

Implementing the Generic Competencies for Public Health in Aotearoa

Advice to the Ministry of Health:

from Sector Focus Groups on the
Public Health Workforce Development Plan
Te Uru Kahikatea and implementing
the Generic Competencies

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Summary

This is a report to the Ministry of Health (the Ministry) from the Public Health Association (PHA) regarding the insights gained from a series of four focus groups to further explore the implementation of the Generic Competencies for Public Health in Aotearoa New Zealand.

These focus groups built on an earlier report about future steps for the Generic Competencies from the public health sector¹. Between the previous report from the sector bodies and these focus groups *Te Uru Kahikatea, The Public Health Workforce Development Plan 2007-2016* was released. Therefore these focus groups and this report is the first time the competencies have been framed in the context of *Te Uru Kahikatea, The Public Health Workforce Development Plan 2007-2016*.

Four focus groups were held, two in Auckland in September 2007, and one each in Wellington and Christchurch in November 2007. Invitations were offered to a representative selection of crown and non government organisations that have Ministry contracts for public health services.

A further meeting with Māori practitioners was conducted early in March 2008. The focus group format was adapted to an informal hui style and the report from this hui is attached as an addendum.

The aim of these focus groups was to obtain advice from the sector about what incentives, tools, guidelines and funding changes are required by the sector to implement the generic competencies and enhance workforce development in public health workplaces.

The key finding of the focus groups is that, in general the sector has little familiarity with the generic competencies and limited skill in workforce development. The recommendations made by the focus groups are broadly supportive of the generic competencies and in line with previous advice from the sector. The focus group recommendations are also consistent with the goals and action areas set out in *Te Uru Kahikatea*. But the reality is that the advice is at a fairly high level of generality. People in the sector are comfortable articulating a vision for workforce development, and identifying barriers to achieving that vision. However the sector finds it difficult to clearly specify incentives, tools and other resources required to achieve that vision.

It is clear that for implementation of the generic competencies to proceed and enhanced public health workforce development to be achieved, the Ministry must now exercise its leadership role and

- Actively market and promote the competencies

¹ PHA (March 2007) Generic Competencies for Public Health Project: Report to the Ministry of Health. PHA in association with the Health Promotion Forum of New Zealand, Māori Community Health Workers, New Zealand Institute of Environmental Health, Public Health Nurses Section of New Zealand Nurses Organisation. Can be accessed at <http://www.pha.org.nz/documents/GenericCompetenciesProjectReporttotheMinistryofHealthMarch2007.pdf>

- Publicly and widely indicate that there will be contractual support for implementation, even if the detail is not yet clear
- Emphasise the expectation that there will be funding and training to achieve an equitable workforce (rather than replacement of experienced but unqualified practitioners) in addition to training of new practitioners
- Assess the pros and cons of the following recommended options, make clear decisions and develop detailed implementation plans.

Recommendations

These recommendations have been formulated by the PHA based on insights from the four Focus Groups and the Māori hui.

Marketing and promotion

In regard to **marketing and promotion** of the generic competencies we recommend that the Ministry:

1. Develop a marketing promotional package that:
 - a) describes how the generic competencies will help 'make a difference' to public health service goals (including health promotion)
 - b) describes why they are needed and engages peoples' interest
 - c) explains how to implement them as a positive tool to support staff
 - d) clarifies the intended levels of competency
 - e) describes the benefits of implementation for both practitioners and organisations
 - f) alleviates fears of assessment processes and possible negative professional consequences.
 - h) proactively markets the benefits to the Māori constituency and reasons for implementing them eg that the Generic Competencies are positive tool and provide 'a glue' across the public health sector.
2. Take into account the relationship (if any) between the GPHCs and Māori competencies (a dual competency framework);
3. Identify and mitigate any risks that might accrue as a result of implementing the GPHC's to the Maori constituency

In regard to **supporting implementation** of the generic competencies and wider workforce development, we recommend that the Ministry:

4. Establish a national steering group / advisory team to:
 - b) assist and guide implementation of the generic public health competencies, and
 - c) champion, advocate for and market public health workforce development, and ensure it is an organisational priority.

Workforce development funding and contracts

Approach to contracting

5. Introduce workforce development performance measures separate from service provision in contracts and develop two way feedback (between the Ministry and the provider) loops through quality assurance specifications.
6. Attach funding to service contracts rather than coming out of the existing price, ensuring it is protected, tagged or 'ring fenced' for workforce training and development.
7. Require high levels of accountability as part of the contracting process. Organisations should be accountable for:
 - a) planning sustainable future workforce development
 - b) reporting on how they have spent workforce development funds, including demonstrating annual improvement in implementing a workforce competency framework.
8. Negotiate (not predetermine) workforce development funding separately for each organisation, using negotiation processes that are flexible and adapted to the capacity of each organisation.
9. Engage Maori Development Organisations as contract brokers for small Maori providers.
10. Develop long term contracts, with adequate funding to fully equip workplaces to do the work, and to enable planning and provide for succession and sustainability.

Funding approach to workforce development contracts

11. Adopt criteria for allocating funding for workforce development in contracts which include that:
 - a) the amount of funding be linked to actual staff numbers rather than being a straight percentage of contract price
 - b) a specific amount be allocated per full time equivalent (FTE) staff member. (however others suggested that a FTE formula risks increasing inequalities)
 - c) there be funding parity in workforce development contracts for all providers to upskill the workforce,, implement the generic competencies and funding parity in service contracts so that achievements can be appropriately rewarded and inequalities addressed.

12. Does not specify or require the achievement of any specific competency in contracts and negotiates funding and contracts that are appropriate and acceptable rather than imposed.

Scope of workforce development opportunities to be funded

13. Fund a wide scope of training opportunities in workforce development contracts which should include:
 - a) professional development (i.e. mentoring, coaching, professional supervision and secondments)
 - b) external training and qualifications
 - c) study leave (including funds for the student and either locum cover or reduction of service contract outputs)
 - d) conferences, (overseas) seminars and workshops
 - e) provider development to shape the organisation to support training
 - f) in-house training and education events
 - g) sabbatical leave and work exchange with other countries especially with other indigenous peoples
 - h) Wider entitlements and criteria for scholarships including Māori scholarships
 - i) Increased bereavement leave (which was identified as the most effective way for to grow, and develop their own competencies and skills.)
 - j) Māori trade training scheme (appendix 3)

Workforce development funding guidelines

- 14 Produce clear workforce development funding guidelines that describe:
 - a) transparent criteria for funding allocation
 - b) what training and education spending is applicable and acceptable
 - c) what accountability is required for workforce development funds.

Additional funding pools

- 15 Consider establishing four funding pools, separate from and extra to organisational workforce development contracts and service contracts and flexible to provide for local needs, covering:
 - a) regional and national training opportunities
 - b) one-of projects and in house training and education events
 - c) external scholarships (costs to include travel, time and accommodation)
 - d) mentoring and coaching (refer also recommendation 23 below re how funding will be used).

Fostering organisational competency and development

- 16 Provide mentoring, as an essential component, and training to service contract holders to:
 - a) assist organisations to create organisational cultures and develop integrated strategic and business plans which include workforce development as part of core business
 - b) up-skill managers and governance boards so that they understand their Public Health contracts, the generic competencies and the need for workforce development.
- 17 Develop a tool kit to assist organisational development, drawing on existing available models (e.g. the Waikato DHBs 'Population Health Planning Resource', and the approach developed by Hinerau Jones of Kaiwhakahaere of Te Awa O Te Ora Trust). Content could cover:
 - a) how to develop organisations that have a culture of learning and development
 - b) how to use the generic public health competencies in job descriptions and recruitment processes
 - c) how to develop integrated strategic/annual/team/individual performance plans that incorporate competency frameworks.
- 18 Provide sufficient funding to encourage organisational participation.
- 19 Give special attention to the needs of small capacity providers.

Foster career pathways

- 20 Assist the establishment of career pathways by:
 - a) encouraging public health organisations to link the generic competencies and progression through unit standards with MECA steps
 - b) encouraging public health organisations to adopt a public health entry level qualification as the norm e.g. a 1 year certification (however not everyone agreed that it should be mandatory)
 - c) providing funding support for professional bodies to meet their workforce development needs
 - d) promoting public health careers to tamariki emerging from school, taking account of total emersion environments

- e) encouraging Māori into DHB funding and planning roles and tane into the public health workforce
- f) consider that for each kaimahi attaining competence the organisation could be eligible for funding for another full time equivalent worker
- g) parity of remuneration with other professions especially at graduate level.

Consider piloting first

- 18 Consider the feasibility and desirability of piloting the implementation of the generic competencies with a range of organisations e.g. Te Tai Tokerau Alliance in Northland.

Cultural Issues

- 19 Ensure that cultural issues are handled appropriately in designing and implementing the tools that will support the implementation of the generic competencies, as follows:
 - a) there must be early and appropriate consultation with and inclusion of Māori, Pacificans and Asian experts during development of any tools or processes
 - b) care must be taken to reduce not inadvertently exacerbate inequalities in the workforce
 - c) prioritise and affirm existing Māori competencies e.g. korero Maori, and marae protocols and recognise Te Tiriti as a core competency.
 - d) Workforce development contracts for Māori organisations should be brokered when appropriate by MDOs e.g. He Oranga Pounamu who have capacity and expertise.
 - e) To increase Māori workforce capacity and capability the Ministry should explore the option of a Māori Trade Training Scheme.
 - f) More funding is needed so Māori and Pacificans organisations can recognise and reward professional development achievements.
 - g) Initiate a Māori summit to better clarify the Māori position on the GPHCs and the relationship these competencies would have (if any) with the development and implementation of Māori competencies (a dual competency framework);
 - i) That this summit be funded by the MOH, and be based upon the “tuakana/teina (older brother/sister – younger brother sister roles and responsibilities) concept,

ii) And that the summit be run “by Māori for Māori.”

