RESPECTING THE DIFFERENCE:
AN ABORIGINAL CULTURAL TRAINING FRAMEWORK FOR NSW HEALTH
PROCESS IMPLEMENTATION EVALUATION REPORT 2013
Artist: Bronwyn Bancroft

About the Artwork: ‘Many Stories Within a Bigger Story’

NSW Ministry of Health would like to acknowledge artist Bronwyn Bancroft, a descendant of the Djanbun clan of the Bundjalung Nation and the creator of all artwork for the ‘Respecting the Difference’ project.

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- Representatives of the Ministry of Health

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Executive Summary

The Aboriginal Cultural Training Framework: Respecting the Difference was launched by NSW Health in late 2011 as a mechanism to improve the cultural competence of NSW Health staff in their dealings with Aboriginal people and communities. The Framework includes a mandatory requirement for all staff to complete a two-hour eLearning package and a six-hour face-to-face workshop that includes both generic and localised content relating to local Aboriginal people, their culture and their health. The framework requires that 80% of all health staff complete the training by the end of 2015.

The evaluation found that implementation of Respecting the Difference training has been much slower than anticipated when the framework was launched. Delivery of the eLearning component was initially hampered by technical difficulties which were not fully resolved until August 2013. Around 35% of staff have completed it to date, but this figure varies considerably across organisations. Delivery of face-to-face training has not commenced in 3 of the 15 Local Health Districts and, in another 4, training numbers are very low (1% or less of total staff). Even where face-to-face training is being delivered regularly, too few courses are being run to ensure that 80% of staff can complete the training in the foreseeable future.

The evaluation included a survey of Chief Executives of the various frontline NSW Health services which was designed to get their perspective of the roll-out of the program. There was a 68% response rate. Results indicated that only about a half of the responding organisations had developed an implementation plan and that almost 20% of respondents had not assigned an individual to take responsibility for implementing the framework. Over 70% reported difficulties in implementing the program though most said these have now been overcome. Despite the results to date, around 80% of the respondent Chief Executives expressed confidence reaching the 80% completion target by the end of 2015.

Seven case studies (six Local Health Districts (LHDs) and one state-wide service) were prepared as part of the evaluation to provide a more detailed account of the experience of a sample of NSW Health organisations. Themes to emerge from these case studies included the following:

Resource issues

Most organisations were attempting to roll out the face-to-face component of Respecting the Difference by using existing Aboriginal staff as part-time facilitators and trainers. These staff spent considerable time and effort in planning, developing and delivering these courses. The time available to these individuals to perform their usual roles and core duties – including workforce development or frontline health service delivery – was therefore reduced. It seems very unlikely that this approach to implementing the framework can achieve anything like the scale required without compromising other important results associated with the usual roles of the staff involved. It also needs to be recognised that using Aboriginal staff in this way risks burn-out as the training requires them to frequently and repeatedly share their own personal experience as Aboriginal people and this can be emotionally draining. When presenters are exposing raw, personal information in this way across their peer network, cultural safety in the workplace can be compromised.

Trainers’ skills

The Framework’s Facilitator Guide requires trainers to “have a strong background in facilitation and Australian Aboriginal cultural awareness.” Given the nature of this type of training – designed to challenge (and, in many cases, ultimately change) participants’ long-held assumptions, attitudes and values as well as their workplace behaviours – this background is vital. Instead, in some cases, Aboriginal staff with little previous experience in training delivery have been asked to lead the training, including using quite advanced training techniques. Again, this raises concerns about the cultural safety of staff and whether they have the necessary skills and experience to present such challenging information across their peer network.
Organisation

Different types of training facilities were used by the organisations examined in the Case Studies. Some used LHD training rooms or TAFE facilities, while others, attempting to immerse participants in an Aboriginal cultural experience, used offsite facilities. There are advantages and disadvantages in these different approaches in terms of cost, effectiveness and scale and these need to be considered.

While the responsibility of staff to complete the mandatory eLearning component of the training can be promoted using a variety of methods, line managers and senior managers need to regularly monitor completion rates and to remind staff of the importance of the training. Getting staff into face-to-face training – particularly frontline staff – can be even more difficult and line managers can, in practice, resist releasing staff unless senior managers make it clear that they need to find a way to do so.

Institutional Commitment

The slow pace of roll-out of Respecting the Difference in some locations may suggest that not all organisations are equally committed to its implementation. Not all have large Aboriginal populations to service but even those that do are unlikely to embrace the framework unless there is clear direction from the top and down through line management that it is important and is directly linked to the health service’s and thus the Chief Executive’s priorities and key performance indicators. The basic reason for improving Aboriginal cultural awareness needs therefore to be continuously reinforced: it is about closing the enormous gap in health outcomes between Aboriginal and non-Aboriginal people.

Training Structure and Content

Across the organisations reviewed, there is considerable variation from the standard model in content and approach to delivery. Although one size clearly does not fit all, a well-defined process is needed to ensure that local variations do not lead to the omission of essential content or to the reduced likelihood of improved and more effective practices in the workplace.

Effectiveness

Mechanisms to maximise the transfer of learning to the workplace need to be encouraged. Training needs to support and lead to a review of services and procedures in the workplace so that they can better meet the needs of Aboriginal clients and ultimately improve health outcomes. Simply training individuals, but ignoring the workplace will not be effective. The case studies showed that some health services are taking steps to address this issue – for example, delivering training to a whole operational unit, creating a “Respecting the Difference Aboriginal Cultural Redesign” position, and formalising application of learning through structured pre- and post-course conversations between staff and their managers that identify opportunities for workplace change.

Conclusion

Most staff consulted in the evaluation who were involved in planning, developing and delivering the training were not confident that the 80% completion target by end 2015 could be met. Certainly, a massive effort would be required to achieve this in most health services – for example, an LHD with 10,000 staff commencing face-to-face delivery in 2014 would need to run three workshops per week for two years, each with 25 participants to achieve target (ignoring staff turnover). The cost and human resource implications of this are significant, not to mention the difficulty in ensuring a high level of Aboriginal community involvement (e.g. local Elders) in delivery.

The face-to-face training component is mandatory and, if implemented in a targeted and outcomes-focused way, can have a real impact on the quality and cultural responsiveness of health services and on the achievement of Closing the Gap goals. However, this is not like some types of mandatory training that are primarily about communicating technical or procedural information. It is not, as one person put it, the type of training where people can sit at the back of a large auditorium and “nod off or do their knitting”.
Rather, *Respecting the Difference* training requires a high level of personal engagement from participants, trainers and community representatives. It requires participants to question their attitudes and beliefs. It challenges organisations and operational units to critically evaluate how they are engaging with Aboriginal people and communities and to make real changes in the workplace that can ultimately improve health outcomes.

While a focus on numbers must be maintained, quality training delivery, the application of learning in the workplace and behavioural change are what this is really all about.

**Summary of Recommendations (See 6.2 for details)**

1. Improve data collection
2. Improve other reporting
3. Re-publicise the program
4. Re-consider the 80% completion target for the face-to-face component
5. Encourage LHDs to appoint a senior executive to take responsibility for implementation
6. Establish a clear process for approving variations of the training model
7. Encourage and support the application of learning in the workplace
8. Establish an impact evaluation framework
9. Link *Respecting the Difference* to accreditation
10. Collect and analyse Patient Journey data
11. Link *Respecting the Difference* to Continuing Professional Development
12. Explore funding opportunities
13. Responsibly apply the Code of Conduct in the delivery of face-to-face training
14. Strengthen Chief Executive reporting requirements
SECTION ONE

Introduction

“Culture can influence Aboriginal and Torres Strait Islander people’s decisions about when and why they should seek health services, their acceptance of treatment, the likelihood of adherence to treatment and follow up, and the likely success of prevention and health promotion strategies. Ensuring that health services and providers are culturally competent will lead to more effective health service delivery and better health outcomes.”

National Aboriginal and Torres Strait Islander Health Plan – 2013-2023

1.1 Background

Achievement of national and state Closing the Gap goals in Aboriginal health requires all health sector staff to have the ability to deliver respectful, responsive and culturally sensitive services. Staff need to be equipped with knowledge and skills to interact effectively with Aboriginal people and communities and to implement work practices which meet their needs and expectations. Without these, there is a risk that Aboriginal people will disengage from health services and health outcomes for Aboriginal people will continue to lag behind the population as a whole.

The importance of improving the cultural competency of health staff and organisations is reinforced by national and state policies, strategic frameworks, research papers and service guidelines. These include:

- The National Aboriginal and Torres Strait Islander Health Plan – 2013-2023 (e.g. see quote above);
- The National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework – 2011-2015 (e.g. “Provide education and training to the potential and current health workforce that reflects current, accepted approaches to health service delivery for Aboriginal and Torres Strait Islander peoples”);
- Good Health – Great Jobs, The NSW Health Aboriginal Workforce Strategic Framework 2011-2015¹ (e.g. “Build a NSW health workforce which closes the gap in health outcomes between Aboriginal and non-Aboriginal people by providing culturally safe and competent health services”);
- Towards an Aboriginal Health Plan for NSW (e.g. “The prevailing attitudes and level of understanding, particularly by non-Aboriginal people in the system, directly affected the experience Aboriginal people had, and indeed whether they would enter the system at all to receive help”);
- NSW Aboriginal Health Impact Statement and Guidelines – Policy Directive;²

¹ PD2011_048
² PD2007_082
In this context, *The Aboriginal Cultural Training Framework: Respecting the Difference* was launched by NSW Health and the Aboriginal Workforce Unit in late 2011 as a mechanism to improve the cultural competence of NSW health staff in their dealings with Aboriginal people and communities. It aimed to:

“motivate NSW Health staff to build positive and meaningful relationships with Aboriginal people who may be clients, visitors or Aboriginal staff, and to improve their confidence in establishing appropriate and sustainable connections.”

This Policy Directive outlines the Framework’s target audience, aims, training requirements, learning outcomes, and responsibilities.

