from 7.7 to 84.5) • Yallourn North – Glengarry (905% from 6.3 to 63.1) • Castlemaine (903% from 6.4 to 64.5).	
Aboriginal and Torres Strait Islander health	10 IAREs in rural Victoria had **ASR of total admissions per 100,000 Aboriginal persons** above the Victorian average (32,590.6) in 2012/13. • Swan Hill (110,181.6) • Gippsland (57,310.1) • Mildura (56,317.7) 13 out of 34 Victorian IAREs had IRSEO (2011) scores above the Victorian average (29).	*Public Health Information Development Unit (PHIDU). (2016). Aboriginal & Torres Strait Islander Social Health Atlas of Australia* *Source: http://phidu.torrens.edu.au/social-health-atlases/data*
Priority Area 3: Sustainability		
GP profile	Seven SA2 areas had GP practices with only one GP, five of these practices had GPs over 55 (denoted by * below). • Mildura Region* • Irymple* • Maryborough Region* • Ballarat – North* • Otway* • Bendigo Region – North • Horsham Region	

Section 3 – Health Workforce Programs – Priority Activities

This section summarises the priorities arising from the Health Workforce Needs Assessment (identified in Section 2) and options for how they will be addressed. This includes options and priorities that:

- *Should be considered in the development of the Activity Work Plan, and supported by RWA grants funding;*
- *may be undertaken using RWA program-specific funding; and*
- *may be led or undertaken by another agency.*

Additional rows may be added as required.

List 'hot spot' towns in this table that will be managed with 2018-19 Access, Improving Workforce Quality and Building a Sustainable Workforce program funding						
		Strategy/Activity				
Priority / 'Hot Spot' - Town	Reason/Evidence	Access	Quality	Sustainability	Desired Outcome	Synergies with other Programs
SA2 - Robinvale	Exceeds GP/Pop ratio, current GPs >55, high transit population with large refugee and Aboriginal population; above average for three consecutive years in Total and Chronic PPHs, cardiovascular disease, diabetes complications and cellulitis.	Investigate the potential recruitment of additional GPs having regard to the need to ensure a safe place of work for them to practice.	Upskilling in chronic disease management	Undertake succession and sustainability planning Establishment of ACCHO shared supervision model for Registrars	Improving the communities' access to primary health care services	AGPT – GP Registrar Training RHOF and MOICDP – delivery of outreach services Health Workforce Scholarship Program

List 'hot spot' towns in this table that will be managed with 2018-19 Access, Improving Workforce Quality and Building a Sustainable Workforce program funding						
		Strategy/Activity				
Priority / 'Hot Spot' - Town	Reason/Evidence	Access	Quality	Sustainability	Desired Outcome	Synergies with other Programs
SA2 - Kerang	50% GPs>55; registered vacancies seeking GPs with procedural skills, after-hours issues; no accredited GP training practices; above national average for 3 consecutive years in Total and Chronic PPHs, cardiovascular disease, diabetes complications, and cellulitis	Recruitment of GP with required procedural skills	Upskilling in chronic disease management	Accreditation of practices for GP training After Hours Models	Improving the communities' access to primary health care services	AGPT – GP Registrar Training PHN – After Hours Rural Extended & Advanced Procedural Skills (REAPS) Health Workforce Scholarship Program RHOF – delivery of outreach services
SA 2 – Loddon (includes Boort, Wedderburn, Inglewood, Pyramid Hill)	Exceeds GP/Pop ratio, long term GP vacancy; aged care coverage issues; above national average for 3 consecutive years in Total and Chronic PPHs, chronic respiratory disease, cardiovascular disease and kidney/UTI;	Recruitment of GP with requisite skills and experience	Upskilling in chronic disease management	Accreditation of practices for GP training After hours and aged care coverage models	Improving the communities' access to primary health care services	AGPT – GP Registrar Training PHN – After Hours Health Workforce Scholarship Program RHOF – delivery of outreach services