- 20 Engage Māori Leaders to support implementation and advise about the appropriate timing for implementation. Provide dollars to address capacity issues, to enable their participation and to recognise their contribution,

In regard to **training provision and access**, we recommend that the Ministry:

Develop a co-ordinated, stair-cased training system

- 21 Work collaboratively with public health and tertiary education organisations to develop a co-ordinated, stair-cased training system, which:
- a) incorporates a range of training levels
 - b) allows for an option to alternate between education and practice modules that are accessed at the practitioners own pace (“rolling training”)
 - c) allows the NZQA unit standards approach to be stair-cased to other training and qualifications
 - d) incorporates practical workshops that acknowledge, recognise and value already competent practitioners.

Regionally-based facilitation

- 22 Explore the following possibilities for regional cooperation, collaboration and leadership to champion and support workforce development through shared information, opportunities and facilities: with special attention for organisations with little capacity and taking into account the need for different approaches in different regions
- a) a designated worker (workforce development) in large providers, or in a regional lead agency, or shared between several smaller agencies
 - b) a lead agency, with leadership to share and coordinate regional knowledge and training
 - c) multi agency networks and collaborations
 - d) training centres of excellence in each district to offer specific aspects e.g. integrated business planning.

- e) utilise current Māori leadership bodies e.g, Te Tai Tokerau Alliance.and provide dollars to address capacity, enable their participation and recognise their contribution.

E-based training and qualifications

- 23 Encourage the development of e-based training to facilitate wide uptake of the generic competencies.

Tertiary training providers

- 24 Explore a range of 'user friendly' tertiary providers to provide courses throughout the country.
- 25 Provide funding to ensure quality training will be available and accessible.

In-house and on-site training

- 26 Explore the development of on site training programmes such as the Ngati Hine Health Trust joint venture model and the Auckland Health Protection Officers training for use in the public health sector.
- 27 Partner with the Ministry of Education to plan training informed by Ka Hikitia: Managing for Success, The draft Māori Education Strategy 2008 – 2012
- 28 Adopt strategic and collective planning approaches for training provision

Develop an alternative to NZQA pathways

- 29 Consider the need to develop an alternative pathway for achieving the generic competencies for those who do not wish to adopt the NZQA pathway by:
 - a) developing a self assessment tool to enable staff to determine and develop their own learning needs
 - b) developing implementation guidelines for supervisors, managers, mentors and workforce
 - c) enabling recognition and acknowledgement of prior learning
 - d) providing recognition and acknowledgement of specialist skills beyond the generic competencies(e.g. work stream and cultural)
 - e) establishing a non-NZQA standard setting body (SSB) to set and monitor standards, and explore and establish the best implementation processes for assessment.

Mentoring and coaching

- 30 Establish a pool of nationally accredited and well trained mentors and coaches who are readily accessible to small providers (refer recommendation 11d) re funding)
- 31 Explore the development of Te Whariki tool for use in the wider public health sector. This exploration should also consider the marketing of the tool and training of management to use it.

Gather key information

- 32 Conduct an annual analysis to scope the public health workforce composition and clarify actual training requirements.

Relationships

- 33 Provide training to;
 - a) upskill Ministry contract (Portfolio) managers on relationship and contract negotiation skills,
 - b) ensure Ministry have cultural competency to work with Māori providers.

Background

The focus groups which this document reports on built on the development of the 'Generic Competencies for Public Health in Aotearoa.'² The PHA submitted the Generic Competencies and a report on how they should be developed and implemented to the Ministry in early 2007.³ The Ministry called an expert working group together to consider the competencies report and explore future directions, involving participants from the public health and tertiary education sectors. At the working group meeting there was broad support for generic public health competencies but some debate about the PHA recommendation that using the national qualifications framework and a relationship with an ITO was the most effective way to achieve the desired nationally consistent approach to implementing the competencies.

A further key development, in May 2007, was the launch by the Ministry of 'Te Uru Kahikatea Public Health Workforce Development Plan 2007-2016'.⁴ This provides the framework for building a public health workforce for the 21st century. In August 2007 the PHA and the Ministry signed a contract for a series of sector focus groups to consult on implementation of the generic public health competencies, in the context of the Workforce Development Plan. Planning and delivery of the workshops was a joint venture between the PHA and the Ministry.

Purpose of Focus Groups

The primary purpose of the focus groups was to explore what support will be needed for provider organisations to implement the generic public health competencies. Participants were asked to identify incentives, tools, guidelines and funding changes needed to implement the generic competencies and public health workforce development in general. They were also asked what workforce-based training would be useful, and what is needed to support the workforce to access non-workplace training and education.

Who was Consulted

Four focus groups of the five initially planned were conducted between September and November 2007. The objective was to get feedback from organisations across the

² PHA (March 2007), Generic Competencies for Public Health in Aotearoa-New Zealand. This can be accessed at <http://www.pha.org.nz/documents/GenericCompetenciesforPublicHealthMarch2007.pdf>

³ PHA (March 2007), Generic Competencies for Public Health Project: Report to the Ministry of Health. This can be accessed at <http://www.pha.org.nz/documents/GenericCompetenciesProjectReporttotheMinistryofHealthMarch2007.pdf>

⁴ Ministry of Health (2007), Te Uru Kahikatea, The Public Health Workforce Development Plan 2007-2016. This can be accessed at <http://www.moh.govt.nz/moh.nsf/indexmh/public-health-workforce-development-plan-2007>

spectrum of the public health sector. Invitation lists were determined after a review of Ministry public health contracts. Lack of national or regional contract lists provided some challenges in this process.

The first two workshops were held in Auckland in September 2007. The first was for large urban based Public Health Units (PHUs), and the second included Ministry portfolio managers and key programme leads. Two more workshops held in November 2007 were regionally based but retained a sector focus. The meeting in Wellington was primarily for large non-government organisations (NGOs), and small rural PHUs, and the final meeting in Christchurch enabled smaller NGOs and South Island providers to have input. Appendix 1 provides details of the dates of the workshops, participants at each workshop and details of the presentation team. Appendix 2 provides a sample agenda for the workshops.

The presenting team debriefed after each meeting and the programme was reviewed and adapted for the next consultation.

Whilst the first two meetings in September 2007 produced some useful feedback, some participants were not aware of why they were involved in the focus groups or of their role within workforce development. This lack of clarity reduced the effectiveness of participation in some cases. For this reason further planned focus groups were delayed until November, to enable effort to be put into ensuring that those involved in subsequent workshops had a workforce development focus in their organisations and to promoting the recommended background reading as preparation.

The planned focus group specifically for Maori providers was cancelled due to an apparent lack of numbers. At the Wellington meeting Maori providers were offered an opportunity to caucus but they choose to work in mixed groups and at the Christchurch meeting some Maori did choose to caucus. Any comments from other meetings that were identified as having Maori input or perspectives have been grouped in this report.

Subsequent to drafting this report Māori providers met early in 2008 and the insights from that hui are attached as an addendum.

In regard to Pacificans input, despite her best efforts the organiser failed to engage Pacificans providers in the process. Only the Wellington meeting had an identified Pacificans contribution.

Regional Health Promoting School coordinators were not able to attend a focus group but arranged for Bruce Macdonald to attend one of their hui.

Some people unable to stay for the full day workshop have since offered further information which has been included in this report. Hine Jones, a Maori provider in Otautahi, has developed two model education tools. The organiser has since met with Hine, briefly explored these models and the information is included in the appropriate sections of the report and in Appendix 3.

Content and Format of Focus Groups

The format of the focus groups was a combination of short presentations and small group work. The main elements of the day were:

- **Purpose of the day** - explained to ensure expectations were clear.
- **Looking ahead a 5 year vision** - participants asked to envision what workforce development could look like in their workplace in 5 years time.
- **Growing our workforce** - presenters from the Ministry introduced Te Uru Kahikatea Workforce Development Plan 2007-2016 and the Ministry Workplan for 2008-2009
- **Barriers to workforce development** - participants identified the barriers that are presently stopping or limiting workforce development in their workplace.
- **Introduction to the Generic Competencies** - the Generic Competencies for Public Health and the draft code of ethics (work in progress) were introduced with a brief look at implementation options.
- **Seeking your advice** – participants were asked to provide practical ideas about how to implement the Generic Competencies and these ideas form the basis of the recommendations in this report.
- **Funding changes** – as part of the advice participants were asked specifically about what changes would be needed to contracts to implement the Generic Competencies in their organisation.

While each person in the presentation, and facilitation team had a slightly different perspective all came together in common agenda for these meetings – as follows:

- Viv Head shared information about Te Uru Kahikatea (TUK) The Workforce Development Plan, potential implementation options and looked for clear advice about what tools the sector needs to implement the Generic Competencies for Public Health.
- Bruce Macdonald consulted specifically on what funding changes will be needed to enable implementation, and
- Helen Rance shared information and raised awareness about the Generic Competencies.

