NSW Aboriginal Population Health Training Initiative (APHTI)

EVALUATION

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Executive Summary

Background

The NSW Aboriginal Population Health Training Initiative (APHTI) is a three-year training program in which Aboriginal participants undertake studies leading to a Master of Public Health (MPH) degree and complete a series of work placements in population health services. The APHTI commenced in 2011 and aims *"to contribute to the development of the Aboriginal population health workforce, with the long-term objective of improving the health of Aboriginal people in NSW"*. The objectives of the APHTI are to:

- provide a more adaptive and competent Aboriginal population health workforce;
- increase the number of Aboriginal people with postgraduate qualifications in population health;
- increase the number of Aboriginal people who have achieved public health workplace-based competencies;
- increase exposure of Aboriginal trainees to population health career opportunities; and
- increase the population health workforce's exposure to Aboriginal population health issues, and the value of traineeships.

There have been three intakes of APHTI trainees: four trainees were recruited in 2011; two in 2013; and five in 2014. The APHTI helps meet commitments made by the NSW Government relating to Aboriginal workforce development and to "Closing the Gap" in health outcomes between Indigenous and non-Indigenous Australians.

The evaluation was commissioned to describe how the APHTI has been implemented, to identify significant achievements and challenges in its implementation, and to measure the impact of the APHTI on increasing the NSW Aboriginal population health workforce.

Methods

The evaluation had three components:

1. A combination of face-to-face, telephone and group semi-structured interviews were conducted with 31 key stakeholders, including APHTI trainees (n=11), Local Health District (LHD) coordinators (n=4), workplace supervisors (n=4), MPH convenors within universities (n=1), NSW Ministry of Health staff (n=5), APHTI Advisory Committee members (n=5) and Aboriginal workforce coordinators within participating LHDs (n=1). Interviews explored the experiences of key stakeholders in participating in, implementing or coordinating the APHTI. Interview data were analysed by qualitative thematic analysis.
2. Key APHTI documents were analysed, including the Competency Framework, the APHTI Implementation Report (2012), mid program and final assessment resources, resources developed for LHDs, the 'Where to study my MPH' resource for APHTI trainees and supporting documents developed by LHDs.
3. APHTI participants' outcome data were analysed, including trainees' exit interview summaries, academic transcripts and summaries of mid program reviews and final assessments.

Results

Program implementation, achievements and challenges

Overall, stakeholders reported a positive experience of the APHTI. The first group of trainees reported some difficulties as systems and resources were being developed and refined, but, despite these, all trainees were pleased that they had entered the program. All trainees saw it as being a benefit to their development and to their future career. Most LHD stakeholders were also satisfied with their experience of the APHTI and all who were interviewed for the evaluation indicated that their LHD would consider engaging trainees again.

Key issues raised by stakeholders on specific aspects of program implementation included:

- Some trainees experienced difficulties with some university course and workplace elements – especially where higher-level maths was required. This meant that some LHDs had to provide their trainees with more support than they had anticipated. However, all trainees have passed these subjects, some with distinction and high distinction grades;
- LHDs implemented different arrangements when it came to the ongoing employment status of their trainees. Post-program job security was a concern for some trainees;
- Overall, trainees and other LHD staff were very satisfied with the suitability and outcomes of their APHTI placements and projects. LHD coordinators spoke highly of some of the projects completed by their trainees,

describing some as breaking new ground in targeting Aboriginal issues in health promotion and in addressing long-standing issues in the delivery of mainstream services;

- Trainees stressed the importance of having a good first placement – one that was culturally safe, which oriented the trainee to working in population health and which was appropriate to the knowledge and skills of trainees who were just starting in this field;
- Trainees and LHD staff involved in supporting trainees reported that they generally balanced the work and study elements of the program well;
- The first group of APHTI trainees had problems applying the Competency Framework to their work, especially in developing, compiling and documenting evidence of competency. Most had difficulty interpreting the requirements for the presentation of evidence. However, the latter intakes of APHTI trainees appear to have had a more positive experience with the Competency Framework. LHD coordinators and supervisors now see the Competency Framework as being "fit for purpose" and providing a good basis for planning and monitoring trainee learning;
- Most trainees reported a high level of satisfaction with the program from a cultural safety perspective. Trainees used words like "respectful", "caring" and "fantastic" to describe most placements and said that there were mechanisms in place (both at the workplace and Ministry level) to raise and to address any cultural concerns;
- Trainees were generally satisfied with the support they received in the program at all levels. The quality of support currently provided by the APHTI Coordinator at the Ministry was especially highlighted. From the perspective of workplace supervisors, while there may have been some instances where supervisors had to provide more support than anticipated, the general experience of providing support to APHTI trainees was positive;
- The costs associated with engaging APHTI trainees have influenced LHDs' decisions on whether to participate. The current funding model appears to be working well.
- There may be potential to place APHTI trainees in organisations other than LHDs. An APHTI trainee is soon to be employed for the first time outside the LHD network. There may also be potential benefits in supporting the placement of trainees elsewhere (e.g. the Aboriginal Community Controlled Health Sector).

Impact on the NSW Aboriginal population health workforce

Early employment outcomes of the APHTI have been positive, with all four of the first group of graduates securing jobs in NSW Health, including two currently in management roles. As the first group of four trainees completed the program in 2014 and another seven trainees are still in training, it is too early to draw many conclusions about the effectiveness of the program in achieving its aim of contributing to the development of the Aboriginal population health workforce.

The APHTI is making progress in achieving its defined program objectives, including those related to: Aboriginal staff attainment of postgraduate qualifications in population health workplace-based competencies in public health; and exposure to population health career opportunities.

The APHTI has so far maintained a 100% retention rate of its trainees. This reflects the high level of support provided to both trainees and their LHD employers. Two participating LHDs are now supporting their second groups of APHTI trainees and others have indicated their interest in hosting more trainees in the future.

Discussion

The current APHTI model appears to be working well – the employment and educational outcomes of the first group of APHTI graduates are good, the current trainees and employers are satisfied with the way the program is being implemented and demand for the program is growing. That said, trainees and other LHD stakeholders made a number of suggestions to enhance the program including more joint development activities with other Ministry training programs, face-to-face workshops for LHD coordinators and supervisors and improvements to the induction of new trainees.

Consideration should be given to clarifying the aims of the APHTI to better reflect how most stakeholders perceive it. Rather than being exclusively concerned with the development of the "Aboriginal population health workforce" the aim could instead be expressed as *"the development of Aboriginal workforce capability and influence in population health so that the health of Aboriginal people in NSW can ultimately be improved".*

The high level support provided by the Ministry to both trainees and LHDs was widely acknowledged as a major success factor in the APHTI. This should be maintained and further systematised to ensure that the knowledge and approach of the current APHTI Coordinator can be passed on to a successor at some point.

There was broad agreement that the APHTI should continue to be open to Aboriginal people from a broad range of backgrounds and with different capabilities. This might mean that some trainees will require more support to complete the program, but this can produce an even better end result for trainees, their communities and the NSW health system.

Ongoing attention should be given to building the "APHTI brand" as a mark of quality. The APHTI Advisory Committee should explore perceptions of the program and ensure that a positive reputation is built for the program and its graduates.

Inconsistencies in the employment conditions of APHTI trainees and in their post-program job security were a source of concern for some trainees. Ways of overcoming or reducing the effect of these inconsistencies on trainees need to be explored. However, care is needed to avoid imposing a "one-size-fits-all" solution that reduces the program's current flexibility, and which may deter some employers and prospective trainees from participating.

Trainees generally reported that they felt culturally safe in their traineeships, but there were a few isolated incidents of concern. All staff involved in the delivery of the APHTI should be required to have completed *Respecting the Difference* training – or at least the two-hour eLearning component.

1 Background

1.1 What is the APHTI?

The NSW Aboriginal Population Health Training Initiative (APHTI) is a three-year training program in which Aboriginal participants undertake studies leading to a Master of Public Health (MPH) degree and complete a series of work placements in population health services. Launched in 2011, the program is delivered through partnerships between the Population and Public Health Division of the NSW Ministry of Health and the Local Health Districts (LHDs) in NSW.

The APHTI's aim is *"to contribute to the development of the Aboriginal population health workforce, with the long-term objective of improving the health of Aboriginal people in NSW".* Its objectives are to:

- Provide a more adaptive and competent Aboriginal population health workforce;
- Increase the number of Aboriginal people with postgraduate qualifications in population health;
- Increase the number of Aboriginal people who have achieved public health workplace-based competencies;
- Increase exposure of Aboriginal trainees to population health career opportunities; and
- Increase the population health workforce's exposure to Aboriginal population health issues, and the value of traineeships.

1.2 What is the policy and program context of the APHTI?

In 2009, when planning for the APHTI commenced, the program was aligned to commitments made by the NSW Government relating to Aboriginal workforce development and to "Closing the Gap" in health outcomes between Indigenous and non-Indigenous Australians. A number of Australian and NSW strategies and frameworks recognise the importance of increasing Aboriginal representation across the health workforce as a way of delivering more culturally competent services and of achieving better health outcomes for Aboriginal people. These include the *National Partnership Agreement (NPA) on Closing the Gap in Indigenous Health Outcomes*; the *NSW Aboriginal Health Plan: 2013-2023*; *Good Health, Great Jobs: The NSW Health Aboriginal Workforce Strategic Framework 2011–2015;* and the *NSW Public Sector Aboriginal Employment Strategy*.

