First Nations Health Workforce Implementation Plan

phn
WESTERN QUEENSLAND
An Australian Government Initiative

Prepared by
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ACKNOWLEDGEMENT

The Western Queensland PHN (WQPHN) acknowledges Aboriginal and Torres Strait Islander peoples as the First Peoples of Australia, whose ancestral lands, and waters we work and live on.

We honour the wisdom and pay respect to Elders past, present and future and recognise their cultural authority as First Nations people of Australia.

We would like to thank Petraichor Partners, the Nukka Murra Alliance and our MOU Partners, RFDS (Queensland Section), Health Workforce Queensland and CheckUp for their invaluable contribution in shaping this report.

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STRATEGIES AND KEY ACTION AREAS

Strategies and key action areas

Actions identified in this implementation plan represent the initial actions over a 5-year period on the plan. The seven strategies present a commitment to strengthen the Aboriginal Community Controlled Sector, reflecting the aspirations of the National Strategic Framework and 10-year Plan.

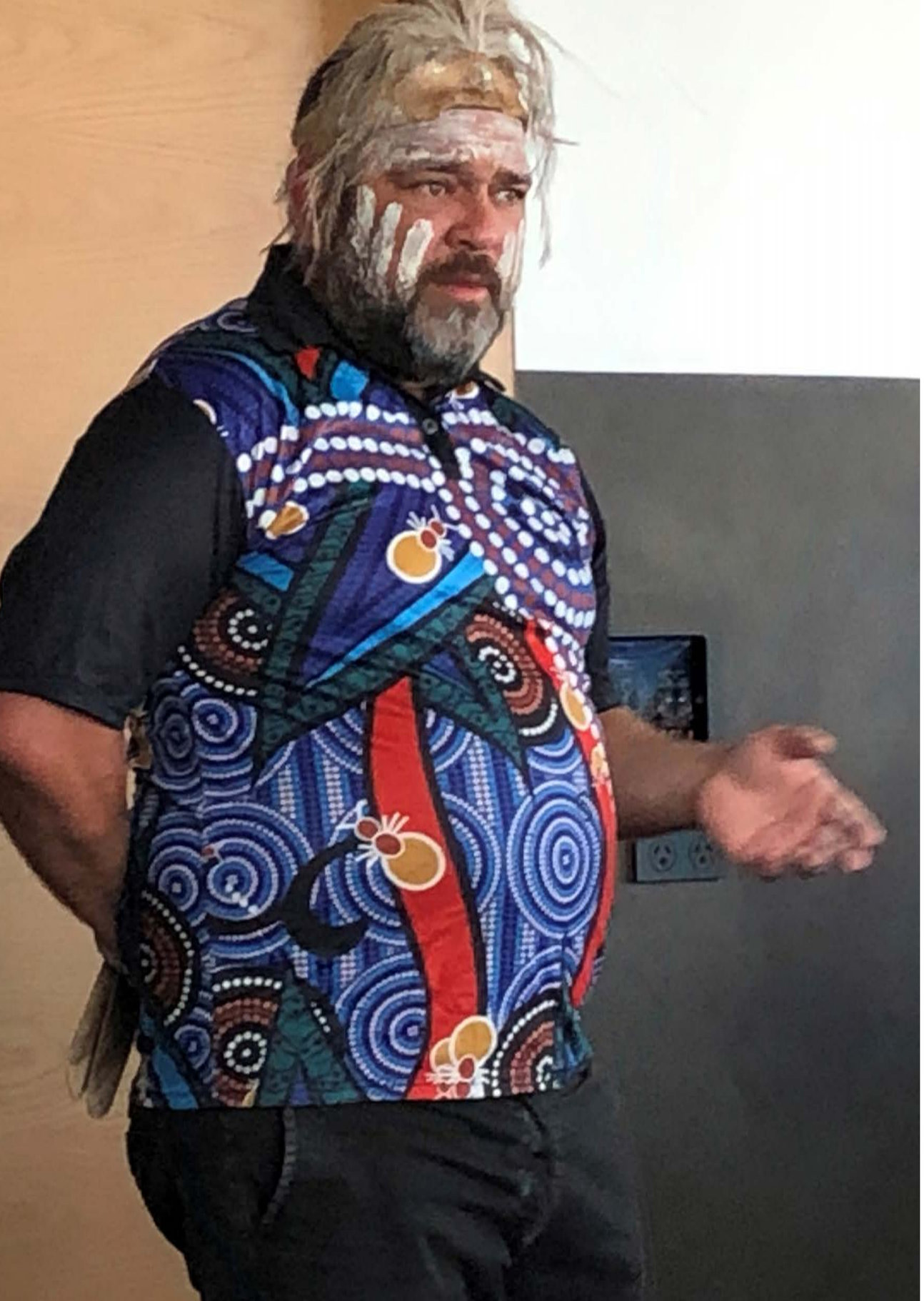
This plan seeks to have a profound impact on the wider primary health care landscape through a respectful, enterprising, and innovative partnerships focus on the mutual objective of culturally safe services, contributing to better health outcomes for First Nations communities of Western Queensland.

The intention is to ensure that the Nukal Murra Alliance and the Western Queensland community have access to a local, productive, efficient, integrated and highly skilled career workforce supporting the needs and services models of the region.

The Strategic Framework highlights seven key areas of focus, all of which are interdependent and connected across policy, program, and implementation. Each strategy is supported by evidence that highlights the critical importance of applying this evidence in practice.

There are unquestionably unique issues that challenge all health care providers working in remote and very remote areas here and overseas. These are further compounded by the unique experiences and circumstances faced by First Nations people in Australia. To respond to these challenges the Nukal Murra Alliance and its partners are seeking to undertake an ambitious program to reset the workforce agenda by placing culture at the heart of the equation, as well as using partnerships and evidence of what works well to drive their strategic agenda.

Figure 5. Western Queensland First Nations Strategic actions and interdependencies are underpinned by Cultural dimensions



1 | First Nations leadership

This strategy recognises the critical importance of strengthening the capacity of the four Aboriginal Community Controlled Health Services in Western Queensland under the Nukal Murra Alliance through activities designed to increase their participation in decision making of workforce planning at the state and regional level, and to ensure Aboriginal and Torres Strait Islander staff are supported to achieve their leadership potential.

Key Considerations

- Nukal Murra Alliance Members actively participate in and contribute to workforce planning and codesign strategies for Western Queensland and are supported to innovate and develop new approaches that will improve health outcomes for their communities.
- Current and emerging managers of AICCHS have access to professional development and training in programs to develop leadership competencies and opportunities to progress through levels of management.
- The NMA acknowledges the critical importance of leadership models that promote the recruitment, retention, and career progression for First Nations staff.
- Aboriginal leadership capabilities underscored with cultural values.
- The wider PHC system recognises and values the skill sets, cultural knowledge and lived experience of the Aboriginal and Torres Strait Islander workforce.
- Aboriginal and Torres Strait Islander people working in health, pursuing more senior roles or transitioning to leadership positions require a supportive workplace and opportunities, training and development in leadership, and mentors to guide them on their journey.

1.1	Executive skill development for existing and emerging leaders of AICCHS	
	Key actions to consider	**What this looks like in practice**
1.1.1	**Establish Western Queensland Leadership Network**	**Identify Western Queensland Aboriginal and Torres Strait Islander health leaders including:** • leaders in current sector operational roles. • leaders in non-operational roles that offer advice, guidance or support to current efforts. • leaders that offer intergenerational advice and support. **Convene a workshop of leaders to discuss how a network for Western Queensland could:** • Help deliver the outcomes and objectives important to advancing the health and wellbeing of Aboriginal and Torre Strait Islander people in Western Queensland. • Support the professional and personal development of current operational leadership. • Collaborate to identify future strategic priorities and challenges and what the network can do to address issues. **Create a regional approach that without duplicating or competing with current efforts, brings leaders together to:** • Build strong working relationships. • Foster the development of opportunities for Western Queensland health sector to leverage reform that improves outcomes. • Support the efforts of organisations to identify and build future leadership capability.
1.1.2	**Establish leadership development collaborative**	**Map the diversity, transferability and benefits of current leadership development efforts across the region.** **Based on this information and continuing discussions with Nukal Murra, consider how a regional approach to leadership development should function in Western Queensland. Prepare a Discussion Paper that:** • Considers the benefits and potential operations of a Regional Leadership Development Collaborative. • Circulate and convene a discussion including ACHSM and other leadership institutions that reflects on the paper to identify potential ways of improving on it.