Notes from all workshops have been collated into themes. Email copies of original notes from any one particular workshop can be obtained from the facilitator Helen Rance; email helenr@hauora.co.nz

What Participants Said

1 *Looking Ahead: What is Your Five Year Vision?*

The first task for the focus groups was to develop a vision of the workforce in five years time. The key components of the vision articulated by workshop participants are that:

- The Public Health sector will have a clearly understood vision, a common language and shared understanding of competence and the competencies. Social outcomes and community wellbeing will be the focus of all Public Health services.
- Inequalities will be eliminated, particularly for Maori and Pacificans workforces, and public health will have a professional infrastructure that is equitable with that of doctors and other medical based professions. Clinical staff will recognise, understand and value community service roles.
- Providers will be funded for ongoing workforce development which will sit alongside programme development and delivery.
- All provider organisations will be public health competent and workforce development will be embedded in a culture of learning and development. Professional development will be considered the norm, rather than a privilege. Organisations will recognise, support and reward professional development as a pathway to achieving their goals and strategic purposes for the benefit of the community they serve.
- Organisations will be continually evolving and fostering the development of transferable skills. They will have highly skilled governance and management which will provide the leadership to take the workforce forward.
- The workforce will be stable, multidisciplinary, cohesive and inclusive of all disciplines within the public health sector. It will be well rounded, well trained and fully competent. The right people will be recruited to match the community they work in. Mandatory training will provide an entry level of public health knowledge and skills and all workers will be constantly learning.
- Quality training will be geographically and financially accessible. It will be flexible and provide for the diversity of roles and needs within the sector and will be stair cased through multiple levels.
- Ministries of Education and Health will collaborate to offer seamless workforce development provision. Centres of excellence will offer specialist training e.g. focus on community development, or developing community health workers. Consultation with the Public Health workforce will result in training programmes based on need.
- Certification will demonstrate different levels of competence and will be transferable to other employers and training programmes. Informal experience and formal qualifications will both be recognised and valued.

- Clear career pathways will link between positions and qualifications and link between qualifications and salaries.
- Objectives will be based on rangatiratanga and will empower and respect Maori intrinsic values and principles. Navigational pathways such as Te Whare Tapa Wha will set directions and raranga harakeke will weave it all together.
- Maori competencies will be recognized in qualifications and increased Maori expertise in public health will have clear career pathways.
- Non-Maori staff will engage effectively with Maori and be culturally competent .
- Pacificans collective workforce training needs gaps will be addressed and reduced.
- Workforce development will bridge clinical skills with broad kaupapa Maori concepts.
- Annual health workforce analysis will inform workforce requirements and professional development planning.
- A national steering group will champion and market public health workforce development, and ensure it is an organisational priority.

2 *Barriers to Workforce Development and Growth*

During the focus groups participants identified barriers that currently impede workforce development and growth in their workplaces. This activity helped focus attention on the issues that need attention.

2.1 *Contract and funding issues*

- a) Training is often seen as a cost rather than an investment and it is difficult to prioritise when it is not explicit in contracts. Workforce investment is not supported by short term contracts formulae.
- b) Funding and resourcing is not adequate to address inequalities in the workforce (especially for community health workers, Maori and Pacificans workforces).
- c) Engaging with DHB and Ministry contracting processes is time consuming and too prescriptive.
- d) No incentive for NGOs to train staff because once staff are trained they can get better pay with DHB PHUs

2.2 Infrastructure issues – training access and availability

- a) Good quality accessible public health training is lacking, e.g. the Certificate of Achievement Introduction to Health Promotion, particularly in isolated areas.
- b) The public health and tertiary education interface does not seem to be comfortable or effective.
- c) No comprehensive database of training opportunities exists, management are often ignorant of what is on offer, or what is credible, and there is no central point to obtain information.
- d) The training that is funded / approved by the employer is frequently what is available not what is necessarily needed.
- e) Competing training and education priorities:
 - generic public health training competes with specific work stream training
 - personal, professional and organisational needs are all different
 - all training competes with work stream obligations.

2.3 Infrastructure issues – provider configuration and capacity

- a) Lack of critical mass makes it difficult to free up staff for training and there is no capacity to back fill when workers are away for training. Especially difficult in small organisations where each staff member covers a range of programmes.
- b) Organisational culture can conflict with goals and objectives of workforce development, e.g. politically driven programs place emphasis on service outputs to the detriment of workforce development.
- c) Lack of leadership/decision making and little employer understanding of health promotion and public health.
- d) Lack of planning tools and lack of/or insufficient training plans.
- e) Long lead-in times before people become really useful.
- f) PHWD is not considered a priority by some DHBs.
- g) Lack of infrastructure and capacity within organisations to deal with protracted contracting processes.

2.4 Infrastructure issues – career structures

- a) Few or no career pathways and lack of incentives, rewards and recognition for achievement.
- b) Lack of knowledge about how competencies will contribute to career pathways.
- c) A perceived reluctance to invest in training because staff move or are poached after training. Poaching is a particular issue for NGOs that can't compete with much higher wages offered by PHUs.

2.5 Infrastructure issues – workforce planning

- a) Scarcity of data about composition of the public health workforce and where efforts need to be focused for future sustainability inhibits effective workforce planning.
- b) Recruitment: some people attracted to the field have little idea of what it is really all about – lack of understanding of the broader context.

2.6 Infrastructure issues - other

- a) Few strategic collaborations exist (collaborations have potential to share resources).
- b) Difficult to fit real life responsibilities, e.g. family/whanau, around training especially when it involves travel.

2.7 Maori and Pacificans workforces

- a) Whilst there is a lack of Maori and Pacificans workers in the workforce, high community and professional demands raise expectations on the few workers available. Although the local context may vary they have a wide range of skills but training does not cater for their needs particularly for Pacificans workers.
- b) Difficulties around contracting processes for small Maori organisations were a feature of the Otautahi Christchurch Maori caucus.
- c) In the past rural services had been brokered by Maori development organisations (MDOs) but latterly each provider has needed to negotiate their own contract. Having neither the expertise nor capacity to access funding for workforce development and service sustainability, they prefer contracts to be brokered by MDOs eg He Oranga Pounamu.

- d) Bureaucracy, indecisive Ministry and DHB staff and directive (dictatorial) relationships have hindered ambitions of small organisations to develop their workforce.
- e) Some Maori organisations are taking risks, by carrying financial deficits to maintain non funded staff until the Ministry recognises their need.
- f) Differing regional approaches from funders have caused inconsistencies in service provision and competitive situations between providers.
- g) There is insufficient collaboration: organisations need to come together using existing forums and establish clear agendas.

2.8 Other funders and service providers

- a) With some public health service providers contracted outside the Ministry jurisdiction, e.g. local authorities, there is a risk of a lack of consistency implementing the competency framework and inequality of workforce development.

3 Advice on Implementing Generic Competencies and Improving Public Health Workforce Development

Three questions were asked of the focus groups:

- 1 What incentives, tools and resources would support the implementation of the generic competencies for public health (e.g. tools to enhance performance development systems/policy, mentoring models, funding and contracting approaches)?
- 2 What workplace-based training would be useful and what kind of workplace-based training would work for your organisation?
- 3 What is needed to support the workforce to access non-workplace training and education?

The feedback obtained of relevance to the first of these questions is summarised below – in terms of the various sub-themes or areas of action required for ‘supporting implementation’ of the generic competencies. As discussion at the workshops tended to link work-place based and non-workplace training and education rather than discussing them independently, responses to questions two and three are provided together under the heading ‘training provision and access’.

3.1 Supporting implementation – system-wide commitment required

Effective implementation of the generic public health competencies was recognised to have three essential components:

- The Ministry was complimented for its commitment to lead and progress workforce development and hope was expressed that this commitment and leadership will continue.
- Provider organisations need ongoing commitment to organisational development inclusive of competency frameworks and increasing workforce development.
- Practitioners need commitment to ongoing training, education and professional development.

3.2 Supporting implementation - marketing and promotion

Multi-pronged dialogues and approaches to implementation and marketing will be needed to appeal to the diverse workforce and range of providers. To bring people on board both the Ministry and the tone of the marketing approaches must be empowering rather than regulatory.

Many participants hadn't been aware of the generic public health competencies until they were in the focus group process. Raising awareness of the generic competencies and marketing them was seen a major factor to making them an acceptable and operational tool rather than just another document.

Whilst there was some call for the generic competencies to be developed into a multi-level tool, this shows a misunderstanding of the competencies. The generic competencies are a shared baseline, generic to all disciplines in public health in Aotearoa. Further levels of competency need to be achieved through discipline specific training.

Specific recommendations on marketing and promotion were that the Ministry:

- Develop a marketing promotional package that -
 - describes how the generic competencies will help 'make a difference' to public health service goals (including health promotion)
 - describes why they are needed and engages peoples' interest
 - explains how to implement them
 - clarifies the intended levels of competency
 - describes the benefits of implementation for both practitioners and organisations and
 - alleviates fears of possible negative professional consequences.
- Establish a national steering group / advisory team to -
 - assist and guide implementation of the generic public health competencies, and

- champion, advocate for and market public health workforce development, and ensure it is an organisational priority.

