NSW GOVERNMENT Health
South Western Sydney Local Health District

Population Health Workforce Development Plan

2016

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Images on cover page (left to right):

1. NSW RHS Dietitian Eloise Le Compte during a Kids in the Kitchen nutrition education event
2. BreastScreen NSW, SWSLHD Radiographer Ulfa Gamildien showcases the mammography machine on the mobile unit
3. Public Health Immunisation Nurse Kylie McNulty

Images on back page (top to bottom):

1. Environmental Health Officer Peter Cavagnino
2. Senior Health Promotion Officer HARP Marty Janssen at Youth Week 2016 event promoting Blood Battles mobile app
3. Bilingual Community Educators recently trained by NSW RHS
4. Health Promotion Service staff Robert Bell, Deidre Upton, Clarke Scott, Nerida Deane

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Acknowledgements

South Western Sydney Local Health District acknowledges the traditional owners of the land described in this document as South Western Sydney; the Darug, Dharawal and Gundungurra peoples and their continuing connection to this land. We pay our respects to the Elders past and present and thank them for their leadership in improving the health of local Aboriginal people and communities.

We would like to thank the Population Health executive staff who worked in partnership with HCA to develop this WDP. Their collaborative approach, support and guidance were critical to the development of this WDP. Thank you also to the staff that attended the focus groups and contributed their perspectives, experiences and ideas to developing and improving Population Health. Finally, thank you to the following members of the WDP Steering Committee:

Peter Sainsbury	Wendy Roberts	Mandy Williams
Mark Thornell	Sandy Eagar	Kate Alexander
Liz Bail	Iman Zakhary	Leng Boonwaat
Cheryl McFarlane		

Workforce Development Plan preparation

This Workforce Development Plan (WDP) was prepared by Human Capital Alliance (HCA) Principal, Lee Ridoutt and Staff Consultant, Carla Cowles, for Population Health South West Sydney Local Health District (SWSLHD), August 2016. Maria Beer, Acting Deputy Director, and Alison Dunshea, A/Senior Project Officer (Workforce Development), Population Health were also significant contributors to this WDP.

Human Capital Alliance

HCA is a management and research consultancy firm specialising in helping clients align their human and capital resources to their (organisational, occupational, industry, national) objectives. As part of this broad expertise, HCA has developed highly valued evaluation and review expertise employing strategic and analytical approaches.

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Foreword

Most people find themselves by accident or design working in population health because of a desire to help people and help communities. Consequently we start at an advantage: we have a hugely dedicated workforce! However, dedication is not enough. We provide a wide range of services, delivered in sometimes challenging circumstances and we require a highly skilled and sometimes specialised workforce. We want to harness our workforce so that we can provide the best possible services to the people and communities of south-western Sydney.

The *Population Health Workforce Development Plan 2016* has been developed by Population Health to examine our workforce requirements and training needs and ensure that units and services have the required workforce to deliver the work we are currently doing and the work we need to do in the future.

This plan aligns with the corporate priorities of the District, Population Health's own Operational Plan and addresses actions from the SWSLHD Your Say Action Plan. It is built from a population health workforce needs analysis that each unit and service contributed to and a series of focus groups with staff.

Outlined within the plan are strategies to build and improve our leadership capabilities, our operational and foundational population health competencies and the way we work together. There is also a strong commitment to create open and transparent communication within Population Health.

The plan would not have been possible without the assistance of Human Capital Alliance and the contributions of all staff to the needs analysis and focus groups. So thank you to everyone. I would like to especially thank Maria Beer who enthusiastically managed this project from the beginning and Alison Dunshea who ensured the project was completed.

I am really pleased and excited to present the *Population Health Workforce Development Plan 2016.* The population health executive values their staff and is committed to supporting and developing a highly skilled and effective workforce for the future. This plan helps us along the journey.

Stephen Conaty
Acting Director, Population Health
South Western Sydney Local Health District

Executive summary

This WDP has been developed for Population Health SWSLHD to match the workforce with the program needs of the unit.

It is the culmination of two highly collaborative and consultative projects that were undertaken to identify the focus of workforce developed and to understand the cultural elements that may facilitate the development and functioning of the Population Health workforce.

Processes and methods

Project 1: Workforce analysis

This five stage workforce analysis project involved:

1. development of a competency framework (61 competencies) for Population Health
2. profiling of the current workforce supply (in terms of FTE) against the competency framework
3. assessment of the demands or needs (in terms of FTE) of Population Health
4. identifying the gaps between workforce supply and demand
5. development of workforce development strategies.

Project 2: Focus groups with staff

The primary purpose of Project 2 was to investigate staff perspectives for how Population Health could create an attractive workplace. Staff were asked to identify key factors for an attractive workplace and to contribute realistic strategies for Population Health. Three focus groups were facilitated across two days with 39 staff. Staff who did not attend the focus groups also contributed to the project via a short online survey.

Findings

Project 1 identified gaps within Population Health for 'foundational' or 'underlying' competencies, that is, competencies that do not require actual time but are required for part of the *thinking* for Population Health work, such as, 'Apply procurement processes to ensure effective purchasing and contract performance.'

Gaps for 'operational' competencies, that is, competencies where actual time is required, were also identified across Population Health between the demand or needs and the actual supply or availability of competencies. Some of the most highly demanded operational competencies in low supply included;

- Conduct clinical processes and procedures (e.g. screening, assessments, nursing care and support) as part of a population health program
- Implement and manage a comprehensive population health (communicable and/or non-communicable disease control, policy, environmental) program and respond flexibly to changing circumstances to develop practical solutions
- Monitor and evaluate the quality and effectiveness of a population health program within current and forecasted budget constraints.

While some gaps were more concentrated within specific units and services, they provide a clear focus for workforce development.

The findings from **Project 2** indicated that 'Leadership', 'Management Style' and 'Open Communication' are seen as important factors for an attractive workplace. In general, staff felt Population Health was performing well in relation to 'Professional Development' and 'Work-life Balance', but there were **key areas for improvement in Leadership, Organisational structure, Work organisation/Workspace and supportive technology.**

A range of solutions and strategies, that were also relevant workforce development strategies, were put forward by staff and included in the WDP.

Plan implementation

Based on the findings from Projects 1 and 2, ten key *desired* outcomes were identified as the focus for workforce development strategies.

A range of realistic and achievable strategies that match these outcomes have been included in the plan. Priority areas have been highlighted to allow for a more focussed implementation of the WDP.

To fast-track the plan, four initial steps have been identified.

Promotional event to launch the WDP
Establishment of a Workforce Development Committee
Publish and distribute the WDP
Immediate action to support Outcome 6: Open and transparent communication and engagement with and between staff

Photo: BreastScreen NSW, SWSLHD Marketing Manager Tanya Vojsk

Monitoring and evaluation of the WDP

Successful implementation of the WDP will be dependent on regular and ongoing monitoring and evaluation. It is critical to review the WDP to ensure it is being implemented on time across Population Health, to assess what is and isn't working and to adjust or re-focus strategies if required.

Monitoring should take place at all staff levels and the establishment of a Workforce Development Committee will be a valuable tool to oversee this process.

Acronyms and abbreviations

BS	BreastScreen NSW, SWSLHD
CHETRE	Centre for Health Equity Training Research and Evaluation
DPH	Director Population Health
DDPH	Deputy Director Population Health
FTE	Full Time Equivalent
HCA	Human Capital Alliance
HETI	Health Education and Training Institute
HPPU	Healthy People and Places Unit
HPS	Health Promotion Service
IM&T	Information Management and Technology
LHD	Local Health District
PHU	Public Health Unit
RHS	Refugee Health Service
SPOQ	Senior Project Officer Work Health and Safety and Quality
SPOW	Senior Project Officer Workforce Development
SWSCEWD	South Western Sydney Centre for Education and Workforce Development
SWSLHD	South Western Sydney Local Health District
WDC	Workforce Development Committee
WDP	Workforce Development Plan

Photo: CHETRE Staff

Introduction

In 2015 Population Health SWSLHD identified a need to **strategically develop** its **workforce** where **staff training needs** are **matched** with the **projected demands** of the unit. Population Health has experienced a number of changes as a result of organisational restructures, highlighting the need to assess the available workforce capacity to meet the tasks of the unit. In response to this need, Population Health embarked on the development of a WDP.

The overarching goal for the WDP was to:[1]

> *"…match current and future workforce numbers and skills to program needs, identify training needs and any gaps in the current Population Health staff profile, enhance capacity to meet future demands, and strengthen the knowledge and skills base to provide high quality population health services to the population of south western Sydney.'*

In developing the WDP, Population Health sought to explore the following key questions:

1. What staff profile (numbers and competencies) does Population Health need to deliver the actions outlined in the *Population Health Operational Plan 2014 - 2018* and individual unit Business Plans, and meet the Key Performance Indicators (KPI)'s in the South Western Sydney Service Agreement?
2. Do Population Health staff have the required professional competencies and generic capabilities outlined in the NSW Public Sector Capability Framework to work in their designated roles?
3. What are the training and development needs based on the assessment of required and existing competencies?
4. What training programs and opportunities are required to fulfil the training and development needs of Population Health staff? For instance but not limited to, skills in research capacity; management; and quality improvement.