36 A Model for Health Sector Leadership. In Leadership in Healthcare, Turner P, Organisational Behaviour in Health Care Palgrave Macmillan, Cham. https://doi.org/10.1007/978-3-030-04387-2_5

37 Harfield S, Davy C, Dawson A, Mulholland E, Braunack-Mayer A, Brown A. Building Indigenous health workforce capacity and capability through leadership - the Miwatj health leadership model. Prim Health Care Res Dev. 2021 Oct 7;22:e52. doi: 10.1017/S1463423621000554. PMID: 34615567; PMCID: PMC8515491.

38 Bailey, J., Blignault, I., Carriage, C., Demasi, K., Joseph, T., Kelleher, K., Lew Fatt, E., Meyer, L., Naden, P., Nathan, S., Newman, J., Renata, P., Ridoutt, L., Stanford, D. & Williams, M. 2020, 'We Are working for our People': Growing and strengthening the Aboriginal and Torres Strait Islander health workforce, Career Pathways Project Report, Lowitja Institute, Melbourne

1.1.2	**Continued...**	• Prepare, circulate and secure agreement to a final proposal to establish a Regional Leadership Development Collaborative. • Secure agreement that the first initiative of the Collaboration will be a Western Queensland Aboriginal and Torres Strait Islander Leadership Development Program.
1.1.3	**Research and co-design leadership curriculum, resources, and collateral**	**Prepare a draft proposal that outlines the creation of a leadership development program for Western Queensland. This proposal should address:** • Learning outcomes, program delivery and evaluation design. • How the proposal is firmly grounded in a locally delivered, collaboratively managed regional approach. • Includes meaningful cultural leadership considerations. • Map how a pilot program will be introduced. **The proposal should identify potential criteria for selecting participants, ensuring that the Aboriginal and Torres Strait Islander staff in current middle and executive leadership roles or identified individuals in pipeline roles are given consideration.** **Outline the use of innovative approaches to delivery of professional development for time-poor, geographically remote cohorts with variable educational foundations.** • This proposal should include, for example, the ways in which it will use self and peer led multi-mode online learning and micro credentialing. **The design of the proposal offers participants, organisations and community clear stakeholder benefit. This might include use of service-learning approaches, residential schools and access to learning and development infrastructure and technology.**
1.1.4	**Undertake a pilot of leadership program and undertake formative evaluation**	**Based on agreed criteria, select an initial group of between 10 and 15 individuals, from Nukal Mura members, to participate in the pilot program.** **Deliver the pilot program ensuring that there are effective mechanisms to gather provider and participant perspectives that help with evaluation.** **Undertake appropriate summative and formative assessments, gather student and organisational reflections and feedback, and support outcome mapping at 1- and 5-years post-graduation.** **Seek sponsorship and philanthropic investment to support the leadership program.** **Based on the evaluation, ensure that current organisational leadership and management has a strong appreciation of, and information about the operations of, benefits from and the contributions required from potential participants.** **Based on the evaluation and discussions:** • Identify internal and external groups from which future participants might be drawn. • Develop online and face to face collateral that informs these groups about the benefits of leadership development. • Develop opportunities for individuals to discuss with the program with their manager, including their interest and questions about the program. **Ensure pathways across individuals, organisations and the program provide clear and effectively connection.**

1.2	First Nations Leadership within regional governance structures	
	Key actions to consider	**What this looks like in practice**
1.2.1	**Promote leadership development candidates within the AICCHS and wider partner networks**	**Candidates enrolled in and completing the professional development programs are supported into management roles and leadership opportunities within the AICCHS sector and wider intersectoral and interprofessional networks.** **Candidates can access leadership placements and work experience opportunities across clinical and nonclinical settings within AICCHS Networks and wider partner organisations.** **Provide regular updates on key outcomes from the Leadership program, including testimonials and successful transitions to management roles and appointments.** **Issue updates to the region that outlines progress in delivering the WQFNHWIP n. Preparation of suitable publications to increase awareness and celebrate outcomes.** **Consider peer reviewed and industry journals of articles focused on the region's efforts to develop more culturally safe services.** **Include the updates and articles in the regional online Cultural Safety collection.**

1.3	Develop leadership competency standards to improve culturally safety	
	Key actions to consider	**What this looks like in practice**
1.3.1	**Minimum standards for ethical and culturally safe leadership in the health sector across the region**	**Identify cultural safety standards described in current policy, programs and practice across the region:** • Describe acceptable professional practice by registered professions. • Set standards for acceptable behaviour of public and not for profit employees. • Set acceptable behaviours of public or not for profit Boards and Board members. **Convene a workshop for organisational and community cultural leadership to discuss the standards that should apply in matters relating to cultural safety.** **Development of a set the standards that relate to ethical and culturally safe behaviour of organisation leadership including executive and management employees.** • Prepare a Discussion Paper on Standards for Ethical and Culturally Safe Health Leadership. Circulate and canvass the views of AICCHS in the region in regard to cultural leadership in communities. Based on this discussion prepare a second draft. • Submit the second draft to individual AICCHS and the Nukal Murra Alliance for consideration and adoption. **Using the insights gathered above, identify the bodies and organisations whose engagement and support for the standards is necessary to ensure effective introduction.** **Undertake negotiations with the relevant bodies or organisations to promote the adoption or recognition of the Western Queensland Standard for Ethical and Culturally Safe Leadership in the Health Sector, including within the Health Equity Strategy Frameworks.**
1.3.2	**Develop and deliver programs that support the adoption, promotion, and use of the Standards.**	**Develop and offer professional development and staff awareness programs for Aboriginal and non-Aboriginal staff working in Western Queensland.** **Develop a report card that describes the Western Queensland health sector, and provider engagement and outcomes against the Standards.**

2 | Cultural safety

This strategy recognises training and development of the AICCHS health workforce remains a principal action to improve cultural competence, but health systems and processes within organisations also need to change to secure attractiveness of workplaces in order to achieve better workforce outcomes. Improvements in individual cultural competence will require access to resources and collateral to support work environments where Indigenous cultural values, strengths and differences are respected, power and decision making is balanced, and racism is removed in all forms.

Key Considerations

- Reframing cultural competency training beyond individual health professionals to systematic organisational processes and capabilities that remove racism and promote health equity.[39]
- High quality tools and resources reflecting the diversity of regions and of the Aboriginal and Torres Strait Islander communities of WQ to increase health professional cultural competency.
- First Nations leadership development is critical to secure cultural safety outcomes, because as leaders, they will be expected to have the knowledge to oversight the implementation, monitoring and evaluation of cultural safety good practice and be able to positively influence these outcomes within an organisation.[40]
- Acknowledging the importance of continuous learning and cultural immersion through local community partnerships and cultural networks.[41]
- Respectful engagement with local cultural leaders to proactively support and acknowledge local cultural authorities and secure consent and sharing of wisdom in codesign and adoption of resources and collateral.
- Development of organisational indicators to assess cultural safety credentials and integrity in primary care through adoption of the Marrie Institutional Racism Matrix.[42]
- Cultural identify (family/community, country and place) and self-determination are recognised as strong cultural determinants that impact on the health and wellbeing of First Nations people, and knowledge of these factors are essential to ensure cultural safety.[43]

2.1	Strengthen cultural safety credentials and performance	
	Key actions to consider	**What this looks like in practice**
2.1.1	**Commission an audit across WQ catchment, prepare report and gap analysis of cultural resource needs and key learnings**	**Undertake a 'desktop audit' of all AICCHS to develop a baseline of current resources and collateral supporting cultural competency development:** • Include health professional induction and training processes and resources. • Dedicated staffing. • Organisational policies and procedures. • Cultural safety framework. • Online resources and self-guided learning materials. **Based on the desktop audit, consider priority actions needed to ensure high standards of universal coverage of minimum health professional competency development, and ongoing professional development needs of staff.** **Make subsequent adjustments to the cultural safety professional development program. Create additional self-directed ongoing development opportunities.** **Conduct the assessment of staff continuing development every two years.**
2.1.2	**Develop a cultural safety data development plan to guide data capture, survey tools and program logic**	**Creation of serviceable measures and reliable data sources for cultural safety to measure performance.** **Useable assessment tools for each of the domains of cultural safety, allowing individual and collective comparisons over time.**

39 Cultural Competence in the Delivery of Health Services for Indigenous People, Close the Gap Clearinghouse, AIHW July 2015, https://www.aihw.gov.au/getmedia/4f8276f5-e467-442e-a9ef-80b8c010c690/ctgc-ip13.pdf.aspx?inline=true accessed November 2021.

