/ DECEMBER 2024

THE MCKELL INSTITUTE SA/NT

Operating without a plan

A DECADE WITHOUT MEDICAL WORKFORCE PLANNING IN SA

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Acknowledgement of country

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Key Findings

THE POLICY PROBLEM

There has been a systematic failure to conduct medical workforce planning for doctors in the South Australian public hospital system for more than a decade.

Inadequate workforce planning has serious and lasting consequences for patients, workers, and productivity. Understaffing causes stress and burn out for doctors and leads to long wait times and delayed procedures for patients which – in turn – leads to increased costs and reduced productivity.

Without adequate planning, mismatches between the workforce supply and the sector demand is not just likely, it is certain.

RECOMMENDATIONS

1 Implement medical workforce planning in SA

After a decade of neglect, the South Australian Government needs to implement minimum medical staffing standards across the sector. Standards must be informed by **ongoing consultation with clinicians and their representative industrial body.** Clinicians are experts in their fields and - in the absence of more reliable data - are best placed to reliably speak to the adequacy of staffing levels.

2 Improve data and implement regular reviews

It is possible to mathematically calculate medical staffing workloads however it is reliant on an accurate understanding of current and future workforce needs. The South Australian Government should prioritise the collection and analysis of accurate, intelligible, and accessible staffing and patient information wherever possible. Likewise, workforce planning is a continuous and ongoing process, regular staffing reviews should be conducted as a means of validating or modifying staffing standards.

3 Accelerate re-establishment of a federal medical workforce planning agency

A federal medical workforce planning agency is essential to facilitate planning and cooperation between governments, the health and education sectors, and the workforce to ensure the development of an appropriate, sustainable, and effective health care workforce. South Australia is an ideal test jurisdiction for workforce planning.

BENEFICIARIES OF THE REFORM

Medical workforce planning takes the guess work out of staffing. It builds structural, economic, social, and technical resilience. It enables governments to attract the required medical workers in the immediate and medium term, to ensure hospitals are well placed to meet growing demand, and doctors can provide appropriate and timely care of patients.

As a smaller jurisdiction with enviable lifestyle advantages, South Australia has an opportunity to become national leader in the medical workforce planning.

South Australian Doctors deliver critical, compassionate and life-changing care often under great pressure. Governments can build the best infrastructure in the world, but it is the people who work in our hospitals that keep it running. A healthy state needs a healthy and sustainable medical workforce.

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Introduction

Everyone has the right to safe and timely medical care. The healthcare system is under constant strain and there is serious concern about the sustainability of medical staffing levels in Australian hospitals. South Australia is no different, the public hospital system is buckling under a shortage of doctors, nurses and trained staff. Ambulance ramping, long wait times, delayed elective surgeries, and staff burnout dominate the news cycle.

Now is the time to act. As a smaller jurisdiction with enviable lifestyle advantages, South Australia has a unique opportunity to become the national leader in the medical workforce planning.

Healthcare has changed significantly over the last two decades and, as a result, the demand for services is growing faster than both the population and the economy [1]. Increasing demand is, in part, driven by an ageing population and the associated increasing rates of co-morbidities. The supply of medical staff is simply not keeping up [2]. This is partly attributed to changes in the demographics of the medical workforce and growing demands for greater work-life balance and partly to the lack of serious and holistic medical workforce planning for more than a decade [1] [3] [4]. Significant attention has rightly been given to General Practitioners and primary health workers, but it is vital that Governments also invest in hospital sector staffing. There is an immediate need for systematic and data-driven medical workforce planning.

The need for medical workforce planning in our public hospitals has been clearly established by both the State and Federal Governments. In 2021 the Australian Government released their 'National Medical Workforce Strategy 2021 – 2031' and in 2022 SA Health released the 'Workforce Strategic Directions 2022' report [1, 5]. Both documents clearly identify the need to conduct extensive workforce planning but, as of December 2024, there is no evidence any workforce planning has been conducted for doctors in the South Australian public hospital system in more than a decade.

South Australian nurses have rightly won nurse-to-patient ratios. This report demonstrates that after a decade of neglect similar attention needs to be directed towards establishing minimum staffing standards for doctors.

Inadequate workforce planning manifests as staff shortages and puts pressure on the public health system and has serious and lasting consequences for patients, workers, and productivity.

As this report details, a lack of planning contributes to burnout and stress for doctors working in hospitals, exacerbating issues with attraction and retention. In extreme cases it leads to trained staff exiting the public health system. In fact, in March 2024 the SA Government conducted their 'People Matter' staff wellbeing survey in which almost 4 in 10 surveyed Doctors indicated they did not see themselves staying in the public hospital system over the next three years.

Workforce planning is also necessary to ensure staff have adequate time for both service delivery and – vitally - trainee supervision. A failure to do so is detrimental as it sees the long-term sustainability of the sector sacrificed for the provision of immediate care. Every Australian Doctor – including GPs – is trained in our hospitals. Without adequate Senior Doctors the training chain collapses. Understaffing leads to long wait times, an overreliance on locum doctors, and delayed procedures for patients which – in turn – increases the burden of disease and leads to budget blowouts and reduced productivity.