In addition to these questions, Population Health was also interested in investigating and understanding the **cultural elements** that can **contribute to or impede** the **development and functioning** of the **workforce**. In doing this Population Health aimed to explore the following questions:

1. What does an attractive workplace look like?
2. What strategies can be identified that have attracted staff to work in SWSLHD Population Health?
3. What would make Population Health a more attractive place to work in and what strategies could be put in place to achieve this?
4. Does Population Health feel that the results from the Your Say Survey reflect the workplace issues in Population Health?

This WDP is a culmination of the findings from these investigations undertaken by workforce planning consultancy firm, HCA, who were engaged to develop the WDP.

Aboriginal Immunisation Officer, Julie Cherry

[1] Population Health SWSLHD (2015). *Population Health Workforce Development Plan 2015-2020: Scoping paper*. Liverpool: Population Health SWSLHD.

Brief description of the processes and methods

The development of the WDP was undertaken in two projects (Figure 1):

- Project 1: Workforce needs analysis – a five stage process that included the development of a competency framework, workforce profile, identification of the workforce needs of services, needs and gap analysis and design of workforce development strategies
- Project 2: Focus groups with staff – consultation with staff to explore strategies for developing an attractive workplace.

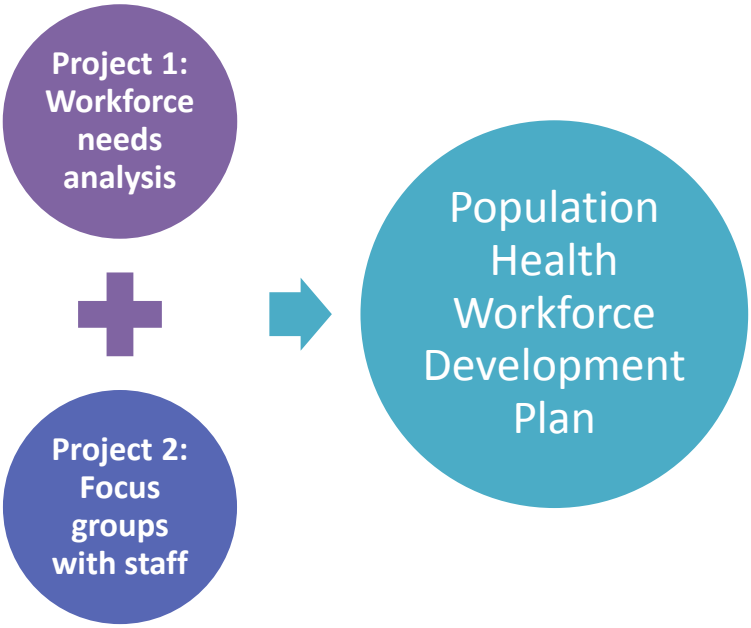


Figure 1: Development components of the Population Health Workforce Development Plan

Project 1: Workforce needs analysis

A highly consultative and collaborative process was adopted for Project 1. The Executive staff of Population Health worked collaboratively with the consultants at all stages of the project. This was a crucial element to obtain a clear understanding of the areas of work for each service and unit, to assess the current available workforce and to determine priority areas for workforce development.

The project was also supported by a Steering Committee established for the project comprised of staff from across Population Health and Local Health District (LHD) Human Resources. In addition to the Executive staff, the committee provided important guidance throughout the project, particularly in the initial stages of the project.

The five stages of the project are outlined in Figure 2 and described in more detail in the following sections.

Stage 1: Development of a competency framework

The first stage involved the development of a competency framework for Population Health. Existing competency frameworks[2],

[2] Genat, B, Robinson, P., Parker, E. (2009). *Foundation Competencies for Master of Public Health Graduates in Australia*. Australian Network of Academic Public Health Institutions (ANAPHI);
Australian Health Promotion Association (APHA) (2009). Core Competencies for Health Promotion Practitioners. Maroochydore, Queensland: APHA;
Centre for culture, ethnicity and health (n.d.). *Cultural Competencies for Health Promotion Initiatives*. Richmond, Victoria: CEH;
Health Promotion Forum of New Zealand (2012). *Health Promotion Competencies for Aotearoa-New Zealand*. Auckland, NZ: Health Promotion Forum of New Zealand;
Gadiel, D., Ridoutt, L., Lin, V., Shilton, T., Wise, M. and Bagnulo, J. (2013). *Audit of the Preventive Health Workforce in Australia: Final report of project findings*. Sydney: Human Capital Alliance;
The Council on Linkages Between Academia and Public Health Practice, (2014). *Core Competencies for Public Health Professionals*. Accessed online at http://www.phf.org/resourcestools/Documents/Core_Competencies_for_Public_Health_Professionals_2014June.pdf in August 2015;

relevant to the work of Population Health, were reviewed and analysed to draft a Population Health competency framework. A workshop was held with Population Health managers and directors to further develop the framework, with a finalised version developed in consultation with the Steering Committee and Executive staff.

Stage 2: Workforce profile

Following the development of the competency framework, the next stage involved obtaining a workforce profile. An assessment tool was developed to assess workers in each unit against the competency framework. Managers in each unit of Population Health made an assessment of each worker for the competencies they currently held to obtain the collective level of possession, or *supply*, of the competencies across Population Health. The number of staff by head count and total Full Time Equivalent (FTE) was also collected for each service and unit.

Figure 2: Overview of Project 1

Stage 3: Identifying the service workforce needs

Similar to the workforce profile tool, an assessment tool to identify the workforce needs, or *demand*, of each service and unit was developed based on the competency framework.

A series of meetings, as a well as a review of the Population Health Operational Plan and past funding and activity trends, were held with each service to determine current and future direction of the service, identifying specific areas of service growth and/or decline.

Managers within each service and unit translated each area of work in to a demand and estimated in terms of the FTE requirement of competencies for each area of work. The purpose was to identify types of competencies and the amount required for each area of work.

Stage 4: Gap analysis

Information collected from the workforce profile and service workforce needs was used to undertake a gap analysis of Population Health. This was completed by totalling the workforce needs for each service and for Population Health as a whole and comparing this with the current available workforce. The focus of the gap analysis was to identify:

- gaps in the workforce defined in terms of competence by FTE
- critical competencies for effective functioning of the services and units
- critical areas for workforce development.

Discussions with managers from each of the services and units were held to interpret the

Certificate II to Diploma Population Health units of competency from the Health Training package www.training.gov.au.

findings and to ascertain that they were a reliable reflection of the current and future situation. Summary reports were provided to each service and unit which included a profile of the workforce, critical competencies and focal areas for workforce development.

Stage 5: Workforce development strategies

In the final stage the findings for Population Health as a whole formed the basis for identifying key areas for workforce development and planning. Strategies to address these areas were formulated to assist with completing a final WDP and provided as a final overview report[3].

Project 2: Focus groups with staff

The main purpose of the focus groups was to explore, *"What do staff believe would make Population Health a more attractive place to work in and what strategies could be put in place to achieve this?"*

Feedback obtained from the focus groups also contributed to the development of the WDP.

Three-hour focus groups were facilitated across two days with 39 staff. One focus group was designated for managers only, and other staff across Population Health were invited via email to attend the other focus groups.

Focus group sessions were centred on extracting the needs of staff and formulating feasible and realistic strategies that could contribute to the WDP. The findings were analysed and discussed in a final report[4] that highlighted areas for Population Health to celebrate, areas for improvement and key strategies, as suggested by staff, to improve the workplace.

Health Promotion Service, Administration Officer, Roxana Iturrieta

[3] Ridoutt, L. and Cowles, C. (2016). Overview of competencies in Population Health, SWSLHD. (Unpublished). Sydney: Human Capital Alliance

[4] Cowles, C. & Ridoutt, L. (2016). *Factors for an attractive workplace: Findings from the Population Health, SWSLHD Focus Groups: Summary Report*.(Unpublished). Sydney: Human Capital Alliance

Project 1 findings – workforce needs analysis

Foundation or underlying skills

Competencies assessed as being required by all workers in Population Health were categorised as 'foundation' or 'underlying' skills[5]. These competencies would not necessarily require time in the performance of Population Health work — rather they would be needed as part of the *thinking* to facilitate performance. While there was some variance between Population Health units over specific competencies as to whether they were 'foundation' or 'operational', there was broad agreement on 27 of the 61 competencies being foundational.

Figure 3 illustrates the proportion of total workers possessing mastery of each of the 'foundation' competencies across all Population Health units.

The foundation competencies most in deficit were those associated with project management, especially financial administration, including:

- 45. Apply knowledge of the principal funding/finance sources relevant to a public health system
- 46. Apply financial processes to achieve value for money and minimise financial risk
- 47. Apply procurement processes to ensure effective purchasing and contract performance.

Gaps also existed for:

- 9. Apply principles and knowledge of environmental risk management
- 50. Support, promote and champion organisational development, and assist others to engage with change.