List 'hot spot' towns in this table that will be managed with 2018-19 Access, Improving Workforce Quality and Building a Sustainable Workforce program funding						
		Strategy/Activity				
Priority / 'Hot Spot' - Town	Reason/Evidence	Access	Quality	Sustainability	Desired Outcome	Synergies with other Programs
SA 2 - Nagambie	Exceeds GP/Pop ratio; 67% Non-VR doctors (RLRP), long term GP vacancy; bush nursing service	Recruitment of GP with requisite skills and experience	Education support for non-VR doctors	Undertake succession and sustainability planning	Improving the communities' access to primary health care services	
SA 2 - Cohuna	Exceeds GP/Pop ratio; part time GP workforce, current GP vacancy; above average for three consecutive years in Total and Chronic PPHs, cardiovascular disease, diabetes complications and cellulitis.	Recruitment of GP with requisite skills and experience Regional approach with Kerang and Barham	Upskilling in chronic disease management	Undertake succession and sustainability planning	Improving the communities' access to primary health care services	Rural Extended & Advanced Procedural Skills (REAPS) Health Workforce Scholarship Program RHOF – delivery of outreach services NSWRDN (Barham) – regional approach
SA2 – Buloke (includes Charlton, Sea Lake, Donald, Wycheproof)	50% GPs>55; part time GP workforce, solo practices, long term GP vacancies; above average for three consecutive years in Total and Chronic PPHs, cardiovascular disease, diabetes complications and cellulitis.	Recruitment of GP with requisite skills and experience	Upskilling in chronic disease management	Undertake succession and sustainability planning	Improving the communities' access to primary health care services	Health Workforce Scholarship Program RHOF – delivery of outreach services

List 'hot spot' towns in this table that will be managed with 2018-19 Access, Improving Workforce Quality and Building a Sustainable Workforce program funding						
		Strategy/Activity				
Priority / 'Hot Spot' - Town	Reason/Evidence	Access	Quality	Sustainability	Desired Outcome	Synergies with other Programs
SA2 – Yarram	Exceeds GP/Pop ratio; 50% Non-VR doctors (RLRP); 30% vulnerable age population; after hours coverage;	Recruitment of GP with requisite skills and experience	Education support for non-VR doctors	Undertake succession and sustainability planning After Hours Models	Improving the communities' access to primary health care services	PHN – After Hours AGPT – Registrar training
SA2 - Longford-Loch Sport	Exceeds GP/Pop ratio, single practice with part time GP;	Provision of general practice services		Undertake succession and sustainability planning	Improving the communities' access to primary health care services	
SA2 - Churchill	Exceeds GP/Pop ratio; 33% Non-VR doctors (RLRP); above national average for 3 consecutive years in PPHs – Total & Chronic conditions and chronic respiratory;	Recruitment of GP with requisite skills and experience	Education support for non-VR doctors Upskilling in chronic disease management		Improving the communities' access to primary health care services	Health Workforce Scholarship Program RHOF – delivery of outreach services
SA2 – Wonthaggi-Inverloch	40% GPs>55;32% vulnerable age population; 4 registered GP vacancies; after hours coverage;	Recruitment of GP with requisite skills and experience		After hours models	Improving the communities' access to primary health care services	PHN – After Hours

List 'hot spot' towns in this table that will be managed with 2018-19 Access, Improving Workforce Quality and Building a Sustainable Workforce program funding						
		Strategy/Activity				
Priority / 'Hot Spot' - Town	Reason/Evidence	Access	Quality	Sustainability	Desired Outcome	Synergies with other Programs
SA2 – Drouin	33% Non-VR doctors (RLRP); GP vacancies seeking procedural skills; 1.52% Indigenous population; above national average for 3 consecutive years in PPHs – Diabetes complications	Recruitment of GP with requisite skills and experience including procedural	Education support for non-VR doctors Upskilling in chronic disease management		Improving the communities' access to primary health care services	RHOF and MOICDP – delivery of outreach services Health Workforce Scholarship Program Rural Extended & Advanced Procedural Skills (REAPS)
SA2 – Glenelg (includes Heywood, Casterton)	Exceeds GP/Pop ratio; 2.2% Indigenous population; 80% GPs>55; registered GP vacancies seeking A&E skills	Recruitment of GP with requisite skills and experience including procedural		Undertake succession and sustainability planning	Improving the communities' access to primary health care services	RHOF and MOICDP – delivery of outreach services
SA2 – Camperdown	34% vulnerable age population; long term GP vacancy seeking anaesthetic skills	Recruitment of GP with requisite skills and experience including procedural		Undertake succession and sustainability planning	Improving the communities' access to primary health care services	AGPT – GP Registrar Training RHOF – delivery of outreach services Rural Extended & Advanced Procedural Skills (REAPS)
SA2 – Stawell	1.77% Indigenous population; long term GP vacancies seeking A&E skills; above national average for 3 years in Total PPHs	Recruitment of GP with requisite skills and experience including procedural	Upskilling in chronic disease management	Undertake succession and sustainability planning	Improving the communities' access to primary health care services	AGPT – GP Registrar Training Rural Extended & Advanced Procedural Skills (REAPS) RHOF and MOICDP – delivery of outreach services