Following a decade of neglect, it is evident that there is sincere political will to respond to the growing crisis in South Australia's health sector. Since taking office, the South Australian Labor Government has acknowledged the failures of the past and are focused on capacity building – committing an additional $7.1 billion in health funding, including $742.3 million (over five years) to help ensure the system is "*appropriately and permanently resourced to meet higher levels of demand moving forward*" [6]. Likewise, the Federal Labor Government have announced a suite of initiatives intended to directly and indirectly relieve pressure on the hospital system including $56.3 million to towards increasing aged and palliative care demands, new Medicare Mental Health Centres, and increasing the number of bulk billed GP visits.

The public health system is a complex organism, and no single policy lever will solve the problem. But given South Australian hospitals are struggling to staff existing facilities, medical workforce planning is more necessary than ever to ensure positive patient outcomes, worker safety, and sustainable growth of this industry. Without adequate planning, mismatches between the workforce (including graduates) and demand are not just likely, they are certain.

What is Workforce Planning?

The question at the centre of medical workforce planning is deceptively simple: how many doctors and medical staff, and with what capabilities, do we need to provide safe, timely and effective care for patients? It is an evidence-based discipline that is – at its core – about planning for, and managing, the most important organisational resource: its people. It requires *"the repeated, systematic and cyclical identification, analysis and planning of organisational needs in terms of people"* [7].

Workforce planning requires two separate but interrelated tasks. The first, **operational workforce planning** covers a well-defined period, usually 12 months, aligned with the organisation's planning cycle. The second, **strategic workforce planning** is concerned with organisational strategy and covers a longer period of time, often 3 to 5 years [8].[1] In both cases workforce planning requires consideration of supply and demand issues as well as strategic alignment with – in this case – government and health objectives.

It is central to the efficient and productive functioning of an organisation and, when enacted correctly, guides workforce training and development. Vitally, it is a *continuous and ongoing* process reliant on an accurate understanding of current and future workforce needs, that makes explicit the workforce requirements of an organisation [8, p. 7]. It requires the generation of organisational intelligence to inform current and future staffing needs in order to develop a clear understanding of internal and external factors. Where suitable it should include workforce and labour market analysis including supply, demand, skills mix, trainee development, leave entitlements, workforce demographics and succession planning, operational changes, and technological innovations to anticipate and plan for future demand.

Medical workforce planning requires close cooperation between governments, professions, and the higher education and training sectors to ensure the future workforce demands can be met [9].

In essence, the aim is to ensure employers are cognisant of, and resilient to, structural and cultural changes across their workforce. In this way it is distinct from a workforce strategy, like the National Medical Workforce Strategy 2021-2031, which sets a direction and argues for the importance of workforce planning but is not itself workforce planning [1].

WHY IS WORKFORCE PLANNING IMPORTANT?

At its core workforce planning takes the guess work out of staffing. Which is vital in a sector as important as the public hospital system. Inadequate workforce planning can have serious and lasting consequences for patients, workers, and productivity. A failure to conduct workforce planning manifests as inadequate staffing. Understaffing causes stress and burn out for doctors and leads to long wait times and delayed procedures for patients which – in turn – leads to increased costs and reduced productivity.

In contrast, when enacted appropriately, medical workforce planning builds structural, economic, social, and technical resilience. It enables governments to attract the required medical workers in the immediate and medium term to ensure hospitals can meet the growing demand in the sector.

PATIENT IMPACTS

It has been widely accepted that patient care is heavily influenced by the wellbeing and capacity of the staff caring for them [10, 1]. In the UK, a number of reviews into care and treatment in the National Health Service (**NHS**) have identified workforce planning issues as central to hospital mortality, with inadequate levels of available staff, a reliance on locum or temporary staff, and the poor provision of weekend and night cover being identified as especially troubling [11, 12, 13].

Inadequate staffing can lead to the frequent implementation of escalation protocols, an increase in reported clinical incidents, extended wait times, delays to medical procedures and clinical mistakes [14, 1].

Increased workload brought on by inadequate staffing can also impact doctors' ability to fully discuss care with their patients and families, delay discharges, and impacts the quality of handovers and – ultimately - care [10].

STAFF AND TRAINING IMPACTS

Consistent and systematic understaffing can impact doctors' health and well-being in several ways ranging from feeling overworked and frustrated - to fatigue, burnout and mental illness. It contributes to, and exacerbates, staff attrition and makes it difficult to recruit and retain staff, further contributing to prolonged skills shortages. Protracted instances of understaffing and overwork can create serious psycho-social hazards.

Workforce planning is also necessary to ensure staff have adequate time for both service delivery (including administrative duties) and – vitally - trainee supervision. A failure to do so is deleterious in the long term, as the long-term efficacy and sustainability of the sector is sacrificed for the provision of immediate care [14].