The framework effectively has two components:

The **eLearning component** is an interactive resource which provides a base of knowledge in Aboriginal history, culture and people and explores some of the key challenges in delivering more appropriate and culturally sensitive service to Aboriginal people and communities. The eLearning is intended to allow individuals to work at their own pace and in an environment which is most supportive to their learning. It is meant to be completed before the subsequent face-to-face training so that participants share a common base of knowledge. The nominal training time for this component is 2 hours.

The **face-to-face workshop** component has two content elements – “generic” and “local”. As the program overview describes:

“The Generic content assists participants to bridge the information gained from the eLearning and engage with the trainer and their peers in a safe learning environment. Participant learning then flows to the Local content to explore the community / communities which are provided services by their organisation.”

In delivering the local content, there is an expectation that organisations will invite Elders and other local Aboriginal people in the community to take part in the workshops and that local content will be built into the workshop delivery. The nominal training time for this component is 6 hours, including 2 hours for the generic element and 4 hours for the local.

The Ministry has developed and distributed resources and tools designed to support organisations to implement this mandatory program. These include:

- A detailed Facilitator’s Guide
- A PowerPoint template to assist in the development and presentation of local and generic content
- Guidelines on communicating with and about Aboriginal people
- Web links to important policy and procedural information relevant to the program
- Handouts and worksheets for use by participants
- A Certificate of Completion template

The framework requires that 80% of all health staff complete the training by the end of 2015.
1.2 About the Evaluation

1.2.1 Purpose

The evaluation is an “implementation review” and describes the roll-out of the Framework over 2012 and 2013. It assesses the reach and uptake of the training and aims to develop an understanding of why the implementation effort is or is not on track and to provide a basis for future management and support of the program.5

1.2.2 Methods

The primary methods used in the evaluation were:

- Analysis of data compiled by the Health Education and Training Institute (HETI) on eLearning and face-to-face completions across NSW Health. Other data on eLearning completions provided by Local Health Districts (LHDs) were also used.
- Qualitative interviews conducted on-site and by phone with key staff and with a sample of participants from six LHDs and NSW Ambulance.
- Presentation of seven Case Studies, based on these interviews, to provide a more detailed account of the experience of a sample of organisations in implementing Respecting the Difference.
- Conduct of a web-based survey of Chief Executives of LHDs and other NSW Health organisations to get their perspective of the roll-out of the program in their areas of control.

These methods do not necessarily provide a complete picture of all the issues faced by NSW Health organisations in implementing the program. The Case Studies provide an insight into the operational barriers and enablers experienced by a selected group of organisations and highlight recurring themes which may apply more broadly. Similarly, the CEO survey results provide only an indicative picture of progress based on the responses received.

1.2.3 Key Evaluation Questions

The key questions explored by the evaluation were:

- How is the implementation of the Framework tracking? Is current or planned delivery likely to result in the 80% target being reached by 2015?
- What do key stakeholders think about the relevance, content, form and delivery of the program and of the target?
- What has hindered or helped implementation?
- Can key stakeholders present any evidence of improvements in the cultural competence of staff or any other indications of program impact?
- What should be done to improve the future take up and outcomes of Respecting the Difference?
- What needs to be put in place now so that outcomes can be measured in the future?

5 The Framework describes three key areas for evaluation – development and implementation of the training; assessment of learning outcomes and training; and effectiveness. The current evaluation focuses on the first of these key areas, but makes recommendations on how planning for future evaluations might be able to better measure learning outcomes and training effectiveness.
SECTION TWO

Progress in Training Delivery

2.1 Data Limitations

eLearning completion data

The training records of NSW Health staff are currently being centralised in a new state-wide system called “HETI Online”. While this promises to provide a more reliable means of analysing training data in the future, HETI has advised that the data currently available on eLearning completions may be incomplete, inaccurate or missing entirely. Reasons for this may include:

- Use of multiple Learning Management Systems across the state and multiple methods of collecting and inputting data into these systems. Some of these systems have had major technical problems during the period under review and some records were reported to be lost or inaccessible;
- Difficulties associated with the splitting of LHDs from the old Area Health Services (AHS). In some cases, it was not possible to separate LHD completion data from AHS completion data. Estimates have been made in these cases, based on share of total staff, but these may not be accurate;
- Complications brought about by LHD staff accessing the eLearning from HETI’s current eLearning platform (“HETI Moodle”) instead of their own local system. As HETI Moodle is a self-registration system, duplicate accounts may be created and there may also be data entry errors or omissions;
- Early technical problems with the eLearning software itself resulted in users’ completion of the package not being recorded by the system. Instead, up until 22 August 2013, users needed to complete a “Declaration of Learning” (i.e. clicking a box to declare they had completed the program) to have their completion recorded and certificate issued. False declarations were therefore possible (e.g. HETI indicated that it had identified instances where people had made their declaration of learning after only a few minutes engagement with the system);
- Failure of some health services to provide timely reports on their own counts of eLearning completions. As an indication, HETI indicated that a 3 month turnaround in the provision of these data was not uncommon.

Details of the characteristics of learners were generally not available and so have not been considered in this evaluation. Such data will be more readily available once HETI Online is fully implemented and will enable detailed analysis that will be crucial to future impact evaluations. For example, it will allow an analysis of how many frontline or clinical staff are completing the training. This is important as these staff are the people most likely to be in contact with Aboriginal clients and able to influence service and consequent health outcomes.

Face-to-face completion data

Up until December 2013, data on completion of the face-to-face component were not reported to HETI. The most recent reports have provided some data on 2013 face-to-face completions, but none on the period prior to that. The data that were provided included information on face-to-face cultural awareness programs that existed prior to the introduction of Respecting the Difference. In some cases these programs may not fully comply with the content and delivery requirements of the framework e.g. courses that run over 2 hours not 6 or which include no local content.

Face-to-face completion data for other NSW Health organisations were not available, but anecdotal information suggests little progress has been made.
2.2 Progress in Local Health Districts

eLearning completions in Local Health Districts are summarised in Table 1.

Key points to be drawn from this data are:

- The numerical equivalent of 35% of LHD staff have completed the eLearning package, but rates vary substantially from LHD to LHD – from 3% in Southern NSW LHD to 72% in South Western Sydney;
- Across all LHDs, a similar number of people completed the eLearning component in 2012 and 2013, but in some LHDs the number has increased or decreased. Significant increases occurred in Hunter New England, Illawarra Shoalhaven, South Western Sydney, Western NSW and Central Coast. Significant decreases occurred in Murrumbidgee, Nepean Blue Mountains, Northern NSW, Sydney, and Western Sydney;
- For eLearning, achieving 80% LHD staff completion by end-2015 may be possible, particularly if there is a renewed promotional effort and if the decline in completions in some LHDs is reversed.

For a number of reasons, comparing progress across LHDs in face-to-face completions is problematic. First, when Respecting the Difference was introduced, LHDs were at various stages of readiness to implement this component. Some had long-standing Aboriginal Cultural Awareness/Respect programs in place and could continue to run these or redevelop them relatively quickly with minimal changes (e.g. Mid-North Coast, Northern NSW and Hunter New England LHDs). LHDs without such programs in place were required to invest considerable time and resources to developing a program from scratch (e.g. Illawarra Shoalhaven, Western NSW, Northern Sydney, Sydney, South Western Sydney) and most of these have only recently commenced training. Others have yet to develop a face-to-face training package at all. Second, there appears to have been significant variation in the content and duration of the face-to-face training that has been reported by LHDs – ranging from the full six-hour program required by the Framework to much briefer, two-hour sessions.

Table 1. eLearning Completions – Local Health Districts

<table>
<thead>
<tr>
<th>LOCAL HEALTH DISTRICTS</th>
<th>2012</th>
<th>2013</th>
<th>TOTAL</th>
<th>STAFF % (a)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Coast LHD</td>
<td>330</td>
<td>1165</td>
<td>1495</td>
<td>26%</td>
</tr>
<tr>
<td>Northern Sydney LHD</td>
<td>12</td>
<td>1799</td>
<td>1811</td>
<td>17%</td>
</tr>
<tr>
<td>Far West LHD</td>
<td>49</td>
<td>141</td>
<td>190</td>
<td>26%</td>
</tr>
<tr>
<td>Hunter New England LHD</td>
<td>1532</td>
<td>5514</td>
<td>7046</td>
<td>49%</td>
</tr>
<tr>
<td>Illawarra Shoalhaven</td>
<td>197</td>
<td>1093</td>
<td>1290</td>
<td>20%</td>
</tr>
<tr>
<td>Mid North Coast LHD (b)</td>
<td>379</td>
<td>453</td>
<td>832</td>
<td>22%</td>
</tr>
<tr>
<td>Murrumbidgee LHD</td>
<td>774</td>
<td>200</td>
<td>974</td>
<td>27%</td>
</tr>
<tr>
<td>Nepean Blue Mountains LHD (c)</td>
<td>1433</td>
<td>698</td>
<td>2131</td>
<td>46%</td>
</tr>
<tr>
<td>Northern Sydney LHD (b)</td>
<td>480</td>
<td>188</td>
<td>668</td>
<td>13%</td>
</tr>
<tr>
<td>South Eastern Sydney LHD</td>
<td>217</td>
<td>318</td>
<td>535</td>
<td>5%</td>
</tr>
<tr>
<td>South Western Sydney LHD</td>
<td>3394</td>
<td>4470</td>
<td>7864</td>
<td>72%</td>
</tr>
<tr>
<td>Southern NSW LHD</td>
<td>9</td>
<td>77</td>
<td>86</td>
<td>3%</td>
</tr>
<tr>
<td>Sydney LHD</td>
<td>4825</td>
<td>908</td>
<td>5733</td>
<td>55%</td>
</tr>
<tr>
<td>Western NSW LHD</td>
<td>146</td>
<td>1477</td>
<td>1623</td>
<td>28%</td>
</tr>
<tr>
<td>Western Sydney LHD (c)</td>
<td>3877</td>
<td>1492</td>
<td>5369</td>
<td>48%</td>
</tr>
</tbody>
</table>

ALL LHDs                      | 17654| 19993| 37647 | 35%         |

(a) Staff numbers source: NSW Health Information Exchange. Unaudited instances on Payroll in February 2014. Excludes VMOs and Third Schedules.