The APHTI is one of several population health training programs run by the NSW Ministry of Health. These programs include the NSW Public Health Officer (PHO) Training Program, the NSW Biostatistics Training Program and the NSW Aboriginal Environmental Health Officer Training Program.

1.3 How does the APHTI work?

Within the Ministry of Health, the Population Health Training team manages the APHTI. This team is part of the Evidence and Evaluation Unit of the Centre for Epidemiology and Evidence within the Population and Public Health Division. A Senior Policy Officer coordinates the APHTI and is the primary contact point for trainees, LHDs and other stakeholders.

The Ministry of Health provides funding to cover approximately half of the trainees' salaries, all of the university fees, state-wide training opportunities, travel expenses, and various program administration and set up costs. LHDs cover the residual salary costs and provide study leave and training and support in the workplace[1].

An APHTI Advisory Committee meets biannually to provide advice and guidance on the program's implementation. According to its Terms of Reference, members of this committee *"are selected for their skills, experience and capacity to contribute to the cultural integrity, strategic direction, workplace relevance and learning quality of the APHTI."* Membership includes representatives of the university sector, the Ministry's Centre for Aboriginal Health, Centre for Epidemiology and Evidence and Aboriginal Workforce Unit, Aboriginal Training Programs, NSW health services, the Aboriginal Community Controlled Health Sector, and an APHTI graduate.

Each participating LHD appoints an APHTI coordinator to plan, coordinate and support their APHTI traineeships. LHDs must ensure the cultural safety of trainees, oversee the planning of learning to maximise integration of university study and workplace learning, assist trainees to identify suitable mentors and appoint workplace supervisors for each placement.

LHDs recruit, employ, induct and supervise their trainees. Prospective APHTI trainees are generally expected to have a Bachelor level degree accepted by the university at which they have chosen to enrol in an MPH. Award and salary

[1] This funding model was introduced in 2014. The original funding model required the LHDs to cover a greater share of the overall costs.

conditions of the APHTI trainees are determined by the LHDs, but the Ministry expects trainees to have skills and experience equivalent to a Public Sector Clerk, Grade 5/6 level. LHDs are not obliged to employ trainees at the end of the program unless otherwise stipulated in their contracts of employment.

There have been three intakes of APHTI trainees – 2011 (four trainees – who were recruited in the pilot phase of the program); 2013 (two); and 2014 (five). At the time of the evaluation, recruitment of a further four trainees was underway. No trainees were engaged in 2012 and this led to a revision of the funding partnership model and a subsequent increase in demand for the program from LHDs.

Trainees generally enrol in one of six universities and are offered one day per week of study leave during semester. The program has flexibility for additional study leave if needed by trainees (e.g. during exam time). This is made available at the discretion of the LHD.

In the workplace, trainees rotate through three to six work placements over the three years to gain practical experience in population health. Workplace learning is guided by the APHTI Competency Framework, which defines the workplace competencies to be attained. The following competency areas are defined in the framework: professional practice; population health management; communication; evidence informed practice; epidemiology and data management; communicable diseases and risk management; health promotion; and health evaluation. The Ministry supports LHDs and trainees to develop work placement plans and projects for each placement and to incorporate these into learning contracts.

A mid-program review is held halfway through the traineeship to provide trainees with an opportunity to discuss their progress and to have any completed competencies assessed by a panel of external reviewers. At the end of the program, trainees complete a portfolio of evidence addressing the APHTI competencies, and meet with a panel of external assessors. This panel includes one Aboriginal person and one non-Aboriginal person who are familiar with the APHTI and who have expertise in competency-based assessment and population health. Care is taken to ensure that trainees feel culturally safe and are supported throughout the assessment process – including advice and support in completing their portfolios, the provision of examples and templates, the option to invite a support person to the assessment, and briefings on the assessment process itself.

1.4 Evaluation overview

The NSW Ministry of Health commissioned Powers and Associates to undertake an independent evaluation of the APHTI. The evaluation aimed to describe how the APHTI has been implemented, to identify significant achievements and challenges in its implementation, and to measure its impact on increasing the NSW Aboriginal population health workforce. Guided by these aims, the following evaluation questions were established:

1. Program implementation:
   - What has been the process for implementing the APHTI and the costs associated with implementation?
   - What factors (both positive and negative) have affected implementation?
   - Have program participants (including trainees, supervisors, coordinators, funders and other key stakeholders) been satisfied with program implementation and has it met their expectations?
   - Has the APHTI been implemented in a culturally appropriate way that is acceptable to trainees and other key stakeholders?
   - How has implementation evolved over time?
   - What aspects of the APHTI were considered most/least useful?
   - How can the program be improved in the future at the state and district level?
   - What support and monitoring arrangements should be maintained in future?
   - Will additional resources be required to continue or further develop the program?
2. Program impact:
   - How has participating in the APHTI impacted on the development of the trainees' skills and competencies and guided their career pathways?
   - What are the employment outcomes of graduates, and has the APHTI increased the Aboriginal population health workforce?
   - Has the APHTI increased the number of Aboriginal people who have achieved public health workplace based competencies?

- Has the APHTI increased the number of Aboriginal people who have gained post graduate qualifications in public health?
- Has the APHTI increased the population health workforce's exposure to Aboriginal population health issues and the value of traineeships?
- What were the unexpected benefits of the APHTI?

A combination of qualitative methods, document analysis and secondary analysis of routinely collected information were used to investigate these evaluation questions.

2 Methods

The evaluation of the APHTI had three components: qualitative interviews with key stakeholders; analysis of APHTI resources and other program documents; and analysis of routinely collected trainee outcome data.

2.1 Qualitative interviews

A combination of face-to-face, telephone and group semi-structured interviews were conducted with key stakeholders, including APHTI trainees, LHD coordinators, workplace supervisors, MPH convenors within universities, NSW Ministry of Health staff, APHTI Advisory Committee members and Aboriginal workforce coordinators within participating LHDs. Several interview schedules were developed to guide discussions (one for each stakeholder group (Attachment A)).

Interviews explored the experiences of key stakeholders in participating in, implementing or coordinating the APHTI. Data from interviews were recorded initially in handwritten notes and then transferred to an electronic format for storage and to aid analysis. Interview data were analysed by qualitative thematic analysis. During analysis, responses were grouped under the evaluation questions and then reviewed in depth to identify key themes. Between 23 October 2014 and 19 December 2014, 31 key stakeholders were interviewed. Most stakeholders were interviewed in an individual, face-to-face format. However, three telephone interviews and two group interviews were conducted and one written submission was received. Table 1 provides an overview of who was interviewed and how.

2.2 Document analysis

The NSW Ministry of Health and LHDs have developed several resources to guide the implementation of the APHTI. These resources and other program documents provide insight into the ways in which the APHTI has been implemented in NSW since it commenced in 2011. The evaluation therefore included a document analysis, with the following APHTI resources and documents reviewed in depth: the Competency Framework; the APHTI Implementation Report (2012); mid program and final assessment resources; resources developed for LHDs; the 'Where to study my MPH' resource for APHTI trainees; and supporting documents developed by LHDs.

2.3 Analysis of routinely collected trainee outcome data

The progress of APHTI participants is regularly monitored to ensure that their training needs are being met and that they are meeting the training and administrative requirements of the APHTI. This is done through regular meetings between trainees, workplace supervisors and LHD coordinators and through assessment activities, including mid program review and final assessment. To assess the impact of the APHTI, data from the monitoring of APHTI trainees and other output data were analysed, including trainees' exit interview summaries, academic transcripts, summaries of mid program reviews and summaries of final assessments.

Table 1: Who was interviewed and how?

Stakeholder Group	Total	Individual One-to-One	Individual Telephone	Written Response	Group
Trainees[2]	11	6	1	0	4
LHD Coordinators	4	3	1	0	0
LHD Supervisors	4	3	1	0	0
LHD Aboriginal Workforce Coordinators	1	1	0	0	0
University MPH Convenors	1	1	0	0	0
Ministry of Health Staff	5	5	0	0	0
Advisory Committee Members[3]	5	0	0	1	4
TOTAL	**31**	**19**	**3**	**1**	**10**

2.4 Ethical considerations

Because of the small sample sizes involved, ensuring the anonymity of interview responses proved to be challenging. This report includes data that accurately represent evaluation participants' views and trainees' accomplishments, while protecting their privacy and safety. Major identifying details have been removed from the evaluation report, quotations were sometimes paraphrased and, in some cases, distinctive stories that might make some individuals identifiable were omitted altogether.

[2] "Group" table count only includes trainees who were not consulted individually. This group included two trainees who had commenced the APHTI shortly before the evaluation commenced.

[3] "Group" table count only includes those Advisory Group members who were not consulted individually.

The evaluation of the APHTI was approved by the Aboriginal Health and Medical Research Council of NSW Ethics Committee and Hunter New England LHD Human Research Ethics Committee. Site specific approvals were obtained from Central Coast LHD, Hunter New England LHD, South Western Sydney LHD, and Western NSW LHD.