List 'hot spot' towns in this table that will be managed with 2018-19 Access, Improving Workforce Quality and Building a Sustainable Workforce program funding						
		Strategy/Activity				
Priority / 'Hot Spot' - Town	Reason/Evidence	Access	Quality	Sustainability	Desired Outcome	Synergies with other Programs
SA2 – Nhill Region (including Nhill, Dimboola, Kaniva, Rainbow, Jeparit)	Exceeds GP/Population ratio; 30% vulnerable population, 33% Non-VR GPs (RLRP); solo practices; above national average for 3 consecutive years in total PPHs	Provision of general practice services	Education support for non-VR doctors Upskilling in chronic disease management	Undertake succession and sustainability planning	Improving the communities' access to primary health care services	Health Workforce Scholarship Program RHOF – delivery of outreach services
SA2 – Portland	2.58% indigenous population, 3 registered vacancies for periods 8 to 50 months, one vacancy seeking GP with O&G skills, non DWS;	Recruitment of GP with requisite skills and experience including procedural		Undertake succession and sustainability planning	Improving the communities' access to primary health care services	AGPT – GP Registrar Training Rural Extended & Advanced Procedural Skills (REAPS) RHOF and MOICDP – delivery of outreach services
SA2 – Otway (includes Apollo Bay)	Exceeds GP/Population ratio; two (2) practices with only one GP with main practice at Apollo Bay; 100% GP>55; locums servicing other practice; 1 registered vacancy for 7 months seeking GP with A&E skills; after hours	Recruitment of GP with requisite skills and experience including procedural		Undertake succession and sustainability planning	Improving the communities' access to primary health care services	AGPT – GP Registrar Training Rural Extended & Advanced Procedural Skills (REAPS) PHN – After Hours

List 'hot spot' towns in this table that will be managed with 2018-19 Access, Improving Workforce Quality and Building a Sustainable Workforce program funding						
		Strategy/Activity				
Priority / 'Hot Spot' - Town	Reason/Evidence	Access	Quality	Sustainability	Desired Outcome	Synergies with other Programs
	coverage issues; emergency retrieval;					
SA2 – Horsham	1.64% Indigenous population; 55%GP>55; 2 registered vacancies for 10 months, one seeking GP with O&G skills; non DWS; above national average for 3 consecutive years in total PPHs	Recruitment of GP with requisite skills and experience including procedural	Upskilling in chronic disease management	Undertake succession and sustainability planning	Improving the communities' access to primary health care services	AGPT – GP Registrar Training Rural Extended & Advanced Procedural Skills (REAPS) RHOF and MOICDP – delivery of outreach services Health Workforce Scholarship Program

Section 4 – Health Workforce Programs – Other Activities

This section summarises the other activities arising from the Health Workforce Needs Assessment (identified in Section 2 and 3) and options for how they will be addressed. This includes options and priorities that:

- *Should be considered in the development of the Activity Work Plan, and supported by RWA grants funding;*
- *may be undertaken using RWA program-specific funding; and*
- *may be led or undertaken by another agency.*

Additional rows may be added as required.