(b) 2012 eLearning totals for Mid North Coast LHD and Northern NSW LHD are based on an estimated share (44% and 56% respectively) of completions recorded under North Coast AHS. Total AHS figure (858) supplied by HETI.

(c) 2012 eLearning totals for Nepean Blue Mountains LHD and Western Sydney LHD include their estimated share (27% and 73% respectively) of Sydney West AHS completions. Total AHS figure (5278) supplied by NBM LHD.
Keeping these points in mind, the following key points can be made about progress in the delivery of the face-to-face component:

- Completion rates vary substantially. A number of LHDs having not commenced training (Central Coast, Nepean Blue Mountains, and Western Sydney) and are unlikely to start anytime soon. Others have trained significant numbers (Western NSW, Murrumbidgee, Mid North Coast, Illawarra Shoalhaven, and Hunter New England);
- In contrast to the eLearning completions, only 3.1% of all LHD staff have completed any form of cultural awareness training in the last two years;
- This difference in the completion rate of the two components suggests that many staff who complete the eLearning component are not being given timely access to the face-to-face training. The framework recommends that the two component be delivered as close together as possible (within six months);
- For face-to-face, achieving 80% LHD staff completion by end-2015 is unlikely at the current rate, although some individual LHDs may reach around 40% if they maintain or moderately increase their training.

2.3 Progress in other Health Organisations

Progress in implementing the framework in other NSW Health organisations is summarised in Table 2. Note that this is just a sample of these organisations and includes only those whose staff have accessed eLearning via the HETI Moodle and for which total staff numbers were available through NSW Health Information Exchange.

Key points to be drawn from this data are:

- 13% of staff from this group of NSW Health Organisations have completed the eLearning. The situation in other Health Organisations is unclear, but, as most use HETI’s eLearning platform, it can reasonably be assumed that the completion rates in these organisations are very low;
- As was the case with LHDs, achieving 80% LHD staff completion of eLearning by end-2015 may be possible, but a renewed promotional effort may be needed.

Only two organisations reported that they had delivered the face-to-face component of the Framework – the Clinical Excellence Commission, and Justice Health and Forensic Mental Health. The latter of these has been the most active with almost a third of its staff having completed the face-to-face training.

It may be timely to seek information from these organisations on their plans for delivery of the face-to-face component. Some smaller organisations might consider jointly developing and running these courses and the Ministry of Health might facilitate this.

Table 2. eLearning Completions − Other NSW Health Organisations

<table>
<thead>
<tr>
<th>OTHER HEALTH ORGANISATIONS</th>
<th>2012</th>
<th>2013</th>
<th>TOTAL</th>
<th>STAFF % (a)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency for Clinical Innovation</td>
<td>0</td>
<td>18</td>
<td>18</td>
<td>15%</td>
</tr>
<tr>
<td>Ambulance Service of NSW</td>
<td>125</td>
<td>209</td>
<td>334</td>
<td>7%</td>
</tr>
<tr>
<td>Bureau of Health Information</td>
<td>15</td>
<td>4</td>
<td>19</td>
<td>59%</td>
</tr>
<tr>
<td>Clinical Excellence Commission</td>
<td>35</td>
<td>18</td>
<td>53</td>
<td>54%</td>
</tr>
<tr>
<td>Health Education and Training Institute (b)</td>
<td>109</td>
<td>94</td>
<td>203</td>
<td>162%</td>
</tr>
<tr>
<td>Health Infrastructure</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>13%</td>
</tr>
<tr>
<td>HealthShare</td>
<td>46</td>
<td>54</td>
<td>100</td>
<td>2%</td>
</tr>
<tr>
<td>Justice Health and Forensic Mental Health</td>
<td>49</td>
<td>499</td>
<td>5481</td>
<td>40%</td>
</tr>
<tr>
<td>Ministry of Health</td>
<td>82</td>
<td>66</td>
<td>148</td>
<td>18%</td>
</tr>
<tr>
<td>Sydney Children’s Hospital Network</td>
<td>309</td>
<td>760</td>
<td>1069</td>
<td>21%</td>
</tr>
<tr>
<td><strong>ALL LHDs</strong></td>
<td><strong>772</strong></td>
<td><strong>1725</strong></td>
<td><strong>2497</strong></td>
<td><strong>13%</strong></td>
</tr>
</tbody>
</table>

(a) Staff numbers source: NSW Health Information Exchange. Based on February 2014 payroll. Excludes VMOs and Third Schedules.
(b) HETI total staff number may not include contingent workers who completed the eLearning package (hence Staff % >100%).
SECTION THREE

Survey of Chief Executives

3.1 About the Survey
- Recognising the demands on the time of Chief Executives, the survey was brief (estimated to take between 4 and 8 minutes to complete).
- Responses were anonymous, only identifying the type of organisation (LHD, Shared State-Wide Service, Pillar or Specialty Network) and its broad geographic coverage (metropolitan, regional/rural or state-wide).
- The survey was distributed to all NSW Chief Executives on 1 December 2013 and reminders were sent on 17 December 2013 and 10 January 2014.
- 68% of the 25 NSW Health Chief Executives ultimately completed the survey. Of these:
  - 10 were LHDs (out of 15 − 66% response)
  - 3 were Specialty Networks (out of 3 − 100% response)
  - 3 were Pillars (out of 6 − 50% response)
  - 1 was a Shared State-Wide Service (out of 6 − 17% response)

3.2 Results

3.2.1 Attendance at the “Lead the Change: An Executive Challenge Workshop”

This workshop, conducted in Redfern on 2 May 2012 and hosted by the Director General, effectively launched Respecting the Difference and emphasised its importance to Chief Executives. Chief Executives were asked if they attended this workshop. Responses were:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>9</td>
</tr>
<tr>
<td>No</td>
<td>8</td>
</tr>
</tbody>
</table>

Comments: Given that almost half of respondents did not attend the workshop, it might be timely to again reinforce the importance of the Framework in a way that captures the attention of Chief Executives.

3.2.2 Steps taken to drive implementation

Chief Executives were asked what specific steps they had taken in their organisations to drive implementation of Respecting the Difference. Responses were:

<table>
<thead>
<tr>
<th>Activity</th>
<th>14</th>
<th>82.4%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assignment of a person to take responsibility for implementing the program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active promotion of the program to staff</td>
<td>15</td>
<td>88.2%</td>
</tr>
<tr>
<td>Distribution and/or display of program resources (e.g. USB drives, brochures, posters)</td>
<td>6</td>
<td>35.3%</td>
</tr>
<tr>
<td>Embedding completion of the program into service accreditation processes</td>
<td>3</td>
<td>17.7%</td>
</tr>
<tr>
<td>Developing a local implementation plan that includes completion targets and milestones</td>
<td>9</td>
<td>52.9%</td>
</tr>
</tbody>
</table>

Comments: Given the intended scale of the roll-out of Respecting the Difference, it was surprising that only about a half of the organisations had developed an implementation plan that included targets and milestones. The fact that almost 20% of respondents had not assigned an individual to take responsibility for implementing the program was also surprising. Having a senior executive drive the implementation would seem desirable.
3.2.3 **Current status of implementation**

Chief Executives were asked to choose a statement that they believed best described the current status of implementation in their organisations. Responses were:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation of the program has gone relatively smoothly from the start</td>
<td>5</td>
<td>29.4%</td>
</tr>
<tr>
<td>We had some initial difficulties in implementing the program, but things are running well now</td>
<td>9</td>
<td>52.9%</td>
</tr>
<tr>
<td>We continue to have difficulties in implementing the program</td>
<td>3</td>
<td>17.7%</td>
</tr>
</tbody>
</table>

Comments: The responses suggest that over 70% of organisations have had difficulties in implementing the program and that this may have retarded progress in meeting targets. (See also 4.2.8 below)

3.2.4 **Reporting against the Framework’s KPIs**

The survey sought information on the extent to which Chief Executives were currently reporting against the 10 Key Performance Indicators (KPIs) outlined in the Framework. Responses to this question were received from 14 of the 17 respondents as follows:

| KPI-1: Leadership commitment to implementing the training framework      | 10    | 71.4%      |
| KPI-2: Programs for each target audience established                    | 5     | 35.7%      |
| KPI-3: All staff provided access to training programs                   | 10    | 71.4%      |
| KPI-4: Appropriate involvement of Aboriginal community groups in implementing training programs | 3     | 21.4%      |
| KPI-5: Percentage of staff undertaking online learning annually         | 10    | 71.4%      |
| KPI-6: Submits a plan outlining strategies, targets and timeline for participation of all staff and targeted audience groups to attend face-to-face workshops and that targets for year 1 are achieved | 3     | 21.4%      |
| KPI-7: Evaluation of learning outcomes indicate learning outcomes are achieved (target of 80%) | 2     | 14.3%      |
| KPI-8: Training evaluation reports indicate “Respecting the Difference” Aboriginal Cultural training has provided staff with the tools to provide better services to Aboriginal individuals and communities | 2     | 14.3%      |
| KPI-9: “Respecting the Difference” Aboriginal Cultural training is visible both in the health service and community and has high priority and is valued | 4     | 28.6%      |
| KPI-10: “Respecting the Difference” Aboriginal Cultural training is visibly linked to recruitment and retention strategies providing appropriate services for Aboriginal people and performance outcomes for Aboriginal health | 2     | 14.3%      |

Comments: KPIs that have the potential to highlight the current reach and impact of training were not among the more commonly reported. For example, KPIs 2 and 6 would provide Chief Executives with a measure of progress in implementing the face-to-face component were reported by a minority of respondents. Similarly, KPIs 7 and 8 would provide evidence of program impact, but these too were reported by a minority. Accountability and results would be strengthened if these KPIs, in particular, were re-emphasised.