3 Results

3.1 Program implementation, achievements and challenges

3.1.1 Recruitment

From the program's commencement in February 2011 to October 2014, five of the fifteen LHDs in NSW had engaged APHTI trainees – Hunter New England (four trainees – two in 2011 and two in 2014), Western NSW (two trainees – one in 2011 and one in 2014), Central Coast (two trainees in 2013), South Western Sydney (one in 2011), and Sydney (one in 2014). At the time of the evaluation, recruitment for another four trainees was underway (including, for the first time, a trainee to be employed outside the LHD network in the Justice Health and Forensic Mental Health Network).

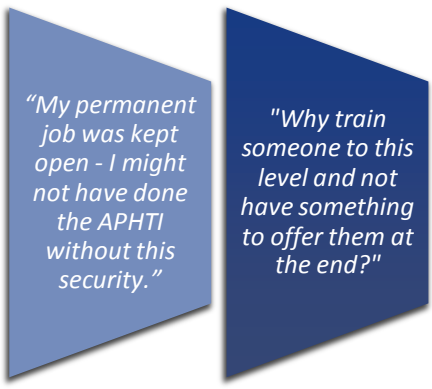
The first group of participating LHDs (2011) supported APHTI traineeships under a partnership arrangement that required the LHD to cover most of the trainees' salary costs. With no LHDs agreeing to participate in 2012 and only one participating in 2013, a different funding model was required. The Ministry of Health now covers approximately half of the trainees' salaries, all of the university fees and a number of other training costs. Following this modification to the funding model, interest in the APHTI from LHDs has increased and the competition for the traineeships each year is strong.

During semi-structured interviews, LHD staff who had been involved in supporting the first two intakes of APHTI trainees mentioned being attracted to the program for several reasons. Most felt that their LHD had a strong commitment to Aboriginal workforce development and saw the APHTI as another mechanism for developing Aboriginal staff. One participant mentioned that their LHD had been considering how to improve Aboriginal representation in management roles and saw the program as a way of achieving this goal. Some interviewees also felt that increasing Aboriginal workforce participation, specifically in population health, was important. One said that *"there are not enough Aboriginal staff who are highly skilled in health promotion"*, and saw the APHTI as part of the solution to this.

LHD staff who had been involved in supporting trainees felt that there is a need to ensure that all trainees have prerequisite skills and knowledge before commencing the APHTI – including being proficient in Word and Excel and having a basic understanding of population health terminology. These staff suggested that any gaps in such areas be filled through the program's development budget. One also stressed that trainees need to have clear goals: *"It must be something that they want to do – one candidate did not know enough about population health to know if it was a real goal."*

LHDs implemented different arrangements when it came to the ongoing employment status of trainees. One LHD allowed its trainees to retain their substantive positions for the duration of program. Interviewees who were employed in this LHD saw this as *"demonstrating their commitment to the trainees"*. No guarantees were made about a position in population health at the end of the program, but the LHD did ultimately make one permanent position available for a graduate. One LHD employee who had been involved in supporting trainees pointed out that *"it is asking a lot of an LHD to hold a position open for three years",* while another said that funding to backfill APHTI trainees on a contract basis would, in an ideal world, make it easier to provide this security.

The trainees who were interviewed also held strong views on the issue of post-program job security. While some seemed confident that they would emerge from the program highly employable and with excellent future career prospects, others - especially interviewees with family responsibilities and many years invested in their career progression in NSW Health - were troubled by uncertainty about the future and by their loss of job security. Some trainees suggested that their substantive roles be backfilled with contract staff while in the program. However, these interviewees acknowledged the complexity of putting such arrangements in place and felt that the resources required to do so might deter some LHDs from participating in the program. Others suggested that some kind of "transition period" be built into the program at the end of the three years to provide some post-program certainty and to allow people time to find an appropriate job that makes optimal use of their new skills.



Trainees in the first two cohorts applied for an APHTI traineeship by submitting an Expression of Interest (EOI) in response to internal LHD advertisements[4]. In the case of one LHD, the program was set up to enable its two trainees to continue in their current roles for the period of their traineeship, but a formal, internal EOI process was still conducted. This LHD's arrangements were unusual in that its two trainees continued to perform their substantive roles while in the program.

While some trainees mentioned that they knew about the program through their personal or work networks, others felt that they had entered the program with a basic understanding of what the program (and working in population health) entailed. The second of these views was commonly expressed by interviewees who were part of the first APHTI intake, as one put it: *"there was not much information available at the time about the program and what was in an MPH… but I was attracted to the program where I could stay on the same pay and get a credential."*

Trainees also mentioned differences in pay rates as being a contentious issue. APHTI trainees were paid at a range of levels, from Health Manager Level 1 to Health Manager Level 2. Although it could be argued that trainees are notionally all operating at the same level and should receive the same pay, the fact that some trainees were working in management roles (sometimes in their pre-APHTI jobs) means that there is also a strong argument to maintain this flexibility in salary levels.

Despite these concerns, overall trainees felt that getting into the APHTI was a great career opportunity. The training and job opportunities that the program was perceived to create were attractive.

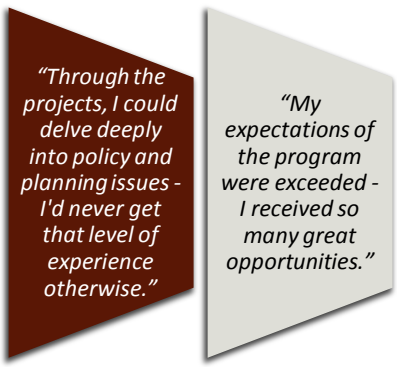
3.1.2 Placements and projects

During semi-structured interviews, LHD staff who had been involved in supporting trainees described the processes LHDs used in organising placements for their trainees in fairly broad terms. These interviewees reported sometimes experiencing difficulties in scheduling appropriate placements over the three years of the program and in aligning these, wherever they could, with the subjects being studied by trainees at university. These interviewees said they had tried to build some degree of trainee choice into their LHD's processes, but that this was not always possible.

LHD coordinators spoke highly of some of the projects completed by their trainees and described some as breaking new ground in targeting Aboriginal issues in health promotion, and in addressing long-standing issues in the delivery of mainstream services. These interviewees highlighted that some projects had continued as LHD priorities after the APHTI trainee had finished the program. This highlighted for them the importance and potential value of using the APHTI trainees to work on projects that add real value to the organisation.

The projects undertaken by trainees were a mix of Aboriginal health related projects and mainstream projects. Trainees liked this mix as they felt the task of improving Aboriginal health outcomes requires action in both spheres. Of the projects described by the trainees interviewed in the evaluation, 11 were focused on Aboriginal health (e.g. a survey of Aboriginal chronic care patients) and 13 on mainstream health (e.g. a project which reviewed issues and risks associated with needle and syringe vending machines and which trialled free dispensing).

Some of the trainees who were interviewed described the processes used by LHDs to plan work placements and projects as being fairly *ad hoc* and not providing them with much say in determining the location and timing of placements. One trainee, for example, indicated that in their first placement *"there was not a lot of work to do"* and that the supervisor was *"unaware that I was coming"*. Despite this, trainees were generally happy with their placements and felt that any planning process of this type is limited by the opportunities available and the priorities of the workplace at any given time, as one said: *"in Health, sometimes you don't get the time or the headspace to do this type of forward thinking"*.



Overall, trainees were enthusiastic and highly appreciative of the work placements and projects that they had undertaken while participating in the APHTI. While some in the first group of trainees reported experiencing challenges (e.g. one trainee said *"I didn't really understand how the program was intended to work and what the placements were intended to achieve until half way through it"*), most trainees felt that these issues have since been addressed and that they now receive excellent support from the Ministry, including in resolving any difficulties that might arise from placements and projects. Trainees generally saw the

[4] From 2014, all LHDs have also advertised externally.

program as providing an ideal opportunity to broaden their experience and to immerse themselves in important policy and program issues.

Some trainees mentioned experiencing other difficulties in the course of undertaking certain placements. These interviewees reported that sometimes planned placements were delayed or cut short because of structural changes within and between LHDs. A small number of trainees said that they had placements where the Aboriginal cultural competency of other staff was questionable. Again, trainees mentioned that some of these issues occurred during the early stages of the APHTI's implementation when program partners were still developing operational procedures and support arrangements. Current trainees felt that there were ways of raising and resolving these difficulties (e.g. the Ministry negotiating with the LHD to reassign a trainee to a more appropriate placement).

A number of trainees reflected on the importance of having a good first placement – one that was culturally safe, which oriented the trainee to working in population health and which was appropriate to the knowledge and skills of trainees who were just starting in this field. Some were happy with their first placement, describing it as providing a smooth transition from their previous positions or as lining up well with the commencement of their university studies. Some had less satisfying initial placements, as one put it: *"I was thrown in the deep end"*.