Workforce planning requires a holistic engagement with the entire medical training system. The Group of Eight's workforce report identified that Australia's pipeline of medical professionals is a sovereign capability risk and called for *at least* 1,000 additional domestic graduates per year [16, p. 7]. In contrast, South Australia is expecting 261 commonwealth-supported students to graduate this year, down from 286 in 2017 [17].

PRODUCTIVITY IMPACTS

Workforce planning increases productivity by ensuring the right staff and skills mix. It assists with the attraction, attention, and retention of high performing staff and with the management of economic cycles and changes in market demand, including skills shortages and over supply.

Health workforce planning, specifically, builds resilience and agility to enable the sector to absorb shocks and adapt to change. It enables governments to plan and lobby the education sector to ensure the right graduates are being trained to meet workforce demands. And, in turn, ensure that when those graduates enter the hospital system there are adequate doctors available to supervise their training.

It plays a central role in identifying, monitoring, and managing risk, including by tracking variations in workforce trends like changing demographics (ageing, feminisation, cultural changes) [8]. Demographic changes can manifest in several ways for example through increased demands for flexible working arrangements, which in turn change the FTE composition of the work force [8].

1. These are distinct from 'workforce management planning' which responds to immediate and specific workforce issues – such as restructuring and recruitment.

Failing to Plan is Planning to Fail: A History of Medical Workforce Planning in (South) Australia

2008

In December of 2008 the Council of Australian Governments (COAG) signed a 'National Partnership Agreement on Hospital and Health Workforce Reform' to improve health workforce, hospitals and capacity nationally [15]. It laid out a reform agenda that included the establishment of a national agency that would improve health workforce capacity, efficiency and productivity in part by *"funding, **planning** and coordinating clinical training across all health disciplines"* and *"supporting health workforce research and **planning**"* [15, p. 16]. In doing so, COAG recognised that the creation of a new single body that could work across health, education, and jurisdictional borders was critical to effective workforce planning [15].

2009

That agency, Health Workforce Australia **(HWA)**, was established the following year in 2009 and its responsibilities included funding, planning and coordinating pre-professional entry clinical training across all health disciplines and supporting health workforce research and planning - including through a national workforce planning statistical resource [16].

2012

HWA produced their keystone plan 'Health Workforce 2025 — Doctors, Nurses and Midwives' in 2012. That report was a significant undertaking and marked the first time long-term, national medical workforce planning was conducted in Australia [9].

2014

Two years later in 2014, under the auspices of efficiencies, the Abbott Government and - then Minister for Health - Peter Dutton successfully passed the Health Workforce Australia (Abolition) Bill 2014 disestablishing both AWH and the milestone workforce plan [17].

2021

The abolition of HWA created a seven-year-long void in workforce planning until 2021, when the Federal Government release their new 'National Medical Workforce Strategy 2021 – 2031' which calls for – among a number of objectives – the formation of a national *"planning and advisory body with authority to inform and make recommendations to governments regarding the medical workforce"* [1]. The re-establishment of such an agency is also strongly supported by the Australian Medical Association, the peak body for professional doctors in the country [3].

2022

At a state level, in 2022, SA Health released their 'Workforce Strategic Directions 2022' report – 'Phase 3' of which is the *"development of the SA Health Strategic Workforce Plan 2022-2032"* -an *"integrated workforce model and a strategic workforce plan"* that would cover *"longer term strategies of up to five years"* [5].

2024

Two years on, in 2024, there is no evidence any workforce planning has been undertaken for doctors in the South Australian public hospital system for more than a decade. The national workforce planning agency has not been established and the SA workforce plan has not been released. This has created an entirely predictable crisis for medical staff and patients in South Australia.

How are Doctor Numbers Currently Determined in South Australia's Public Hospital System?

In the absence of a holistic, evidence informed, workforce strategy 'job planning' is the only formal way of controlling minimum standards of medical staffing in the South Australian hospital system.

According to the Salaried Medical Officers Enterprise Agreement (2022) job planning is an annual process for Senior Medical Practitioners and Consultants that 'defines the agreed duties, responsibilities and objectives' of any given position 'for the coming year'.

Unfortunately this useful process is not always conducted by the employer as required – leaving even this type of planning incomplete.

Although job planning is a valuable and useful tool, it is not – in and of itself – workforce planning. Genuine workforce planning requires accurate, detailed, and timely information about the current staffing composition. Currently, it is unclear if adequate data is being collated. The SA public sectors workforce information report and online dashboard do not provide a clear break-down of medical staff in SA [18] [19]. Without a clear understanding of current supply and demand, it is impossible to plan for the future.

In effect, South Australia's medical workforce is operating without a plan. A more proactive alternative would be to implement a system of workforce planning that clearly sets out minimum staffing standards across the state.

Overworked and Understaffed – SA Doctors Pushed to their Limits

The absence of workforce planning has serious implications for both patient outcomes and the health and sustainability of the workforce. The South Australian public hospital system is one of the largest employers in the state and is responsible for servicing a growing and ageing population of 1.82 million people.