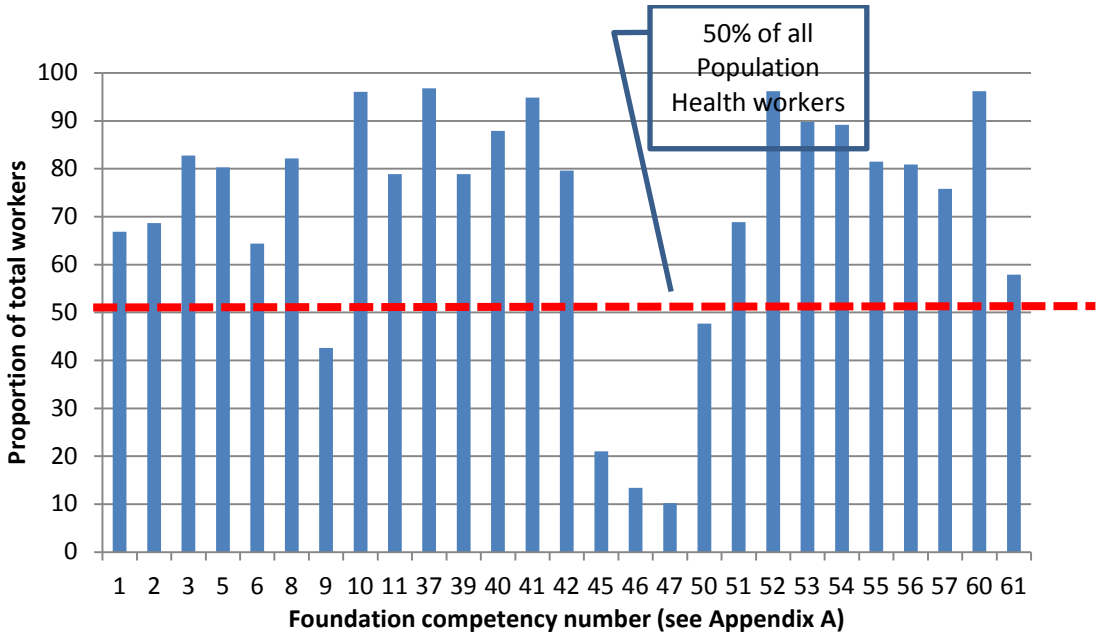


Figure 3: Proportion of all Population Health workers possessing foundation competencies

[5] Note that some competencies, particularly administrative type competencies, were identified as 'foundation' because they underpinned the delivery of population health services but were not necessarily considered to be required for all workers.

To a lesser extent, crucial deficiencies existed for:

- 1. Apply knowledge of the determinants of health (biological, behavioural, ecological and social)
- 2. Apply knowledge of the health policies and systems that impact on health
- 6. Develop and apply effective committee or working group management strategies including establishing agreements, governance and communication processes and facilitating productive meetings.

Some of these could form the focus of initial workforce development investment.

The 'gap' between foundation competencies that should be held (all competencies, by all workers) and those actually held is detailed in Table 1.

Table 1: Gap in foundation competencies across units

Population Health unit	Gap between required and actual competence possession (% of total competence)
Health Promotion Service (HPS)	41.3%
Healthy People & Populations Unit (HPPU)	19.6%
Public Health Unit (PHU)	18.3%
Refugee Health Service (RHS)	11.8%
Centre for Health Equity Training Research and Evaluation (CHETRE)	20.1%
Breast Screening Unit (BSU)[6]	47.2%

[6] The Breast Screening Unit, as shown in Table 1, is quite idiosyncratic when compared with the other Population Health units. It is largely a clinical service, staffed by clinicians. Unlike the gap for the HPS, which represents a genuine deficiency in foundation competence that will impact on job performance, the gap in BSU is somewhat inflated, and unrelated to actual competence demand. Only two of the total 61 public health competencies are significantly demanded. A short outline of the BSU situation is provided in Appendix D, showing its difference to all the other units. Because of this difference it was determined to exclude BSU from the rest of the Population Health Unit analysis so as not to skew the results.

On average the level of possession of foundation competencies is much lower in HPS (as a proportion of total workers) and almost half of the foundation competencies are not held within HPS. It is important to note that the results are only indicative as managers were required to estimate competencies held by workers. It is also likely that many workers have some level of competence against many foundation skill areas but are not yet 'masters'.

Operational skills - Areas of work requiring competence

The other 34 of 61 competencies were designated as 'operational' competencies, that is, those that require worker time to perform. The total FTE demand across all Population Health units for each of the 'operational' competencies is provided in Figure 4.[7]

Figure 4 indicates that some competencies are more highly demanded. The top 10 competencies most demanded across all Population Health units are listed in Table 2 (numbers shown are total FTE requirements).

[7] Note that Figure 4 does not represent all competence demanded by each Population Health unit, as some units also identified 'foundational' competencies as requiring FTE.

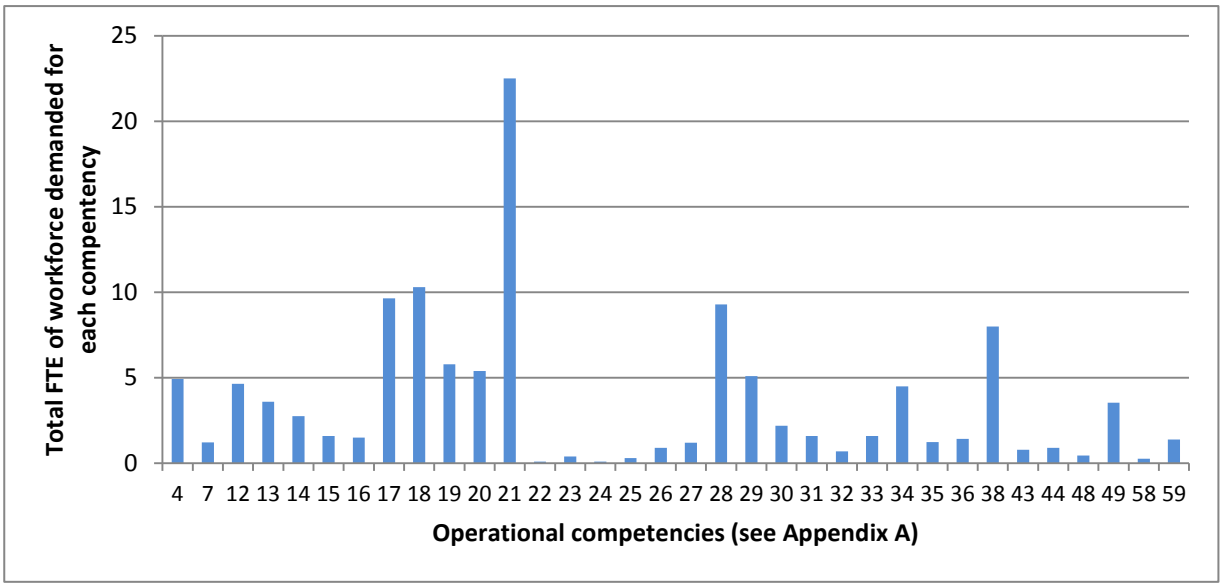


Figure 4: Map of the Operational competencies demanded by all Population Health units

Table 2: Top 10 in demand competencies across Population Health

Competency (See Appendix A for full list)	Total FTE
21	22.5
18	10.3
17	9.7
28	9.3
19	5.8
20	5.4
29	5.1
4	4.9
12	4.7
34	4.5

Due to the significant clinical workload of RHS and to a lesser extent PHU, clinical competencies (essentially Competency 21, 'Conduct clinical processes and procedures (e.g. screening, assessments, nursing care and support) as part of a population health program') are the most demanded[8].

These operational competencies, with the exception of clinical skills, **could provide a focus for Population Health workforce development investment.**

The demand for some operational competencies is concentrated in specific Population Health units (supply too can be concentrated).

Competencies almost **exclusively demanded and available in PHU** include:

- 23. Prepare for a public health emergency or disaster to ensure constant readiness to respond
- 25. Plan a public health emergency or disaster management response, such as for floods, bushfires and pandemics that identify local, national and international mechanisms (including legislative and regulatory frameworks), resources, equipment, personnel, roles and responsibilities

[8] Competency 21 is one of only two competencies significantly demanded also by BSU, not unsurprising given the Unit's primarily clinical objectives. Hence, these numbers would have been even higher (and potentially therefore misleading) with the inclusion of Breast Screen Unit data,

- 26. Advise on the public health management of environmental health risks
- 27. Plan and implement key elements of evidence-based approaches to environmental health risk management and hazard control including the role of existing health agencies, critical infrastructure, legislative and regulatory measures.

Competencies primarily **demanded and available in HPS** include:

- 19. Plan and develop a comprehensive population health (communicable and/or non-communicable disease control, policy, environmental) program that includes a goal, specific, measurable and achievable objectives, realistic timetables and appropriate strategies
- 20. Monitor and evaluate the quality and effectiveness of a population health program within current and forecasted budget constraints
- 29. Use team building strategies to establish agreed outcomes, decision-making processes, and sustainability of an intervention
- 30. Collaborate with others and value their contribution to seek consensus and commitment to promote the health of the population.

This concentration of competency requirements and available supply in specific units may be appropriate considering the work performed, however, it may also be important to **minimise risk** by ensuring **competencies are broadly possessed** across a number of units.