		Other Health Workforce Access Program Activities	
Need or Issue (If locational include place)	Evidence	Strategy/Activity	Desired Outcome
Retention of health professionals	There are a wide range of motivators for health professionals to take up rural practice and to remain in these areas for extended periods of time, these include financial incentives, community engagement, professional satisfaction, access to locum relief and opportunities for spouse and children	Provide support activities to enable retention of health professionals in rural communities	Increase the recruitment and retention of health professionals in rural Victoria
		Other Health Workforce Quality Program Activities	
Need or Issue (If locational include place)	Evidence	Strategy/Activity	Desired Outcome
		Other Health Workforce Sustainability Program Activities	

Need or Issue (If locational include place)	Evidence	Strategy/Activity	Desired Outcome
Defined general practice integrated training pathway	Rural interns undertaking PGY1 in a rural health service are unable to secure PGY2 positions as this year is unfunded in most regional health services. The trainees leave the rural health service to secure funded PGY2 positions and advanced skills training elsewhere, generally in large regional or metropolitan hospitals. The lack of secured funding at this initial and crucial point of GP training has the following impact on the recruitment and retention of GPs in rural Victoria: • registrars leave their preferred rural region to further their training elsewhere • registrars are often older and have personal or lifestyle commitments preventing them from relocating easily • those that return to metropolitan areas are unlikely to return to rural locations at the end of their training	Progress the development of a general practice integrated training pathway in rural Victoria including the funding of PGY2 posts	Increase the recruitment and retention of the Australian trained GPs in rural Victoria with the right skills for the community.

Section 5 – Eligible Health Professions

This section lists eligible health professions for support under the program (as approved by the Health Workforce Stakeholder Group).

General Practitioners

Nurses

Nurse Practitioners

Allied Health Practitioners within the following disciplines:

- Aboriginal Health Worker
- Dietetics and Nutrition
- Exercise Physiology
- Occupational Therapy
- Oral Health
- Osteopathy
- Orthotics and Prosthetics
- Physiotherapy
- Podiatry
- Psychology
- Speech Pathology
- Audiology
- Optometry
- Pharmacy
- Radiography
- Sonography
- Social Work

Section 6 – Health Workforce Stakeholder Group

Membership		
Position	Contact	Organisation
Western Victoria HWSG		
Chair	Ms Megan Cahill	RWAV
Member	Ms Rowena Clift	Western Victoria PHN
Member	Ms Leanne Beagley	Western Victoria PHN
Member	Mr Greg McMeel	MCCC
Member	Ms Ann Ellis	MCCC
Member	Ms Cathy Ward	MCCC
Member	Assoc Prof Barry Morphett	Western Victoria Regional Training Hub
Member	Mr Dean Taylor	DHHS – Regional Office
Member	Ms Cath Harmer	DHHS
Member	Ms Tarah Tsakonas	DHHS
Member	Ms Sue Daly	DHHS – Regional Office
Member	Mr Dale Fraser	Ballarat Health
Member	Dr Rosemary Aldrich	Ballarat Health
Member	Dr Rodney Fawcett	Barwon Health
Member	Ms Debra Schulz	Barwon Health
Member	Dr Nic Van Zyl	South West Healthcare
Member	Ms Louise Lyons	Victorian Aboriginal Community Controlled Health Organisation
Member	Ms Eveline Beaumont	RWAV
Gippsland HWSG		
Chair	Ms Megan Cahill	RWAV
Member	Ms Marianne Shearer	Gippsland PHN
Member	Ms Marg Bogart	Gippsland PHN