Inadequate workforce planning manifests in a range of ways, all of which are identifiable in South Australia's public hospital system, including: high rates of staff burn out; low attraction and retention rates; inability to cover staff leave; long patient wait times and frequent delays; and recurrent instances of hospitals being over-capacity.

By almost every metric, the South Australian health system, and the workers within it, are under significant strain and have been for a number of years. Repeat instances of any one of these markers should trigger a review of staffing, let alone the compounding crisis we see unfolding currently.

To September 2024, SASMOA have exercised their right of entry twelve times this calendar year [20]. Right of entry is permitted when there is a suspected contravention of the WHS Act. This section draws on the accompanying Entry Holder Reports as they provide a timely snapshot of some of the workforce issues across the state's public hospital system and provide detail of the resulting health and safety concerns [21].

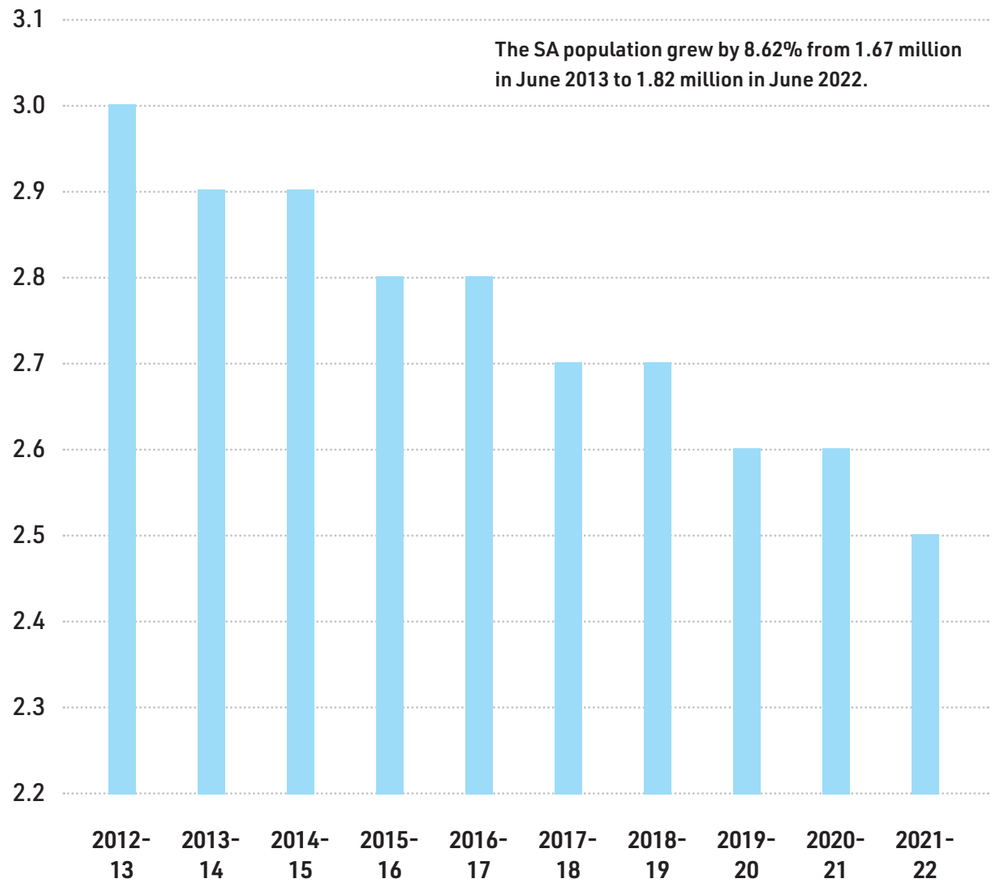
SOUTH AUSTRALIAN HOSPITALS CONSISTENTLY OVER CAPACITY

In 2024 we have seen recurrent instances of "code white" across the SA health system. Code White occurs when a hospital is 'treating more patients than official capacity'. In May 2024 the Department declared a system-wide internal emergency. As a result, elective surgeries were paused for more than 3 weeks causing significant disruption to patients [22, 23]. Frequent escalation protocols, like this, should trigger an investigation into staffing.

In June 2024 SafeWork SA took the uncommon step of issuing an "intervention order to improve" after its inspectors found work health and safety laws being violated [24]. The intervention was in response to escalating demand "without adequate measures to minimise risks to workers' psychological health and safety" and was accompanied by the threat of a $250,000 fine [24]. It followed a stream of stories in the media about excessive demand, violence and burnout in the hospital systems [23] [22]. Including what SASMOA's Chief Industrial Officer Bernadette Mulholland described as the *"worst night in the hospital system"* on June 12, 2024 [25].