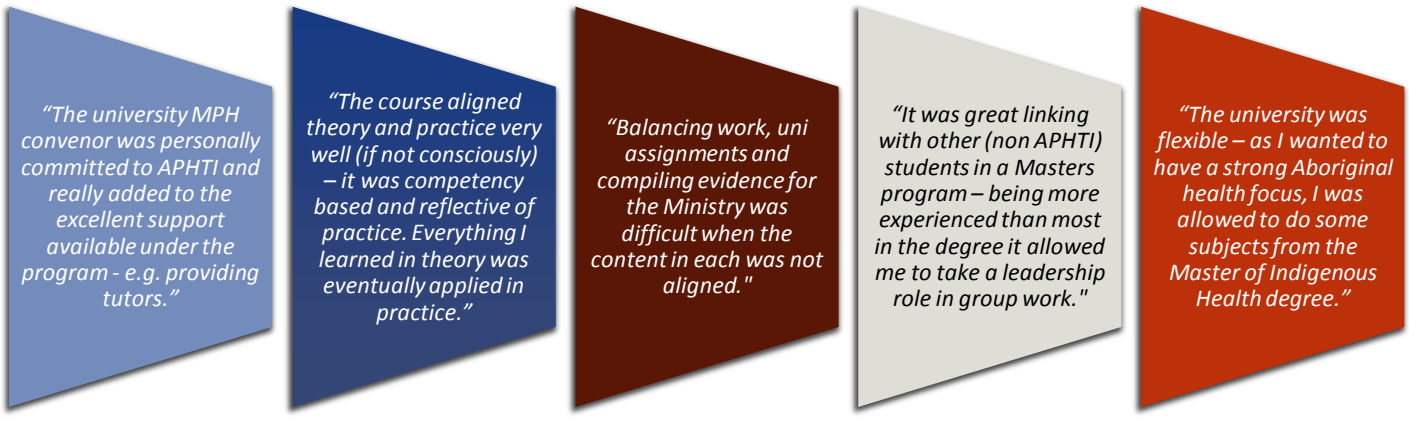
Some trainees, especially those without any prior exposure to population health, indicated that they initially had difficulties in grasping key concepts and understanding unfamiliar terminology. Some also reported having difficulty making the transition from clinical roles (which they described as being patient-driven and about meeting an immediate individual need) to population health roles (which they described as usually being more strategy-driven and about meeting an ongoing community need). These trainees said that they might have benefited from a more comprehensive orientation to population health.

3.1.3 Balancing the requirements of work, study and the APHTI

Trainees mentioned that their experiences of balancing the work and study components of the program were influenced by factors such as their APHTI cohort, the universities where they were enrolled, the degree of alignment in the timing of university studies and related work placements, their academic and workplace backgrounds, and other personal factors. In general, trainees with recent experience of university reported finding the study component easier than those who had not recently studied at a tertiary level.

Most trainees said that they participated in study activities about one day per week and that the allocation of a "study day" greatly assisted them to balance their responsibilities. Most of those interviewed reported a satisfactory alignment of course content with work placements. Interviewees from the Ministry mentioned that they had tried to encourage this alignment wherever possible by liaising directly with universities at the commencement of traineeships.

Trainees' comments on their experience of universities included:



Most LHD staff who had been involved in supporting trainees felt that they had been successful in supporting trainees to effectively balance their work, study and program responsibilities, although there was some variation depending on the circumstances and past university experiences of individual trainees. For the most part, APHTI supervisors indicated that as long as they knew when their trainee was studying they could plan around this. Some trainees commented on the attractiveness of the APHTI as a development pathway that could accommodate people with family responsibilities. For example, trainees could continue to work in their LHD and were not required to complete placements in the Ministry or other locations.

3.1.4 The Competency Framework and the APHTI resource materials

The first group of APHTI trainees all indicated that they had significant problems applying the Competency Framework to their work, especially in developing, compiling and documenting evidence of competency. Although it was originally founded from a well-established model used in the NSW Public Health Officer (PHO) Training Program, in practice, the first APHTI trainees reported having difficulties in interpreting the requirements for presentation of evidence. At that point, no templates or examples had been developed to guide trainees, supervisors and LHD coordinators and the original learning contract model proved to be difficult to use.

The latter intakes of APHTI trainees reported a more positive experience in applying the Competency Framework to their work, which they attributed to learning from the experiences of the first group of trainees and improved support provided by the Ministry. Comments from subsequent trainees were more positive, describing the support provided as *"very thorough"* and as a tool to *"keep you on track and to guide your workplace experiences"* and to *"keep you honest and comparable to a standard"*. Trainees felt that the newly formatted learning contract was easier to use, although they mentioned that placement planning still required the careful investment of time to ensure evidence was properly documented.

In September 2012, there was a review of the Competency Framework, which resulted in some adjustments to the level of competency to be achieved in some areas and added a new health evaluation element. Most trainees believed that the revised framework is comprehensive and appropriate for the program, although some suggested that the addition of competencies in *"managing people and projects and negotiation skills"* is worth considering[5]. Most trainees felt that the process of compiling evidence is now working smoothly, which one trainee attributed to, among other things, the support provided by, and the expertise of, the Ministry's APHTI Coordinator.

Like the trainees, LHD coordinators and supervisors felt that the Competency Framework is now "fit for purpose" and is providing a good basis for planning and monitoring trainee learning. LHDs acknowledged that the competency portfolios required a lot of work to complete, but they saw them as being valuable both as a way of ensuring that all the APHTI competencies are planned and delivered and as a future marketing tool for the trainee.

Another issue that some trainees had with the competencies related to having to demonstrate Aboriginal cultural competence[6]. To some of the first intake of trainees, it seemed that this was asking Aboriginal people to demonstrate that they could relate to other Aboriginal people and they found this requirement objectionable. As trainees in subsequent intakes did not mention this, the issue may have now been resolved, but, as one trainee explained, *"the process of questioning what you, as an Aboriginal person, think you know about other Aboriginal people and communities is still useful – it challenged some of my own assumptions."*

Trainees were aware of the other APHTI resource materials, such as the "Where to Study My Master of Public Health?" document, but did not have specific comments about them – as one trainee said: *"It's a postgraduate program – you don't need to be spoon-fed."*

LHD coordinators and workplace supervisors were broadly aware of the available program resources, although they did not seem to use them regularly. Some of these interviewees referred to resource materials they had developed themselves, including a work plan template to summarise key dates across all elements of the APHTI for their trainees and a glossary of population health terminology (developed as a task set for a trainee).

LHD staff who had been involved in supporting trainees identified the Ministry's APHTI Coordinator as an effective program resource. As was the case with the trainees, these interviewees saw the APHTI Coordinator as being readily available to: assist LHDs with all aspects of program implementation; advise on the Competency Framework; support recruitment; at times act as a mediator between trainees and the LHDs; and generally troubleshoot. LHD staff involved in supporting trainees felt that this support was critical to the program's success and that steps should be taken to ensure that the Ministry retains the capability and knowledge to continue providing this support when the current APHTI Coordinator moves on to another role.

Some workplace supervisors who were interviewed identified a need to strengthen the ways in which workplace supervisors are supported. A guide for APHTI supervisors was suggested: *"to establish boundaries for what a*

[5] Competency Area 2 – Population Health Management – includes such elements as "manages projects effectively" and "works effectively with others and in teams", but does not include people management. APHTI may not be the most appropriate vehicle for developing these competencies to any substantial degree, but given that the trainees all had management aspirations, some basic grounding in management could be considered.

[6] It was unclear from the interview which competency or competencies this referred to – possibly, 1.7 "works in a culturally safe manner".

supervisor and a coordinator are meant to do". There was also strong support for more regular, face-to-face meetings between APHTI supervisors. Supervisors mentioned that teleconferences had been held, but that these were often rescheduled or cancelled and did not always provide the opportunity for sharing of workplace experiences and ideas, as one interviewee put it: *"Resources are handy, but there is a need for interaction between supervisors – the occasional teleconference is not enough. We need to get together at least once a year."*

3.1.5 Cultural safety

While interviewees' understanding of the term "cultural safety" was not explored, it could reasonably be assumed that a culturally safe workplace is one where Aboriginal staff members feel safe to express their identity as Aboriginal people, and generally feel that Aboriginal culture is respected, understood and supported.

Most trainees reported a high level of satisfaction with the program from a cultural safety perspective. Trainees used words like *"respectful"*, *"caring"* and *"fantastic"* to describe most placements and said that there were mechanisms in place (both at a workplace and Ministry levels) to raise and to address any cultural concerns. Where issues of cultural concern were raised, these were viewed by trainees as isolated incidents (for example relating to individuals who lacked cultural awareness, or who said something offensive without knowing it), rather than as a result of serious institutional problems with cultural respect, or because of a lack of program support.

One trainee described a situation where the LHD was quick to investigate a workplace issue to ensure that it had not arisen as a result of a cultural safety concern – as it turned out, it had not, but the trainee involved said that they appreciated management's sensitivity and concern in investigating the incident.

While the selection process for LHDs seeking to engage APHTI trainees includes an assessment of cultural readiness, LHD coordinators felt that they need ongoing support to ensure that they identify placements in areas that are well prepared for their trainees in all respects, including the cultural competence of their staff.