3.2.5 **Confidence in meeting the 80% target**

Chief Executives were asked to indicate how confident they were that their organisations would achieve the 80% target for completion of the Respecting the Difference program. Responses were:

<table>
<thead>
<tr>
<th>Confidence level</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very confident</td>
<td>7</td>
<td>41.2%</td>
</tr>
<tr>
<td>Confident</td>
<td>6</td>
<td>35.3%</td>
</tr>
<tr>
<td>Not confident</td>
<td>4</td>
<td>23.5%</td>
</tr>
<tr>
<td>No chance at all</td>
<td>0</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Comments: The high level of confidence expressed by Chief Executives was somewhat surprising given the feedback provided by most staff interviewed in the 7 organisations as part of the evaluation. Given the lack of implementation planning in most locations (see 4.2.2 above) and the difficulties experienced in getting started in most locations (see 4.2.3) it may be that some Chief Executives do not appreciate the scale of the task.
3.2.6 Feedback on value and impact of the training

Chief Executives were asked to indicate the nature of the feedback they had received on Respecting the Difference (the program as a whole, including eLearning and face-to-face) from participants and from their Aboriginal staff. Responses on participant feedback were:

<table>
<thead>
<tr>
<th>Feedback Type</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generally favourable</td>
<td>13</td>
<td>76.5%</td>
</tr>
<tr>
<td>Generally unfavourable</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>A mixed response</td>
<td>3</td>
<td>17.7%</td>
</tr>
<tr>
<td>No feedback</td>
<td>1</td>
<td>5.9%</td>
</tr>
</tbody>
</table>

Responses on Aboriginal staff feedback were:

<table>
<thead>
<tr>
<th>Feedback Type</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generally favourable</td>
<td>11</td>
<td>64.7%</td>
</tr>
<tr>
<td>Generally unfavourable</td>
<td>1</td>
<td>5.9%</td>
</tr>
<tr>
<td>A mixed response</td>
<td>2</td>
<td>11.8%</td>
</tr>
<tr>
<td>No feedback</td>
<td>3</td>
<td>17.7%</td>
</tr>
</tbody>
</table>

Comments: Chief Executives reported generally favourable feedback from participants and Aboriginal staff on the training.

3.2.7 Completion of the training by Chief Executives

Chief Executives were asked if they themselves had completed the eLearning component, the face-to-face component, both, or neither. The responses were:

<table>
<thead>
<tr>
<th>Component</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed eLearning only</td>
<td>8</td>
<td>47.1%</td>
</tr>
<tr>
<td>Completed face-to-face training only</td>
<td>1</td>
<td>5.9%</td>
</tr>
<tr>
<td>Completed both</td>
<td>4</td>
<td>23.5%</td>
</tr>
<tr>
<td>Completed neither</td>
<td>4</td>
<td>23.5%</td>
</tr>
</tbody>
</table>

Comments: Only a quarter of respondents had completed both components of the program. As almost a half of respondents had also not attended the “Lead the Change” workshop in May 2012, further efforts may be required to ensure that all Chief Executives have had the opportunity to experience the training themselves. About a quarter of respondents had done neither the eLearning nor the face-to-face component.

3.2.8 Difficulties faced in implementing the program

Chief Executives who reported past or continuing difficulties in implementing the program were asked to describe these and how they overcame them. Responses were:

- “Accessing program. Utilised IT Staff to fix problem.”
- “Data collection. The data collection tools have now been improved.”
- “IT connectivity was extremely difficult, as was the specific tasks required to complete on line. Resolved with lots of communication.”
- "Unstable workforce & management in Aboriginal Health Unit. This has now been addressed and appointments have been made."
- “Needs Executive commitment and development of a strategy – this takes time and trust and the organisation was still working through significant change in both structure and personnel.”
- “Implementation stalled as a result of not having the appropriate staff member on board. Recruited and in post.”
- “Get the right person/team to develop the training plan/objectives and timeframes. Once the right person was appointed and could work with the L&D Manager, the plan presented to Executive was to hire an external facilitator for the face-to-face training. During NAIDOC week, we trained some 150 people – 5 full days of training and since then, it has gone very well. The external facilitator is excellent and he and (our staff member) are doing a great job. We now have a calendar, an evaluation system and good promotion (thanks to our communication officer who has participated in all training so far and has promoted in internal newsletters, etc.).”
- [Overcame lack of progress by] “Setting the expectation that it was a requirement by Directors to ensure that all staff complete the RD training.”

Comments: Staffing issues, initial technological problems and lack of an appropriate management strategy to drive implementation were the main themes to emerge from this question.
SECTION FOUR

Case Studies

4.1 Mid-North Coast Local Health District

**Key Points**

- Mid North Coast LHD has made relatively strong progress in rolling out the training. From 2012 to 2013, 832 staff (22%) completed the eLearning component. In 2013, 300 attended face-to-face workshops based on its long-standing “Cultural Awareness Program” (CAP).
- A new version of CAP was approved in November 2013 that brings it more fully into line with the Respecting the Difference framework.
- The quality of the face-to-face training is high and participants report a high degree of satisfaction with it.
- Training is delivered off-site at venues where staff can “immerse themselves in an Aboriginal cultural experience” – it involves Elders as well as guest speakers from a range of different health units.
- There are long waiting lists to do the training which is offered around 10 times per year.
- Training is led by existing LHD staff who continue to do their usual jobs.
- The LHD is exploring a position to support Respecting the Difference in a “service redesign” model. The aim would be to support Respecting the Difference by aligning redesign strategies – e.g. working in partnership. Units would review their services and procedures to ensure they are culturally competent and can assist the application of Respecting the Difference training in the workplace.

**Background**

Mid North Coast Local Health District extends from the Coffs Harbour to Port Macquarie, an area of some 11,000 square kilometres. It includes the large towns of Bellingen, Coffs Harbour, Dorrigo, Kempsey, Macksville, Port Macquarie and Wauchope and services a population of over 200,000. Before 2012, this LHD was part of the North Coast Area Health Service along with what is now the Northern NSW LHD.

Around 10,000 Aboriginal or Torres Strait Islander people live in the area covered by the LHD. This is around 5 per cent of the population. Current Aboriginal staffing levels are around 2.4% (around 90 Aboriginal staff). The LHD’s Board has an Aboriginal Health Close the Gap Sub-Committee which provides advice on a wide range of issues relating to Aboriginal client services, health programs and workforce development issues. The LHD also has an Aboriginal Workforce Development Committee.

Responsibility for the implementation of the face-to-face component of Respecting the Difference rests with the Aboriginal Health Program which is part of the Aboriginal Health and Primary Partnerships Directorate.
The LHD and, previously, the Area Health Service, have for many years run a one-day Aboriginal Cultural Awareness Program (CAP) designed to improve the cultural competence of staff. In November 2013, a revision of this program was endorsed by the Aboriginal Sub-Committee and this has brought CAP in line with the Respecting the Difference framework. The revision reduced the face-to-face delivery time from 8 to 6 hours because the eLearning component was seen to now cover some of the content of the original course.

**Progress**

**eLearning Component**

Information collected by HETI indicates that 832 staff (around 22% of total) had completed the eLearning package by the end of 2013. The LHD explained that there had been significant problems with its Learning Management System and that, as a result, data on training undertaken prior to August 2013 might have been lost. The integrity of the data that is available might be questionable in other respects too (i.e. duplications, commenced but not completed etc.)

With a new system in place (and a move to the centralised HETI Online system scheduled for 2014), these problems will be resolved and the LHD’s aim is for 80% of staff to have done the eLearning component by the end of 2015. However, this may be achieved without staff completing the eLearning as close in time as possible to the completing the face-to-face training. At the current rate, most staff will need to wait a long time to do this face-to-face training.

**Face-to-Face Component**

In 2013, the LHD reported that 300 staff attended workshops. All face-to-face courses delivered in the LHD up until the end of 2013 were based on the longstanding Aboriginal Cultural Awareness Program (CAP) rather that Respecting the Difference. The new version of the program (6 hours not 8) was only approved on 8 November 2013. The content of the two courses is very similar, so the LHD argues that completion of CAP should fulfil the requirement of Respecting the Difference. Face-to-face training courses are facilitated by Aboriginal staff who do this on a part-time basis while continuing to perform the tasks associated with their core job in the LHD.

In recent years, around 8 courses have been run per year – 4 in the north and 4 in the south – with some 20 to 25 participants in each. This has recently been increased to 10 courses (5 and 5), but even this would see a maximum of 250 people trained per year. This figure does not even cover the number of new staff joining the LHD each year so achieving the 80% target is very unlikely at the current rate. Even assuming that half of the current staff have completed CAP, current course numbers would need to be quadrupled to reach the target.

The quality of the face-to-face training being delivered in the region appears to be very high. The training is delivered off-site at venues where staff can “immerse themselves in an Aboriginal cultural experience” – for example at the Sea Acres Rainforest Centre in Port Macquarie and the Botanical Gardens in Coffs Harbour. As one staff member put it “we are not about numbers here, we are about quality”. The LHD’s approach is resource-intensive and includes organising the involvement of Elders and

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**“Even assuming that half of the current staff have completed CAP, current course numbers would need to be quadrupled to reach the target.”**

**“We are not about numbers here, we are about quality.”**
guest speakers from a range of different health units. The LHD says they have long waiting lists of people keen to do the training. The LHD believes that it needs more people in frontline positions to do the face-to-face training and has started to use a more targeted approach.

**Barriers**

*Insufficient resources*

While this LHD highly values Aboriginal cultural awareness training and has a long history in its delivery, achieving the 80% completion target by the end of 2015 was considered impossible without a significant injection of external resources. Senior management said that to increase the roll-out to the extent required to meet the target would probably require the engagement of a team of consultants and that this would incur significant costs. Costs of backfilling clinical staff engaged in the training would also be substantial.

Given budget constraints, expansion of training would require the LHD to redirect more funds from service delivery. Aboriginal Health already funds some of the training delivery costs (venues, catering etc.) The alternative would be to use more Aboriginal staff time in delivery, but this too has budget and service delivery consequences as some of the current staff delivering the training are themselves employed in clinical positions. As one current trainer put it, under the current part time arrangements, “expansion would kill me”.

The LHD is currently exploring the establishment of a new full-time role that would go some way towards relieving some of these pressures. Part of this role would be to support District-wide service redesign activities and to link these to learning from *Respecting the Difference* training.