Looking at the latest data from the Australian Institute of Health and Welfare (AIHW) provides some further insight. Figure 1 shows a significant drop in the number of available beds per 1000 people in South Australia. Over that same period the State's population grew by 8.62% from 1.67 million in June 2013 to 1.82 million in June 2022 [28]. Although it should be noted that the latest data runs to 2021/22, and the South Australian Government has been making investments to increase hospital beds in the interim, it is vital that workforce planning is undertaken in tandem to ensure those beds are sustainably and appropriately staffed.

FIGURE 1 AVAILABLE HOSPITAL BEDS PER 1000 PEOPLE IN SA

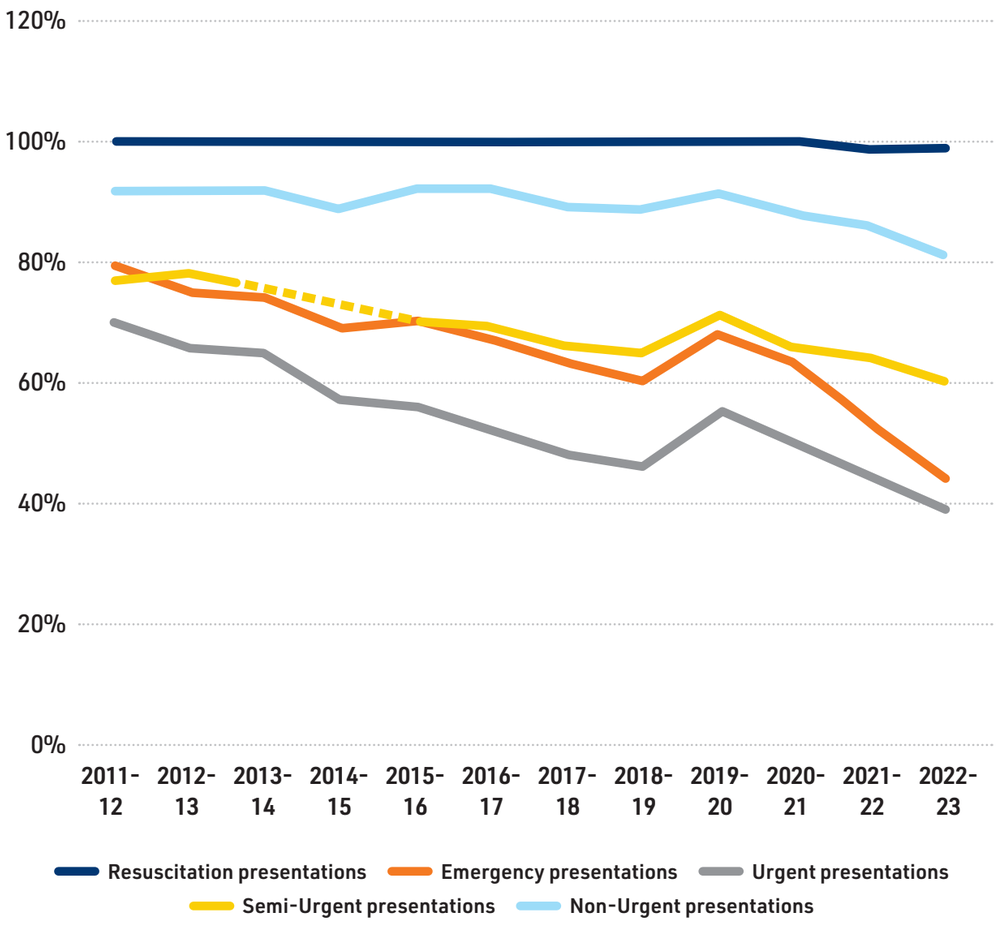


Source: Australian Government, Australian Institute of Health and Welfare, 'Available beds per 1,000 people, by region, public hospitals (including psychiatric' and 'Average full-time equivalent), Data: July 18, 2024.

CRISIS IN EMERGENCY DEPARTMENTS

The percentage of Emergency patients seen within the target timeframes across the State has collapsed. As depicted in Figure 2 wait-time for every Emergency Department presentation type (excluding Resuscitation) has been trending downwards for more than a decade – excluding a short blip during the beginning of the COVID-19 crisis. This can have additional safety implications for staff as overcrowding, long wait-times, and overcrowding can cause tensions among patients to rise. This was evident in three cases of serious assault towards medical staff in July 2024 [27].