3.3 Supporting implementation – workforce development funding and contracts

3.3.1 Approach to contracting

The way in which funding and contracting for workforce development was managed was seen as crucial to the effective implementation of the generic competencies and the wider achievement of public health workforce development.

The focus groups strongly recommended that the Ministry adopt the following approach to contracting:

- Introduce workforce development performance measures separate from service provision in contracts
- Protect or ‘ring fence’ workforce funds, which should be added on to contracts rather than coming out of the existing price
- Require high levels of accountability as part of the contracting process. Organisations should be accountable:
 - for planning sustainable future workforce development
 - for reporting on how they have spent work force development funds, including demonstrating annual improvement in implementing a workforce competency framework.
- Negotiate workforce development funds separately for each organisation, using negotiation processes that are flexible and adapted to the capacity of each organisation.
- Engage Maori Development Organisations as contract brokers for small Maori providers.

Without separate and clearly specified contracts and ring-fencing of funds there is insufficient incentive for organisations to implement the generic competencies and other enhancements in workforce development, and a high risk that funds will be siphoned into service provision.

It is important to tailor service specifications for each service provider and the negotiation process must be flexible to align with organisations’ different needs. ‘One size does not fit all’ and a single template will further disadvantage small organisations who have limited resources for training.

There is an expectation that the Ministry will demonstrate leadership, have clear expectations of providers and empower organisations.

3.3.2 Funding approach to workforce development contracts

While a range of mechanisms was suggested to work out the funding formula, everyone agreed that the formula must be transparent and the first priority is to address inequalities in the workforce.

The focus groups recommended that Ministry criteria for allocating funding for workforce development in contracts include that:

- The amount of funding be linked to actual staff numbers rather than being a percentage of contract price.
- A specific amount be allocated per full time equivalent (FTE) staff member (however others suggested that a FTE formula risks increasing inequalities).
- There be funding parity between PHUs and NGOs in workforce development contracts so staff development can be equitably accessed and parity in service provision contracts so achievements can be appropriately rewarded.

3.3.3 Scope of workforce development opportunities to be funded

Specific providers and disciplines within the sector have specific needs and a broad range of opportunities will be necessary. Flexibility will be needed to reduce inequalities.

The focus groups recommended that:

- The scope of training opportunities that could be funded by the Ministry workforce development contracts should include -
 - professional development, (i.e. mentoring, coaching, professional supervision,)
 - external training and qualifications,
 - study leave, (funds for the student and either locum cover or reduction of service contract outputs)
 - conferences, seminars and workshops
 - external scholarships (costs to include travel, time and accommodation)
 - provider development to shape the organisation to support training
 - in-house training and education events
 - sabbatical leave and staff exchange with other countries.

Workforce development funding guidelines

It is important that public health organisations are well informed about how the new workforce development funding works and what the accountability requirements are.

The focus groups recommended that the Ministry produce clear guidelines that describe:

- transparent criteria for funding allocation
- what training and education spending is applicable and acceptable
- what accountability is required for workforce development funds.

3.3.4 Additional funding pools

There was some discussion of the potential value of having some additional avenues for obtaining funding for workforce development, over and above individual organisational contracts.

It was recommended that the Ministry consider:

- Establishing four funding pools, separate from and extra to organisational workforce development contracts and flexible to provide for local needs, covering:
 - regional and national training opportunities
 - one-off projects and in house training and education events
 - external scholarships (costs to include travel, time and accommodation)
 - mentoring and coaching (see section 3.14 for details on what funding should be used for).

3.4 Fostering organisational competency and development

Effective workforce development planning must be underpinned by supportive organisational cultures and infrastructure. An organisational culture of workforce learning and development, where workforce development is the norm rather than a privilege, should be embedded into business planning and core business. Competencies should be linked into an integrated planning cycle that includes a strategic plan, an annual plan for the organisation as a whole, team plans and individual performance plans. Organisations must invest time in and plan for the capacity and capability to support workforce development. Development of infrastructure was seen as easier for large organizations and crown agencies to achieve. Fostering such a culture across the public health sector is essential.

A specific concern expressed was that it can be difficult for practitioners to access training because managers are not well informed of opportunities. Frequently training is opportunistic because it's on offer rather than addressing professional development needs. The suggested solution is for managers to be trained so they and practitioners have a shared understanding and expectations around the generic public health competencies and the need for workforce development.

Two models already exist which it is recommended inform the content of a toolkit, or training and mentoring programmes. One was developed by Waikato DHB and the second was developed by Hinerau Jones of Kaiwhakahaere of Te Awa O Te Ora Trust.

The Population Health Planning Resource 2007-2012⁵ was developed by the Waikato DHB with four objectives in mind. It was intended to inform future service delivery, enable across-the-sector alignment of activity, stand as the basis for public health services and contract planning, and remain as a living document, with emerging strategies, research and impacts incorporated within its findings as needed. Whilst the content of this resource is excellent, its 260 pages are somewhat daunting for use as guidelines or a tool kit.

Hinerau Jones of Kaiwhakahaere of Te Awa O Te Ora Trust, has developed a training tool to build organisation capacity. Whilst the model reflects kaupapa Maori it is applicable to any provider. The model applies to the whole organisation and the roles that people play within it. It triggers the good things about the organisation across nine areas and elevates them to be moemoea (dreams, aspirations). The nine areas are; mission and vision, governance, management, kaimahi, finances, tangata whai ora, community, research and planning, and monitoring and evaluation. The purpose of this model is to bring ownership to dreams and values and with this held high in the puku and heart. This process leads to clarity of purpose and values and from that provides direction. Training for this model is best done over a two day workshop incorporating all roles in the organisation from governance to staff.

In regard to fostering organisational competency and development It is recommended that the Ministry:

- Provide mentoring and training to contract holders to -
 - Assist organisations create organisational cultures and develop integrated strategic and business plans which include workforce development as part of core business.
 - Up-skill managers and governance boards so that they understand their Public Health contracts, the generic public health competencies and the need for workforce development.
- Develop a tool kit to assist organisational development, drawing on existing available models (e.g.the Waikato DHBs 'Population Health Planning Resource', and the approach developed by Hinerau Jones of Kaiwhakahaere of Te Awa O Te Ora Trust). Content could cover –
 - How to develop organisations that have a culture of learning and development
 - How to use the generic competencies in job descriptions and recruitment processes
 - How to develop integrated strategic/annual/team/individual performance plans that incorporate competency frameworks.

⁵http://www.waikatodhb.govt.nz/Media/docs/population_health/population-health-planning-resource.pdf

3.5 Supporting implementation – establishing career pathways

Whilst Multi Employer Collective Agreements (MECAs) exist in DHBs and across some regulated health professions e.g. Primary Health Care Nurses, many Public Health workers have no career pathways, support or incentives that rewards or recognises improvements in competency.

The focus groups recommended that to assist in establishing career pathways the Ministry

- Encourage public health organisations to link the Generic Competencies and progression through unit standards be with MECA steps
- Encourage public health organisations to adopt a public health entry level qualification as the norm e.g. a 1 year certification (however not everyone agreed that it should be mandatory)
- Provide funding support for professional bodies to meet their workforce development needs.

3.6 Supporting implementation – pilot first

Rather than undertaking nation-wide roll-out initially, one of the focus groups suggested the Ministry consider adopting a pilot implementation project. In order to achieve this, the Ministry should consider the feasibility and desirability of:

- tendering for a pilot with a range of organisations
- developing a detailed implementation plan
- providing resources to prepare the organisations
- implementing the Generic Competencies over time and
- then evaluating to inform further roll-out and build a case for future funding.

3.7 Supporting implementation - cultural Issues

The public health workforce is culturally diverse, and it is important that cultural issues are handled appropriately in designing and implementing the tools that will support the implementation of the generic competencies.

Several broad recommendations came out of the focus groups regarding cultural issues:

- There must be early and appropriate consultation with Maori, Pacificans and Asian experts during development of any tools or processes.
- Care must be taken to reduce not increase the inequalities in the workforce.

- Acknowledge existing Maori competencies e.g. korero Maori, and marae protocols.
- Workforce development contracts for Maori organisations should be brokered when appropriate by MDOs e.g. HOP who have capacity and expertise.
- To increase Maori workforce capacity and capability the Ministry should explore the option of a Maori trade training scheme (see the model in appendix 3).
- More funding is needed so Maori and Pacificans organisations can recognise and reward professional development achievements.

3.8 Training provision and access – a co-ordinated, staircased training system

All the focus groups expressed strong support for the provision of training and the need for a variety of methods, providers, and levels to allow for diverse learning styles, starting points and circumstances. Section 3.3.3 above has already outlined the scope of on-job and off-job workforce development opportunities that should be funded within contracts. The focus groups also stressed that practitioners need time allocation to pursue applicable training. Beyond that, the discussion was at a fairly broad level as to how training provision and access should be organised.

The focus groups recommended that the Ministry work collaboratively with public health and tertiary education organisations to develop a co-ordinated, staircased training system, which:

- Incorporates a range of training levels
- allows for an option to alternate between education and practice modules that are accessed at the practitioners own pace ("rolling training")
- Allows the NZQA unit standards approach to be staircased to other training and qualifications
- Incorporates practical workshops that acknowledge, recognise and value already competent practitioners.