Member	Mr David Glasson	EV GP Training
Member	Dr Kelly Seach	EV GP Training
Member	Prof Robyn Langham	School of Rural Health, Monash University
Member	Ms Larissa Attard	Gippsland Regional Training Hub
Member	Ms Cath Harmer	DHHS
Member	Ms Tarah Tsakonas	DHHS
Member	Ms Rebecca Woodland	Bairnsdale Regional Health
Member	Dr Pip Hawkins	Latrobe Regional Health
Member	Mr Frank Evans	Central Gippsland Health
Member	Ms Louise Lyons	Victorian Aboriginal Community Controlled Health Organisation
Member	Ms Eveline Beaumont	RWAV
Murray HWSG		
Chair	Ms Megan Cahill	RWAV
Member	Mr Matt Jones	Murray PHN
Member	Ms Janice Radrekusa	Murray PHN
Member	Ms Cathy Ward	MCCC
Member	Mr Greg McMeel	MCCC
Member	Prof Julian Wright	Department of Rural Health, The University of Melbourne
Member	Mr Andrew Kallaur	DHHS – Regional Office
Member	Mr Neville Page	DHHS – Regional Office
Member	Ms Tarah Tsakonas	DHHS
Member	Ms Cath Harmer	DHHS
Member	Dr Alison Dwyer	Northern Health
Member	Dr Michael Kirk	Northern Health
Member	Dr Humsha Naidoo	Bendigo Health
Member	Dr Glenn Davies	Albury Wodonga Health
Member	Mr Michael Delahunty	Echuca Regional Health
Member	Dr John Elcock	North East Health Wangaratta
Member	Mr Trevor Saunders	Goulburn Health
Member	Dr Fiona Wright	Mildura Base Hospital

Member	Ms Louise Lyons	Victorian Aboriginal Community Controlled Health Organisation
Member	Ms Eveline Beaumont	RWAV

Terms of Reference
Enter here or attach **See Attached Terms of Reference**

Section 7 – Endorsement

Health Workforce Stakeholder Group endorsement of the Health Workforce Needs Assessment.

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Chair – Murray HWSG

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Chair – Gippsland HWSG

……

Chair – Western Victoria HWSG

Section 8 - Checklist

This checklist confirms that the key elements of the needs assessment process have been undertaken. RWAs must be prepared, if required by the Department, to provide further details regarding any of the requirements listed below.

Requirement	✓
Governance structures have been put in place to oversee and lead the needs assessment process.	✓
Opportunities for collaboration and partnership in the development of the needs assessment have been identified.	✓
The availability of key information has been verified.	✓
Stakeholders have been defined and identified (including members of the Health Workforce Stakeholder Group); and Consultation processes are effective.	✓
Formal processes and timeframes (including a Project Plan) are in place for undertaking the needs assessment.	✓
All parties are clear about the purpose of the needs assessment, its use in informing the development of the RWA Activity Work Plan and for the department to use for programme planning and policy development.	✓
The RWA is able to provide further evidence to the department if requested to demonstrate how it has addressed each of the steps in the needs assessment.	✓
Quality assurance of data to be used and statistical methods has been undertaken.	✓
Identification of service types is consistent with broader use – for example, definition of allied health professions.	✓
The results of the Health Workforce Needs Assessment have been communicated to participants and key stakeholders throughout the process, and there is a process for seeking confirmation or registering and acknowledging dissenting views.	✓
There are mechanisms for evaluation (for example, methodology, governance, replicability, experience of participants, and approach to prioritisation).	✓

References

(in addition to statistics made available to RWAs or publicly accessible)

[Insert PHN region] Health Workforce Stakeholder Group
Terms of Reference

1. Background

As part of the Rural Health Workforce Support Activity (RHWSA) the Rural Workforce Agency Victoria (RWAV) will address primary health workforce shortage and workforce maldistribution in regional, rural and remote Victoria.

2. Role and functions

To enable the delivery of this key objective RWAV will convene the [Insert PHN region] Health Workforce Stakeholder Group (HWSG) to support the identification of health workforce needs through an annual Health Workforce Needs Assessment (HWNA), endorse the HWNA and subsequent Activity Work Plan (AWP). The HWSG will also support the development and application of collaboratively agreed key RWAV Rural Medical Workforce Programs initiatives with the aim of:

- Growing a sustainable Victorian medical workforce by continuously encouraging interest in rural and regional Rural Generalist careers through the coordinated efforts of the RWAV Future Workforce Program
- Supporting the medical health workforce have equitable access to advanced skills training required to meet the service needs of the rural and regional communities in which they practice, and the retention of the health professionals in those communities
- Improving access and continuity of access to essential primary health care coordinated by the RWAV VicOutreach, and the Retention and Workforce Support teams