FIGURE 2 PERCENTAGE OF EMERGENCY PATIENTS SEEN ON TIME - SOUTH AUSTRALIA

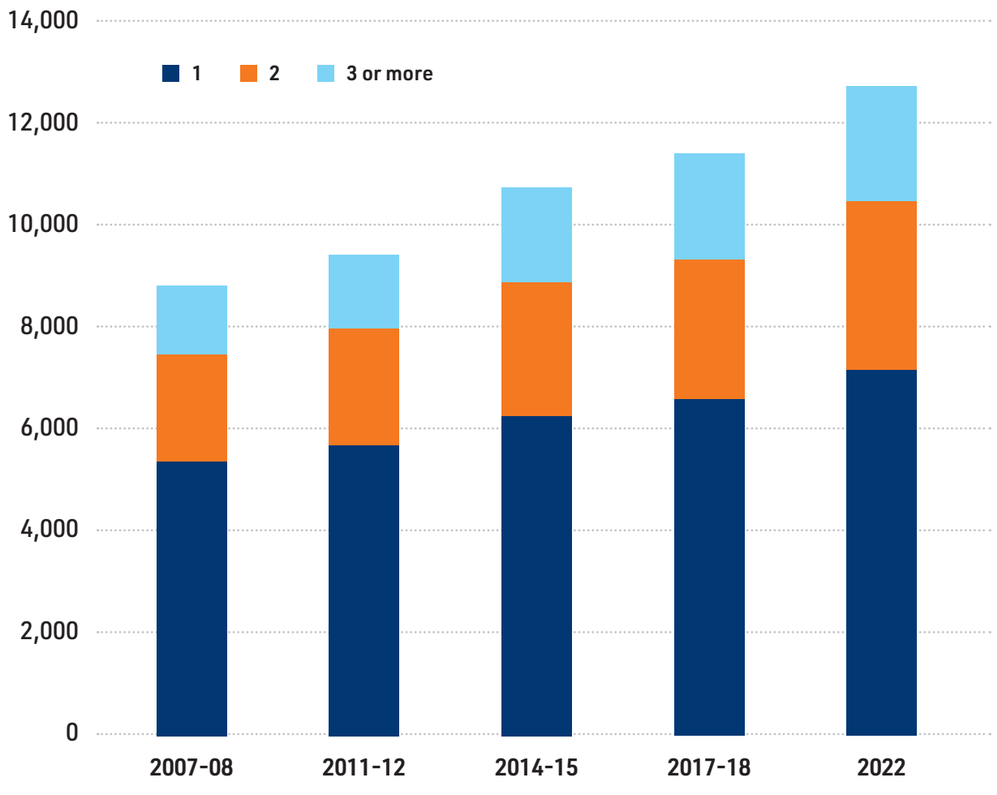


Source: Australian Government, Australian Institute of Health and Welfare, Time spent in emergency departments, Measure: Percentage of patients seen on time, Data: July 18, 2024.[2]

CHRONIC CONDITIONS

Chronic conditions are the leading cause of illness, disability and death in Australia and, consequently, a key driver of hospital demand and strain on the health system [29]. Over the past 40 years, the burden of disease in Australia has shifted away from infectious diseases and injury towards chronic conditions. According to the ABS one in two Australians have at least one chronic condition. Figure 3 shows a considerable growth in the proportion of people with one or more chronic conditions over the last 15 years.

FIGURE 3 CHRONIC CONDITIONS IN AUSTRALIA – ESTIMATE ('000)



Source: ABS, 2023, Table 1.1 Summary health characteristics, 2001 to 2022 [data set], National Health Survey, 2022.

Although increased primary care is needed to reduce the volume and severity of chronic conditions in the short- and medium- term this is reflected as increased demand in the hospital system.

2. The semi-urgent presentation data from 2013-2015 is unavailable because more than 10% of presentations had missing or invalid time data.

FATIGUE, BURNOUT AND LOW MORALE

A recent survey conducted by the Royal Australian and New Zealand College of Psychiatrists found 73 per cent of psychiatrists had experienced symptoms of burnout in the past three years, and 82 per cent cited workforce shortages as the top factor contributing to so many psychiatrists experiencing the symptoms of burnout [28]. Common symptoms included "anxiety, insomnia, and exhaustion, with some experiencing feelings of trauma, pessimism, hopelessness and symptoms of PTSD" [28, p. 7].

Similarly, Right of Entry reports submitted to SafeWork SA by SASMOA reveal chronic understaffing is creating a significant psychosocial risk for medical staff. Reports include instances of workers drawing down their sick leave, low morale, fatigue and burnout caused by ongoing pressure [29].

A report following a visit to the Northern Adelaide Local Health Network revealed a 'complete absence of leave-cover in some services' that was inhibiting staff from taking leave, knowing that it would increase the workload of their colleagues. This was compromising patient safety, continuity of care, training supervision and compounding incidents of fatigue and burnout as staff delayed taking necessary leave. The same report revealed some of the services in the division had no cap on patients resulting in an individual caseload of more than 100 patients [30].

Employers have a legal duty to eliminate or minimise 'to the greatest extent that is practicable' all known and foreseeable risks of harm to employees' health and safety at work.

ATTRACTION AND RETENTION

It has been well established that Australia is facing 'unprecedented workforce shortages' throughout the health system [4]. This increases staff workload and makes it difficult for existing staff to take paid leave when needed – which can, in turn - exacerbate fatigue and burnout and increase the rate of staff turn-over.

In March 2024 the SA Government conducted a staff wellbeing survey, it offers some critical insight as it found almost 4 in 10 Doctors did not see themselves remaining in the public hospital system within the next three years.