3.9 Training provision and access – regionally-based facilitation

The focus groups recognised that getting improved workforce development incorporating the generic public health competencies up and running around the country would be facilitated by having regional focal points. A number of alternative approaches were identified, but they were only sketched out and there was no consensus as to their relative merits.

It is recommended that the Ministry further explore the following possibilities for regional cooperation, collaboration and leadership to champion and support workforce development: through shared information, opportunities and facilities:

- A designated worker (workforce development) in large providers, or in a regional lead agency, or shared between several smaller agencies
- A lead agency, with oversight to share and coordinate regional knowledge and training
- Multi agency networks and collaborations
- Training centres of excellence in each district to offer specific aspects e.g. integrated business planning.

3.10 Training provision and access - e-based training and qualifications

Electronic media such as resource packages for work based training, or preparation for assessment could help address rural and regional education needs and provide for learning at ones own pace. The growing range of e based aids has potential to be used as a distance learning tool or to enhance other training opportunities. It was noted that techniques such as blogging, wiki, e forums, podcasts, texting are all becoming more accessible and popular.

It is recommended that the Ministry encourage the development of e-based training to facilitate wide uptake of the generic competencies.

3.11 Training provision and access - tertiary training providers

The Ministry is in negotiation with Manukau Institute of Technology (MIT) to develop an undergraduate diploma in health promotion for 2009. However the focus groups raised the need for a range of user friendly tertiary institutions for course provision not just a single provider.

It is recommended that the Ministry explore a range of user friendly tertiary providers to provide courses throughout the country.

3.12 Training provision and access - in-house and on-site training

As well as formal training, in-house and on-site options can incorporate mentoring, coaching, supervision, workshops and conferences. This is a very practical approach with immediate applicationn.

A comprehensive and successful training model incorporating organisational development, in-house and external training developed by the Ngati Hine Health Trust was introduced at

the Auckland focus group. Ngati Hine Health Trust provides health services through its provider arm, Hauora Whanui, social services through Whanau Whanui, and education and training through Matauranga Whanui. Firmly established in the mid north since 1994, the trust delivers both health and social services in Whangarei and the mid-north.

Subsequent investigation of the model revealed it has the following characteristics:

- The small provider organisations have workforce development plans incorporated into their provider contracts with Ngati Hine Health Trust.
- Family Start Model: Ministry of Social Development wanted all Family Start staff to have a minimum qualification, e.g. Undergraduate Diploma in Community work,
- Joint ventures were set up to enable staff to study. The organisations provided 50% of the funding (sourced from Family Start) and the other 50% came from the individuals/students. Staff were not bonded.
- This model was supported by paid study leave.
- The organisation collaborated with Northland Technical Institute to supply mentors.
- Quality lectures were delivered every Friday for two years which provided the course content for the Diploma.
- To ensure accessibility trainers were bought to Kaitaia. Then other students were bought to this site to meet the minimum number of students for viability as required by Northland Technical Institute.
- The contract with Family Start made clear and explicit the standard required e.g. Social Workers Registration by 2005
- Funding from Family Start was time limited - provided only for that group of students for that time. Family Start now has a scholarship arrangement for future staff.
- Five staff suddenly became marketable and moved on.⁶

This is a positive, empowering model which has potential to be adapted to engage diverse organisations especially in regions of geographic isolation.

It is recommended that the Ministry explore the development of this joint venture model for use in the public health sector.

3.13 Training provision and access – developing an alternative non-NZQA pathway

The focus groups stressed the need for well trained workplace assessors, and for quality training for workplace assessors and moderators. Many felt that assessment needs to be broader than just being linked to NZQA qualifications and should include workplace assessment processes. Some members of the workforce find the NZQA language in assessment tools and aspects of the associated processes difficult to understand and use. A standard setting mechanism will be required to set and monitor standards if the sector chooses to establish an alternative pathway outside the NZQA framework for some who prefer that.

⁶ More information can be found on Te Puni Kōkiri case study web site. <http://governance.tpk.govt.nz/share/ngatihine.aspx>,

The focus groups recommended that the Ministry develop a meaningful alternative pathway for achieving the generic competencies for those who do not wish to adopt the NZQA pathway by:

- Developing a self assessment tool to allow staff to determine and develop their own learning needs
- Developing implementation guidelines for supervisors, managers, mentors and workforce
- Enabling recognition and acknowledgement of prior learning
- Providing recognition and acknowledgement of specialist skills beyond the generic competencies (e.g. work stream and cultural)
- Establishing a non-NZQA standard setting body (SSB) to set and monitor standards, and explore and establish the best implementation processes for assessment.

3.14 Training provision and access - mentoring and coaching

Mentoring and coaching techniques can fit with and enhance any other form of training and education provision. These supportive and empowering tools may assist people who are not so comfortable with a qualifications approach to reach required levels of competence.

Hinerau Jones, Kaiwhakahaere of Te Awa O Te Ora Trust, has developed a coaching model that applies to a manager or leader and the employee. It is a practical tool called the whariki. It gives opportunity to the employee to self assess themselves by way of placing cards on the whariki.

Placing cards in the centre reduces personalization. It is like the Marae Atea (korero revolves around a subject of great value) and we talk to it. It creates dialogue of wonderful things and in korero we begin to relate to the other common things of import to both.

The whariki is a positive tool which elevates the worker and realises their values so that those very values trigger competencies that are owned by the worker. This enables the worker to demonstrate and 'strut their stuff', 'walk their talk' and it places the employer in a great position to awhi the competencies along where more development is needed.

Te Wahriki can identify competencies and training need, and it can also identify competency strengths. It is a very positive and enabling tool. The secret is in the cards. Although it was first developed for use in a Maori organisation this process could be easily adapted for any employer or organisation.

It is recommended that the Ministry:

- Establishes a pool of nationally accredited and well trained mentors and coaches who are readily accessible to small providers (funding of this was recommended in section 3.3.4 above).
- Explore the development of Te Whariki tool for use in the wider public health sector. This exploration should also consider the marketing of the tool and training of management to use it.

3.15 Training Provision and access – information requirements

During some focus group discussions, a key information gap identified was the lack of knowledge regarding the makeup of the public health workforce and magnitude of training needs to achieve the generic competencies. This lack of information will hinder effective workforce planning and implementation of the competencies if it is not resolved.

The focus groups recommended that the Ministry:

- Conduct an annual analysis to scope the public health workforce composition and clarify actual training requirements.

4. Conclusion

Having taken stock of the overall tenor of the advice provided by the focus groups, the PHA is heartened by the significant degree of congruence between sector views and Te Uru Kahikatea, The Public Health Workforce Development Plan 2007-2016 and previous PHA advice on how to implement the generic public health competencies. Appendix 4 collates the relevant information from each source.

The recommendations of the focus groups will, if implemented, collectively help achieve the goals of Te Uru Kahikatea, namely to:

Goal 1: Develop an effective and sustainable public health workforce - by achieving the following objectives:

- 1 Establish an integrated stair-cased framework of training, qualifications and ongoing education in public health
- 2 Strengthen the Maori public health workforce and the non-Maori workforce to improve Maori health and reduce inequalities
- 3 Strengthen the Pacific public health workforce and the non-Pacific workforce to improve Pacific health and reduce inequalities
- 4 Build infrastructure for public health development
- 5 Strengthen the public health capability of the wider health workforce

Goal 2: Support public health environments to grow and develop the public health workforce – by achieving the following objectives:

- 6 Advance workforce planning and capacity building to grow the public health workforce
- 7 Strengthen the public health workforce information, policy and research base to inform ongoing public health workforce development
- 8 Nurture and develop supportive workforce cultures to achieve optimal workforce capability and capacity
- 9 Increase the understanding of and promote careers in public health

In particular, the focus group recommendations reinforce the importance of achieving objectives 1, 4, 6, 7 and 8.

The focus groups also provide an endorsement of the concept of the generic public health competencies, and the advice provided is broadly congruent with that already provided by the PHA regarding how to implement them. At a high level, those recommendations were that in order for the generic competencies to increase equity in the workforce and effectiveness in improving health and reducing inequalities there must be:

- A range of accessible and relevant education and training programmes and pathways that are nationally consistent
- Support for the use of competencies in the workplace by employers
- Increased funding to pay for training and development and to reward increases in competency
- Support for the implementation of the generic competencies in contracts to deliver public health services
- Support for generic competencies from public health professional bodies and disciplines.
- A cross-disciplinary body to manage the generic competencies and promote and support training and professional development across the sector.

The only area in which some focus group participant's views differed from the advice previously provided by the PHA concerned the degree of alignment of public health competencies with the NZQA framework. There continues to be some concern about full alignment with NZQA frameworks. Some groups prefer to have an alternative non-NZQA pathway available. While there remains some reservations about the NZQA framework there has not been significant disagreement with the earlier advice that the training be widely available, provide recognised qualifications and be nationally consistent. These points were strongly made in the earlier consultation with Maori participants. The previous report from the multidisciplinary coalition (with the secretariat provided by the PHA) investigated options for nationally recognised, consistent training and felt the NZQA framework was the option that best met those requirements.