The balance between supply & demand

The total supply of workers currently in Population Health (excluding BreastScreen numbers) is 119 FTE. Total demand for operational competencies is 120 FTE, but as some Population Health units also nominated some 'foundation' competencies as requiring workforce time, the potential total workforce demand is 131.4 FTE. **This means there is a current total FTE deficiency of between 1 and 12.4 FTE** (0.8% to 10.3% of total requirements).

There are differences in estimated deficiencies between Population Health units as shown in Table 3. Estimated supply deficiencies range from 41.3% (CHETRE) to almost balance (HPS).

Table 3: Comparison of Population Health units on supply & demand balance

Pop. Health units	FTE supply	Estimated FTE demand (operational comps.)	Estimated demand FTE (foundation comps.)	Total demand	Supply gap (%)
RHS	17.1	20.5	1.7	22.15	29.5
PHU	20.3	22.3	0.2	22.5	10.8
HPPU	9.6	12.6	0.4	13.0	35.4
CHETRE	5.2	4.9	2.4	7.4	41.3
HPS	66.8	59.7	6.7	66.4	-0.2
Total	119	120	11.4	131.4	10.3

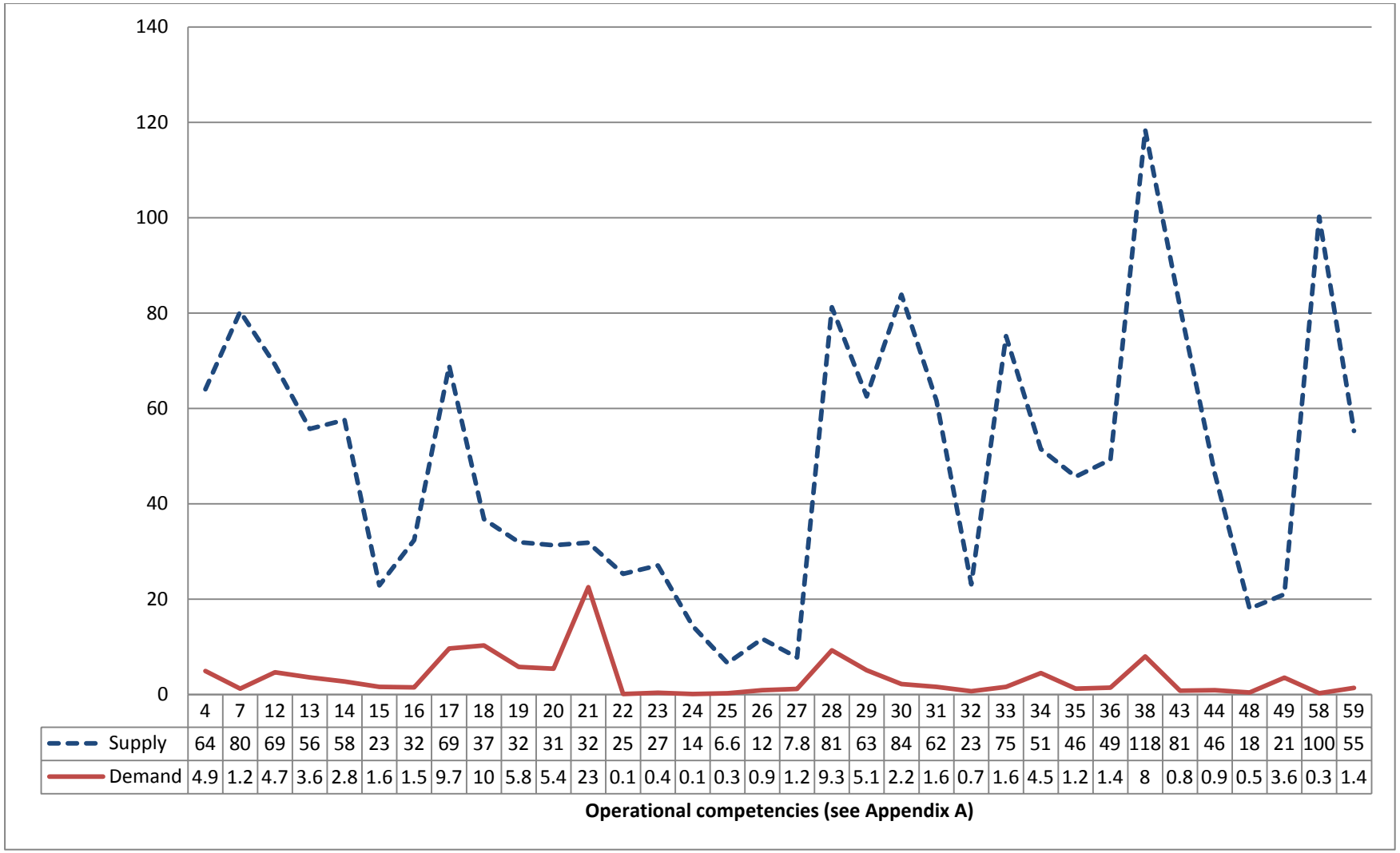
Figure 5 compares requirement and available supply for each operational competency, by calculating the ratio of competence **required** (demand) to competence **available** (supply). High values indicate the relative scarcity of that competency. These types of competencies tend to be high order skills that are possessed by few workers (often managers or senior officers) and may act as limiting factors to work performance, even if their total FTE demand is small.

The competencies with the highest ratios are:

- 21. Conduct clinical processes and procedures (e.g. screening, assessments, nursing care and support) as part of a population health program [mostly RHS and PHU]
- 18. Implement and manage a comprehensive population health (communicable and/or non-communicable disease control, policy, environmental) program and respond flexibly to changing circumstances to develop practical solutions [mostly HPS and PHU]
- 19. Plan and develop a comprehensive population health (communicable and/or non-communicable disease control, policy, environmental) program that includes a goal, specific, measurable and achievable objectives, realistic timetables and appropriate strategies [mostly HPS]
- 20. Monitor and evaluate the quality and effectiveness of a population health program within current and forecasted budget constraints [mostly HPS]
- 49. Manage resources, workforce, finance and staffing effectively and apply sound workforce planning principles [all units]
- 17. Work collaboratively on a comprehensive population health (communicable and/or non-communicable disease control, policy, environmental) program and respond flexibly to changing circumstances to develop practical solutions [all units]
- 28. Identify and develop partnerships with key professionals, community leaders and other relevant stakeholders (e.g. government and non-government agencies) to collaborate on protecting and promoting health [mostly HPS].

Most of **these competencies are within the top 10 competencies demanded** (see Table 2), allowing for a more precise **focus of priority for workforce development investment**.

Public Health Unit staff at Emergency Discussion Exercise 'Cool Spot' 2015



	4	7	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	38	43	44	48	49	58	59
Supply	64	80	69	56	58	23	32	69	37	32	31	32	25	27	14	6.6	12	7.8	81	63	84	62	23	75	51	46	49	118	81	46	18	21	100	55
Demand	4.9	1.2	4.7	3.6	2.8	1.6	1.5	9.7	10	5.8	5.4	23	0.1	0.4	0.1	0.3	0.9	1.2	9.3	5.1	2.2	1.6	0.7	1.6	4.5	1.2	1.4	8	0.8	0.9	0.5	3.6	0.3	1.4

Figure 5: Comparison of FTE requirement for operational competencies with available FTE supply by type of competence

Project 2 findings – focus groups with staff

The main expected outcome from conducting the focus groups was to discuss **tangible** and **realistic strategies** for improving the Population Health workplace to inform the WDP. This expectation was largely shared by staff who attended the focus groups. Overall staff were highly responsive to the opportunity to share their experiences and ideas for developing the Population Health workplace with a total of 39 staff attending one of three focus groups.

Common themes emerged from across all three focus groups in terms of what constitutes an attractive workplace. Staff recognised and acknowledged the **areas where Population Health was performing well** – **Professional Development and Work-life Balance** – while also highlighting key areas for improvement – Leadership, Organisation structure and Work organisation/Workspace and supportive technology. A range of strategies were proposed by staff. Many strategies were relevant to developing the skills and competence of the workforce as well as contributing to staff feeling competent and valued.

What are the factors for an attractive workplace?

During the focus groups participants were asked to consider 16 factors for an attractive workplace (see Appendix B). Across all focus groups **'Leadership'**, often in concert with **'Management Style'** and **'Open Communication'**, was held by staff as being one of **the most important factors** for an attractive workplace.

'Leadership' and 'Management Style' were seen as being related but still independent of one another as noted by one participant,

> *"Leadership is not necessarily management; a leader can be visionary, a driving and encouraging force."*

Participants at managers' focus group, May 2016

But 'Leadership' with 'Management Style' was vital because,

> *"Management is important because they can motivate you to work but they can also make a workplace very uncomfortable and unpleasant."*
>
> *"…a good manager can be open to understanding that everyone works differently."*

'Professional Development', 'Workspace and supportive technology', 'Attractive Compensation / Benefits Package', 'Work Organisation' and 'Work-life Balance' were also valued highly by staff, some of which were seen to co-exist or be dependent on one another.

A post-focus group survey emailed to staff was completed by 28 staff. The results from the survey, as illustrated in Figure 6 (of staff who did not attend focus group), also demonstrates the value staff place on Leadership alongside Management Style and Open Communication.

Population Health's efforts to create an attractive workplace

After nominating factors for an attractive workplace, staff were then given an opportunity to consider how well Population Health was performing against each of these factors on a scale of one to 10, with one being 'Very poor' and 10 being 'Excellent'.