40 Cultural Safety Framework National Aboriginal and Torres strait Islander Health Workers Association. https://www.naatsihwp.org.au/sites/default/files/natsihwa-cultural_safety-framework_summary.pdf

41 Curtis, E., Jones, R., Tipene-Leach, D. et al. Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. Int J Equity Health 18, 174 (2019). https://doi.org/10.1186/s12939-019-1082-3

42 Addressing Institutional Barriers to Health Equity for Aboriginal and Torres Strait Islander People in Queensland's Public Hospital and Health Services. Anti-discrimination Commissioner Queensland, March 2017.

43 Verbunt, E et al. Cultural determinants of health for Aboriginal and Torres Strait Islander people – a narrative of reviews. International Journal for Equity in Health. (2021) 20:181 http://doi.org/10.1186/s12939-021-01514-2

2.1.3	**Prepare deidentified report of Cultural Safety baseline against which future assessment can be compared**	**Complete the region wide assessment and the finalisation of the Western Queensland Cultural Safety Baseline Report within 18 months of the adoption of the WQFNHWIP:** • Identify and review available cultural safety assessment tools and make recommendations on the adoption/creation of a Western Queensland cultural safety assessment tool. • Within the first 12 months following adoption of the WQFNHWIP, complete planning and groundwork for the conduct of a baseline assessment of the level of cultural safety across the Western Queensland AICCHS sector. • Ensure that groundwork includes consultation and information sharing with the Aboriginal and Torres Strait Islander communities of Western Queensland. **Explore the development of cultural safety accreditation assessors to assist workplaces meet minimum requirements, share collateral and experiences, and integrate quality improvement approaches in the workplace.**
2.2	**Increase access to resources and support cultural safety and competency development**	
	Key actions to consider	**What this looks like in practice**
2.2.1	**Develop a shared statement regarding cultural safety and how this applies to the development of First Nations workforce**	**Considering the standards developed above, prepare a draft Western Queensland Cultural Safety Policy Statement. The Statement should establish an unambiguous relationship with the model of care in Western Queensland.** **The Statement should describe the centrality of culture to the employment contract with staff and articulate the relationship of cultural safety to quality professional practice, ethical behaviour, efficient operations and organisational culture.**
2.2.2	**Develop cultural safety guidelines to support workforce development outcomes and organisational capacity**	**Expanding on the cultural safety standards for leadership, establish guidelines that relate to organisational culture, systems and policy, professional behaviour, and individual behaviour for the sector.** **Identify measures, data sources and collection and collation mechanisms and intervals. Review existing cultural safety measurement frameworks and consider them against regional contexts and the standards identified in this plan.** **Construct an assessment tool that:** • Identifies efforts to secure compliance against cultural safety standards, policy and practice across the region. • Establishes an approach to assessment that encourages engagement and further effort to meet or exceed standards rather than a punitive or blaming approach. • Includes assessment of effort at an organisational level, of systems and polices, of professional groups and at an individual level. • Can be readily used by organisations as part of their internal risk management processes and responsibilities.
2.2.3	**Support for locally developed resources and collateral to reflect cultural diversity**	**Build and maintain a relationship with local cultural leaders and Traditional Owner groups providing advocacy and respect for local protocols and advocacy.** **Source local articles, papers and other relevant material for use of the online resource collection and consider digitised versions of local collateral.**
2.2.4	**Develop online portal for managing and accessing cultural resources**	**Establish a resource library of online and peer reviewed resources and materials relevant and make available to assist cultural awareness and orientation.** **High quality suite of localised cultural tools and resources, links to cultural advisors as well as standardised curricula and micro-credentialled options.** **Cultural safety resources to support HRM systems and policies and organisational governance.** **Ensure open access and promote uptake of materials, monitor views and downloads, and evaluate effectiveness.** **Following each biennial assessment of staff competence and knowledge, update the collection as a continuing professional development resource for staff.**
2.2.5	**Develop program collateral for universal coverage to secure cultural safety minimum standards across the region**	**Develop a multi-mode cultural safety staff development program and ensure that all staff complete the program within two years and that new staff complete the program as part of the orientation/induction.** **Develop a Cultural Safety Assessor Program that:** • Supports the effective introduction of cultural safety by regularly assessing the efforts of the sector to foster consistent application of the standards across the region. • Facilitates the independent assessment of performance against standards on a regular basis. **Develops a pool of 'Accredited Assessors' that can be available to any organisation to conduct assessments.**

3 | Funding and strategic investment

This strategy recognises that providing universal access to primary health care for First Nations people will require new investment to recruit, train and support a workforce that can provide more comprehensive care, customised to the unique circumstances of Western Queensland. Planning mechanisms that support current supply and demand for services need to be aligned with population health needs and those system capabilities that support comprehensive care [44] New investment and sustainability modelling including commissioning frameworks must further refine place-based approaches that grow the health workforce in ways that meet the unique needs of First Nations communities.

Key Considerations

- There is maldistribution of health workforce across hospital and primary health care, which needs urgent review and reassessment.
- The current workforce modelling and financial planning is largely underscored by historical supply and demand dynamics and modelling that is not always aligned with population health nor emerging workforce needs.
- Workforce shortages can reduce health expenditure and mask the true cost of services. Over time these persistent vacancies lead to greater inefficiency, professional isolation, increased morbidity and drive up the cost in the longer term.[45]
- New investment and financial planning for workforce needs is required that ensures the community have access to the most appropriate health professional that best meets their need and is connected within the wider primary health care network of services.
- Role redistribution from higher cost workforce through generalist roles, expanded scope of practice, or telehealth supported options has the capacity to identify possible cost savings and increase funds available to support new workforce strategies.[46]
- Decentralising education programmes and expanding local investment in training infrastructure will improve workforce availability and distribution.
- Academic collaborations are a proven mechanism to explore new workforce development opportunities, and co-investment in AICCHS and wider primary care settings.[47]
- Re-evaluation of services in consultation with communities can support reorientation of acute and hospital investments into primary care to bring new investment and increase the reach and effectiveness of services.[48]
- The planned activities and priorities highlighted through the Queensland Health HHS Health Equity Strategies and this implementation plan will present opportunities for new investment in AICCHS (and Nukal Murra).
- New approaches through further reform of commissioning approaches and financial modelling that underpin current workforce affordability and design need to be pursued to trial funds pooling, remote capitation models and public/private collaborations.
- Philanthropic partnerships are contributing to place-based outcomes in many remote communities across Australia and should feature in opportunities for workforce development in Western Queensland, through investment in secondary education, school-based apprenticeships, and social impact investment. [49]

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44 In place of fear: aligning health care planning with system objectives to achieve financial sustainability, Birch S et. al., Journal of Health Services research and Policy, 2015, Vol. 20(2) 109 – 114,
45 Boxall Ann Marie What are we doing to ensure the sustainability of the health system? Research paper No 4, 2011-12, Parliamentary Library. Researchgate
46 7. J Antos et al, 'Bending the curve: effective steps to address long-term healthcare spending growth', The American Journal of Managed Care, October 2009, pp. 676–680.–3–030–04387–2_5
47 McCalman J, Jongen CS, Campbell S, Fagan R, Pearson K, Andrews S. The Barriers and Enablers of Primary Healthcare Service Transition From Government to Community Control in Yarrabah: A Grounded Theory Study. Front Public Health. 2021 Oct 14;9:616742. doi: 10.3389/fpubh.2021.616742. PMID: 34722428; PMCID: PMC8
48 Lyle D, Saurman E, Kirby S, Jones D, Humphreys J, Wakerman J. What do evaluations tell us about implementing new models in rural and remote primary health care? Findings from a narrative analysis of seven service evaluations conducted by an Australian Centre of Research Excellence. Rural Remote Health. 2017 Jul-Sep;17(3):3926. doi: 10.22605/RRH3296. Epub 2017 Sep 6. PMID: 28877588
49 Schwab, R. Sutherland, D. Philanthropy, non-government organisations and Indigenous development. 20 June 2003. Discussion Paper. Centre for Aboriginal Economic Research (ANU) https://apo.org.au/node/9058