2.1 The HWSG will play a key role in:

- Contributing to, reviewing and endorsing the HWNA and make recommendations and/or provide advice to RWAV regarding the allocation of Rural Medical Workforce Program training posts and capacity
- Endorsing the AWP for submission to the Australian Government Department of Health
- Proactively identifying projects that foster collaboration amongst HWSG members in addressing priority health workforce needs in [Insert PHN region]
- Where needed, facilitating the provision of information and support from HWSG members' respective organisations to assist RWAV activities
- Documenting, monitoring and evaluating the career pathways of Victorian medical, nursing and allied health students

2.2 The HWSG will be accountable for:

- Fostering collaboration
- Monitoring and updating the group of changes within their respective organisations/regions
- Contributing to the evaluation of the program

2.3 The HWSG will commit to:

- Attending all scheduled HWSG meetings
- Sharing all communications and information across all HWSG members
- Notifying members of the HWSG, as soon as practical, if any matter arises which may be deemed to affect the operation of the Rural Medical Workforce or Rural Health Workforce Support Activity programs

3. Membership

Nominated members with sufficient authority to regularly represent the views of the member organisations listed below will be appointed as HWSG members for an initial 12 month term

- Two representatives from RWAV
- One representative from each health service within the Rural Medical Workforce Program
- Two representatives from the Regional Training Organisation
- Two representatives from the Primary Health Network
- One representative from the DHHS Regional Office
- One representative from each Aboriginal Community Controlled Health Organisation in the [Insert PHN region]
- One nominated representative from the [insert relevant university] Training Hub

All membership resignations are to be made in writing to the HWSG Chair, and the HWSG Chair reserves the right to revoke the membership of any member in writing at any time

4. Meetings

4.1 Chair

HWSG meetings will be chaired by RWAV's Chief Executive Officer

4.2 Meeting frequency

The HWSG will meet every six months, or as required to help inform the HWNA and AWP activities. Where possible, all members will be given four weeks' notice to attend meetings.

Where required, subgroup meetings will be arranged outside of set HSWG meeting dates at a time convenient to subgroup members

4.3 Quorum

A quorum will consist of 50% of members, plus one. This may include nominated proxies. Members will be required to nominate proxies by providing proxy details in writing to the HWSG Chair

4.4 Secretariat

RWAV will coordinate the secretariat function. This function will include, but is not be limited to:

- Writing and circulating meeting minutes five days prior to the meeting by email wherever possible
- Collating and distributing meeting papers, including a register of documents tabled during meetings
- Maintaining an up-to-date Declarations of Interest register

- Arranging meetings venues at a local venue (e.g. a regional DHHS or PHN office) with teleconference/videoconference facilities wherever possible

5. Confidentiality

Whilst open discussion is expected and encouraged at HWSG meetings, all HWSG members are expected to maintain confidentiality at all times and to be mindful that all confidential and sensitive matters discussed at HWSG meetings are to be treated with absolute professionalism and respect during and after HWSG meetings.

The HWSG Chair and members are responsible for flagging any matters they deem to be confidential, or to be of a sensitive nature at all HWSG meetings. In general, such matters will not be minuted.

HWSG minutes and all meeting papers should be treated as confidential material to be endorsed by the HWSG members at the next scheduled meeting, and signed by the by the HWSG Chair.

6. Declaration of interests and potential conflicts of interest

HWSG members who declare any actual, potential or perceived conflict(s) of interest will be required to make a formal declaration of this in writing to the HWSG Chair within 5 business days of attending their first HWSG meeting, or up to 5 business days before attending the next scheduled meeting. A Declaration of Interests Register will be developed and updated routinely with all declared conflicts of interest. The Register will be maintained and updated by the HWSG Secretariat, and be part discussion at each HWSG meeting.

7. Endorsement and review

This HWSG Terms of Reference is effective from [insert date of first meeting], and an annual review will be conducted and held on an agreed date within the first 12 months.

8. Terms of Reference adopted (*to be completed by the HWSG Chair)*

Name:	
Signature:	
Date:	
Agreed next review date:	