'Professional development' and 'Work-life balance' were clearly seen as two factors where Population Health was performing very

well; many staff noted that they felt supported to seek and access professional development opportunities and to implement strategies, such as working from home or time-lieu, to facilitate a positive work-life balance. However, it is important to note that for a number of staff it was not always felt that these two factors were equitably distributed or applied by all managers.

Key areas for improvement clearly emerged from the focus group discussions. There were three factors that stood out as being 'very poor' for Population Health: **Leadership**, **Organisation structure and Work organisation/Workspace and supportive technology**, the latter two factors being more relevant to specific services and units rather than Population Health as a whole.

These factors were seen to be independent but highly connected and dependent on one another.

'Leadership' was identified across the focus groups as being one of the most important factors for an attractive workplace, and yet for some staff it emerged as an area of dissatisfaction and frustration with Population Health. The discussions around 'Leadership' were closely linked to 'Management style' and 'Open communication'; for some staff there was a perceived lack of transparency in relation to major changes and activities, lack of communication and collaboration and a sense of not being valued, recognised or respected as individual workers.

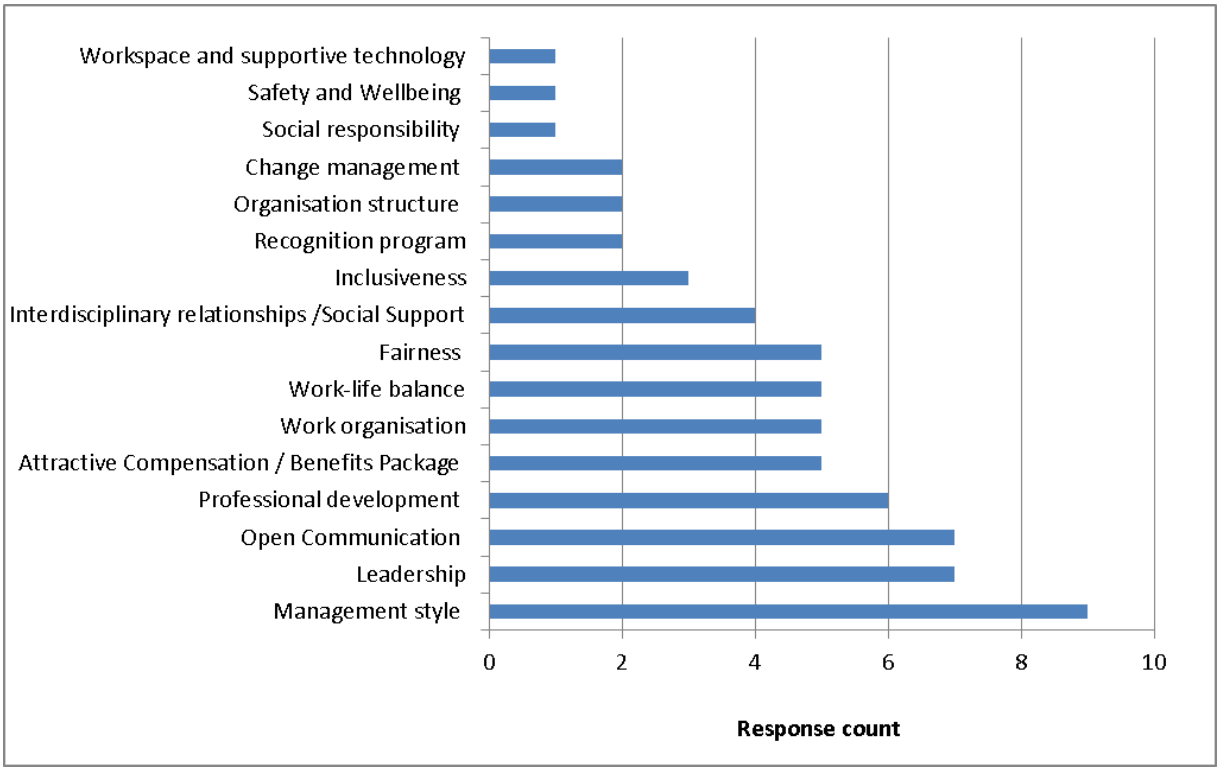


Figure 6: Survey responses for factors for attractive workplaces completed by staff who did not attend a focus group (See Appendix B for full description)

Desired outcomes of the plan

The findings of the needs assessment and staff consultation components revealed deficiencies in critical technical skills, some generic competency requirements and in the allocation, supervision and rewarding of Population Health work. Together these form a set of factors that at the least will reduce the productivity of the Population Health workforce, and at worst will reduce its effectiveness to deliver best practice population health services to the SWSLHD population.

The following desired outcomes of planned workforce development directly address the identified more pressing Population Health workforce needs:

1. Leadership capacity across Population Health is adequate at all levels of work
2. Increased supply across Population Health of appropriate Foundation competencies
3. Increased supply of Population Health operational competencies that are in high demand
4. Professional development opportunities are well-structured, accessible and distributed equitably across Population Health
5. Improved capacity of Population Health services and units to complete Population Health work
6. There is open and transparent communication and engagement with and between staff
7. There is an objective assessment of the adequacy of the current and future quantity of FTE required for Population Health
8. Process of recruitment is appropriate to different Population Health unit demand profiles
9. All staff have appropriate access to their 'tools of trade' in order to perform at optimal levels of productivity
10. Employment conditions are widely promoted and equitably accessible across Population Health

Additional long term outcomes should be developed and considered in the future for less pressing needs. Possible areas of development are foreshadowed below in the Action Plan.

Implementation of Action Plan

The findings of the needs assessment and consultations with staff, and the desired outcomes that evolve from those findings, point to some obvious workforce development strategies. Creating a strong and achievable link between the desired outcomes and the workforce development strategies is imperative to the plan being a success.

Program logic has been used to help maintain the focus on the intended outcomes of the plan during the implementation.

The action plan for workforce development implementation is outlined in Table 4. **Bolded strategies** have been **identified as those to which priority investment** (dedicated worker resources, manager support, funding support) should be **allocated**, and from which a **faster return on investment** would be expected (See Appendix C for a full description of these priorities).

The identified priorities are reinforced by the timeframe in which the strategies are to be implemented.

Table 4: Action Plan for workforce development implementation

OUTCOMES		STRATEGIES	Resources / Inputs	Timeframe
1. Leadership capacity across Population Health is adequate at all levels of work	▪ *Staff across Population Health are appropriately skilled and knowledgeable* ▪ *Staff have increased job satisfaction* ▪ *Staff feel competent, valued and acknowledged* ▪ *Staff have increased understanding of the work undertaken across Population Health*	▪ Identify leadership development processes in the *Transforming your Experience – implementation plan* and assess for appropriateness to Population Health needs	Senior Project Officer Workforce Development (SPOW), All Managers	2017
		▪ Promote relevant South Western Sydney Centre for Education and Workforce Development (SWSCEWD) and Health Education and Training Institute (HETI) management and leadership training opportunities to all staff to develop current and future leaders	All Managers, SPOW	2017-2019
		▪ Implement Line Manager Capability Professional Development Pathway for current and aspiring line managers	All Managers, Workforce Development Committee (WDC)	2017-2019
		▪ **Develop coaching/mentoring program focusing on high demand competencies to provide upskilling for new or future managers**[#]	SPOW	2017-2019
		▪ Identify on-the-job management and leadership training opportunities within Population Health and offer to managers in an equitable way	All Managers	Ongoing
		▪ Identify and offer staff opportunities to lead projects	All Managers	2017-2019
		▪ Include succession and progression considerations in performance reviews for staff	All Managers	2017-2019

[#] Priority 3, refer to Notes in Appendix C

OUTCOMES		STRATEGIES	Resources / Inputs	Timeframe
		wanting to progress to a higher grade, where available and to ensure succession planning for managers (e.g. training for and inclusion on recruitment and selection panels).		
2. Increased supply across Population Health of appropriate Foundation competencies (see Appendix A).	▪ *Improved alignment of staff skills and knowledge with the Population Health Competency Framework* ▪ *Staff understand their personal professional development and training needs* ▪ *Supervisors/managers encourage the professional development and training needs of staff*	▪ **Develop and provide staff with a simple self-assessment tool based on the Competency Framework to allow them to self-assess training needs[#]**	SPOW, WDC	2017 and ongoing
		▪ **Managers / Supervisors to assess individual staff competencies (using self-diagnosis responses as a guide) and develop a strategy for addressing needs individually and collectively[#]**	All Managers	2017
		▪ **Identify and assess existing short public domain courses addressing needed foundation competencies (e.g. determinants of health, interpersonal skills, etc.)[#]**	All Managers, WDC	2017
		▪ **Coordinate the design and conduct of courses/workshops (where appropriate) addressing identified foundation competencies[#]**	SPOW	2018-2019
		▪ Promote self-directed learning resource options (short courses adopted to online environment, prescribed reading, assignments) developed for high volume competency areas	SPOW, All Managers	2017-2019