And a survey conducted by the Royal Australian and New Zealand College of Psychiatrists found 33% of psychiatrists were considering leaving the profession in the next three years [28]. Likewise, the 2023 national Medical Training Survey found that 49 per cent of junior doctors in SA reported "heavy" or "very heavy" workloads and 18 per cent were considering leaving medicine [15].

This can also create a cyclical problem and undermine workforce attraction as word-of-mouth spreads about workplace culture. Importantly, understaffing in the system is not restricted to doctors and a failure to employ sufficient nursing, allied health and administrative staff causes a risk to everyone, including patients and doctors [31].

PRODUCTIVITY IMPACTS

For governments a failure to conduct workforce planning manifests as unmet demand, chronic understaffing, expensive overtime, productivity loss, and dissatisfied constituents.

Research out of Canada has found poor workforce planning to be a risky and expensive endeavour [32]. It found inadequate health workforce data had a negative economic impact because it inhibited the planning models, tools, and processes necessary for workforce planning [28].

The most recent data from the Productivity Commission on Government Health Services shows South Australia is lagging the nation. The average allocation of full-time equivalent (FTE) salaried medical officers in public hospitals (1.9) per 1,000 people in SA was the lowest in the nation in 2021-22 [33].

This problem is not restricted to doctors, it was also true of all public hospital staff - 14.4 FTE in SA compared to a national average of 16.9 [33].

These figures are likely to be exacerbated by the ageing population of SA, which will increase demand on an already overstretched system. These pressures cannot be addressed without both operational and strategic workforce planning.

COMPOUNDED BUT NOT CREATED BY COVID

The Covid 19 Inquiry report has clearly established that although these issues have been significantly exacerbated by the pandemic they were not caused by it.

" COVID-19 exposed existing fractures in the health system. Health workers were overworked and health providers understaffed before the pandemic. Public health workers had to pivot to work on COVID-19, often with extended work hours and no leave. They had to train up an inexperienced surge workforce. There were additional demands on hospitals and primary care systems battling longstanding service backlogs."
[36, p. 213]

UK CASE STUDY

Medical Workforce Planning

Workforce planning has also emerged as a persistent issue in the **United Kingdom**.

In 2018, the Royal College of Physicians **(RCP)** in London released a report providing comprehensive guidelines on safe medical staffing numbers for physicians in the NHS. The report was, in part, a response to an Inquiry some years earlier that had examined the causes of the significant failings in the health system between 2005 and 2009. The report was informed by ongoing staffing crisis in the NHS including findings that 45% of positions were unfilled and frequent reports of significant gaps in trainee on-call rosters that were jeopardising patient care [14, p. 6].

> In short, the RCP identified that inadequate workforce planning was posing a serious risk to both patients and staff – and in the face of a dearth of research in this space they formed a working party of clinicians to design medical staffing guidelines.

The RCP guidelines divide inpatient clinicians into three tiers whereby Tier 1 includes clinicians who were capable of initial patient assessment and Tier 3 comprises expert clinical decision makers who have overall responsibility for patient care[2]. Indicative (rather than absolute) recommendations of staff numbers were then devised based on estimates of the number of hours that each tier of clinicians needs to be present in each situation for a 30-bed ward on both weekdays and weekends. Similar calculations are made for emergency care although demand was mapped over a 24-hour roster. Variation in capabilities and speed between individuals assumed the mid-point performance of each Tier.

The RCP guidelines also highlight the way changes in hospital models need to be better accounted for in staffing calculations. The guidelines use an example of a change in the way UK emergency departments are run that has prioritised patients seeing more senior doctors sooner than they used to.

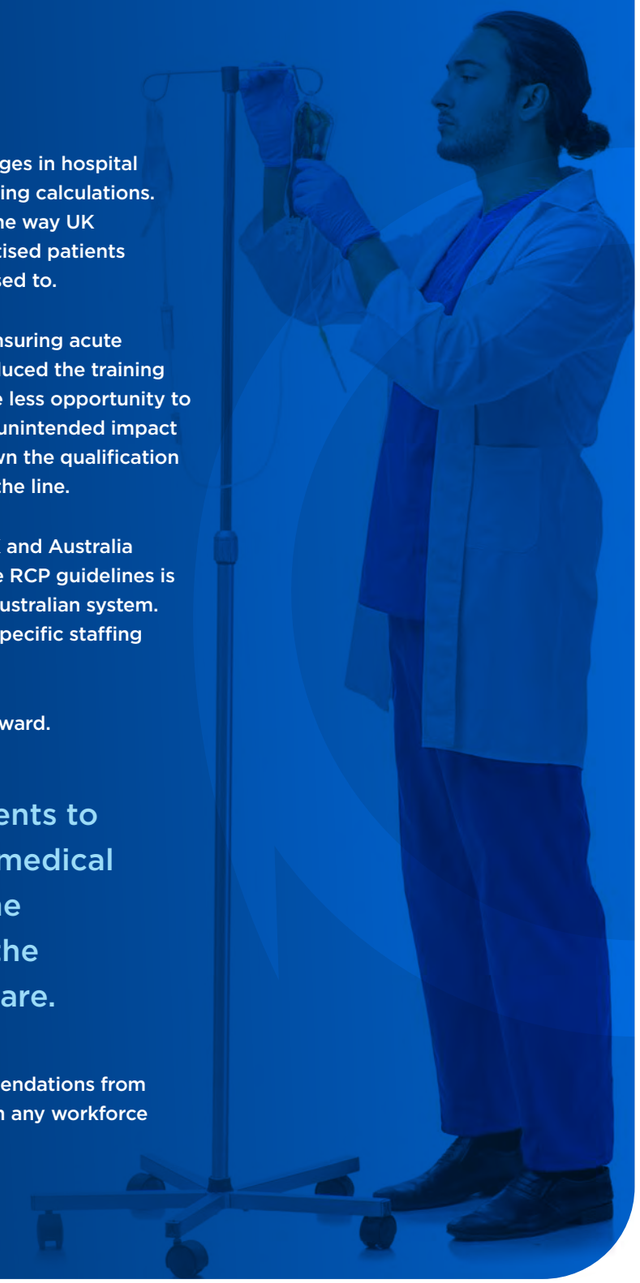
Although this improved patient outcomes by ensuring acute cases are seen quickly it has unintentionally reduced the training opportunities for trainee doctors who now have less opportunity to engage in senior and acute medical cases. The unintended impact being that less training opportunities slows down the qualification and promotion of much needed doctors down the line.