Regardless, the view was widely expressed that the 80% target was always going to be unattainable. As one person put it “I cannot understand how any LHD could get 80% of their people through the face-to-face training and maintain the quality”. As another person said “a high quality approach requires a trade-off between numbers trained and benefits obtained”.

*Trainers’ limitations*

The use of existing Aboriginal staff drawn from the LHD as part-time trainers also imposes some restrictions on both the type of training delivered and the number of courses that can be realistically run. Aboriginal cultural awareness training often requires facilitation of training exercises that require high levels of skill that go beyond just sharing information. While feedback from participants (see below) suggests a high level of satisfaction with the trainers currently being used in the LHD, support is needed to further develop the training skills of existing trainers. Additional support has been suggested as needed from either local sources from the LHD, or NSW-wide from the Ministry of Health.

The training also requires the trainers to share personal history with the participants and this can be draining. As one respondent said “the presenters are exhausted by the end of the day”. Also, as Aboriginal people, they also have family and community responsibilities that sometimes clash with work responsibilities. There is little or no backup available if, for example, a trainer is unexpectedly unavailable.
Not enough clinical staff attending face-to-face training

Respondents indicated that, despite it being mandatory for all staff to do the training, getting clinical staff released had proven to be difficult with release for a whole day seen as too big a drain on resources. Other mandatory training in clinical skills was given a higher priority.

As a result, staff employed in non-clinical roles may be over-represented in the face-to-face training numbers, when the priority should, of course, be those staff who are directly servicing Aboriginal clients. The LHD has recognised this issue and is attempting to address it, but, as one person put it, the risk of not addressing the issue successfully is that “you end up with a very enlightened and culturally aware group of back office people”.

Other Barriers

In the past, when staff needed to access the Ministry’s eLearning site to do the training, staff reported difficulties in accessing and navigating that site. They believed that some staff might have been discouraged because of the time it took to find the Respecting the Difference eLearning program and then establish a new user.

Quality and Appropriateness of the Training

Some comments were made that questioned whether the training was sufficiently focused on observable improvements in service delivery. They asked whether more could be done to translate the training into specific workplace behaviours. The LHD said that they had begun to do some work on this − for example, by analysing numbers of patients being discharged against medical advice or by monitoring levels of contact with Aboriginal Health before and after training − and future evaluations of Respecting the Difference might consider whether indicators of this type could be used to measure the program’s impact.

Others stressed the need to translate the training to what is happening at the operational unit level − “get the most out of examining scenarios, what needs to be done in the workplace, including how to influence operational planning. A lot of people don’t know what other staff are doing and there is a need to form stronger links across the organisation.”

Other comments from staff who had completed the training were overwhelmingly positive. These included:

- “The training makes it very clear that this is about improving health and why understanding culture is important in this.”
- “The old models of care might not work for Aboriginal clients and the training leads people to start thinking about how to do things differently.”
- “I will follow you down the highway to tell you how fantastic the training is. Only problem is that we aren’t running enough of it. People are lining up to get into it, such is its reputation.”
- “The online training was fantastic. Could not have been better. I thought of myself as being very enlightened, but I learnt so much.”
- “Regarding the face-to-face, had feedback from one person who had been here for 14 years and described the training as the best he had ever had:”
- “Nothing was off the table in the discussion. Top marks to those who ran the training and cover the issues so openly. It broke down the fear of offending.”

“The old models of care might not work for Aboriginal clients and the training leads people to start thinking about how to do things differently.”

“You end up with a very enlightened and culturally aware group of back office people.”
“It was very interactive. Used games that involved everyone. Was not a case of ‘death by PowerPoint’.”

“In the breaks, there were lots more exchanges with people asking questions they may have been too embarrassed to ask in the group. Nothing was considered too trivial to ask and the activities seemed designed to elicit these.”

“In the end, it was like a big ‘yarning’ session – like we had the chance to be invited into Aboriginal culture and learn from within”.

“Attended face-to-face in 2012 and did eLearning afterwards. Found the training inspiring – made me want to work in Aboriginal programs.”

“It opened my eyes to the challenges faced by Aboriginal people.”

“It explained the history of health services and how they can influence subsequent generations of Aboriginal people – ‘don’t go the hospital, they won’t help you’. It was confronting – some people in the room cried, but this was handled well.”

“The personal stories shared by the presenters made all the difference.”

“The eLearning was good, but it’s the slap in the side of the head that comes with the face-to-face training that will make the real difference”.

“Good to have an open conversation – allowed opportunity for people to ask the questions they need to ask. No off limits questions.”

“Face-to-face was very good – people come away keen to work with Aboriginal Health units. Need to debrief at the end of the training so that emotions released can be processed.”

“The beauty of the face-to-face is the opportunity to talk with Aboriginal people and get your questions answered.”

“Not about blame but about working together to improve things.”

“I'd have to say that, after 30 years in Health, was one of the most appropriate and relevant sessions ever attended. Did something similar in Queensland but not as good.”

“Gives new or existing staff a more complete view of why Aboriginal clients might react in the way they do – the continuing repercussions of the past.”

“Local content and delivery important. Past presentations did not have this local element. Very refreshing to have local people who are passionate and knowledgeable.”

“The face-to-face focuses more on strategies – the need for follow up because there might be family or other reasons why Aboriginal patient fails to return for follow up treatment. It is very good, practical and opens the eyes.”

“After doing the training, we put out an EOI for local artwork to make the hospital more welcoming for Aboriginal people. We analysed the ‘did not wait’ statistics for Aboriginal clients and starting working with Aboriginal health team to address this. We also had discussions with local Aboriginal people about their needs and created a new outdoors space.”

Moving Forward

With the newly revised package, the LHD intends to adopt a more targeted approach starting with Senior Managers, Emergency Departments and Maternity. It will allocate 5 training spots on each course for these targeted participants.

“After doing the training, we put out an EOI for local artwork to make the hospital more welcoming for Aboriginal people. We analysed the ‘did not wait’ statistics for Aboriginal clients and starting working with Aboriginal health team to address this.”
The LHD is exploring the establishment (by July 2014) of a role which will include support to redesign services in a way that improves cultural responsiveness and eliminates any institutional racism. The review of existing resources in Aboriginal Health will also allow trainers to focus on delivery. It would also make it possible to increase the number of face-to-face courses that are run. The LHD hopes to initially support the funding of the position through the Elsa Dixon Aboriginal Employment Program funding (via the Department of Education and Communities). This would provide 65% of the required funding, initially for 1 year, but then funded on a recurrent basis by the LHD.

This position would also work with services directly as a type of “internal consultant”. As a senior manager explained: “the penny may have dropped for some staff after the training, but they still need practical guidance in the workplace to transfer what they have learned. It’s not just training – it’s service redesign.”

In terms of the Respecting the Difference targets, the view was expressed that LHDs should negotiate their own targets based on what is realistic.

Other ideas expressed by staff consulted in the evaluation included:

- The need for a more structured approach to measuring the impact of this training including, ultimately, Aboriginal health outcomes. As a NSW-wide program, these need to be consistent across the State. The current framework is seen to be somewhat vague. Elements could include client satisfaction (although this is influenced by many factors, not just Aboriginal cultural competence), analysis of client service statistics (e.g. attendance at appointments, “did not wait” figures), new relationships formed across the organisation (for example, the extent to which Aboriginal staff and operational units are being consulted about how to resolve service problems) and evidence of specific behavioural changes in the workplace. As one person put it “you need people to leave a learning experience wanting to change something.”

Fitting all the Respecting the Difference training into a single 8 hour shift – i.e. do the 2 hour eLearning first and then the face-to-face immediately afterwards. Currently this is not possible because the face-to-face is scheduled to commence first thing in the morning. (It would also require access to 20 to 25 computers for the eLearning to be conducted on site.)

All orientation training should include Respecting the Difference training – at least completion of the eLearning.

- Consider running these courses for current university students on a fee-for-service basis. This would ensure that most new staff would have already completed the training when they start and could also raise revenue to help expand the program for existing staff.

- Consider hosting some eLearning in small groups and have a facilitator on hand to lead a discussion of some of the key concepts.

Build the capacity of the LHD’s Aboriginal workforce so that more people could participate in delivering the Respecting the Difference training. They could also assist in their workplace to identify Aboriginal service delivery issues and to develop solutions.
4.2 NSW Ambulance

Key Points

- NSW Ambulance has made only modest progress in implementing Respecting the Difference – as at the end of December 2013, 334 staff (7%)* had completed the eLearning component and no staff had completed the face-to-face.
- Initial technical difficulties with the eLearning package slowed its completion rate in NSW Ambulance.
- The decentralised and largely mobile nature of NSW Ambulance operations makes it very difficult develop and deliver the Face-to-Face Component in a way that fully complies with the framework.
- NSW Ambulance has entered into discussions with the Ministry of Health to vary the standard model to better suit the operational needs of the organisation. This will include a two-hour Face-to-Face Component that is currently delivered as part of an induction program.
- NSW Ambulance indicated that they would be able to reach the 80% completion target by the end of 2015 if this variation were approved.

Background

NSW Ambulance has 4,515 staff distributed across NSW in 226 Ambulance Stations, five Control Centres (fielding emergency and non-emergency calls) and at its headquarters in Rozelle in Sydney. Around 90 per cent of staff are in front line service delivery in roles such as paramedics, patient transport officers, intensive care, special operations, counter disaster, aeromedical and medical retrieval. The remaining staff are in corporate and support roles including mechanical workshops, finance and payroll, human resources and administration. NSW Ambulance currently employs 105 Aboriginal people in a range of roles and this represents about 2.3% of the workforce.

Responsibility for eLearning programs in NSW Ambulance is normally given to the Learning and Development unit and, initially, this was the case for Respecting the Difference. However, a decision was made to transfer responsibility to the Healthy Workplace Strategies unit and to have the Aboriginal Employment Coordinator working in that unit coordinate the program.

Progress

eLearning Component

According to data provided by HETI, 334 staff (7%) had completed the eLearning component from 2012 to the end of December 2013.