3.1	Responding to regional workforce priorities	
	Key actions to consider	**What this looks like in pracitice**
3.3.1	**First Nations regional workforce planning**	**Support a bi-annual forum to specifically review First Nations workforce data.** • Explore options to deliver an equitable distribution of workforce and career development outcomes and opportunities across the region and across areas of agreed priority. **Strategic budget planning to quarantine and align investment to create critical mass and scale for regional investment fund.** • Regional unspent grant funds reallocation. • Examine reorientation of workforce assets through role redistribution and generalist upskilling activities. • Consider cost benefit analysis of redistribution of nursing and allied health roles through telehealth enabled outreach to increase local workforce employment and training opportunities within team care environment.
3.1.2	**Expanded scope of practice for Aboriginal health practitioners in remote Queensland**	**Seek amendments to the scope of practice laws that would allow the greater use of Aboriginal health practitioners, Aboriginal health workers and allied health, and allied health assistants.**

3.2	Innovation and reform for increased workforce investment in western Queensland	
	Key actions to consider	**What this looks like in pracitice**
3.2.1	**Innovation to government and program funding envelopes**	**Increased IAHP flexibility to support training and development.** **Undertake modelling of MBS underutilisation to explore potential funding innovation for CTG activities in select communities:** • Capitation trial for high-risk complex patient cohorts. • Increased workforce support investment for outreach funding allocations. **Support engagement within Queensland Health to re-evaluate the transition to community control investment strategy in Western Queensland.** **Promote opportunities for strategic investment into NMA to progress Health Equity Strategies in Western Queensland.** **Explore partnership opportunities with TAFE to increase investment in AICHSS regional workforce and assets.** **Review of the DESBT First Nations Training Strategy and Indigenous Workforce and Skills Development Grant process to align the WQFNHWIP to optimise employment and real jobs.** **Support further targeted investment through the National Indigenous Australians Agency with a focus on real jobs and employment outcomes.** **Preparation of scalable projects that are locally delivered but regionally coordinated:** • Undertake feasibility of establishing a fully funded IAHA academy in Western Queensland. • Regional SEWB and cultural healing networks.
3.2.2`	**Foster academic partnerships in Western Queensland to leverage research funding to respond to workforce priorities and innovation**	**Support funding applications to assist the planned leadership development initiative.** • Seek academic partnership to assist the design and evaluation and collateral development. **Support research applications to support workforce priorities aligned with emerging innovation in PHC:** • SEWB/AOD workers. • Peer workforce development. • In-reach and at elbow CERT II and III workforce. • Digital technology and telehealth support. • Cultural mentors. • Practice Manager training/upskilling. • Mature-age entry.

3.3	Increase philanthropic partnerships and co-investment strategies in Western Queensland	
	Key actions to consider	**What this looks like in pracitice**
3.3.1	**Secure philanthropic investment into First Nations workforce skills development and employment**	**Commission a strategic review of philanthropic investment currently in Western Queensland.** **Engage a suitably experienced partner organisation (i.e. SVA) to develop a regional investment strategy to highlight philanthropic partner opportunities in Western Queensland:** • Consider social return on investment and social impact opportunities. • Shortlist philanthropic agencies to canvas medium and longer term investment options. • Align investment strategies to health priorities, including social determinants of health and business and leadership skills. • Promote educational pathways for secondary school placements. **Under the NMA, promote sponsorships and professional development bursaries through targeted philanthropy in primary industry and mining corporations in Western Queensland.**

4 | Employment and professional development

This strategy recognises the urgent need to ensure AICCHS and wider primary health care partner organisations can optimise and grow First Nations workforce and enhance professional development opportunities to strengthen cultural safety and build the resilience and sustainability of workforce needed to achieve better health outcomes in Western Queensland. Notwithstanding the very significant challenges facing remote health providers, this strategy seeks to disrupt the historical barriers to training, recruitment, and retention, and create new career pathways and professional development opportunities. Ultimately it seeks to harness the collective strengths of AICCHS and its partners to foster a dynamic and collaborative workforce development capability.

Key Considerations

- AICCHS are the largest employer of First Nations workforce, with a long history of implementing important workforce development strategies that are having a positive effect on operations and are building capacity and securing sustainability within the sector.[50]
- Critical issues that impact on AICCHS, including retention, staff turnover, succession planning, and expanding and innovating the workforce, impede its ability to improve access to care for communities within their respective catchments. [51]
- The work environment, including the attitude of health management, co-workers, access to supervision, and mentoring and training, are critical factors that directly influence the attractiveness health workforce careers.
- Strong intersectoral collaboration between the health and education sectors has been proven to improve workforce design and sustainability and is central to improving outcomes under the WQFNHWIP. [52]
- Localising and co-ordinating education, training and development opportunities will significantly improve the opportunity for local people to build rewarding local careers that serve local communities.[53]
- Pathways to develop and recognise Aboriginal mentors and peer-led networks to ensure they are accessible across all communities of the Western Queensland catchment.
- Better understanding the contribution of continuing professional development (CPD/CPE) to enhancing workplace attractiveness and improving retention of primary health care workers. [54 55]
- Supporting a more localised, affordable, and accessible system for students, employers and Registered Training Organisations (RTO) operating in Western Queensland is necessary to provide an uplift to local employment

4.1	Improved retention and professional development of workforce	
	Key actions to consider	**What this looks like in pracitice**
4.1.1	**Ensure work environments promote learning and development**	**Mechanisms are in place to review, measure and maintain workplace cultural safety requirements.** **Assist strategic review and 'best practice' human resource policies and practice.** **Standardised individual earning and development assessment as part of employee induction and reviewed annually through performance appraisal processes.** **Embed cultural safety training into continuous professional development (CPD) for all employees and health practitioners.** **Elevate mental health first aid and trauma education for all staff within first 12 months of employment.**

50 Panaretto KS, et al. Aboriginal community controlled health services: leading the way in primary care. Med J Aust. 2014;200(11):649–52.

51 Meyer, L., Joseph, T., et al (2020), Career Pathways for the Aboriginal and Torres Strait Islander Health Workforce: Literature Review Report, Career Pathways Project, The Lowitja Institute, Melbourne. This Literature Review report was written in 2018 and published by the Lowitja Institutehttps://www.lowitja.org.au/content/Document/CPP%20Literature%20Review%20Report_Final_July%202020(1).pdf

52 Wakerman, J., Humphreys, J., Russell, D. et al. Remote health workforce turnover and retention: what are the policy and practice priorities?. Hum Resour Health 17, 99 (2019). https://doi.org/10.1186/s12960-019-0432-y

53 Bond, Chelsea & Brough, Mark & Willis, et al. (2019). Beyond the pipeline: a critique of the discourse surrounding the development of an Indigenous primary healthcare workforce in Australia. Australian Journal of Primary Health. 25. 10.1071/PY19044. https://www.researchgate.net/publication/336610398_Beyond_the_pipeline_a_critique_of_the_discourse_surrounding_the_development_of_an_Indigenous_primary_healthcare_workforce_in_Australia/citation/download

54 Humphreys J, et al. 2007 Improving primary health care workforce retention in small rural and remote communities – how important is ongoing education and training? Australian Primary Health Care Research Institute, https://nceph.anu.edu.au/research/projects/improving-primary-health-care-workforce-retention-small-rural-and-remote

55 Taylor, E.V., Lalovic, A. & Thompson, S.C. (2019) Beyond enrolments: a systematic review exploring the factors affecting the retention of Aboriginal and Torres Strait Islander health students in the tertiary education system. Int J Equity Health 18, 136 (2019). https://doi.org/10.1186/s12939-019-1038-7