[#] Priority 1, refer to Notes in Appendix C

OUTCOMES		STRATEGIES	Resources / Inputs	Timeframe
3. Increased supply of Population Health Operational competencies that are in high demand (see Appendix A)	▪ *Improved availability of staff with crucial skills and knowledge within Population Health* ▪ *Population Health projects and programs are designed and developed according to best practice* ▪ *Population Health work is completed with greater efficiency and effectiveness*	▪ **Develop guidelines for cross-unit sharing of staff with high demand competencies[#]**	SPOW, WDC	2017
		▪ **Develop coaching/mentoring program focusing on high demand competencies[#]**	SPOW	2017
		▪ **Identify staff (talent search) who partially possess high demand competencies and target for accelerated training[#]**	All Managers	2017-2018
		▪ Develop a pool of staff with high demand competencies available to work across Population Health units	All Managers	2018-2019
		▪ Raise awareness of unique skill sets (including but not limited to high demand competencies) possessed by Population Health staff	Directorate	2017
		▪ Design and carry out scenario-based or desktop exercises to develop skills and competencies	All Managers	2017-2019
		▪ Pair more experienced team members with less experienced staff for field visits or complex assessments, projects and evaluations, where possible	All Managers	2017-2019
		▪ Identify and promote opportunities for staff secondments across or within units to develop and share high demand competencies	All Managers	2017-2019
		▪ Promote financial management training opportunities to all cost centre managers	SPOW	2017 and ongoing

[#] Priority 2, refer to Notes in Appendix C

OUTCOMES		STRATEGIES	Resources / Inputs	Timeframe
4. Professional development opportunities are well-structured, accessible and distributed equitably across Population Health	▪ *Staff across Population Health are appropriately skilled and knowledgeable* ▪ *Staff have increased job satisfaction* ▪ *Staff feel competent, valued and acknowledged* ▪ *Staff have increased understanding of the work undertaken across Population Health*	▪ Conduct evaluation of current professional development opportunities provided by Population Health ▪ Establish working group to review and update workplace procedures and guidelines related to professional development ▪ Distribute draft professional development guidelines to staff for review and comment ▪ Promote opportunities for staff secondments across or within units to develop and share crucial competencies ▪ Advertise short term and contract job opportunities internally using Expression of Interest (EOI) before advertising externally, where possible (and where not, provide transparency in the process) ▪ Identify individual learning needs using competency self-assessment tool, as part of performance reviews (3 month or annual reviews) as appropriate ▪ Ensure budget is allocated to services and units to support professional development opportunities as feasible	SPOW Directorate All Managers All Managers All Managers All Managers All Managers	2017 2017 2017 2017 2017-2019 2017-2018 2017-2019
5. Improved capacity of Population Health services and units	▪ *Improved integration of Population Health services and units* ▪ *Staff have increased*	▪ Create processes that facilitate staff collaboration across Population Health units on shared projects/areas of interest (e.g. Consult all Population Health staff regarding ideas for	Directorate	2018

OUTCOMES		STRATEGIES	Resources / Inputs	Timeframe
to complete Population Health work	*understanding of the work undertaken across Population Health*	future cross-unit working groups, collaborations and priorities) ▪ Construct work teams so that all competencies are covered by team members, where possible	 All Managers	 2018-2019
6. There is open and transparent communication and engagement with and between staff	▪ *Improved communication within and across all levels of staff* ▪ *Staff have increased understanding of the work and activities undertaken across Population Health* ▪ *Staff have increased awareness and understanding of Population Health policies* ▪ *Increased staff participation in Population Health development activities* ▪ *Staff feel competent, valued and acknowledged*	▪ Distribute summaries of Population Health Executive meetings to all staff ▪ Promote and regularly circulate relevant policies to all staff ▪ Consult with and involve all levels of relevant staff in major changes, initiatives, plans and activities of the units within the Population Health Service, where possible ▪ Implement SWSLHD Leadership Strategy[9] (*Transforming your Experience- Implementation plan*) with a focus on timely and transparent communication and relationships ▪ Develop guidelines for recognition of staff for their performance (e.g. opportunities for staff to showcase their projects at conferences, identifying opportunities and dedicated time to work on quality improvement projects) ▪ Conduct biannual Q & A forum for all Population Health staff ▪ Develop a wiki platform for Population Health staff to enable cross-unit collaboration,	All Managers All Managers All Managers All Managers All Managers Director SPOQ	2017 2017 2017 and ongoing 2017-2018 2018 2016 and ongoing 2016-2017

[9] This strategy is currently under development as at November 2016.

OUTCOMES		STRATEGIES	Resources / Inputs	Timeframe
		communication and sharing of ideas, information and documentation		
7. Assess adequacy of the current and future quantity of FTE required for Population Health	▪ *Population Health effort not hampered by staff shortage* ▪ *Managers have increased understanding of workforce demands of Population Health* ▪ *Operations Plan can be expected to achieve objectives*	▪ Examine and validate current staff shortages identified through needs assessment in selected Population Health units ▪ Calculate future service demands for workforce, after allowing for appropriate growth in service capacity ▪ Conduct review of work processes to identify more productive and efficient work design (e.g. reduced duplication, evolving organisation structures to foster collaboration) ▪ Employ more temporary vs casual staff to improve continuity, accountability and stability in programs ▪ Establish and implement formal processes for increasing FTE, based on well developed business cases	All Managers All Managers All Managers All Managers All Managers	2017 2018 2018 2018-2019 2018-2019
8. Process of recruitment is appropriate to different Population Health unit demand profiles	▪ *Improved alignment of staff skills and knowledge with the Population Health Competency Framework*	▪ Review position descriptions (as positions are vacated/added) and rewrite in line with Population Health Foundation competencies ▪ Review selection criteria for new recruitments to ensure they correspond with key competency demands of Population Health	All Managers All Managers	2017 – ongoing 2017 – ongoing
9. All staff have appropriate	▪ *Improved work productivity*	▪ Identify policies related to staff use & access to supportive technologies and ensure all staff are	IM&T Committee	2018

OUTCOMES		STRATEGIES	Resources / Inputs	Timeframe
access to their 'tools of trade' in order to perform at optimal levels of productivity	▪ *Increased staff satisfaction*	aware of them ▪ Implement training needs identified in Population Health Information Management and Technology (IM&T) Action Plan ▪ Identify supportive technologies required to implement the Operational Plan ▪ Review and trial available supportive technologies for future use by staff ▪ Develop a system of support for staff using specialised software programs (e.g. SPSS, SAS, GIS) ▪ Identify required 'tools of trade' in staff annual performance review process	SPOW, IM&T Committee IM&T Committee IM&T Committee IM&T Committee All Managers	2017-2018 2018 2017-2018 2017-2018 2019 - ongoing
10. Employment conditions are widely promoted and equitably accessible across Population Health	▪ *Improved work productivity* ▪ *Increased staff satisfaction*	▪ Inform all managers and staff of SWSLHD Flexible Work Practices policy ▪ Promote procedure for staff progression to a higher grade, where available	All Managers All Managers	2017-2018 2019

Initial steps to implement the WDP

Four key steps have been identified to support immediate implementation of the WDP (Table 5). These are:

1. Promotional event to launch the WDP
2. Establishment of a Workforce Development Committee
3. Publish and distribute the WDP
4. Immediate action to support Outcome 6: Open and transparent communication and engagement with and between staff

Enacting these steps will be important to generate and maintain momentum for implementing the WDP and to ensure that it remains current and relevant.

Monitoring and evaluation of the WDP

Monitoring and evaluation will be **a critical element to ensure the WDP is implemented** across all units of Population Health. The action plan provided above will form the basis for monitoring implementation.

The action plan should be reviewed at least annually by Population Health executive to monitor progress, evaluate outcomes and ensure currency and relevance.

The WDP could be included as a standing item for staff meetings to ensure it is reviewed and discussed on a regular basis.

The establishment of a Workforce Development Committee (WDC) will also be an important mechanism for reviewing and reporting on the progress of the WDP. Information across Population Health in relation to the WDP can be directed to the committee to assist with monitoring. The WDC may report back to staff via staff meetings, staff forums and via other communication methods.