It took some time for the eLearning package to be supplied to NSW Ambulance and to be incorporated into its online Learning Management System. When it was supplied in October 2012, a significant problem emerged – completion of the eLearning package was not being recorded.

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6 This figure was supplied by HETI and may be in error. NSW Ambulance has advised that: “non NSW Ambulance staff have incorrectly been identified as belonging to NSW Ambulance because they failed to nominated the relevant LHD when completing the module. Our figures indicate that 4% of NSW Ambulance staff undertook the eLearning Training at that time.”
by the system. HETI could not quickly resolve this problem and so a temporary arrangement was put in place for staff to make a "declaration of learning" so that they could record the completion of this compulsory training.

The fixed version of the package was made available in August 2013 and Ambulance staff who had commenced but not completed the original package were told that they could either finish it by 8 November 2013 (making a "declaration of learning") or start afresh on the new version after that date. This uncertainty about the status and functionality of the package delayed the formal launch of the package within NSW Ambulance.

Learning and Development advised that completion of the eLearning package has now been made a prerequisite for the Ambulance Management Qualification, the standard frontline management course for the Service.

**Face-to-Face Component**

As at end-December 2013, NSW Ambulance has delivered no face-to-face training under the approved (six-hour) Respecting the Difference model. It does include a two-hour Aboriginal cultural awareness module in its current induction program for frontline staff – including Trainee Paramedics, Graduate Paramedics, Transport Officers and Control Centre staff – and the Chief Executive has sought the Ministry's approval to vary its model so that this would meet the mandatory training requirements. The content of this program has been mapped against the standard program and it meets all but the requirements for local content. If approved, some 200 staff who have already completed the induction program will be deemed to have met the generic face-to-face training requirements. The task for NSW Ambulance would then be to roll out a similar two hour program for frontline staff and corporate staff who have not completed this induction and to cover the delivery of local content in another way (see Moving Forward below).

**Barriers**

**Resources**

All of the people consulted at NSW Ambulance identified a lack of resources as a major barrier. As has been the case in a number of LHDs, the Aboriginal Employment Coordinator has been assigned the role of coordinating Respecting the Difference training. This work is additional to the role’s normal workload. Coordinating a program for 4,500 staff in such a geographically dispersed organisation is a huge logistical challenge. Without additional resources, the Coordinator’s workforce development results may be adversely affected.

Although eLearning is relatively cost effective and can be increased through better marketing of the program to staff, the Face-to-Face Component would entail significant costs if delivered in the approved six-hour form. As the Service has no internal capacity or knowledge in this area, it would need to hire an expert trainer or consultant to run the face-to-face training. Getting a viable number of trainees in some locations will also be a challenge. Taking people offline for the training also bears a high cost at NSW Ambulance – either the individuals would
need to be paid to do the training on a day off or overtime would need to be paid to a replacement. With travel time and expenses factored in, the Service estimates that it would cost the equivalent of 2.5 or 3 working days for each 1 day spent in training. The current focus on cost-cutting makes this all the more difficult – the service is seeking to find $2m savings in its workforce budget.

NSW Ambulance staff indicated that, when the program was in the planning stage, the Managers Workforce across the sector indicated that they would not be able to implement the model without additional resources, but these resources were not offered.

**The Different Nature of NSW Ambulance**

NSW Ambulance operates very differently from LHDs or other organisations in NSW Health:

- It is a mobile service where staff are not concentrated in one place. Backfilling positions can be logistically difficult and leaving a community without an ambulance is not an option;
- It has limited or no local capacity to coordinate training at a local level – it needs to be coordinated centrally and this is a big task;
- It has different timing constraints on its ability to deliver training – for example, at certain times of the year such as winter, the organisation focuses entirely on frontline operations. Taking annual leave is discouraged during this period and training is kept to a minimum. It is a high volume period and “hospital block” (inability to offload patients at hospitals) causes delays;
- Access to computers to do the eLearning can be a problem – an Ambulance Station with 20 staff might only have one computer. In the case of staff working in metropolitan areas, they are often so busy they spend almost all their time on the road and very little at the station;
- For NSW Ambulance, “localised” means everywhere in NSW. The service covers the whole state and every community and so it is difficult to develop and deliver localised face-to-face content in all locations.

The working environment of NSW Ambulance is very different to that of LHDs and hospitals and so the nature of client contact is different. Ambulance Officers are on scene for 5 to 10 minutes treatment and have a brief to clear the scene in a certain time. In contrast, LHD staff are engaged in longer term contact – days or weeks in hospital. For Ambulance, working with the patient and the family over the long term is not generally an issue. Issues such as how to deal with large numbers of visitors and how to accommodate local rituals and customs may affect LHDs, but rarely do they affect Ambulance services.

While acknowledging that Aboriginal cultural competence is an essential skill for its staff, NSW Ambulance staff consulted in the review indicated that these differences meant that some flexibility was required in the delivery of Respecting the Difference in their organisation. Elements of their proposed approach are outlined below under Moving Forward.

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7 Where there are “multiple presentations” or where individual has a chronic and complex disease that requires regular transportation and treatment, a case manager is assigned and a defined service pathway is established.
NSW Ambulance staff also pointed out that they were unaware of any history of problems or conflicts existing between Aboriginal clients, communities and the organisation and that there was no pattern of complaints or systemic service issues.\(^8\) NSW Ambulance pointed out that, as a mobile service, staff spend a lot of time in community and get to know community members and Elders and learn about cultural differences. This can be built on and improved, but it indicates that the service is not necessarily working from a low base in terms of cultural competence.

**Collaborating with LHDs in the Delivery of the Program?**

Faced with the logistical difficulties described above in rolling out the program, NSW Ambulance has explored the potential to “piggyback” training delivery with LHDs. Unfortunately, this was not as straightforward as had been hoped:

- Some LHDs were not very far advanced in their own roll-out. Those that were less advanced had difficulties meeting demand from their own staff and were unwilling to collaborate;
- There are 226 Ambulance stations in NSW and not all have access to hospitals where training typically takes place. Sometimes the logistics involved in traveling to a venue would be too difficult in any case;
- LHDs have adopted such different approaches (including in content and duration) that linking with them would result in a very inconsistent delivery for NSW Ambulance.
- In one case, feedback about trainers had not been good.

**Organisational Change**

In recent times, NSW Ambulance has been undergoing a corporate restructure. A number of staff members were acting in positions on an interim basis until new staff members were appointed to key roles. With the program now formally launched and Executive Leadership roles now filled, the organisation is now better positioned to promote and provide support for the program.

**Quality and Appropriateness of the Training**

Staff consulted in the evaluation regarded the eLearning package as containing a lot of information, but presented in an appropriate and interactive way. Although the case studies were not specific to NSW Ambulance operations, they were still relevant and highlighted important lessons. The training is considered important and reinforces broader training provided such as “Respectful Workplace” (which offers face-to-face and DVD based training) and is underpinned by values that the organisation is actively promoting.

The difficulty that some staff might face in completing the eLearning module in one sitting was mentioned as a possible problem. As one respondent said: “Even doing a two hour course, staff may need to do the training in small chunks – maybe 20 minutes at a time. If they do,

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\(^8\) Some time ago, there were reportedly cases where Ambulance Officers were mistaken for police (who have had issues with some communities) but a change in uniform has overcome this. Where communities have had a problematic relationship with all government services, Ambulance has participated in initiatives designed to remedy this (e.g. a whole of government service improvement initiative in Moree).
there is a risk that it will be less effective – the message won’t be reinforced and learning outcomes may suffer.”

A number of people indicated that the eLearning was not adequate on its own and needed to be supported by face-to-face training that would “challenge attitudes and allow discussion”. People may retain negative attitudes and not fully understand the importance of the content – even despite the fact that the eLearning makes the case quite clear and explains the problems that occur when Aboriginal people come into contact with systems when they focus too much on process and not enough on people. As one respondent put it: “Staff need to appreciate how a focus on systems can be dehumanizing. Under so much pressure, it is easy to be captured by the system.”

**Moving Forward**

Extensive discussions have taken place with the Ministry regarding the roll-out – scoping the mode of delivery and the logistics of taking so many people offline. The model preferred by NSW Ambulance includes the following:

- Renewed marketing of the eLearning to staff and consultation with the new Ambulance Executive about how best to increase take up. eLearning would not initially be linked to face-to-face delivery;
- Maintaining eLearning as a prerequisite of the Ambulance Management Qualification;
- Continued delivery of two hours of face-to-face training as part of induction training for both corporate staff and paramedics. This will capture all new staff;
- Scheduled roll-out of this two hour module to all staff who have not completed this training (e.g. for longer serving staff who did not go through the current induction program) – possibly also including it in the mandatory Certificate of Practice training that all paramedics must do every three years;
- Engaging a skilled presenter/consultant to deliver. NSW Ambulance will not use an existing staff member such as an Aboriginal paramedic;
- Handling the local content requirement in its own way, whatever is appropriate for each local area – for example linking to LHDs, provision of guidance to paramedics about how to talk with community about issues and improving relationships, learning more about cultural practices and history;
- Increasing community fact sheets to cover all 45 Aboriginal nations in NSW – currently have 9 regional fact sheets. May get an Aboriginal consultant to do this;
- Sorting out program resourcing – there is a need to ensure workforce development role is not compromised in the process of rolling out the training.

NSW Ambulance believes that meeting the 80% completion target (staff completing both the eLearning and the Face-to-Face Component) by the end of 2015 is possible if the 2 hour face-to-face variation is approved. Current data indicates that, at the end of 2013, about 7.5% of staff have completed the eLearning and 4.5% have completed the two-hour face-to-face training.
4.3 Nepean Blue Mountains Local Health District

Key Points

- Nepean Blue Mountain LHD has made only modest progress in implementing Respecting the Difference – as at the end of December 2013, 2131 staff (45.6%) were estimated to have completed the eLearning. Most of these completed it in 2012 when still registered as Area Health Service staff. No staff had done the face-to-face.
- A new Aboriginal Workforce Officer has been relatively recently employed under a temporary contract and has begun the process of developing a face-to-face package. A new Aboriginal Workforce Group, comprising Aboriginal staff, will assist this process.
- Among the reasons given for slower than expected progress in this LHD were the complexity of having to work with three separate local Aboriginal peoples, inability to fill the Aboriginal Workforce Officer position for two years, and the lack of any resources provided by the Ministry to roll out such a big training program.
- Given the likelihood that the face-to-face training package will not be ready until later in 2014, reaching the 80% target by end 2015 would seem improbable.