		First Nations staff can access a suite of micro-credentialled on-the-job workforce training and development opportunities that are linked to employment opportunities across health career pathways. **Foster tertiary student placements across medical, nursing, allied health and pharmacy, and promote transprofessional networks to complement training, cross cultural exchange and multidisciplinary teams.** **Expand workplace and cultural peer support mentoring programs and ensure access to clinical and cultural supervision and support.** **Ensure flexible workplace environments that allow access to infrastructure and on-the-job learning opportunities (including vocational and tertiary training) and staff educators who have assigned support roles in addition to their substantive professional role.**
4.1.2	**Evidence informed retention strategies**	**Undertake a regional survey using deidentified HRM data to build a body of shared knowledge regarding why people choose to leave and the unique workforce challenges in Western Queensland.** **Develop and share new policy and procedures and other arrangements designed to respond to retention issues.** **Explore opportunities to leverage from network and partner organisations to secure long term employment outcomes.** **Ensure competitive wage structures across all disciplines, roles and functions, and consider new models of remuneration, and expanded scope of practice.**
4.1.3	**Expanded professional placement networks**	**Promote clinical and nonclinical work placements within the NMA network to provide opportunities for learning and development through different work settings.** **Support career development opportunities through secondment and higher duties acting roles.** **Formalise agreements with partner organisations to support placements, work experience and secondment opportunities in mainstream provider organisations.**

4.2	**Increase capacity to support employment, training and professional development**	
	Key actions to consider	**What this looks like in practice**
4.2.1	**Increased enrolments in vocational training**	**Jointly design and support a culturally informed regional campaign that promotes health careers, targeting secondary school and mature aged students.** **Support career expo's and pathways to employment through expanded school-based traineeship programs (including clinical and nonclinical placements).** **Optimise RPL for mature age students and ensure access to adult numeracy and literacy support.**
4.2.2	**Better access to local RTO for training support and certification**	**Undertake a review of RTO organisations currently operating in the catchment to better understand which agencies are best suited to remote learning.** **Collaborate with RTO and professional bodies to customise vocational training curricula and content with input from NMA mentors and staff.** **Optimise in the design and delivery of CERT programs and promote locally based trainers, and certifying staff.**
4.2.3	**Partnership agreement with CRRH and SQRH University departments of rural health**	**Develop formal agreements with the CRRH and SQRH with NMA to support a multifaceted training and development collaborative:** • Student placement priorities and model of care. • Investment in cultural safety programs and resources. • Access to infrastructure for learning and development needs. • Support for interprofessional and transprofessional learning networks. • Support for developing student mentoring and alumni within AMS. • Pathways to professional development across all health and non-health disciplines. • Support for research and development grant applications.
4.2.4	**Establish Indigenous Allied Health Australia (IAHA) Academy in Western Queensland**	**Work with Indigenous Allied Health Association (IAHA) to undertake a feasibility into the establishment of an IAHA academy in Western Queensland:** • Prepare a detailed costing estimate and review of infrastructure and resource requirements. • Seek to use the Academy to complement and enhance capacity of internal training and mentoring networks. • Integrate Academy within model of care workforce needs.
4.2.5	**Increase mentoring skills and professional networks**	**Undertake a survey of current Indigenous mentors and staff with previous experience and skill within the NMA catchment.** **Develop an eligibility criterion for potential candidates and liaise with academic partner institutions to develop a competency-based training package to increase mentoring skills within the NMA.** **Develop and explore the role of cultural mentors to provide guidance and support. Expand and enhance tutoring programs and mentoring for First Nations staff and trainees across all professions and disciplines.** **Recognise mentoring skills within remuneration and job roles.** **Encourage faculty recognition for placement of tertiary student as well as vocational training.**

4.3	**Pathways for career development, promotion and leadership**	
	Key actions to consider	**What this looks like in practice**
4.3.1	**Promote pathways into a diverse range of health careers.**	**Pathway resources are developed and mapped for careers in health to assist and guide staff and organisations in proactively managing career options and trajectories:** • Pathways are mapped for all core disciplines and functional portfolios of AICCHS operations. • Pathways indicate entry level grade through to senior and leadership roles. • The resources are developed online in multimedia and available to guide existing and new staff in career development options. • Pathways outline linkages to nominated RTO and professional bodies as well as linkages to partner organisation work placements, bursaries and RPL opportunities.
4.3.2	**Address financial barriers to career development for First Nations staff**	**Staff seeking to enhance professional skills and advance career opportunities are supported with financial, workplace and personal requirements of PD:** • Ensure local employment policies promote and encourage learning and PD opportunities. • Access to bursaries, bonded payments, and support of spouse and family obligations. • Cadetships for students and work transitions.

Align workforce with population health needs

This Strategy seeks to ensure that when planning and evaluating participation of Aboriginal and Torres Strait Islander peoples in the health workforce, the distribution and configuration is appropriate to meet current and emerging health needs of Aboriginal and Torres Strait Islander peoples and communities, based on population health needs and diversity across Western Queensland. Moreover, placing workforce development priorities against recognised health priorities will ensure long-term job security, particularly in multidisciplinary generalist roles.

Key Considerations

- A major contributor to reduced access and utilisation of health services in remote and very remote communities is a chronic shortage in the health workforce,[56] compounded by market failure,[57] and a greater reliance on the public health sector, particularly in communities with high First Nations populations.[58]
- Considerable evidence shows an increase in health status inequalities in systems with universal free health care for remote and lower socioeconomic populations. This is contributing to a greater burden of illness in those that need support the most, and better health status for those need it least, but access it the most.[59]
- When considering historical workforce distribution and configuration, patient expectations and demand pressures are often driven by provider preferences on what can be easily recruited and does not always reflect true patient needs. In other words, demand can be driven by the interests of providers, and does not reflect the 'true demand', nor the preferred workforce preferences and configuration.
- There needs to be an increased commitment to balancing the mismatch of services available with patient and population priorities, through more competency-based learning and development opportunities,[60] as well as a greater emphasis on multidisciplinary approaches.
- Diversifying the primary healthcare workforce has been proven to improve health outcomes when aligned with critical health needs.[61][62]
- Strong evidence suggests that ensuring access to Aboriginal health workers and health practitioners will improve attendance and efficacy of treatments at clinics, reduce discharge against medical advice, enhance referral linkages, and improve patient follow-up, as well as screening and care management processes.[63]
- Aligning careers, competencies, and knowledge in the health sector workforce with the population health needs of the region can result in greater system efficiency and secure longer term job security.[64][65][66]

56 The Australian Productivity Commission Australia's Health Workforce: Research Report. Available online: https://www.pc.gov.au/inquiries/completed/health-workforce/report/healthwork-force.pdf [Ref list]
57 Cosgrave C, Malatzky C, Gillespie J. Social Determinants of Rural Health Workforce Retention: A Scoping Review. Int J Environ Res Public Health. 2019 Jan 24;16(3):314. doi: 10.3390/ijerph16030314. PMID: 30678350; PMCID: PMC6388117.
58 Tang S.Y., Browne A.J. 'Race' matters: Racialization and egalitarian discourses involving aboriginal people in the Canadian health care context. Ethn. Health. 2008;13:109–127. doi: 10.1080/13557850701830307.
59 Korda RJ, Butler JR, Clements MS, Kunitz SJ. Differential impacts of health care in Australia: trend analysis of socioeconomic inequalities in avoidable mortality. Int J Epidemiol. 2007 Feb;36(1):157-65. doi: 10.1093/ije/dyl282. Epub 2007 Jan 8. PMID: 17213209.
60 Frenk, J et al. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. www.thelancet.com Published online November 29, 2010 DOI:10.1016/S0140-6736(10)61854-5
61 Pilkerton CS, Singh SS, Bias TK, Frisbee SJ. Healthcare resource availability and cardiovascular health in the USA. BMJ Open. 2017 Dec 14;7(12):e016758. doi: 10.1136/bmjopen-2017-016758. PMID: 29247082; PMCID: PMC5735408
62 Gaiser, M et al. A systematic review of the roles and contributions of peer providers in the behavioural health workforce. American Journal of preventative medicine. Volume 61, issue 4, October 2021, pages e203 – e210
63 Gwynne Kylie, Lincoln Michelle (2016) Developing the rural health workforce to improve Australian Aboriginal and Torres Strait Islander health outcomes: a systematic review. Australian Health Review 41, 234-238. https://doi.org/10.1071/AH15241
64 Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health, National Academies of Sciences; Engineering and Medicine, 2019
65 Prevention, Health Promotion, and Social Work; Aligning health and Human Service Systems Through a Workforce for Health, Ross, A De Sax Zerden L, American Journal of Public Health 110, S186_S190, https://doi.org/10.2105/AJPH.2020.305690
66 In place of fear: aligning health care planning with system objectives to achieve financial sustainability, Birch S et. al., Journal of Health Services research and Policy, 2015, Vol. 20(2) 109 – 114,