The involvement of trainees in the development of the APHTI's branding – including approving its distinctive Aboriginal artwork – was also mentioned by trainees as a positive and culturally affirming exercise, as one put it: *"this meant a lot to the trainees – it made us feel like part of something special".*

LHD staff who had been involved in supporting trainees indicated that they understood the importance of, and gave attention to, the cultural safety of their APHTI trainees. These interviewees mentioned that trainees were often placed in units where other Aboriginal staff were employed to avoid any feeling of cultural isolation. An Aboriginal staff member who supervised an APHTI trainee in one LHD expressed confidence in the cultural competence of the organisation. Other supervisors described the emphasis placed by their organisations on cultural competence as part of *Closing the Gap* in Aboriginal health outcomes.

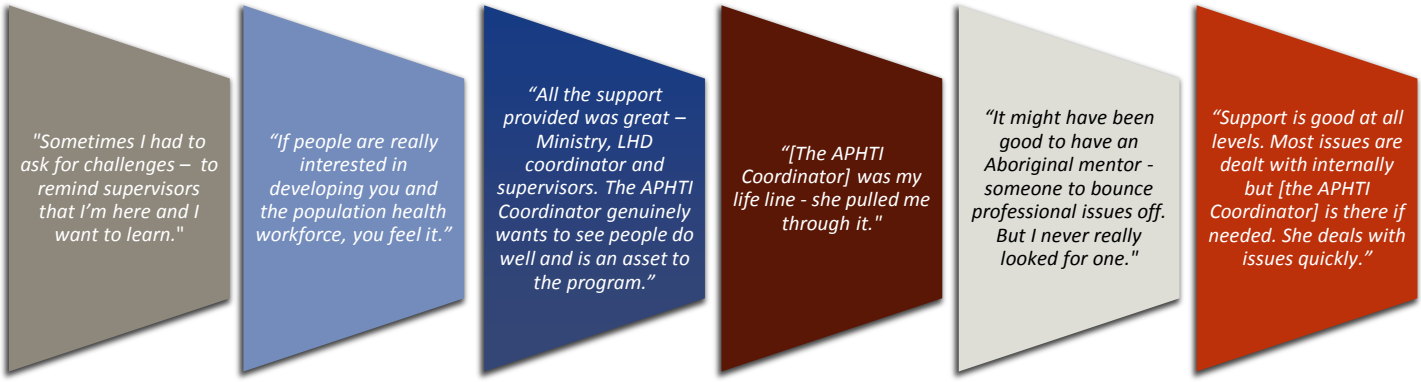
LHD stakeholders expected staff in workplaces hosting APHTI trainees to have completed *Respecting the Difference* cultural training, but it was unclear from the interviews how strictly this was monitored. One LHD coordinator said that they were aware of some issues having arisen (away from their population health unit): "*it only takes one individual to create a problem, even after doing Respecting the Difference"*.

Other Aboriginal cultural sensitivities that LHDs mentioned in the interviews included: maintaining the APHTI as a program that is family and community friendly (i.e. while not all Aboriginal people have family commitments and community responsibilities, many do and may find it difficult to participate in programs that require them to spend long periods away); the desirability of engaging more than one APHTI trainee to provide peer support; and the availability of a mentor, as one trainee put it: "*it's important to have access to advice from outside the workplace at times"*.

3.1.6 Support

Trainees were satisfied with the support they received in the program including at the LHD coordinator level, the workplace supervisor level and the Ministry level. The support provided by the APHTI Coordinator at the Ministry was highlighted by trainees as being of critical importance.

Trainees reported regularly meeting with their LHD coordinators to discuss their experiences, review progress against the Competency Framework and to address any issues. Some said these meetings would benefit from more structure, as one trainee put it: *"they were a bit superficial – 'how are you going?' chats"* but others were impressed by the level of attention and support given to them by the senior staff in the LHD coordinator role, as highlighted in the following quotations:



While some trainees indicated that they had supervisors who were less engaged with them on a day-to-day basis than they would have liked, others said that their supervisors provided a great deal of support, including help and advice with university studies and assignments. Some trainees felt that their supervisors were not always *"as available or as directive as they need to be"* but that this might relate to insufficient attention being given to defining the outcomes expected of some work placements. One described a supervisor as *"an ideal role model"* to develop trainees' management skills.

Support provided by the Ministry was praised by the trainees and identified as a critical success factor for the program. Trainees identified several ways in which the APHTI Coordinator and other Ministry staff supported them during their training, including by: providing ongoing advice on the Competency Framework and the documentation of evidence; troubleshooting issues with placements and liaising with LHDs to resolve them; sorting out administrative problems (e.g. receiving reimbursements for course-related purchases); liaising with universities and organising tutorial assistance; listening to any cultural concerns and helping to resolve these; and generally being a support "safety net" that was there if LHD-based support was not enough.

Other stakeholders who were interviewed in the evaluation also recognised the important role played by the Ministry, and especially the APHTI Coordinator, in supporting the trainees and LHDs participating in the program. The APHTI Coordinator was described by stakeholders as "an impartial external resource", "an advocate", "a connector" and a "problem solver". Having a dedicated resource to resolve issues was seen by APHTI stakeholders as being important. Stakeholders also felt that the program's outstanding retention rate – 100% – testified to the effectiveness of this support to date.

A number of trainees indicated that they also had the support of a mentor in the LHD. However, these interviewees noted that mentors were not necessarily co-located at the trainee's workplace; some worked elsewhere in the health system. Trainees saw access to an Aboriginal mentor as desirable, but not all of them had one.

Most trainees did not mention any APHTI-specific support provided by their universities, although the individual support provided by the University of Newcastle was highly praised by the trainees who studied there.

From the perspective of LHD staff involved in supporting trainees, while there may have been some instances where APHTI supervisors had to provide more support than anticipated, the general experience of providing support to APHTI trainees was positive. All said that their LHD coordinator regularly met with their trainees to discuss progress and to review achievement of competencies against the framework, although this was not always conducted in a structured way. One LHD coordinator, described by trainees as being very supportive, said that the LHD remained *"a bit worried about whether we are giving enough support – our trainees are so capable and self-motivated, they don't demand our attention"*.

Some stakeholders did question whether, in an organisational climate focusing on reducing costs, the current level of support should continue, as one interviewee put it: *"such a Rolls Royce service is important in the program's early days, but we need to be realistic about the level of support we provide."* The idea of shifting more responsibility for support to the LHDs was raised in this context. Another stakeholder involved more directly in the management of the APHTI felt that there was a need to *"consider how we operate when we have more trainees in place - we need to*

find the right balance between nurturing and building personal responsibility."

The management of the program is itself supported by the APHTI Advisory Committee and stakeholders saw this as adding value. In particular, the input from Aboriginal people through the Advisory Committee was highly valued, especially as the program is still relatively new and is continuing to deal with "firsts" (such as the first trainee graduation held in November 2014).

3.1.7 Costs and the APHTI partnership

LHD staff involved in supporting trainees felt that the costs associated with engaging APHTI trainees influenced their LHD's decision on whether to participate. While a few LHDs participated in the program's first intake with minimal external financial incentives, none participated in the second year of this funding model (2012). However, the introduction of a revised funding model in 2014 coincided with six LHDs submitting expressions of interest in that year. LHD staff involved in supporting trainees and other stakeholders who were interviewed perceived that the new funding model prompted this increase in interest. These interviewees felt that, while the perceived value of the program may grow in time as its graduates make their mark on the organisation, for the time being the partnership between the Ministry and LHDs (and other NSW Health organisations that might participate in the future) will remain of great importance.

"The APHTI should never be fully funded by Ministry – the program can only work if the LHD is fully committed."

3.1.8 Effect on workplace awareness of Aboriginal population health issues

Most of the LHD coordinators and supervisors interviewed did not believe that hosting an APHTI trainee had significantly increased their exposure to, and understanding of, Aboriginal population health issues. Most said they were already aware of these issues, as one interviewee put it: *"you really couldn't work in population health in this LHD if you were not aware of and supportive of Aboriginal health issues."* For the same reason, these interviewees believed that there had been minimal change in the level of collaboration between different areas in Aboriginal health because of the APHTI.

3.1.9 Program promotion

Trainees, LHD staff involved in supporting trainees and other stakeholders saw the ongoing promotion of the APHTI to staff, LHDs, other NSW Health organisations and to the Aboriginal and broader community as being important, as one stakeholder put it: *"it would be useful if the achievements of the program and of the individual trainees could be more widely promoted, including the dissemination of the trainees' stories, perhaps through video, to inform and inspire others to undertake further study*." Interviewees highlighted that the recent success of the APHTI in the NSW Aboriginal Health Awards provides an opportunity to promote the program and what it is trying to achieve.

Participants in the evaluation identified several ways in which the program could be promoted, including case studies, videos of people talking about their APHTI experience, presentations at health expos or employment expos and the extension of the program to other NSW health services that have not previously hosted traineeships. One trainee also suggested support for the establishment of an APHTI Alumni, which could support program promotion through a network of program graduates.

3.1.10 APHTI trainees employed or hosted outside LHDs?

The potential to place APHTI trainees in organisations other than LHDs was also raised by evaluation participants. An APHTI trainee is soon to be employed for the first time outside the LHD network (i.e. in the Justice Health and Forensic Mental Health Network) and there may also be potential benefits in supporting the placement of trainees outside NSW Health. For example, employees of the Aboriginal Health and Medical Research Council of NSW (AH&MRC), the peak body for Aboriginal Community Controlled Health Services, pointed out that these services include a range of population health activities that have an important impact on Aboriginal health in NSW.