Background

Nepean Blue Mountains Local Health District is in Sydney’s west and includes both urban and semi-rural areas. It provides primary and secondary health care for people living in the local government areas of Blue Mountains, Hawkesbury, Lithgow and Penrith and tertiary care more broadly across Western Sydney. Before 2012, this LHD was part of the Sydney West Area Health Service along with what is now the Western Sydney LHD.

Around 80 per cent of the LHD’s 4,670 staff are employed in medical, nursing, allied health or other clinical roles with the remainder filling administrative and other jobs. EEO statistics indicate that 1% of staff are Aboriginal or Torres Strait Islanders. The region serviced by the LHD has a population of 345,564 of whom around 2.6% are Aboriginal. Three Aboriginal peoples – the Dharug, Gundungurra and Wiradjuri – are acknowledged as the traditional owners of the lands covered by the LHD.

The LHD’s Organisational Development Unit has responsibility for rolling out the Respecting the Difference program. An Aboriginal Workforce Group, comprising Aboriginal members working in the LHD, has been recently formed and has been given the task of developing the face-to-face training package and consulting staff about what they want included. An Aboriginal Workforce Officer, appointed in mid-2013 under a temporary contract, will also play a key role in development and delivery.
**Progress**

**eLearning Component**

Data provided by HETI and a report provided by the LHD indicated a total of 698 staff (14.5%) had completed the eLearning component in 2013. Many more Nepean Blue Mountains LHD staff are believed to have completed the eLearning when they were part of the Sydney West Area Health Service. One estimate is that as many as 2131 staff (45.6%) have completed the eLearning in total since 2012.

The mandatory nature of the training is made clear and it is being promoted in the LHD through a training checklist system that reminds staff of the training they are required to do.

**Face-to-Face Component**

No face-to-face training has yet been delivered under *Respecting the Difference*. No other forms of Aboriginal Cultural Awareness training have been delivered in recent years.

The LHD indicated that they planned to commence training in the first half of 2014. (See *Moving Ahead* below.)

**Barriers**

**Resources**

Concerns were expressed about the lack of any resources being provided to roll out such a large scale training program. This included issues with the whole process of consultation around the development and roll-out of the program and an apparent “lack of understanding of the complexities faced on the ground”.

Funding for an Aboriginal Workforce Coordinator was available to the LHD and this role might have helped to advance the roll-out as has been the case in some other LHDs. However, this position remained unfilled for almost two years and was only filled with reduced scope of responsibility compared to other similar roles across the state (on a temporary part-time basis) in mid-2013. While this role is intended to be directly involved in future *Respecting the Difference* training delivery, it has other workforce development duties attached to it and may struggle to effectively roll out a 6 hour face-to-face training program to almost 5000 staff.

The person in this role has no training experience, so additional resources (such as a trainer from Organisational Development) will be needed.

The LHD would like to involve its other Aboriginal staff in delivery, but have had limited responses from them so far. Some are willing, but want to know how their commitment will affect their core duties.

**Engaging with Local Aboriginal Communities and Local Content**

The LHD has experienced difficulties in engaging with local communities to help Progress the development and delivery of the Face-to-Face Component. Despite getting a positive response initially, follow up has not been successful and engaging with Elders, in particular, has been difficult for the LHD. There may be a need for the LHD to invest more time in developing better community connections through an outreach program of some sort.
The fact that 3 traditional local Aboriginal language groups would need to be involved in course development and delivery has also been perceived as a barrier. There is community politics to navigate and finding local subject matter experts who are able to provide content across the three language groups was also mentioned as a challenge.

**Getting Staff to do the Training**

The LHD indicated that more work was needed to actively promote the program. The Mandatory nature of the training may not be well understood. Also, some groups are historically difficult to involve. For example, faced with a range of day-to-day pressures, it can be difficult to get doctors to even keep up with their required professional development training – getting them to do 6 hours face-to-face training under Respecting the Difference may be even harder.

There is also the issue of some staff questioning the need to do this training at all. They may resist doing the eLearning component because of a negative mindset about such issues. While the eLearning does address these matters and the urgent need to improve Aboriginal health outcomes, such people may benefit more from the face-to-face training so that they can better understand the issues and have their assumptions challenged.

On a practical level, the LHD pointed out that a 6 hour training module creates some timetabling challenges in an environment geared to 8 hour shifts. They cannot release a person for 6 hours – noting that absent clinical staff may need to be backfilled for the full shift.

Geography is an issue too – the LHD covers an area from St Marys to Lithgow. If training is run in the Nepean, Lithgow staff need to travel 1.5 hours each way. The LHD may therefore need to consider running the training at a number of locations – as other LHDs have done.

**Quality and Appropriateness of the Training**

While the LHD recognises that the eLearning package is a structured and efficient approach to delivery, they pointed out that computer competence is an issue with their more mature workforce. Many have a problem navigating the eLearning and do not have computers at home.

To some extent, the eLearning approach is at odds with LHD’s current training philosophy which emphasises face-to-face delivery. They have what they referred to as a “70:20:10 approach” – 70% one-to-one training delivered on-the-job; 20% through relationships with manager and peers; 10% in classroom training and through eLearning.

There was also a view that six hours of face-to-face Respecting the Difference training might be too much for some of their staff. The LHD would prefer a model that had different requirements based on each person’s role – basic cultural information might be provided for some… while others who have to engage with Aboriginal clients frequently would do much more.

There is also the issue of some staff questioning the need to do this training at all.
Moving Forward

The LHD recognises that their Progress in the roll-out of the program has been slow, but plans to remedy this beginning in the first half of 2014. Key planned tasks include:

- Supporting the Aboriginal Workforce Group to develop the face-to-face package and consult with staff about what they want included. The Group was reported to be keen to be involved, but it was unclear what resources would be made available for this task. The Aboriginal Workforce Coordinator has done some preliminary work on package development, including gathering statistics for inclusion in the template (e.g. demographics, prevalence of certain diseases like diabetes, criminal justice issues etc.)

- Identifying internal resources to be involved in training delivery. Two staff have expressed interest, including a local Dharug man, but he needs more clarity about how the training would fit in with his other duties. The Aboriginal Workforce Coordinator would be involved in delivery, probably working in tandem with an experienced trainer from the Organisational Development Unit.

- Use of an external training resource has been discussed but is unlikely to be approved. This includes the use of TAFE (a model used successfully in Hunter New England LHD) and a temporary Project Officer (such as the person employed in South Western Sydney LHD on a 2 year contract to develop and deliver the face-to-face training).

Given the resources being made available, meeting the 80% completion target (staff completing both the eLearning and the Face-to-Face Component) by the end of 2015 will be very difficult. Coming from its current zero base and assuming a stable workforce, the LHD would need to have an average of 166 people complete the face-to-face training per month to reach the target.

More resources would certainly help. Given that the Aboriginal Workforce Coordinator’s position was unfilled for two years (and now filled at a lower level, with reduced scope of responsibilities and on a part-time basis) there may be scope to apply some of these unspent funds on accelerating the roll-out of Respecting the Difference.
4.4  Illawarra Shoalhaven Local Health District

**Key Points**

- Illawarra Shoalhaven LHD has made relatively good progress in implementing the framework – 1,290 staff (20%) have completed the eLearning component and 453 people have participated in one of the 37 workshops run between July and December 2013.
- Aboriginal Employment & Diversity Officer currently coordinates and delivers a four-hour face-to-face course to staff and is supported by three other Aboriginal staff who continue to perform their usual roles in the LHD.
- Local content delivery including presentations by Elders has not so far been a major feature of the training. Among the ideas the LHD is considering to deliver this content is the conduct of additional 2-hour sessions in a larger auditorium.
- Resources to implement the program are stretched and organising and delivering the training can consume up to 80% of the time of the Aboriginal Employment & Diversity Officer.
- An implementation plan is in place and the LHD works with each site to identify priorities and target groups to receive training.
- Feedback on training quality and relevance was generally positive, but some indicated that they would prefer a more interactive delivery style (a “conversation”)
- The steady roll-out of workshops in this LHD has placed considerable pressure on the trainers, all of whom also maintain their regular jobs.

**Background**

Illawarra Shoalhaven Local Health District covers an area that extends 250 kilometres across the Local Government Areas of Wollongong, Kiama, and Shellharbour. It was previously part of the South Eastern Sydney and Illawarra Area Health Service, along with the current South Eastern Sydney LHD. Around 370,000 people live in the region including some 11,000 Aboriginal people (2.9% of the total). Some parts of the region have a higher percentage of Aboriginal residents – in Shoalhaven, for example, it is 4.7%. The traditional owners of the Wollongong area are the Dharawal people. The Wodi Wodi is a sub-group of the Dharawal nation who occupied areas around Lake Illawarra.

The LHD has a workforce of 6,327 employed across nine hospital sites. It has 128 Aboriginal staff (around 1.8%). The LHD has an Aboriginal Health Committee that reports to the Board of Directors and which includes the local Aboriginal Medical Service, the Chief Executive and the Tier 2 Director responsible for Aboriginal health. This group reviews performance against KPIs set by NSW Health, deployment of funds and the effectiveness of Aboriginal health programs. It also oversees KPIs relating to the implementation of *Respecting the Difference*.

Responsibility for the roll-out of *Respecting the Difference* in the LHD has been assigned to the Workforce Strategy, Culture and Wellness unit. Within this unit, the Aboriginal Employment & Diversity Officer is coordinating and leading the training.
**Progress**

**eLearning Component**

The LHD reported that 1,290 people (20% of total staff) had completed the eLearning component from 2012 to the end of December 2013.