Table 5: Initial steps for the WDP

Activity	Objective	Timing	Responsible
Promotional event to launch the WDP	To promote the WDP and ensure staff understand the strategies and outcomes of the plan	Dec 2016	Directorate
Establishment of a Workforce Development Committee	To oversee the implementation and progress of the WDP To ensure broad representation of staff across Population Health	Dec 2016	DDPH, SPOW
Publish and distribute the WDP	To increase awareness and knowledge of the WDP	Dec 2016	SPOW, All Managers
Immediate action to support Outcome 6: Open and transparent communication and engagement with and between staff	To generate some quick wins	Dec 2016	Directorate

Appendix A: Population Health competency framework

POPULATION HEALTH COMPETENCY FRAMEWORK Key: ‡ Focus on Operational competency † Focus on Foundation competency
Foundational skills
1.† Apply knowledge of the determinants of health (biological, behavioural, ecological and social).
2.† Apply knowledge of the health policies and systems that impact on health.
3. Communicate verbally and in writing with linguistic and cultural proficiency, actively listen to others and respond with respect.
4.‡ Write reports for a variety of audiences and purposes including papers for peer reviewed journals, in-house reports, program plans and program update reports.
5.† Apply interpersonal skills (negotiation, team work, motivation, conflict management, decision making, and problem solving skills).
6.† Develop and apply effective committee or working group management strategies including establishing agreements, governance and communication processes and facilitating productive meetings.
7. Deliver presentations on population health programs or topics at workshops or conferences.
8. Apply core principles of just, ethical and legal public health practice.
9.† Apply principles and knowledge of environmental risk management that apply to climate change.
10. Use current and developing technology, computer software programs (e.g. Microsoft Office) and technology based systems (e.g. internet) as a work tool.
11. Operate audio-visual and multimedia equipment.
Monitoring and surveillance
12.‡ Perform basic research and analysis which others will use to inform public health policy and programs.
13. Collect and prioritise data of population health needs to inform the development of public health policy and programs.
14. Assess, interpret and communicate population health data and indicators and information on different health issues/topics, diseases and prevention.
15. Assess and interpret the epidemiologic measures of occurrence (e.g. prevalence and incidence of diseases and death) and association between exposure (including risk behaviour) and disease (e.g. risk ratios) and measures of public health impact (e.g. population attributable risk).
16. Generate and interpret descriptive statistics and appropriate graphics for summarising and displaying epidemiologic data.
Disease prevention and control
17.‡ Work collaboratively on a comprehensive population health (communicable and/or non-communicable disease control, policy, environmental) program and respond flexibly to changing circumstances to develop practical solutions.
18.‡ Implement and manage a comprehensive population health (communicable and/or non-communicable disease control, policy, environmental) program and respond flexibly to changing circumstances to develop practical solutions.
19.‡ Plan and develop a comprehensive population health (communicable and/or non-communicable disease control, policy, environmental) program that includes a goal, specific, measurable and achievable objectives, realistic timetables and appropriate strategies.
20.‡ Monitor and evaluate the quality and effectiveness of a population health program within current and forecasted budget constraints.

POPULATION HEALTH COMPETENCY FRAMEWORK **Key: ‡ Focus on Operational competency † Focus on Foundation competency**
21. Conduct clinical processes and procedures (e.g. screening, assessments, nursing care and support) as part of a population health program.
Emergency and disaster management
22. Communicate information and advice to the public and other health workers on emergency planning, preparation and response processes.
23. Prepare for a public health emergency or disaster to ensure constant readiness to respond.
24. Implement and manage a public health emergency or disaster management response.
25. Plan a public health emergency or disaster management response, such as for floods, bushfires and pandemics that identify local, national and international mechanisms (including legislative and regulatory frameworks), resources, equipment, personnel, roles and responsibilities.
Environmental health protection
26. Advise on the public health management of environmental health risks.
27. Plan and implement key elements of evidence-based approaches to environmental health risk management and hazard control including the role of existing health agencies, critical infrastructure, legislative and regulatory measures.
Community development, engagement and partnership building
28.‡ Identify and develop partnerships with key professionals, community leaders and other relevant stakeholders (e.g. government and non-government agencies) to collaborate on protecting and promoting health.
29.‡ Use team building strategies to establish agreed outcomes, decision-making processes, and sustainability of an intervention.
30. Collaborate with others and value their contribution to seek consensus and commitment to promote the health of the population.
Communication skills
31. Communicate disease (communicable and/or non-communicable) risk information effectively to the public and to other health workers.
32. Communicate environmental health risk information effectively to the public and other health workers.
33. Identify the health literacy of populations served and develop appropriate strategies.
34. Develop a communication strategy that includes a range of appropriate methods (social marketing, web-based, printed format, face-to-face, etc.).
Policy and procedure development
35. Analyse and implement government population health policy from economic, equity and ethical perspectives.
36. Gather information and develop an advocacy strategy to develop and influence policy to improve population health and reduce inequalities.
Administrative and Management skills
37. Be responsible for own actions, adhere to legislation and policy and be proactive to address risk.
38. Undertake administrative work.
39. Identify team goals and their impact on work tasks.
40. Plan and deliver tasks in line with agreed schedules.
41. Identify and inform supervisor of issues that may impact on completion of tasks.
42. Apply initiative and creativity to develop practical solutions.
43. Contribute to the preparation of submissions, grants or applications for proposals for enhancement funding.

POPULATION HEALTH COMPETENCY FRAMEWORK **Key: ‡ Focus on Operational competency † Focus on Foundation competency**
44. Write submissions, grants or applications for proposals for enhancement funding.
45. Apply knowledge of the principal funding/finance sources relevant to a public health system.
46. Apply financial processes to achieve value for money and minimise financial risk.
47. Apply procurement processes to ensure effective purchasing and contract performance.
48. Apply effective planning, coordination and control methods to contribute to budget build-up and management.
49.† Manage resources, workforce, finance and staffing effectively and apply sound workforce planning principles.
50.† Support, promote and champion organisational development, and assist others to engage with change.
51.† Communicate the organisation's goals, priorities and vision and recognise achievements.
Cultural awareness and competence
52. Facilitate culturally safe work practices and environments.
53. Incorporate strategies for interacting with persons from diverse backgrounds.
54. Recognise the role of cultural, social and behavioural factors in the accessibility, availability, acceptability, delivery and outcomes of public health services.
55. Recognise the historical context and analyse the impact of colonial processes on health outcomes of Aboriginal and Torres Strait Islander people.
56. Respond to diverse needs that are the result of cultural differences.
Professional development and capacity building
57.† Promote individual, team and organisational learning opportunities.
58. Participate in personal development opportunities such as mentoring, peer advising or coaching and develop ongoing goals.
59. Provide supervision, mentoring or other personal development opportunities for colleagues.
60. Actively seek and participate in continuing professional development activities.
61. Actively maintain relevant professional registration or membership, where appropriate.

Appendix B: Factors for attractive workplace

The following list of factors[10] formed the basis for discussions in focus groups with staff.

Factor	Description
1. **Attractive Compensation / Benefits Package**	Competitive (or exceptional) benefit packages; providing supplementary health benefits; allowing for appropriate promotion and ensuring there are genuine career opportunities; job security.
2. **Recognition program**	Recognising / valuing effort and worker contributions and rewarding achievement; showing appreciation; demonstrating workers are integral to outcomes.
3. **Professional development**	Maintaining and enhancing employee competence, transfer acquired skills and competencies to other work settings (e.g. through continuing education); accessibility to services to develop & manage careers (e.g. mentoring); providing opportunity for growth and development; engaging in research-based work and advancing their practice.
4. **Work organisation**	Work distribution and allocation; work design and structure; adequate resources (sufficient staff and support services); appropriate resource support (incl. an appropriate personnel mix); appropriate workload; professional models of service; scope for independent judgement.
5. **Organisation structure**	Flat organisation structures (or operational approaches that deliver the same effect); decentralised / unit based decision-making; worker autonomy and control over practice settings; participation in the governance of their own work; capacity for responsibility and independent judgement in professional work.
6. **Leadership**	Credible / respected and inspired; integrity in carrying out clearly articulated vision with consistency and knowledge; encourages openness and involvement / participation; maintains visibility; provides clarity and focus; risk-taking; strategic; progressive; supportive.
7. **Management style**	Fosters worker participation in decision-making; value staff feedback; innovative / collaborative; being clear on corporate culture; hiring home-grown talent; transparent decision-making; sense of fairness.
8. **Change management**	Purposeful; processes and practice are very transparent; participation of staff in change decisions; staff consultation.
9. **Work-life balance**	Corporate responses to non-work demands; valuing employees' total life commitments; caring for employees as individuals with personal lives;

[10] These factors were drawn from previously unpublished research undertaken by HCA in Victoria where primary factors for attractive workplaces were identified.

Factor	Description
	flexible staffing arrangements.
10. Interdisciplinary relationships /Social Support	Positive workplace relationships with mutual respect between workers; good communication / relationship between peers and with supervisors; socially friendly, welcoming atmosphere; sense of "family" or "team".
11. Open Communication	Accessible and effective internal communications offering frequent, open and two-way feedback system; communication that conveys mutual respect.
12. Social responsibility	Role of larger organisation as local drivers of business, employment creation, expansion, spin-offs, etc. ('community and the hospital'); congruence between stated organisation values, and management and corporate behaviour; community involvement; sustainable practice; abiding by provisions of relevant legislation and adhering to ethical principles in the conduct of the business; Ethical products and services.
13. Fairness	Equity (balanced treatment for all in terms of regards); Impartiality (absence of favouritism in hiring and promotions); Justice (lack of discrimination and process for appeals/grievance resolution); processes and practice transparent.
14. Inclusiveness	Workplace diversity by encouraging participation of underemployed or people at risk of exclusion such as early school leavers, long-term unemployed, women, young employees and old workers; encourage all workers; contribution to organisation life / objectives.
15. Safety and Wellbeing	Commitment to ensuring workplaces maintain the physical safety and health of workers; strong Occupational Health &Safety systems; educating/enabling employees to take on health practices voluntarily including practices in parts of their non-work life.
16. Workspace and supportive technology	Work facilities ensure safety and health of employees; facilitation of supportive social relationships and effective communication; 'tools of trade' that support productivity; congruence between built environment and organisation task (and culture); corporate responsibility in effect of facilities on environment.