5.1	Ensure workforce alignment with population health needs	
	Key actions to consider	**What this looks like in pracitice**
5.1.1	**Existing and future workforce priorities are aligned with population health needs**	**Place-based approach to better understand workforce distribution and ratios against contemporary population health data and disease prevalence:** • Using industry level ratio's under MMM, review current workforce allocation across professional disciplines to determine gaps and priorities to service unmet need. • Expanded scope of practice, increased generalist roles and reorientation of existing workforce investments are needed to put more workforce 'close to patients' in communities and remain connected through team care. **Ensure there is a planning mechanism to review workforce investment in areas that are proven to be most value to community.** **Development and adoption of evidence-based workforce planning models for use in management and planning into the future.**
5.1.2	**Determine relative value of current staffing investments to deliver MDTBC**	**Planners need to look 'across the system' and determine how current workforce is contributing to population level outcomes (i.e. access to care for priority population cohorts).** **Workforce planning needs to look beyond single organisational jurisdictions and be considered within model of care dimensions, with wider population level impacts:** • Considering integrated multidisciplinary teams to address child and maternal health, mental health or chronic disease management. • Team care arrangements ideally link across organisational strata and maximise local employment pathway
5.1.3	**Digital technology supporting redistribution investment to local workforce**	**Digital technology has the potential to increase access and efficiency but also free up investment for new employment opportunities and more vocational training.** **Peer roles are needed to support the digital literacy needs of patients and families, and are essential to secure better access to care and self-management supported outcomes.**

5.2	Ensure focus on team-based care configuration inclusive of Aboriginal health staff	
	Key actions to consider	**What this looks like in pracitice**
5.2.1	**Multidisciplinary teams supporting First Nations staff development**	**Models of team-based care aligned with population health priority areas aim to support opportunities for vocational training investment, student placements and to compliment specialist roles.** **Consider developing career and vocational pathways including mentoring and supervision arrangements for core priorities health streams:** • Child and family health. • Diabetes prevention and management. • Rheumatic heart disease. • Managing people with complex long-term conditions. **Targeting more investment toward SEWB support networks and expanding into the wider primary health care settings as part of team-based care:** • Advocate for greater SEWB roles within multidisciplinary mental health investments. • Expanded SEWB networks through the development of peer provider networks to support strengths-based recovery, resilience building, empowerment, and self-advocacy.
5.2.2	**Invest in peer workforce to improve self-management outcomes**	**Develop the role and capability of peer workforce, through greater recognition of lived experience, cultural supervision, and community connection as equally important skills needed within the workforce configuration, in team care approaches:** • Consider development and piloting of a peer workforce training program to complement multidisciplinary teams. • Support local and regional support networks for peers. • Ensure digital literacy competency. **New funding for population health priorities, including short-term one-off funding, must budget for Aboriginal and Torres Strait Islander workforce development, including upskilling and competency training opportunities, new workforce traineeships, and work placement for AICCHS staff.** **Develop research applications to trial evidence-based interventions on the efficacy of peers in improving health outcomes.**

Interprofessional networks

This strategy recognises the proven benefits of interprofessional and transprofessional networks in building the capacity of workforce settings and human infrastructure. The networks also build a greater appreciation and knowledge of roles, responsibilities and value of First Nations staff clinical and cultural skill sets, which are critical in supporting better health outcomes for Aboriginal and Torres Islander communities.

Key Considerations

- Interprofessional and transprofessional networks aligned with shared health priorities are important determinants to improving population behaviours,[67] and lead to improved primary care through better understanding of practitioner roles and multidisciplinary networks.[68]
- A work environment that supports and encourages interprofessional collaboration will contribute to a learning and development focused work environment, and change attitudes and value placed on team-based approaches to improving care. [69]
- Interprofessional networks within and across primary care organisations help to create a deeper understanding of the professional, social, physical and task-related differences across disciplines, overlaps in roles and responsibilities, gaps in care and most importantly, provide a safe space to allow these relationships to form and develop.[70 71]
- Regional and state-based stakeholders are looking for innovative, system transforming solutions that will ensure the appropriate supply, mix and distribution of the health workforce. One of the most promising solutions can be found in interprofessional collaboration.[72]
- Interprofessional collaboration occurs when multiple health providers from different professional backgrounds (transprofessional) provide comprehensive services by working with patients, their families, carers, and whole communities to deliver the highest quality care. Within these settings, learning and development opportunities can be significant (particularly for supervising students), developing wider competencies, or simply to consider alternative career opportunities.[73] In fact, when highly effective collaborations occur, all stakeholders benefit – organisations, professionals, students, and patients.[74]
- Supporting integrated clinical networks and joint planning around common health issues is important and can lead to new opportunities for supporting mentoring and supervision, important CPD opportunities,[75] as well as the exchange of cross-cultural perspectives which also lead to improved cultural safety.[76]
- Allied health professionals are ideally positioned to facilitate interprofessional interactions and have also been proven to make excellent mentors, including for staff enrolled in vocational training.[77]

67 Pat Hoddinott, Roisin Pill, Maretta Chalmers, Health professionals, implementation and outcomes: reflections on a complex intervention to improve breastfeeding rates in primary care, Family Practice, Volume 24, Issue 1, February 2007, Pages 84–91, https://doi.org/10.1093/fampra/cml061

68 Ryuichi Ohta, Yoshinori Ryu & Manabu Yoshimura (2021) Realist evaluation of interprofessional education in primary care through transprofessional role play: what primary care professionals learn together, Education for Primary Care, 32:2, 91-99, DOI: 10.1080/14739879.2020.1858349

69 Erin M. Spaulding, Francoise A. Marvel, Elsen Jacob, Alphie Rahman, Bryan R. Hansen, Laura A. Hanyok, Seth S. Martin & Hae-Ra Han (2021) Interprofessional education and collaboration among healthcare students and professionals: a systematic review and call for action, Journal of Interprofessional Care, 35:4, 612-621, DOI: 10.1080/13561820.2019.1697214

70 Evert Schot, Lars Tummers & Mirko Noordegraaf (2020) Working on working together. A systematic review on how healthcare professionals contribute to interprofessional collaboration, Journal of Interprofessional Care, 34:3, 332-342, DOI: 10.1080/13561820.2019.1636007

71 Jill E. Thistlethwaite, Roger Dunston & Tagrid Yassine (2019) The times are changing: workforce planning, new health-care models and the need for interprofessional education in Australia, Journal of Interprofessional Care, 33:4, 361-368, DOI: 10.1080/13561820.2019.1612333

72 World Health Organisation (2010) Framework for action on interprofessional education and collaborative practice. Retrieved from: https://www.who.int/publications/i/item/framework-for-action-on-interprofessional-education-collaborative-practiceCentre for the Advancement of Interprofessional Education (CAIPE), (2002). Defining IPE. Retrieved from https://www.caipe.org/about-us

73 Hammick M, Freeth D, Koppel I, Reeves S, Barr H. A best evidence systematic review of interprofessional education: BEME Guide no. 9. Med Teach. 2007 Oct;29(8):735-51. doi: 10.1080/01421590701682576. PMID: 18236271.

74 Holly Wei, Phyllis Horns, Samuel F. Sears, Kun Huang, Christopher M. Smith & Trent L. Wei (2022) A systematic meta-review of systematic reviews about interprofessional collaboration: facilitators, barriers, and outcomes, Journal of Interprofessional Care, 36:5, 735-749, DOI: 10.1080/13561820.2021.1973975

75 Main PAE, Anderson S. Evidence for continuing professional development standards for regulated health practitioners in Australia: a systematic review. Hum Resour Health. 2023 Mar 20;21(1):23. doi: 10.1186/s12960-023-00803-x. PMID: 36941655; PMCID: PMC10026429.