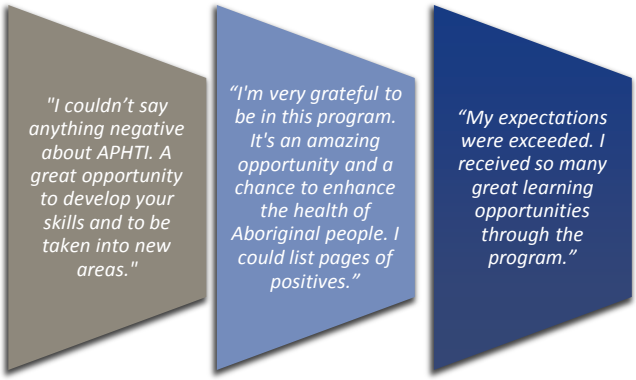
"The AH&MRC would greatly appreciate the opportunity to host APHTI trainees."

AH&MRC staff cited the APHTI's original program documentation, prepared in 2010, which specifically encouraged placements within the Aboriginal Community Controlled Health Sector. While no APHTI trainee has yet been placed in the sector, LHDs are able to partner with the sector, and one participating LHD has plans to place a trainee in a local Aboriginal Community Controlled Health Service.

AH&MRC staff also suggested having trainees employed directly by local Aboriginal Community Controlled Health Services and doing some work placements in the LHD. However, it was noted that the sector does not currently have the resources to establish such additional positions, and that a way of fully funding such positions would need to be identified.

3.1.11 Overall experience of trainees and LHDs

Even taking into account the difficulties faced by the first group of trainees as systems and processes were still being refined, the overall experience of APHTI trainees has been positive. All trainees were pleased that they had entered the program and all saw it as being a benefit to their development and to their future career, as the following quotations demonstrate:

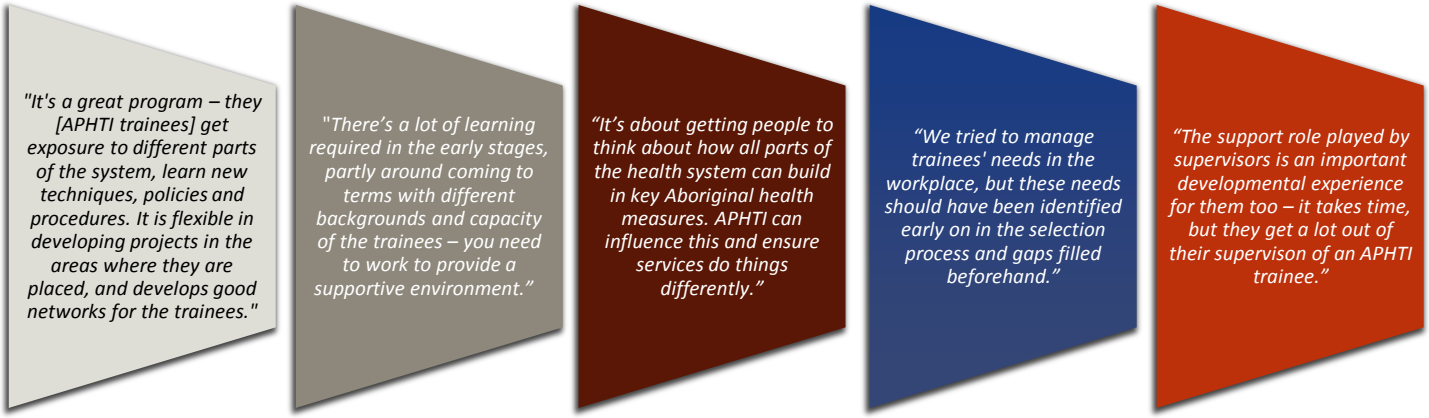


There are indications that APHTI trainees are advancing their careers. Some indicated that they had recently been acting in management positions that they hoped to secure permanently. One was in a dedicated population health position (within the narrow organisational definition of such a role), and most were in positions where knowledge of Aboriginal population health would be an asset. Some of these were still interested in working in population health – as one trainee who had secured a promotion said: *"If a management job in population health had come up, I would have jumped at it."*

In terms of further education, at least two of the APHTI graduates are considering enrolling as PhD students and some current APHTI trainees indicated that they wanted to pursue additional studies at the end of their traineeship (e.g. the PHO Training Program).

Overall, LHD staff involved in supporting trainees were also satisfied with their experience of the APHTI. All who were interviewed for the evaluation indicated that their LHD would consider engaging trainees again, although some were more enthusiastic than others.

The experiences of LHD staff in supervising and supporting trainees were, of course, interwoven with *their trainee's* experiences of the program. While some mentioned that they had supervised trainees who had exceeded their expectations, gained good results at university and operated with a high degree of independence and proficiency in the workplace, others had supervised trainees who they felt required more support both with their university studies and with their transition to working in population health. These interviewees clarified that this was not a criticism of the program, as they felt that the program should offer a development opportunity to Aboriginal people from a range of backgrounds to further their careers.



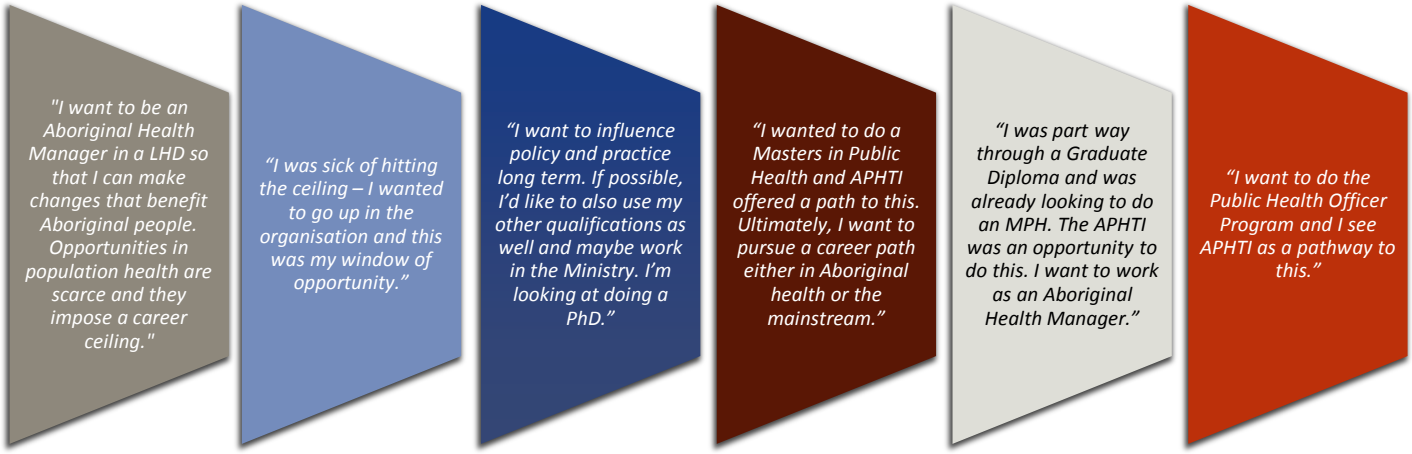
Most LHD staff involved in supporting trainees considered that the program had the potential to improve Aboriginal health outcomes, as one supervisor said: *"They [APHTI trainees] can make a real contribution in each placement and influence things for the better for Aboriginal people from the other side."* Nor was success necessarily judged by these staff on the basis of whether trainees moved into specialised population health roles at the program's conclusion. One said that a trainee that they had supervised had moved into an Aboriginal health management role and that they saw this as *"an even better result for the program – the person can influence things more there and ultimately make a difference in Aboriginal health."*

3.2 Impact on the NSW Aboriginal population health workforce

3.2.1 Employment outcomes

During semi-structured interviews, trainees' expressed a range of career aspirations and reasons for participating in the APHTI. However, most expressed a personal commitment to making a difference in Aboriginal health by influencing policy and practice. While some were open to future career opportunities that might arise specifically in the population health field, there was a general perception that the APHTI would enhance trainees' broader career prospects within NSW Health and that the skills they acquired in population health would be an asset wherever they went.

There are indications that APHTI trainees are advancing their careers. When interviewed, some indicated that they had recently been acting in management positions that they hoped to secure permanently. One mentioned being in a dedicated population health position, but most were in positions for which they felt knowledge of Aboriginal population health would be an asset. Some of the trainees who were not working in a population health role expressed an interest in working in this field again in the future.



The APHTI's employment outcomes so far have been good. One trainee has been employed directly in a population health role, and all are in roles where their knowledge and skills in population health would be an asset both in the execution of their duties and in improving Aboriginal health. Key outcomes include:

- all four of the first group of APHTI trainees who completed the program at the end of 2014 have secured jobs in NSW Health;
- one of these positions is in a specialist population health unit in an LHD, while the other three[7] are in other clinical or non-clinical roles;
- two APHTI graduates have secured management roles; and
- although halfway through the program, both trainees in the second (2013) APHTI intake have been offered the opportunity to act in management roles.