Appendix C: Notes on priority areas

Priority 1 — Increased supply of Population Health 'foundation' competencies

Through the needs assessment process managers assessed each of their workers through the use of the worker profile tool against all 27 of the agreed 'foundation' competencies. Workers were largely not consulted in this process, nevertheless the findings can be used to construct skills matrices for each unit (or in some units at lower levels of organisation such as 'project teams' or 'program areas'). The matrix would look like the following:

The classification of competence status, that is 'Competent', 'Developing competence' and 'Not competent', could be visually recognised by green, orange and red respectively. The matrix may be made public to all workers (if the team environment is culturally safe and accepting of a development philosophy) and thus provide a visual record of progress (turning the chart all green).

Apart from improving accuracy in assessment, it is good practice to involve workers in assessment of their own competence. This improves buy-in to the development process. To facilitate self-assessment a suitable tool may need to be developed.

A form of the worker profile tool can be adapted to this purpose. The tool might look like the following:

Worker	**Competence status**				
	Competence 1	**Competence 2**	**Competence 3**	**…**	**Competence N**
Worker A	Competent Developing competence Not competent	Competent Developing competence Not competent	Competent Developing competence Not competent		Competent Developing competence Not competent
Worker B	Competent Developing competence Not competent	Competent Developing competence Not competent	Competent Developing competence Not competent		Competent Developing competence Not competent
Worker C	Competent Developing competence Not competent	Competent Developing competence Not competent	Competent Developing competence Not competent		Competent Developing competence Not competent
…					
Worker N	Competent Developing competence Not competent	Competent Developing competence Not competent	Competent Developing competence Not competent		Competent Developing competence Not competent

Worker self-assessments may be conducted in conjunction with performance reviews to clarify and validate worker development needs and provide actions for Worker Development Plans.

As selected foundation competencies (see Appendix A) are likely to be subject to significant immediate (and potentially ongoing) worker development demand, 'off the job' classroom based development strategies would be the most efficient investment. Short course / workshop resources will already exist for many 'foundation' competencies.

A search for these resources (by a designated officer), followed by an assessment of their suitability for SWSLHD Population Health workers, could be undertaken and a decision then taken, for each competence to be developed, whether to utilise existing resources or design and develop courses / workshops in SWSLHD fit to the LHD's specific purposes. Of course, designing and developing new learning resources (courses, workshops) will be more costly and time consuming.

Worker name ……..			
Competence	**Importance of competence to perform current job / role**	**Competence status**	**Development needs assessment (based on importance x status)**
Competence 1	Not important Moderately important Very important Critical	Not competent Partially mastered competence Near mastered competence Competent	Not now Would be useful As soon as possible Immediate need
Competence 2	Not important Moderately important Very important Critical	Not competent Partially mastered competence Near mastered competence Competent	Not now Would be useful As soon as possible Immediate need
Competence 3	Not important Moderately important Very important Critical	Not competent Partially mastered competence Near mastered competence Competent	Not now Would be useful As soon as possible Immediate need
…	…	…	…
Competence N	Not important Moderately important Very important Critical	Not competent Partially mastered competence Near mastered competence Competent	Not now Would be useful As soon as possible Immediate need

Priority 2 — Increased supply of operational competencies

Certain operational competencies have already been identified as critical to Population Health service delivery (see Appendix A) but in short, at times limiting supply (that is held by few workers). Moreover, available supply of these competencies tends to be concentrated in one or two units, and is not easily available to projects the primary responsibility of other units.

A **short term solution** is to develop a mechanism whereby the **competencies held by a limited number of workers** (likely to be senior staff) can be **utilised across all of Population Health**. A cross-unit working group could be formed to develop the mechanism, which would likely consist of the following elements:

- An inventory of available people with crucial competencies, to be kept up to date as workers leave, new recruits arrive, development of new competence (see below) occurs.
- A means of facilitating 'back fill' of a worker if the competence requirement is for a protracted period of time.
- An 'order' form, to facilitate communication between unit managers about timing and type of competence required. Crucial competencies are often required for short but critical periods, and timely deployment can mean the required duration of need can be reduced. The 'order' form could designate the project and project stage where competence is required. Project stages could include those indicated in the following example form.

Sample 'competence order form'
☐ program/project design and plan
☐ program/project initiation
☐ communicate project plan to project team and stakeholders
☐ initial start up of program
☐ project rollout and stakeholder engagement
☐ project completion and reporting
☐ evaluation

A **long term solution** or goal could be to **ensure crucial competencies are less scarce** and **less reliant** on somewhat risky deployment mechanisms. Unlike 'foundation' competencies, crucial **'operational' competencies** are best **developed through individualised learning** program strategies. While this is more costly, the return on investment is still likely to be acceptable. The steps in this process will be:

1. Identify individual workers who already have partial competence in crucial competencies (see Priority 1 discussion above). This reduces the cost and obtains a competent worker faster. Eventually the pool of partially competent workers will be depleted and 'not competent' workers will need to be developed.
2. Design through collaboration (worker and supervisor) a suitable program of learning, employing self-directed resources (identified reading lists, on-line learning programs, etc.), buddying with competent workers, and seeking time with a mentor (see below).
3. When 'nearly competent', planned job rotations and / or secondments to roles that would allow practice of the new competency to develop mastery within a supported learning environment would be important.

Priority 3 - Develop coaching/mentoring program

A specific strategy to increase supply of the more critical operational competencies noted above will be to engage persons already possessing scarce competencies in mentor or coaching roles. It is important that such roles are not treated and utilised informally but the time spent by a learner with a mentor is structured and used efficiently.

This implies having a learning program that should be structured in the form of a learning contract, with binding timelines on the learner and resource support from the direct line supervisor (in terms of allowing for dedicated learning time and managing back-up for the learner's normal job requirements). The learning contract will have specific objectives (constructed in collaboration with the mentor / coach) and build on what the learner already knows.

Possession of a specific scare competence, or competencies, should not be the only criteria for selecting a mentor or coach; not all technically competent workers will be well equipped and / or motivated to be a mentor. The level of willingness needs to be assessed as well as other pre-defined selection criteria. Some important selection criteria for a mentor may include honesty and trustworthiness, being an active listener, knowledgeable, fair, organised and sympathetic.[11,12] If finances permit, a short training course for mentors should ideally be made available such as those that can be accessed through HETI. Well prepared mentors / coaches will not only pass on operational competence but model coaching skills as well.

Similarly, workers who are to become the mentees should also be selected according to a set of pre-defined essential criteria. Mentees should at least be committed, respectful of mentors' time and support, and responsible for their own learning.[11]

[11] Straus, S. E., Johnson, M. O., Marquez, C., & Feldman, M. D. (2013). Characteristics of Successful and Failed Mentoring Relationships: A Qualitative Study Across Two Academic Health Centers. *Academic Medicine: Journal of the Association of American Medical Colleges*, 88(1), 82–89. http://doi.org/10.1097/ACM.0b013e31827647a0

[12] Heeralal, P.J.H. (2014). Student teachers' perspectives of qualities of good mentor teachers. *Anthropologist*, 17(1): 243-249.

Appendix D: Worker competency supply & demand in the BreastScreen Unit

There are currently 30 workers[13] in BreastScreen (BS) providing a total FTE of 25.9 FTE. They are currently employed as follows:

Table D1: Employment status of BS workers

	Clinical functions	Corporate functions	Total
FTE	19.9	6	25.9
Head count	24	6	30

The corporate functions include:

- Breast Screen Manager
- Chief Radiographer
- Marketing Manager
- Data Manager
- Quality Manager
- Administration Manager

The 'clinical' workforce includes:

- Clinical Radiologists (2.1 FTE)
- Radiographers (6 FTE)
- Admin Officers (10 FTE)
- Nurse Counsellors (1.8 FTE)

The workforce of BS is deployed to four main areas of work. These four areas of work are estimated, if performed to the level required by BS, to require a total of 32 FTE of the workforce. The distribution is shown in Table D2.

Based on the BS self-assessment the total FTE requirement is 6.1 FTE greater than current total workforce supply. That is, there is currently a skill shortage for the BS work estimated as being required.

The total competency requirements are built from a small number of population health competence areas. In total, only 14 competencies are required by BS workers to perform the work of the unit, some competencies requiring only 0.05 FTE (the equivalent of 1.9 hours per week or approximately 2.5 weeks per year) while the most competence is required to "Undertake administrative work" which requires 17.9 FTE per week (or approximately 680 hours per week). This competency, and "Conduct clinical processes and procedures (e.g. screening, assessments, nursing care and support) as part of a population health program" (which is 12.5 FTE, or the equivalent of 475 hours of workforce per week), are the only two that require more than one FTE per week. These two competencies account for 95% of all competence requirements.

Table D2: Workforce requirements for broad areas of BS work functions

Areas of work	FTE required
1. Screen and assess clients, provide clinical oversight and coordination	15.4
2. Manage service data	0.4
3. Provide Managerial Oversight to Staff and Staffing Groups and service functions (HR, Finance, etc.)	5.7
4. Coordinate and execute administrative functions to facilitate client journey - invitations, bookings, reception duties, follow-up	10.5
Total	**32**

[13] This is an approximation; based on discussions with BS Manager it is difficult to quantify precise number of workers due to varying casual and contract employment arrangements.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