While the overall degree of high level sector alignment is a positive feature of the focus group advice, in some other ways it is disappointing. The PHA is aware that the Ministry had hoped that the focus groups would produce fairly detailed guidance on the incentives, tools/guidance, funding and other resources required to implement the generic public health guidelines and enhance public health workforce development more generally. This has, not, in fact, been the case. As Appendix 4 reveals, the level of specificity of their

recommendations is no greater than and in some cases less detailed than in the 'actions' section of Te Ura Kahikatea or the specific recommendations of the past PHA advice.

The reality is that this is new territory for many in the sector and turning the vision into reality will be challenging. Successfully implementing the generic public health competencies is going to require a significant degree of leadership from the Ministry – supported by the PHA and others in the sector. This will be essential to achieve the detailed analysis of the pros and cons of the different options traversed by the focus groups, and the design of specific incentives, tools, guidelines and funding and contracting vehicles which are needed before detailed implementation plans can be finalised.

Appendix 1: Focus Group Timing, Participants and Presenters

Schedule of meetings

26 September '07	Auckland	Large PHUs; Auckland, Waikato, Hutt Valley, Christchurch
27 September '07	Auckland	MoH portfolio managers and programme leads
19 November '07	Wellington	Large NGOs, Pacific providers, small rural PHUs
21 November '07 cancelled	Auckland	Maori providers
26 November '07	Christchurch	Small NGOs, South Island providers including Maori and Pacificans
4 March '08	Auckland	Maori

PHWDP Focus Group Participants

Auckland 26 September

Large Urban PHUs

1	Murdoch Pahi	Hutt Valley Health	Murdoch.Pahi@huttvalleydhb.org.nz ,
2	Gerrie Van Der Zanden	Strategic Manager PHU, CDHB	gerrie.vanderZanden@cdhb.govt.nz ,
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12	Jenny Hugtenburg	Team Leader School Health Services (PHNs)	Jenny.hugtenburg@huttvalleydhb.org.nz ,

Auckland 27 September

Ministry Programme Leads

1	Rebecca Williams	'Alcohol and illicit drugs' Alcohol Health Watch	director@ahw.co.nz ,
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14	Liz Stephenson	Portfolio Manager MoH	Liz_Stephenson@moh.govt.nz ,

Wellington 19 November

Large NGOs, Rural PHUs, Pacificans.

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22	Riki Nia Nia	Capital Coast Health	Riki.Nia_Nia@ccdhd.org.nz ,

Christchurch 26 November

South Island and small NGOs

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Auckland 4 March 2008

Maori

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Appendix 2: Sample Focus Group Agenda

Public Health Workforce Development Focus Groups

26 November 2007, Otautahi Christchurch
Te Waipounamu Providers

9.45	Mihi
	Introductions
	<p>Purpose of the day</p> <ul style="list-style-type: none"> • obtain your advice on how to implement the generic public health competencies; because we need to know what will work for your organisation. • what support does your organisation need to implement the generic competencies? • what specific tools/guidelines would help your workplace to implement the generic competencies? • what funding changes could help your organisation to implement the generic competencies and workforce development in general?
	<p>Looking ahead 5 years Dream time</p> <p>What workforce development would you like to achieve in your organisation or workforce.</p>
	<p>Growing our workforce</p> <ul style="list-style-type: none"> • Brief overview of goals and objectives of Te Uru Kahikatea • Outline MINISTRY work programme for 2007/2008 and into 2008/2009
	What are the barriers to workforce development?
	Introduction to the Generic Competencies for Public Health
	<p>Seeking your advice</p> <ol style="list-style-type: none"> 1. What incentives, tools and resources would support the implementation of the Generic Public Health Competencies into your organisation (eg. tools to enhance performance development systems/policy, mentoring models)? 2. What workplace-based training would be useful for your workforce to meet the Generic Public Health Competencies and what kind of workplace-based training would work for your organisation? 3. What is needed to support the workforce to access non-workplace training and education?
	<p>Funding discussion</p> <p>What funding will be required to support the implementation of the Generic Public Health</p>

	Competencies into your organisation?
	Next steps
3.00	Ka mutu

Appendix 3: Training Options

1 Ngati Hine Health Trust Matauranga Whanui

Manager Maxine Shortland

The Ngati Hine Health Trust provides health services through its provider arm, Hauora Whanui, social services through Whanau Whanui, and education and training through Matauranga Whanui. Firmly established in the mid north since 1994, the trust delivers both health and social services in Whangarei and the mid-north.

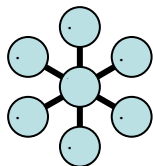
Workforce development model

- Smaller organisations have workforce development plans incorporated into their provider contracts.
- Family Start Model: Ministry of Social Development wanted all Family Start staff to have a minimum qualification, eg. Undergraduate Diploma in Community work,
- Joint ventures were set up to enable staff to study. The organisations provided 50% of the funding (sourced from the Family Start contract) and the other 50% came from the individuals/students. Staff were not bonded.
- The organisation collaborated with Northland Technical Institute to supply mentors.
- Quality lecturers delivered every Friday for two years to cover Diploma content
- To ensure accessibility trainers were bought to Kaitaia. Then other students were bought to this site to meet the minimum of students for viability as required by Northland Technical Institute.
- Contract made clear and explicit the standard required eg Social Workers Registration by 2005
- Funding from Family Start was time limited and has not been sustainable. It was provided only for that group of students for that time. Family Start now has a scholarship arrangement for future staff.
- Five staff suddenly became marketable and moved on.

2 Harakeke Model

The harakeke model was presented by one of the small groups at the Otautahi Christchurch Focus group. It is a concept rather than a working model and immediately gained support of the meeting.

This model has the support hub in the middle of services linking and aligning together.



The Hub could be core competency and organisations can draw from hub resources. This allows retention of competencies and manages alignment. Tools are all the same so everyone knows what to expect.

Organisations would be autonomous with a process for monitoring performance management, especially to ensure both staff and organisational competence.

Training would be based on competency need not knowledge of a specific disease or area of interest. This hub provides coach and mentor roles. Presently public health is not valued as a career option so there is a need to sell the vision of public health compared to personal health.

The grass roots community focus could suffer if too much value is placed on qualifications and it may be hard to convince workforce, of the need for qualifications, as they see their role is in the community.

Need to be clear about what the incentive is and what is in it for the organisations.

3 Maori Trade Training Scheme

The Maori Trade Training Scheme was suggested at one of the workshops as a model that might be adaptable for Public Health. It is a work based apprenticeship model which leads to NZQA qualifications. The following media report outlines the approach.

19 September 2007

Training Scheme To Boost Young Maori Into Local Jobs

EIT Hawke's Bay and Te Taiwhenua o Heretaunga are piloting an innovative scheme aimed at equipping young Maori in Hastings with work skills and jobs with local builders.

To be launched at the Heretaunga Park Complex in Orchard Road, Hastings, on Tuesday (14 August), Marae Trade Training is a training and employment partnership also involving the Ministry of Social Development and the Hawke's Bay building industry.

EIT and Te Taiwhenua o Heretaunga are anticipating an enthusiastic response from young Maori interested in taking up the training opportunity.

The work-based programme offers three to four-year apprenticeships in the building industry, backed up with compulsory block theory classes at EIT. An initial cohort of at least 15 apprentices is expected to get underway this year, and EIT chief executive Chris

Collins says with annual intakes the scheme could eventually see around 45 young Maori in training at any one time.

Candidates will be required to apply in writing, meet minimum criteria and be interviewed for selection. Successful applicants will be eligible for Te Taiwhenua o Heretaunga Marae Trade Training Scholarships.

Apprentices will be required to koha labour back by working voluntarily on at least one marae maintenance project each year.

Graduates of the programme will receive the EIT and National Certificate in Carpentry Level 4 and are expected to be part of the building sector long-term.

Te Taiwhenua general manager Alayna Watene said a huge reservoir of young Maori talent remained untapped while the economy was demanding more highly-skilled workers. That called for an investment in whanau's greatest asset - "the most important resource in Maoridom".

"Marae Trade Training presents an opportunity to develop more qualified and licensed Maori tradespeople and potential employers throughout the building sector."

Ms Watene said the taiwhenua was delighted to have established a workforce development partnership with EIT and was looking forward to progressing its relationship with the local tertiary education institution.

For EIT, the programme was about ensuring the success of Maori in trades training, said Mr Collins. "It provides targeted opportunities for young Maori in a way that meets some of their needs, and at the same time it addresses the need from throughout the building industry for more trained workers."

http://www.eit.ac.nz/news_and_events/training_scheme_to_boost_young_maori_into_local_jobs.aspx

Appendix 4: Collated Recommendations of Key Documents on Generic Competencies and Workforce Development

Te Uru Kahikatea: Goal and Objectives	Te Uru Kahikatea: Actions	Previous PHA Advice/Solutions	Barriers identified by Focus Groups	Solutions from the Focus Groups
GOAL 1: Develop an effective and sustainable public health workforce				
<p>Objective 1 Establish an integrated, staircased framework of training, qualifications and ongoing education in public health.</p>	<p>1.1 Develop and implement generic public health competencies across the public health workforce to provide a common framework for professional development and a foundation for skill development across specific public health issues.</p>	<p>That the Ministry of Health develop a relationship with an industry training organisation (ITO) or other standard setting body (SSB) so that work-based training and assessment is available as a training option.</p>	<p>Good quality accessible public health training is lacking, e.g. the Certificate of Achievement Introduction to Health Promotion, particularly in isolated areas.</p>	<p>Develop a marketing promotional package that –</p> <ul style="list-style-type: none"> a) describes how the generic competencies will help ‘make a difference’ to public health service goals (including health promotion), b) describes why they are needed and engages peoples’ interest, c) explains how to implement them, d) clarifies the intended levels of competency, e) describes the benefits of implementation for both practitioners and organisations, and f) alleviates fears of possible negative professional consequences.