It could be argued that, in terms of employment outcomes, the current stated aims and objectives of the APHTI may not adequately reflect the value that many stakeholders believe the program offers. Stakeholders saw the APHTI as a means not just of growing the "Aboriginal population health workforce", but rather as a way of equipping Aboriginal people with population health knowledge and skills they need to better influence policy and practice. The fact that four of the first six trainees are now in management roles – in both Aboriginal and mainstream areas of health – is an outstanding result in this respect.

In terms of further education, at least two of the APHTI graduates interviewed were considering enrolling as PhD students and some current APHTI trainees indicated that they wanted to pursue additional studies at the end of their traineeship (e.g. the PHO Training Program).

[7] One of these three is employed in the Ministry's Population and Public Health Division. It could therefore be argued that this is also a population health role.

3.2.2 Achievement of program objectives

In terms of the stated objectives of the APHTI:

- **Increasing the number of Aboriginal people with postgraduate qualifications in population health** – All four of the first group of APHTI trainees have successfully completed an MPH degree, and another seven trainees are currently undertaking an MPH. Overall academic performance has been good, with some trainees achieving a Distinction or High Distinction grade average.
- **Increasing the number of Aboriginal people who have completed public health workplace competencies** – All four graduates of the program have completed a final assessment, have met all of the requirements of the Competency Framework, and have been issued with a Certificate of Attainment.
- **Increasing the exposure of the organisation's population health units and workforce to the value of traineeships** - Two participating LHDs are now supporting their second groups of APHTI trainees and others have indicated that they would be interested in hosting further trainees in the future.
- **Increasing Aboriginal staff exposure to career opportunities in population health** – All trainees have undertaken placements and projects in population health in their LHDs.
- **Creating a more adaptive and competent Aboriginal population health workforce** – Trainees from the first intake have secured employment in a variety of clinical and non-clinical roles in NSW Health.

All of the trainees who were individually interviewed for the evaluation had been employed by NSW Health prior to commencing the APHTI. Their duration of employment in the health sector ranged from 4 years to over 20 years. Four of the seven trainees interviewed had been in clinical roles delivering services directly to patients and three had been working in non-clinical roles such as environmental health or were Project Officers. Two of the trainees indicated that they had direct experience working in population health (both in health promotion), although two others pointed out that they had been exposed to some of the principles and terminology of population health through their past work.

The highest prior qualification held by interviewed trainees were: a Masters degree in a health-related field (n=1); a Bachelor degree in a health-related field (n=2); a Bachelor degree in a non-health related field (n=1); a Graduate Diploma in a health-related field (n=2); and a Graduate Certificate in a health related field (n=1). Some trainees reported that there were elements of the APHTI and Master of Public Health degree for which they felt academically unprepared. This was especially the case with Epidemiology and Biostatistics work and study, as trainees felt that these elements require a certain level of proficiency in mathematics. However, all trainees to date have passed these subjects - some with Distinction and High Distinction grades.

4 Discussion

4.1.1 How much change is needed?

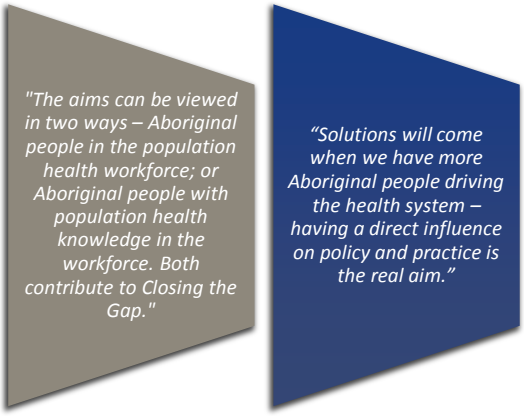
The current APHTI model appears to be working well – the employment and educational outcomes of the first group of APHTI graduates are good, the current trainees and employers are happy with the way the program is being implemented and demand for the program is growing.

The first intake of APHTI trainees was a closely monitored group and the problems they experienced with the program's design and implementation have largely been resolved. That said, trainees and LHDs did make a number of suggestions to enhance the program, including:

- conduct more joint development activities involving participants of other Ministry training programs (e.g. the NSW Public Health Officer and Biostatistics Training Programs);
- explore the benefits of peer-to-peer mentoring between relevant Ministry training programs;
- conduct regular face-to-face workshops for LHD coordinators and supervisors;
- enhance the induction of new trainees to ensure that they are properly orientated to population health work – while the Ministry now provides good one-to-one support to LHDs in planning initial placements, it would be helpful to provide some documented good practice in organising such placements. Ideally, there should be an "orientation placement" that settles trainees in and equips them with all the basics required to get the most out of the program;
- consider how to enhance trainees' exposure to management skills and experience in some way through the traineeship – for example, placements where trainees "shadow" a manager to get an insight into work in such roles.

4.1.2 Should the APHTI's aims be clarified?

Stakeholders expressed a range of opinions on the aims and objectives of the APHTI, its potential benefits for NSW Health and for Aboriginal people, and whether this should influence the way the program is coordinated in the future. There was broad agreement that the program's current focus on "the development of the Aboriginal population health workforce" was appropriate, although this did not necessarily mean that program success should be measured by the number of graduates employed in specialist population health roles. Rather, stakeholders agreed that a higher priority was to have more Aboriginal people with population health knowledge and skills employed in leadership positions where they could influence policy and practice. These positions could be in a broad range of clinical or non-clinical roles where knowledge and skills in population health would be invaluable and ultimately help to improve the health of Aboriginal people in NSW. In this sense, the program is showing early signs of great success.



In short, the APHTI's current stated aim may not adequately reflect what the program does and the value it creates. The APHTI's aim might be better expressed as *"the development of Aboriginal workforce capability and influence in population health so that the health of Aboriginal people in NSW can ultimately be improved".*

4.1.3 Ministry support?

The high level of support provided by the Ministry to both trainees and LHD staff involved in supporting trainees was widely acknowledged as a success factor in the APHTI. Some stakeholders consulted in the evaluation did raise questions about whether there was too much support being provided and whether this was sustainable beyond the start-up phase of the program. These are reasonable questions to ask in a climate where organisational cost pressures are always present and there are many priorities and programs competing for resources.

While conducting an economic appraisal of the APHTI was not a focus of this evaluation, there are good arguments for continuing to implement the program. The program's 100% retention rate is a testimony to the effectiveness of the APHTI model and should be considered from an efficiency and cost management perspective. So far, all money invested in the program and its support arrangements have produced an outcome.

There is a need, however, to ensure that the support is systematised. The current APHTI Coordinator was seen to be effective as a source of support, combining a detailed knowledge of the program with a personal and professional

commitment to the program and its participants. This knowledge and approach will need to be passed on to a successor at some point and the Ministry should plan for this.

4.1.4 Program targeting?

Some stakeholders also looked at the program's aims from the perspective of the trainees targeted by the program and the messages it might send to Aboriginal communities. There was broad agreement that the APHTI should continue to be open to Aboriginal people from a broad range of backgrounds and with different capabilities. This might mean that some trainees will require more support to succeed, but this can lead to an even better end result for trainees, their communities and the organisation. If the APHTI is successful in increasing the number of Aboriginal leaders in NSW Health, this will have flow on effects to communities including how they view the health system and how they respond to its efforts to improve health outcomes.

4.1.5 Building the "APHTI brand" as a mark of quality

Building the APHTI brand will require attention to recruitment (ensuring that people selected have the ability to both complete the program and, in the process, to add value to their workplace), support systems (for trainees and their employers) and communication (communicating the APHTI's success stories and involving more employers in the program).

Most importantly, the program needs to continue to ensure that being an APHTI graduate is something that employers will recognise immediately as a mark of quality. An issue of concern to emerge from the interviews was the risk that some trainees may emerge from the program without a skill level that would make them immediately employable in the population health field.

It is possible that this perception of risk was based on a misconception of the competency level that is actually expected of APHTI graduates – or, at least, their readiness for certain roles. Readiness to be employed in specific roles will depend on a range of factors and APHTI trainees will enter and exit the program at different levels. Regardless, it is a perception that needs to be explored and the APHTI Advisory Committee should be consulted to clarify this issue.

4.1.6 The APHTI as a "pathway" to the NSW Public Health Officer (PHO) Training Program?

A number of stakeholders raised the issue of whether and how the APHTI might link with the PHO Training Program, which is open to MPH graduates who have 3 years of health-related experience and a vocational commitment to public health. A well-established and highly valued program, the PHO Training Program was described by stakeholders as providing a breadth of experience across NSW Health, access to excellent networks and a pathway to management roles.

There have been efforts in the past to increase the number of Aboriginal people participating in the PHO Program (including a scholarship-style program that aimed to support a small number of Aboriginal people to complete postgraduate public health studies in preparation for entry into the PHO Program). However, in its 25 years of operation, only 2 of the 100 PHO graduates have identified as being of Aboriginal descent

At least one current trainee indicated that getting into the PHO Program was a major reason for becoming an APHTI trainee. There is nothing inherently wrong with this and trainees should not be discouraged from following this path if they choose to do so. It is not clear, however, what additional skills or benefits an APHTI graduate entering the PHO Program would gain. Promoting the APHTI as a pathway to the PHO Program therefore requires careful consideration.