Differences between hospital systems in the UK and Australia mean that the exact methodology set out in the RCP guidelines is unsuitable for a perfect replication within the Australian system. And for that reason, we will not delve into the specific staffing calculations.

It does, however, provide insight into a path forward.

> It is possible for governments to mathematically calculate medical staffing workloads with the information contained in the existing model of health care.

Overleaf, we have identified a series of recommendations from the RCP guidelines that could be used to inform any workforce planning in South Australia.



2. It should be noted the RCP excluded consultants from the calculations, because their working arrangements were deemed to be more complex and individualised.

Valuable Lessons from the UK Guidelines:

1. **Regular staffing reviews** – The RCP guidelines suggest regular staffing reviews as a means of validating or modifying staffing numbers. A series of indicators should be identified to ensure staffing is both adequate and consistent. Some possible indicators include:
   a. **Ongoing consultation with clinicians** - Clinicians are experts in their fields and - especially in the absence of more reliable data - are best placed to reliably speak to the adequacy of staffing levels.
   b. **Timeliness of care**
   c. **Incident reports and complaints**
   d. **Frequence of escalation protocols**

2. **Improved data collection and analysis** - Government should prioritise gathering accurate, intelligible, and accessible training, staffing, patient, and population information wherever possible.

3. **Explicit training support** – Trainee educational needs must be prioritised. The guidelines warn against the temptation of a 'pyrrhic victory' whereby short-term gains from more efficient delivery undermines future capabilities by failing to adequately train new doctors.

4. **Establish different guidelines for smaller hospitals** – smaller (often regional) hospitals may require different calculations as it may be possible to combine some duties.

5. **Track changing work dynamics and leave** – the RCP estimates account for periods of leave and seek to better understand how demographic changes are impacting the way hospitals operate.

6. **Prioritise direct care** - sufficient time should be made available for clinicians to speak with patients and their families. This ensures all pertinent information is known to the medical team and is especially important in instances where patients are unable to advocate for themselves. Recognising that indirect patient care takes up a significant portion of clinicians time and should be accounted for explicitly.

7. **Prioritise daytime and weekday patient care** - Wards should be staffed to ensure as much patient care as possible is completed during the day. Research suggests this is a key issue for patient and worker safety (and tiring for clinicians) and the guidelines recommend rosters are scheduled in such a way to minimise 'legacy' work.

8. **Establishing baseline calculations** - The UK model is based on 80% of maximum activity in a ward with the implementation of mechanisms to continuously monitor for surges in activity and enact effective escalation protocols as necessary.

Conclusion

Without adequate planning continued mismatches between the workforce (including graduates) and demand is not just likely, it is certain. The public health system is a complex organism, and no single policy lever will resolve these issues overnight. Nor are doctors the only health workers experiencing understaffing, overwork, and burnout.

It is, however, clear that workforce planning is a missing piece of this puzzle. South Australian nursing staff have rightly won a nurse-to-patient ratio. This report demonstrates that after a decade of neglect similar attention needs to be directed towards establishing minimum staffing standards for doctors.

Evidence informed workforce planning for medical staff can ease worker burnout, reduce wait times and improve patient outcomes overall. It is central to the health and safety of medical staff entrusted with the health of the community. If conducted properly it will also enable individual hospitals and government to better calculate and monitor demand. And – in doing so – improve budgetary estimates and provide a clearer understanding of the shape and scale of the problems at hand.

At a time when South Australian hospitals are struggling to staff existing facilities medical workforce planning is more necessary than ever to ensure the positive patient outcomes, worker safety, and sustainable growth of this industry [34].

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