76 Nelly D. Oelke, Wilfreda E. Thurston & Nancy Arthur (2013) Intersections between interprofessional practice, cultural competency and primary healthcare, Journal of Interprofessional Care, 27:5, 367-372, DOI: 10.3109/13561820.2013.785502

77 Jack Seaton, Anne Jones, Catherine Johnston & Karen Francis (2021) Allied health professionals' perceptions of interprofessional collaboration in primary health care: an integrative review, Journal of Interprofessional Care, 35:2, 217-228, DOI: 10.1080/13561820.2020.1732311

6.1	Support the development of interprofessional networks within AICCHS and partner networks	
	Key actions to consider	**What this looks like in pracitice**
6.1.1	**Review current interprofessional networks and structures within NMA**	**Develop a better understanding of Interprofessional Networks and Collaboration within the AICCHS to inform how to better stimulate these networks to align with workforce development objectives:** • Use a survey approach including interviews with clinical leaders and members of the multidisciplinary teams. • Review against nKPI priority areas of child and family, chronic disease management, and health screening. • Share key findings and recommendation with NMA to guide future actions.
6.1.2	**Enhance interprofessional networks within NMA to increase capacity for supporting education and training aligned with population health priorities**	**Transforming informal collaboration into more directed and purposeful structures to increase capacity for learning, development, and collaboration.** **Development of best-practice guidelines to assist clinical leaders to support the establishment of interprofessional networks as part of 'core business':** • Development of leadership competency training to assist staff educators, practitioners, and managers responsible for IPC outcomes. • Encourage inter-sectoral membership from partner organisations where appropriate, including opportunities for online and virtual networks. **Utilise CQI as a mechanism to encourage and trial interprofessional education and competency initiatives:** • Consider CQI programs that link to formal CPD opportunities for members of the multidisciplinary team. • Consider health practitioner regulatory requirements and align CPD with mandatory training requirements (these have been proven to motivate participation and improve practitioner knowledge and behaviour). **Fostering interprofessional networks aligned with health priorities will balance the need to ensure the right combination of skill and experience to develop competencies and learning objectives.** **As interprofessional networks mature, they will provide candidates for mentoring and supervision roles in NMA, including remote supervision across the network:** • While some disciplines may be better suited than others, evidence suggest allied health workforce would be. **IPC can also contribute significantly to primary health care planning, as well as workforce planning and potentially research investment.**
6.1.3	**Implement interprofessional practice to support cross-cultural exchange and strengthen cultural safety**	**The concepts of interprofessional collaborative practice, cultural competency and primary health care are fully integrated within the model of care and linked to better health outcomes.** **The development of IPC will provide an important mechanism to allow cultural knowledge and perspectives to be provided through transprofessional networks and collaboration:** • Team care discussions and case planning. • Continuous learning and competency development opportunities. • Understanding roles and responsibilities and placing value in grass-roots staff perspectives and knowledge. • Opportunity to integrate cultural advisors into IPC forums and discussions. • Health professional is an all-encompassing term that includes individuals with the knowledge and or skills to contribute to the physical, mental and social well-being of a community.

Evidence informed workforce development

This strategy recognises that building the capacity for enabling a data-driven workforce implementation plan requires aligning investment against strategic priorities of staffing and career development, and better understanding supply and demand dynamics for identified gaps and workforce deficits. Evidence-based knowledge translation will inform regional and place-based decision-making support to create new employment pathways and workforce innovation, reinforce cultural safety, and ensure equitable distribution of the right workforce, working to the right scope, as a team.

Key Considerations

- Given the dynamic workforce design, and historical and program factors that contribute to current workforce configurations within clinical and health service contexts, more collaborative data sets are needed to enable evidence-based review and knowledge translation of what is working well, and what is not working and needs a reset.
- Building the capacity for AICCHS to generate their own evidence, and to review this evidence in ways that aligns with their strategic interests and aspirations for improving First Nations health, will ensure this critical analysis is undertaken in the region, close to communities, and not be driven by mainstream and research institutions.[78]
- It is impossible to consider culture and health independently. The development and analysis of data to measure the relative impacts of the actions identified in the WQFNHWIP will also provide evidence of how these strategies remove racism and address health equity for first nations people.[79]
- Analysis of evidence relating to workforce retention/sustainability is important to understand the contribution of the workforce to enhancing healthcare and health outcomes.[80]
- Collection, maintenance, and analysis of shared human resource data can be an important source of data and provide a solid evidence base of the dynamics that underpin the health workforce retention and professional development outcomes.[81] With targeted use of expanded health intelligence, more predictive analytics can be explored, inclusive of health professional and patient feedback, that helps understand qualitative elements of factors working to better support First Nation workforce outcomes.
- This strategy will aim to improve information gathering, collecting, sharing, reporting and analysis to inform decision making and assist alignment with population health needs,[82] and more strategic workforce planning and performance across Western Queensland.
- Shared data protocols will assist workforce planning through more systematic and tailored analysis of contemporary indicators designed to measure baseline data, population health, view historical trends and explore workforce planning scenarios.
- Securing Indigenous data sovereignty and governance has been highlighted as an essential consideration in place-based initiatives,[83] [84] and adoption of appropriate protocols for shared workforce data use, and publication will underscore cooperation across AICCHSs and partners.

78 Luke J, Verbunt E, Zhang A, et al Questioning the ethics of evidence-based practice for Indigenous health and social settings in Australia BMJ Global Health 2022;7:e009167.
79 Watego, C., Singh, D. & Macoun, A. 2021, Partnership for Justice in Health: Scoping Paper on Race, Racism and the Australian Health System, Discussion Paper, The Lowitja Institute, Melbourne, DOI: 10.48455/sdrt-sb97
80 McCalman J, et al. Working well: a systematic scoping review of the indigenous primary healthcare workforce development literature. BMC Health Serv Res. 2019;19(1):1–18. https://doi.org/10.1186/s12913-019-4580-5.
81 Russel d et al Rural health workforce retention: strengthening the evidence base11th National Rural Health Conference https://ruralhealth.org.au/11nrhc/papers/11th%20NRHC%20Russell_Deborah_C1.pdf
82 Griffiths K. Smith J. Measuring health disparities in Australia: using data to drive health promotion solutions. Health Promot J Aust. 2020; 31: 166-168
83 Trudgett, S et al. A framework for operationalising Aboriginal and Torres Strait Islander data sovereignty in Australia: Results of a systematic literature review of published studies. eClinicalMedicine 2022;45 101302. www.thelancet.comVol45MonthMarch,2022
84 Maiam nayri Wingara Indigenous Data Sovereignty Communique: Indigenous Data Sovereignty Summit 20/06/2018. 2018.

7.1	Establish data sharing protocols, agreements and capabilities to support evidence-based approaches	
	Key actions to consider	**What this looks like in pracitice**
7.1.1	**Data sharing agreements are in place to support collection, analysis, and reporting of workforce data**	**Build on existing agreements (including grant agreements) and ensure consistent workforce data is provided by all partners to the agreement.** **Agreements recognise existing and future Indigenous Data Sovereignty Governance requirements.** **Data custodian(s) are identified including roles, responsibilities, and compliance.** **Support the development of Indigenous Data Sovereignty Governance principles to ensure codesign of an appropriate approach to implementation that adheres to relevant protocols, cultural practice and data standards.** • Commission a review of existing frameworks and principles and support a co-design process. • Prepare guidelines regarding data collection, analysis and reporting requirements. **All parties will agree to support data recognition and collection protocols that will include high quality monitoring and evaluation.** **Data strategies are crucial in tracking the feedback and career development outcomes of staff and are needed to inform approaches to improve recruitment and retention.** **Work collaboratively across organisations to identify suitable data collection points to support the collection of consistent data on retention, skills development, new recruitment, and other data capture requirements needed to measure impacts of activities on workforce dynamics and other outcome measures.** **Ensure data and intelligence on the number and proportion of Aboriginal and Torres Strait Islander staff working in NMA is more accurate.**