It also raises questions about how best to build the APHTI's own reputation and its brand as a mark of quality and a source of highly skilled graduates. The APHTI should stand alone as a program that supports Aboriginal people to excel in NSW Health and move into positions where they can influence policy and practice.

4.1.7 Promoting the APHTI

Many people consulted in the evaluation said that more should be done to promote the program to prospective trainees and employers, and to the Aboriginal and broader community. The program has some positive and inspiring stories to tell. The first group of APHTI trainees have graduated and the program has won a prestigious award.

More LHDs and other suitable organisations need to be encouraged to consider the benefits of engaging an APHTI trainee. While the "early adopters" of the program all indicated that they had a strong existing commitment to Aboriginal workforce development and that this motivated their involvement in the APHTI, there may be other LHDs

with less capability in Aboriginal population health, which would improve their awareness of such issues if they engaged an APHTI trainee. If they can be encouraged and supported to do so, this will enhance the achievement of the program's stated objectives.

4.1.8 Clarifying pay and employment condition issues

Inconsistencies in the pay received by APHTI trainees and in their post-program job security were a source of concern for some trainees. Ways of overcoming or reducing the effect of these inconsistencies on trainees need to be explored by the APHTI Advisory Committee, but care is needed to avoid imposing a "one-size-fits-all" solution that reduces the program's current flexibility and might possibly deter some employers and prospective trainees from participating. Experience gained in other programs (e.g. the Aboriginal Environmental Health Officer Training Program) could be considered. Giving trainees at least some post-program job security in the form of some kind of transition period or "buffer zone" in which to find a new job was suggested.

4.1.9 Improving cultural safety

Trainees generally reported that they felt culturally safe in their traineeships, but there were a few incidents of concern. The current APHTI resource document – "Information for LHDs" – indicates an expectation that LHDs "promote" *Respecting the Difference* cultural training to all staff involved in delivery of the APHTI. It would seem to be reasonable to require staff involved in the delivery to have actually *completed* this training – or at least the two-hour eLearning component. This is not an extra imposition on LHDs – there is an existing mandatory requirement for NSW Health staff to do this training, but it should not be assumed that all staff have completed it.

ATTACHMENT A: Interview Questions

1. Interview questions for APHTI trainees (current and graduated):

- What motivated you to apply for and participate in the APHTI?
- What has been your overall experience on the APHTI? Please describe any positive or negative experiences?
- Have you been satisfied with the training you have received on the APHTI? Has it met your expectations? Were there any unexpected benefits?
- How has participating in the APHTI developed your skills in public health?
- What was your experience with working across the competency areas of the APHTI?
- Did you have any difficulties achieving any of the competencies?
- How do you value your overall training experience on the APHTI?
- Do you have any comments on the APHTI Competency Framework and its use in guiding your workplace learning?
- Can you please describe your workplace projects? How many of your placements have had an Aboriginal health focus? Have you had the opportunity to do both Aboriginal health projects and projects in other areas?
- How did you feel about the placement/project allocation process?
- During your training, did you have regular communication with your workplace supervisor, your MPH convenor and MOH? How frequent was this communication?
- What kind of support were you provided during your training (e.g. from your workplace supervisor, your MPH convenor, MOH)? Did you feel you were provided with enough support? How useful were the APHTI resources provided by MOH (e.g. 'Where to Study my MPH', mid program review and final assessment pack)?
- Do you feel the APHTI has been implemented in a culturally appropriate way?
- Have you felt culturally safe during your training?
- What was your highest qualification prior to undertaking the APHTI (Diploma, Advanced Diploma, undergraduate degree, postgraduate degree)?
- What experience did you have in the health system prior to the APHTI? (years and level)
- Where did you study your MPH? What was your experience with concurrently working and studying?
- Do you feel that your previous work and study experience helped you complete your MPH?
- Do you have any suggestions for improvements to the APHTI?
- Where are you currently employed? (for graduated trainees)
- Do you feel that participating in the APHTI has advanced your career opportunities?
- What are your goals and ambitions for your future career?
- Are there any other learning experiences that you would have like to have had on the APHTI?

2. Interview questions for workplace supervisors:

- How many APHTI trainees have you supervised?
- Can you describe each trainee and the projects they have conducted with you?
- Have you been satisfied with the work they have conducted?
- What motivated you to be an APHTI workplace supervisor?
- What has been your overall experience with the APHTI? Please describe any positive or negative experiences?
- Have you been satisfied with the APHTI? Has it met your expectations? Have there been any unexpected benefits?
- How were projects allocated to trainees?
- Were you able to provide placements for trainees with an Aboriginal health focus? Did trainees have the opportunity to do both Aboriginal health projects and projects in other areas?
- Do you feel you were able to provide supervision to APHTI trainees in a culturally appropriate way?
- Have you completed *Respecting the Difference* or other cultural awareness training?
- How useful are the APHTI resources provided by MOH?
- Have you developed any additional resources to support APHTI trainees?

- Has the structure of trainees concurrently studying their MPH and conducting placements been successful in your workplace?
- Has having APHTI trainees increased your workforce's exposure to Aboriginal population health issues?
- Has this exposure changed ways of working and thinking about Aboriginal health in your workplace?
- Do you have any suggestions for improvements to the APHTI?

3. Interview questions for LHD coordinators:

- What motivated your LHD to offer APHTI traineeships?
- What has been your overall experience with the APHTI? Please describe any positive or negative experiences?
- Have you been satisfied with the APHTI? Has it met your expectations?
- How did you decide what projects were allocated to the trainees? Were you able to provide placements for trainees with an Aboriginal health focus?
- Do you feel you have been able to provide culturally appropriate and safe placements and work environments for APHTI trainees?
- Has having APHTI placements increased your workforce's exposure to Aboriginal population health issues?
- Has this exposure changed ways of working and thinking about Aboriginal health in your workplace?
- How useful are the APHTI resources provided by MOH?
- Has your LHD developed any additional resources to support APHTI trainees?
- Has the new funding structure for the APHTI introduced in 2013 increased your capacity to provide financial support for trainees?
- How did governance and management of the APHTI partnership work within your LHD?
- How could the governance partnership with LHD's be strengthened?
- What have been the costs associated with employing an APHTI trainee?
- Do you have any suggestions for improvements to the APHTI?
- Has being a partner in the delivery of the APHTI facilitated better collaboration between different areas in relation to Aboriginal health?
- Do you anticipate your LHD will continue to offer APHTI placements in the future?

4. Interview questions for MPH convenors:

- What has been your overall experience with the APHTI? Please describe any positive or negative experiences?
- What additional support have you provided to APHTI trainees for their MPH studies?
- How regularly do you have contact with APHTI trainees studying their MPH at your university?
- In your experience, has the structure of trainees concurrently studying their MPH and conducting work placements been successful?
- How useful are the APHTI resources provided by MOH? (e.g. 'Where to Study my MPH')
- Have you considered cultural issues experienced by APHTI trainees when providing support for their MPH?
- Have you been satisfied with the APHTI? Has it met your expectations?
- Do you have any suggestions for improvements to the APHTI?

5. Interview questions for MOH staff:

- What has been your involvement with the development of the APHTI?
- From your involvement, what factors (both positive and negative) have affected its implementation?
- Have you been satisfied with the way APHTI has been implemented and the outcomes to date?
- How has the implementation evolved over time?
- From your experience, has the APHTI been provided in a culturally appropriate and safe way?
- Do you feel the APHTI meets the aim of improving the health of Aboriginal people by increasing the number of Aboriginal people working in the health services of NSW who have well developed skills and knowledge in population health?
- Do you feel additional support arrangements or resources are required for APHTI trainees?
- Do you have any suggestions for improvements to the APHTI? (at both state and LHD level?)

6. Interview questions for APHTI Advisory Committee members:

- From your involvement with the APHTI, what factors (both positive and negative) have affected its implementation?
- Have you been satisfied with the way APHTI has been implemented and the outcomes to date?
- From your experience, has the APHTI been provided in a culturally appropriate and safe way?
- Do you feel the APHTI meets the aim of improving the health of Aboriginal people by increasing the number of Aboriginal people working in the health services of NSW who have well developed skills and knowledge in population health?
- Do you feel additional support arrangements are required for APHTI trainees?
- Do you have any suggestions for improvements to the APHTI? (at both state and LHD level?)

7. Interview questions for Aboriginal Workforce Coordinators

- What has been your involvement with the development of the APHTI?
- From your involvement, what factors (both positive and negative) have affected its implementation?
- Have you been satisfied with the way APHTI has been implemented and the outcomes to date?
- From your experience, has the APHTI been provided in a culturally appropriate and safe way?
- How did governance and management of the APHTI partnership work within your LHD?
- Do you feel the APHTI meets the aim of improving the health of Aboriginal people by increasing the number of Aboriginal people working in the health services of NSW who have well developed skills and knowledge in population health?
- Do you feel additional support arrangements are required for APHTI trainees?
- Do you have any suggestions for improvements to the APHTI? (at both state and LHD level?)