Te Uru Kahikatea: Goal and Objectives	Te Uru Kahikatea: Actions	Previous PHA Advice/Solutions	Barriers identified by Focus Groups	Solutions from the Focus Groups
	<p>1.2 Integrate generic public health competencies into professional development, education, training and workforce planning.</p>	<p>That the Ministry of Health contract for work to begin with the ITO or the SSB to develop the generic public health competencies into unit standards and a National Certificate of Public Health (Level 4) that can be accessed through:</p> <ul style="list-style-type: none"> • sector-based “in-house” workplace training or • tertiary education organisations such as institutes of technology, polytechnics and wānanga. 	<p>The public health and tertiary education interface does not seem to be comfortable or effective</p>	<p>Establish a national steering group / advisory team to:</p> <ul style="list-style-type: none"> d) assist and guide implementation of the generic public health competencies, and e) champion, advocate for and market public health workforce development, and ensure it is an organisational priority.
	<p>1.3 Progressively develop and build commitment to a national training and qualifications framework, including building relationships with the Tertiary Education Commission and tertiary education organisations.</p>	<p>That the Ministry of Health contract for a stock-take of existing training material within the sector and use this as a basis for developing course and assessment material for the National Certificate in Public Health (Level 4).</p>	<p>No comprehensive database of training opportunities exists, management are often ignorant of what is on offer, or what is credible, and there is no central point to obtain information.</p>	<p>Fund a wide scope of training opportunities in workforce development contracts which should include:</p> <ul style="list-style-type: none"> k) professional development (i.e. mentoring, coaching, professional supervision) l) external training and qualifications m) study leave (including funds for the student and either locum cover or reduction of service contract outputs) n) conferences, seminars and workshops o) provider development to shape the organisation to support training p) in-house training and

				<p>education events</p> <p>q) sabbatical leave and staff exchange with other countries.</p>
	<p>1.4 Progressively fill the gaps in the availability and appropriate-ness of training at all levels. As a priority, progress the develop-ment of a nationally available undergraduate qualification in public health.</p>	<p>That tertiary education organisations (TEOs):</p> <ul style="list-style-type: none"> •review existing qualifications in public health so that all graduates enter the workforce with the generic competencies •ensure all new qualifications in public health include the generic competencies so that all graduates enter the workforce with the generic competencies. 	<p>The training that is funded / approved by the employer is frequently what is available not what is necessarily needed.</p>	<p>Consider establishing four funding pools, separate from and extra to organisational workforce development contracts and service contracts and flexible to provide for local needs, covering:</p> <p>e) regional and national training opportunities</p> <p>f) one-of projects and in house training and education events</p> <p>g) external scholarships (costs to include travel, time and accommodation)</p> <p>h) mentoring and coaching.</p>
	<p>1.5 Progressively address the barriers to the accessibility of public health training.</p>		<p>Competing training and education priorities:</p> <ul style="list-style-type: none"> • Generic public health training competes with specific work stream training. • Personal, professional and organisational needs are all different. • All training competes with work stream obligations. 	<p>Consider the feasibility and desirability of piloting the implementation of the generic competencies.</p>
	<p>1.6 Lift the capability of the public health workforce to lead health sector and community action</p>		<p>Difficult to fit real life responsibilities, e.g. family/whanau, around training especially when it involves travel.</p>	<p>Work collaboratively with public health and tertiary education organisations to develop a co-ordinated, stair-cased training</p>

	to promote and improve health and reduce inequalities. This will be done by developing a system-atic approach to improving the leadership capability of the public health workforce through increasing or extending access to leadership programmes, mentoring and scholarships.			<p>system, which:</p> <ul style="list-style-type: none"> e) incorporates a range of training levels f) allows 'rolling training' i.e. alternate education and practice modules accessed at the practitioners own pace g) allows the NZQA unit standards approach to be stair-cased to other training and qualifications h) incorporates practical workshops that acknowledge, recognise and value already competent practitioners
				Encourage the development of e-based training to facilitate wide uptake of the generic competencies.
				Explore the development of the Ngati Hine Health Trust joint venture model for on-site training for use in the public health sector.
				Explore a range of 'user friendly' tertiary providers to provide courses throughout the country.
				Develop a meaningful alternative pathway for achieving the generic

				<p>competencies for those who do not wish to adopt the NZQA pathway by:</p> <ul style="list-style-type: none"> c) developing a self assessment tool to enable staff to determine and develop their own learning needs d) developing implementation guidelines for supervisors, managers, mentors and workforce e) enabling recognition and acknowledgement of prior learning f) providing recognition and acknowledgement of specialist skills beyond the generic competencies(e.g. work stream and cultural) g) establishing a non-NZQA standard setting body (SSB) to set and monitor standards, and explore and establish the best implementation processes for assessment.
<p>Objective 2 Strengthen the Māori public health workforce and the capability of the non-Māori workforce to improve Māori health and reduce inequalities.</p>	<p>2.1 Develop a planned and strategic approach, and an implementation plan, to:</p> <ul style="list-style-type: none"> • strengthen the Māori public health workforce • increase the capability of the non-Māori workforce to improve Māori health and 	<p>The Ministry of Health should incorporate targets for Māori and Pacific Peoples workforce development in contracts.</p>	<p>Funding and resourcing is not adequate to address inequalities in the workforce (especially for community health workers, Maori and Pacificans workforces).</p>	<p>Ensure that cultural issues are handled appropriately in designing and implementing the tools that will support the implementation of the generic competencies, as follows:</p> <ul style="list-style-type: none"> e) there must be early and

	reduce inequalities.			appropriate consultation with Maori, Pacificans and Asian experts during all development of any tools or processes
	2.2 Maximise opportunities in all the other PH WDP objectives to further Māori public health workforce priorities.		Whilst there is a lack of Maori and Pacificans workers in the workforce, high community and professional demands raise expectations on the few workers available. Although the local context may vary they have a wide range of skills but training does not cater for their needs particularly for Pacificans workers.	f) care must be taken to reduce not increase the inequalities in the workforce g) acknowledge existing Maori competencies e.g. korero Maori, marae protocols etc, so Maori can move towards professionalism and professional credibility
			Difficulties around contracting processes for small Maori organisations were a feature of the Otautahi Christchurch Maori caucus.	h) Workforce development contracts for Maori organisations should be brokered when appropriate by MDOs e.g. He Oranga Pounamu who have capacity and expertise.
			In the past rural services had been brokered by Maori development organisations (MDOs) but latterly each provider has needed to negotiate their own contract. Having neither the expertise nor capacity, to access funding for workforce development and service sustainability, they prefer contracts to be brokered by MDOs eg He Oranga Pounamu.	i) To increase Maori workforce capacity and capability the Ministry should explore the option of a Maori trade training scheme. j) More funding is needed so Maori and Pacificans organisations can recognise and reward professional development achievements.
			Bureaucracy, indecisive Ministry	

			and DHB staff and directive (dictatorial) relationships have hindered ambitions of small organisations to develop their workforce.	
			Some Maori organisations are taking risks, by carrying financial deficits to maintain non funded staff until the Ministry recognises their need.	
			Differing regional approaches from funders have caused inconsistencies in service provision and competitive situations between providers.	
			There is insufficient collaboration: organisations need to come together using existing forums and establish clear agendas.	
Objective 3 Strengthen the Pacific public health workforce and the capability of the non-Pacific workforce to improve Pacific health and reduce inequalities.	3.1 Support the development and implementation of a strategic approach to: <ul style="list-style-type: none"> strengthen the Pacific public health workforce increase the capability of the non-Pacific workforce to improve Pacific health gain and reduce inequalities. 	The Ministry of Health should incorporate targets for Māori and Pacific Peoples workforce development in contracts.	Same as for Objective 2	
	3.2 Maximise opportunities in all the other PH WDP objectives to further Pacific public health workforce priorities.			