7.2	Develop standardised reporting of First Nations workforce outcomes	
	Key actions to consider	**What this looks like in pracitice**
7.2.1	**Create consistent and comparable data and report metrics**	**Codesign standard reports to be prepared from NMA and wider participating data sources, including workforce agencies and WQPHN.** **Collaborate with all health sectors and relevant agencies to examine data sharing and analysis opportunities and to harmonise information reporting and planning analysis.** **Ensure data reporting including analysis is comparable to state and national measurement indicators.** **Codesign and customise data conventions to be universally applied across network, including potential extraction tools and data portal development.**
7.2.2	**Annual baseline of First Nations workforce**	**Within first 12 months of this plan, undertake a comprehensive review of workforce with available data to establish a baseline of positions and vacancies against which to measure forward years:** • **Promote high co**mpliance and uptake of survey tool to map the workforce profile (gender, title, years of service, training etc.) and distribution within the NMA. • Develop a deeper understanding of workforce distribution and health inequalities. • Workforce analysis to be undertaken at the jurisdictional (PHN, HHS, AICCHS) and regional level (commissioning locality). **Better understand workforce dynamics impacting on retention and the effectiveness of pathways into health careers and factors that influence retention against specific disciplines.** **Develop data collection protocols within all vocational training initiatives including school-based apprenticeships to allow quantitative and qualitative analysis.**

7.3	Develop academic partnerships research using workforce data	
	Key actions to consider	**What this looks like in pracitice**
7.3.1	**Build the capacity and expertise in collecting, using, and interpreting data in a meaningful way**	**Selected academic partners are assisting NMA in the development of Indigenous Data Sovereignty & Governance principles, and facilitating co-design of data collection domains and approaches.** **Within 12 months of the strategy, collaborate with academic partners to develop an "Outcomes Framework" to provide contemporary measures against each of the strategies.** **Reporting aligned with comparable frameworks.**

7.3.2	**Align workforce data evaluation against burden of illness data**	**Support analysis of workforce data to better understand distribution and ratios against population health and burden of disease analysis in both regional and place-based jurisdictions:**
		• Meaningful use of workforce data through measurement of impacts in health data (including access, experience, and workforce diversity).
		• Align data analysis to critical health priories and nKPI data sets including:
		  • Child and maternal health.
		  • Diabetes prevention and management.
		  • Rheumatic heart disease.
		  • Screening and follow-up.
		
		Include critical social determinants data in place-based analysis to provide localised contexts (including education levels, earning and learning, digital technology, as well as remoteness and transport, housing stress and poverty indicators).
		
		Support the application of data models for workforce planning and evaluation, including predictive analysis and risk modelling.

7.3.3	**Build the capacity for First Nations research opportunities**	**Work with the NMA and partners to develop the policy framework to enable targeted and opportunistic research applications to various state, national and philanthropic programs:** • Support identified workforce/health priorities, unlock potential new models of workforce innovation, enhance interprofessional and transprofessional collaboration, and bring additional investment into the region. • Support a participatory approach (including linkage to community where appropriate). **Support pathways to formal and informal research skill development and professional networks (including linkage through faculty appointment for regionally based providers).** **Provide training and development to increase local investigators and research and evaluation skills within clinical and nonclinical teams.**
7.3.4	**Develop contemporary measures of cultural safety to monitor improvement and related impacts**	**Collaborate with academic partners/advisors to develop data collection, analysis, survey and case studies to measure whether targets for cultural safety initiatives are being achieved.** **Under the data sharing and IDS&G protocols, expand analysis to wider public NGO, private and statutory organisations, and settings within the region.** **Support reporting analysis at regional, subregional and place-based jurisdictions**

STRATEGIC ACTION KEY RESULTS AREAS

Strategic action key results areas

1 First Nations Leadership		Owner	Timeframe
1.1	Executive skill development for existing and emerging leaders of AICCHS		
i.	Establish Western Queensland Leadership Network		
ii.	Establish leadership development collaborative		
iii.	Research and co-design leadership curriculum, resources, and collateral		
iv.	Undertake a pilot of leadership program and undertake formative evaluation		
1.2	First Nations leadership within regional governance structures		
i.	Promote leadership development candidates within the AICCHS and wider partner networks		
1.3	Develop leadership competency standards to improve cultural safety		
i.	Minimum standards for ethical and culturally safe leadership in the health sector across the region		
ii.	Develop and deliver programs that support the adoption, promotion, and use of the Standards		

2 strengthening cultural safety		Owner	Timeframe
2.1	Strengthen cultural safety credentials and performance		
i.	Commission an audit across WQ catchment, prepare report, gap analysis of cultural resource needs and key learnings		
ii	Develop a cultural safety data development plan to guide data capture, survey tools and program logic Prepare deidentified report of Cultural Safety baseline against which future assessment can be compared		
2.2	Increase access to resources and support cultural safety and competency development		
i.	Develop a shared statement regarding cultural safety and how this applies to the development of First Nations workforce		
ii.	Develop cultural safety guidelines to support workforce development outcomes and organisational capacity		
iii.	Support for locally developed resources and collateral to reflect cultural diversity		
iv.	Develop portal for managing and accessing cultural resources		
v.	Develop program collateral for universal coverage to secure cultural safety minimum standards across the region		

3 funding and strategic investment			
3.1	Responding to Regional Workforce Priorities		
i.	First Nations regional workforce planning		
ii.	Expanded scope of practice for Aboriginal health practitioners in remote Queensland		
3.2	Innovation and reform for increased workforce investment in Western Queensland		
i.	Innovation to government and program funding envelopes		
ii.	Foster academic partnerships in Western Queensland to leverage research funding to respond to workforce priorities and innovation		
3.3	Increase philanthropic partnerships and co-investment strategies in Western Queensland		
i.	Secure philanthropic investment into First Nations workforce skills development and employment		

4 employment and professional development		Owner	Timeframe
4.1	Improved retention and professional development of workforce		
i.	Ensure work environments promote learning and development		
ii.	Evidence informed retention strategies		
iii.	Expanded professional placement networks		
4.2	Increase capacity to support employment, training and professional development		
i.	Increased enrolments in vocational training		
ii.	Better access to local RTO for training support and certification		
iii.	Partnership agreement with CRRH and SQRH University departments of rural health		
iv.	Establish Indigenous Allied Health Australia (IAHA) Academy in Western Queensland		
v.	Increase mentoring skills and professional networks		
4.3	Pathways for career development, promotion and leadership		
i.	Promote pathways into a diverse range of health careers.		
ii.	Address financial barriers to career development for First Nations staff		

5 Align workforce with population health needs		Owner	Timeframe
5.1	Ensure planning for workforce aligns with population health needs		
i.	Existing and future workforce priorities are aligned with population health needs		
ii.	Determine relative value of current staffing investments to deliver MDTBC		
iii.	Digital technologies support redistribution of investment to local workforce		
5.2	Ensure focus on team-based care configuration		
i.	Multidisciplinary teams support First Nations staff development		
ii.	Invest in peer workforce to improve self-management outcomes		
iii.	Increase awareness and knowledge of social determinants in front line workforce		
iv.	Ensure workforce configuration meet model of care and community needs		

6 interprofessional networks		Owner	Timeframe
6.1	Support the development of interprofessional networks within AICCHS and partner networks		
i.	Review current interprofessional networks and structures within NMA		
ii.	Enhance interprofessional networks to increase capacity for supporting education and training aligned with population health priorities		
iii.	Implement interprofessional practice to support cross- cultural exchange and strengthen cultural safety		

7 evidence informed workforce development		Owner	Timeframe
7.1	Establish data sharing protocols, agreements and capabilities to support evidence-based approaches		
i.	Data sharing agreements are in place to support collection, analysis, and reporting of workforce data		
7.2	Develop standardised reporting of First Nations workforce outcomes		
i.	Create consistent and comparable data and report metrics		
ii.	Annual baseline of First Nations workforce		
7.3	Develop academic partnerships research using workforce data		
i.	Build the capacity and expertise in collecting, using, and interpreting data in a meaningful way		
ii.	Align workforce data evaluation against burden of illness data		
iii.	Build the capacity for first nations research opportunities		
iv.	Develop contemporary measures of cultural safety to monitor improvement and related impacts		

Western Queensland PHN acknowledges the traditional owners of the country on which we work and live and recognises their continuing connection to land, waters and community. We pay our respect to them and their cultures and to elders past and present.

Australian Government

phn WESTERN QUEENSLAND
An Australian Government Initiative

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