<p>Objective 4 Build infrastructure for public health professional development.</p>	<p>4.1 Support the development of a multidisciplinary collective approach to public health workforce development across professional boundaries.</p>	<p>That PHUs and NGOs and other organisations that employ public health staff should use workforce development budgets to ensure that all employees have the generic public health competencies within, say, six years.</p>		<p>Explore the following possibilities for regional cooperation, collaboration and leadership to champion and support workforce development through shared information, opportunities and facilities:</p> <ul style="list-style-type: none"> f) a designated worker (workforce development) in large providers, or in a regional lead agency, or shared between several smaller agencies g) a lead agency, with oversight to share and coordinate regional knowledge and training h) multi agency networks and collaborations i) training centres of excellence in each district to offer specific aspects e.g. integrated business planning.
	<p>4.2 Establish (where they do not already exist) professional development mechanisms for key public health workforce groups to lead professional development, develop competencies and standards, and achieve external recognition; in particular:</p> <ul style="list-style-type: none"> • support the development 			

	<p>of groups/mechanisms to lead the professional development of health promotion and health protection workforces</p> <ul style="list-style-type: none"> • work with leaders/stakeholders for public health nurses, community health workers and other public health disciplines to identify ways of supporting the professional needs of the respective workforce groups • investigate options for an industry-wide approach or body to manage public health professional and sector development. 			
	<p>4.3 Support key professional/occupational groups to develop professional competencies (which are built on the public health generic competencies) that strengthen discipline-based and inter-professional career pathways, and recruitment and retention strategies.</p>			
<p>Objective 5 Strengthen the public health capability of the wider health work force.</p>	<p>5.1 Build the public health capability of the wider health workforces; in particular:</p> <ul style="list-style-type: none"> • support the development of a training course or courses for public 		<p>Recruitment: some people attracted to the field have little idea of what it is really all about – lack of understanding of the broader context</p>	

	<p>health/health promotion in a primary health care setting</p> <ul style="list-style-type: none"> • ensure training for 'public health in a primary health setting' is part of all public health training courses and qualifications • identify opportunities to strengthen the public health component of clinical training programmes and competencies (eg. GPs, practice nurses) • support the wider health sector to build workforce capacity and capability to deal with new and re-emerging diseases and mass casualty events • support emergency response training for the wider health sector (including community-based organisations) to ensure an integrated approach is achieved nationally and to enable public health services to obtain surge capacity (e.g. from primary care). 			
	<p>5.2 Analyse training and career pathways for common programmes across sectors; e.g. health protection (public health services), environmental health (local government) and emergency management</p>			

	(Co-ordinated Incident Management System).			
GOAL 2: Support public health environments to grow and develop the public health workforce				
Objective 6 Advance workforce planning and capacity building to grow the public health workforce.	6.1 Develop and trial a public health workforce planning model and tool(s) to assist the Ministry of Health, DHBs and providers to plan for their workforce needs and to build the capacity of their workforces.		Lack of planning tools and lack of/or insufficient training plans.	
	6.2 Incorporate the planning tool(s) into overall health workforce planning at local and regional levels and into national programme planning for public health.			
	6.3 Develop ongoing review mechanisms. This work requires workforce modeling and benchmarking, and is informed by links to: <ul style="list-style-type: none"> • the information initiatives in Objective 7 • existing resources and information sources • capacity planning (service delivery planning). 			
Objective 7 Strengthen the public health workforce information, policy and research base to inform	7.1 Develop and implement initiatives to obtain (on an ongoing basis) relevant workforce and service delivery information to		Scarcity of data about composition of the public health workforce and where efforts need to be focused for future sustainability inhibits effective	Conduct an annual analysis to scope the public health workforce composition and clarify actual training requirements.

ongoing public health workforce development.	inform public health workforce development using and linking to existing or new information sources and initiatives (e.g. the DHBNZ Health Workforce Information project).		workforce planning	
	7.2 Identify and implement ongoing research activities to inform and support public health workforce development; in particular: <ul style="list-style-type: none"> • assess the workforce needs of people from other ethnicities (e.g. Asian) working in public health • assess the capacity and capability of the public health workforce to respond to emergent and irregular demands. 			
	7.3 Align all public health workforce development approaches, initiatives and activities with relevant policy, regulation and legislation (e.g. the HPCAA and the Public Health Bill).			
Objective 8 Nurture and develop supportive workplace cultures to achieve optimal workforce capability and capacity.	8.1 Develop tools and national guidelines (drawing on existing tools where they exist) to support planning and healthy workplace environments for public health providers at an organisational level. This includes guides to	Public health employers should use the generic competencies as part of staff recruitment and retention, programme development, and quality assurance processes.	Training is often seen as a cost rather than an investment and it is difficult to prioritise when it is not explicit in contracts. Workforce investment is not supported by short term contracts formulae.	Introduce workforce development contracts separate from service provision contracts. Protect or 'ring fence' workforce funding, which should be added on to contracts rather than coming out of the existing price.

	best practice human resource development, and recruitment and retention activities.			
	8.2 Develop and progressively implement a set of organisational competencies that could be built into organisational development programmes.	Public health employers should champion the use of practitioner competencies in your district or region.	Engaging with DHB and Ministry contracting processes is time consuming and too prescriptive.	Require high levels of accountability as part of the contracting process. Organisations should be accountable for: c) planning sustainable future workforce development d) reporting on how they have spent workforce development funds, including demonstrating annual improvement in implementing a workforce competency framework.
	8.3 Develop and progressively implement a set of organisational Māori responsiveness competencies for improving Māori public health.	Public health employers should collaborate with other employers to support and foster competency-based training and development of staff in public health organisations in your district or region as a priority for individual staff before providing training and development in specialist areas.	No incentive for NGOs to train staff because once staff are trained they can get better pay with DHB PHUs	Negotiate workforce development contracts separately for each organisation, using negotiation processes that are flexible and adapted to the capacity of each organisation. Engage Maori Development Organisations as contract brokers for small Maori providers
	8.4 Develop and progressively implement a set of organisational Pacific responsiveness competencies for improving Pacific public health.	Public health employers should support employees in accessing relevant training.	Lack of critical mass makes it difficult to free up staff for training and there is no capacity to back fill when workers are away for training. Especially difficult in small organisations	Adopt criteria for allocating funding for workforce development contracts which include that: d) the amount of funding be

			where each staff member covers a range of programmes.	linked to actual staff numbers rather than being a straight percentage of contract price
	8.5 Instigate contractual requirements for workforce development plans and monitoring in Ministry of Health public health provider contracts, and implement ongoing review mechanisms.	The Ministry of Health should incorporate the following into funding agreements/contracts: <ul style="list-style-type: none"> • training costs for staff including travel and accommodation • costs of locums and/or variance in outputs • cost of more highly qualified staff • training for managers. 	Organisational culture can conflict with goals and objectives of workforce development, e.g. politically driven programs place emphasis on service outputs to the detriment of workforce development.	<p>e) a specific amount be allocated per full time equivalent (FTE) staff member. (however others suggested that a FTE formula risks increasing inequalities)</p> <p>f) there be funding parity in workforce development contracts between PHUs and NGOs so staff development can be equitably accessed, and funding parity in service contracts so that achievements can be appropriately rewarded.</p>
		The Ministry of Health should establish a funding pool (similar to The National Mental Health Workers Training Grant) to support training especially for those employees who do not have a recognised qualification at level 4 (or above).	Lack of leadership/decision making and little employer understanding of health promotion and public health.	<p>Provide mentoring and training to service contract holders to:</p> <p>d) assist organisations to create organisational cultures and develop integrated strategic and business plans which include workforce development as part of core business</p> <p>e) up-skill managers and governance boards so that they understand their Public Health contracts, the generic competencies and the need for workforce</p>

				development.
			Long lead-in times before people become really useful.	Develop a tool kit to assist organisational development, drawing on existing available models (particularly the Waikato DHBs 'Population Health Planning Resource', and the approach developed by Hinerau Jones of Kaiwhakahaere of Te Awa O Te Ora Trust). Content could cover:
			PHWD is not considered a priority by some DHBs	a) how to develop organisations that have a culture of learning and development
			Lack of infrastructure and capacity within organisations to deal with protracted contracting processes.	b) how to use the generic public health competencies in job descriptions and recruitment processes
			Few strategic collaborations exist. (Collaborations have potential to share resources.)	c) how to develop integrated strategic/annual/team/individual performance plans that incorporate competency frameworks
			With some public health service providers contracted outside the Ministry jurisdiction, e.g. local authorities, there is a risk of a lack of consistency implementing the competency framework and inequality of workforce development	Establish a pool of nationally accredited and well trained mentors and coaches who are readily accessible to small providers. Explore the development of Te Whariki coaching tool for use in the wider public health sector. This exploration should also

				consider the marketing of the tool and training of management to use it.
<p>Objective 9 Increase the understanding of, and promote careers in, public health.</p>	<p>9.1 Develop a sector-wide approach to improve the profile and understanding of, and promote careers in, public health. This work links to the brand development work led by DHBNZ to grow positive perceptions of careers in the health sector as a whole.</p>		<p>Few or no career pathways and lack of incentives, rewards and recognition for achievement.</p>	<p>Assist the establishment of career pathways by:</p> <p>h) encouraging public health organisations to link the generic competencies and progression through unit standards with MECA steps</p> <p>i) encouraging public health organisations to adopt a public health entry level qualification as the norm e.g. a 1 year certification (however not everyone agreed that it should be mandatory)</p> <p>j) providing funding support for professional bodies to meet their workforce development needs.</p>
	<p>9.2 Implement initiatives to promote public health careers, including recruitment tools and materials (print- and webbased); in particular:</p> <ul style="list-style-type: none"> • develop information initiatives that focus on tertiary study leavers and the returning workforce 		<p>Lack of knowledge about how competencies will contribute to career pathways.</p>	

	(e.g. the public health careers booklet) <ul style="list-style-type: none"> • establish a web-based guide to public health workforce development and careers. 			
	9.3 Implement initiatives to encourage entry into under-represented disciplines in public health.		A perceived reluctance to invest in training because staff move or are poached after training. Poaching is a particular issue for NGOs that can't compete with much higher wages offered by PHUs.	
	9.4 Improve the wider health workforce's understanding of public health competencies and skills through initiatives and communication opportunities.			