**Face-to-Face Component**

453 people had completed the face-to-face training in 2013, its first year of delivery and 37 workshops have been delivered in total across the region.

Implementation of the face-to-face program did not commence until July 2013, but has gathered significant momentum since then. Initially, a one day face-to-face program was run for the Executive Group (Chief Executive, Tier 2 personnel and Senior Managers) which was facilitated by Ngaire Brown, a local Aboriginal doctor. This training was very well received by participants and created a good climate to drive implementation more broadly.

The Aboriginal Employment & Diversity Officer currently coordinates and delivers the four-hour face-to-face course to staff and is supported by three other Aboriginal staff who continue to perform their usual roles in the LHD. Each group has between 20 and 25 participants.

Training is mainly conducted at three sites – Shoalhaven, Shellharbour and Wollongong. On average one session is delivered per week at each of these sites. In addition, the training is also delivered at ancillary sites – Milton-Ulladulla, Kiama, Berry, Bulli and Coledale. The plan is to complete face-to-face training of all staff in these ancillary sites by the end of 2014.

The LHD has an implementation plan for the roll-out and works with each site to identify priorities and target groups to receive training. Participants in the face-to-face training must first complete the eLearning component, as is recommended in the framework.

**Barriers**

**Lack of Resources**

Resources to administer and deliver the training are severely stretched. As well as the significant time devoted to delivering the face-to-face training, there is also the organisational tasks. Scheduling needs to be done well in advance and this can be difficult – at least 6 to 8 weeks’ notice is usually needed and best results have been obtained when 12 weeks is given. Venues need to be booked, courses need to be promoted (including through flyers and emails), people need to be registered and training resources and handouts need to be printed and compiled. There is also a need to trouble shoot various things including glitches in the electronic booking system and follow up of complaints (e.g. people being turned away from courses because they had not enrolled beforehand or had not completed the eLearning component). Even the eLearning component requires support as some people with low computer literacy need help to navigate the eLearning.
The Aboriginal Employment & Diversity Officer said that up to 80% of her time can be devoted to Respecting the Difference. This has the potential to adversely affect other results expected from the position, especially the important task of maximising employment opportunities in the LHD for Aboriginal people in the region. Efforts to source more funds for the administration and delivery of the program have so far been unsuccessful. Instead, the program had to rely on managers agreeing to release three Aboriginal staff so that they could spend some of their time helping out.

Backfilling staff participating in the program also has significant resource implications. One respondent estimated that, to backfill nurses, it would cost more than $3 million to deliver the Face-to-Face Component in the LHD. The Chief Executive feared that this had the potential to “turn people off the program”.

Pressure on Trainers Given Limited Resources

There may also be a human cost to delivering the program in these circumstances. The delivery of this type of training can be emotionally draining on the individual. The Aboriginal trainers invariably draw on personal experiences and sharing these with strangers can be difficult. There is a need to ensure cultural safety for these individuals – if people react inappropriately to a trainer’s personal stories it can be very stressful and hurtful.

To help reduce these risks, the LHD generally does not allow trainers do more than one Respecting the Difference session per week as it is too emotionally draining. These trainers all work in other parts of health and so also have to perform their regular jobs. As the LHD has found, there is a breaking point – for example, following a complaint about a course made by one participant, one of the three Aboriginal trainers decided not to continue. This meant that a big gap would now need to be filled in the LHD’s delivery schedule.

Experience and skill levels of trainers can also contribute to stress. This is challenging training that can involve presenting confronting information and sensitively processing the responses of participants. For this reason, the training should ideally be delivered by a skilled and experienced Aboriginal facilitator. If staff with other responsibilities are used, their skills and capacity to do this training need to be thoroughly assessed and support arrangements need to be put into place if required.

Perceived Relative Importance of the Training

Frontline staff in the LHD work in a climate where demands on them are growing and more and more mandatory training is being imposed, particularly clinical training. While there is an expectation that nursing staff will complete all their mandatory training, in practice clinical training takes precedence.
Commitment from the top of the organisation can help reinforce the relative importance of Respecting the Difference training, but the culture of the health sector tends to focus on “things that we can see and measure each week”, as one respondent put it, rather than on training “where we may never know if it has worked or not.” As another respondent put it, “the culture centres on dollars and risk” and “if penalties apply to individuals and corporations if standards are not met, that is where the focus will be placed.”

One respondent also mentioned that there were people in the system who would be reluctant to undertake training of this type – “know-it-all’s who have the attitude that ‘if I don’t know it now, I don’t need to know’.”

Again, Senior Management needs to reinforce the importance and relevance of the training for all staff. Making the training compulsory may not be enough. As one respondent put it: “If someone is doing the training just because they have to, are they likely to get the desired learning outcome?”

Localisation and Elder Involvement

The LHD is currently focusing exclusively on the generic element of the Face-to-Face Component. It found that there are difficulties in getting involvement of local Elders in delivery. Some are involved in a big cultural education program run by DEC and it may be too much to expect them to work with Health too. It is important too to involve Elders that have the capacity to inspire positive change – not all can do this.

At a practical level, just paying Elders for their time is problematic – they are not employees, often do not have an Australian Business Number and no cash payments can generally be made. The LHD suggested that the Ministry might help to address this. Other LHDs did not report this difficulty and it may be that information on their procedures to contract Aboriginal consultants in this situation just need to be shared.

Quality and Appropriateness of the Training

A range of views were expressed by respondents on the quality and relevance of the training. The eLearning was generally regarded highly. As one respondent put it: “I have completed the eLearning and it is excellent. One of the better packages I’ve done, covering a very difficult subject. It doesn’t just present platitudes – it’s realistic and relevant.”

Feedback on the face-to-face training was mixed. Comments included:

- “I found the face-to-face training relevant and interesting. Highlighted some of the mistakes that can be made in dealing with Aboriginal clients – for example, a person presenting to ED being turned away and told to go to Aboriginal Health instead.”
- “I’ve had some feedback from staff who have done the face-to-face training that it was not what they were expecting. Wanted to hear more about what the issues were in the local Aboriginal community. Wanted more real life personal interaction about our services, both positive and negative.”
- “Currently, the face-to-face is too much like a lecture. Needs to be more like a conversation.”

“If someone is doing the training just because they have to, are they likely to get the desired learning outcome?”
“Having sat through the training, only 1 or 2 people seemed actively engaged in the process. Had feedback from others that they found the training ‘uninspiring’.”

“It’s important. We have a significant Aboriginal population here and a lot of doctors have had very limited exposure to Aboriginal people.”

“We’ve had mainly positive feedback but 2 complaints just in the last week. One complained that the training did not pay enough attention to practical strategies in the workplace and spent too much time on history and context. Another complained about the lack of local content and the fact that the trainer was originally from another region.”

The Chief Executive stressed the importance of the training and the need to open up to different approaches in working with local Aboriginal communities. She gave the example of a letter she had received from an Aboriginal staff member who had decided to resign. The staff member said that something needed to be done about the awareness of senior staff as “they didn’t know how to treat Aboriginal people”. In the course of performing the job, the staff member engaged with the Aboriginal community, spoke with Elders and attempted to break down barriers between the community and the system. However, this approach was resisted by some others in the organisation and, in frustration, the staff member resigned. This highlighted to the Chief Executive the need to do more to “bridge these two worlds”.

Another respondent said that the training should provide guidance to staff in working with Aboriginal colleagues. An example was given of a staff member introducing an Aboriginal co-worker as “our Aboriginal Cadet”. In this case, the co-worker was made to feel uncomfortable – she just wanted to be seen as one of the nurses and not singled out for her Aboriginality.

**Moving Forward**

The LHD has made good Progress in rolling out the face-to-face training, although current content and delivery arrangements may need to be reviewed in line with feedback received from participants. The situation in this LHD highlights the tension in rolling out a big training program with limited resources: getting the numbers through the program may come at the expense of maximising the learning outcomes of the program.

Other issues and ideas that were raised in the consultations included:

- In the last year, some more time has become available on the timetable – a window of opportunity between shifts where there is double staffing (Day-Afternoon Changeover). This is a state-wide change. Nursing Unit Managers could work with clinical educators to schedule training in this slot. This does not have to be all done in one sitting.

- To cover the local content element not so far covered in the Face-to-Face Component, it might be necessary to run some large group sessions, say in an auditorium that can accommodate bigger audience. This would involve Elders who would engage in a conversation with the audience about local issues;

- There is a need for more practical focus, so more work is needed to develop a way of measuring observable changes in the service;
Revisit the potential to have a dedicated full-time trainer deliver the training;

- Use a more targeted approach to roll-out the training to the priority areas. Start where Aboriginal contact is highest, and measure and evaluate things before and after. Focus on providing better service to Aboriginal clients in these areas.
- To increase completion rates by nurses, link their attendance to the accrual of Professional Development (PD) Points. Nurses need to accrue 20 of these points per year with 1 hour of training giving 1 point. Encourage line managers to refer to this option in their regular PD discussions.
- Explore the inclusion of this training into the university course? The earlier staff complete the training the better and, when they come through the system, they can influence older staff?

Maybe support the practical application of *Respecting the Difference* by producing videos and getting people to do a refresher course every year that focuses on these – for example, case studies looking at why someone might be upset in the waiting room and suggest ways to follow up. Similarly, include content on a website that gives pointers on resolving typical problems. Maybe better if everybody does such training every year – not just a fraction over 5 years.

Mandatory training, if designed correctly and if it highlights what is and is not expected in behaviour, will be accepted. On a practical management level, if a person has done such training and has then behaved in an inappropriate way, HR is then empowered to take corrective or disciplinary action.

- This type of training needs to be embedded in the organisation – built into the standard professional development of the entire workforce.
- This training needs to be embedded in the induction program. Orientation of new clinical staff is in January and February and this is a great time to get their attention. The worst time is winter.
- "You don’t just want to get numbers through – you want to get results.”
4.5 Sydney Local Health District

Key Points

- Sydney LHD has made very good progress in the delivery of the eLearning component with over half of all staff completing the package by end November 2013. The face-to-face training had not commenced at this time, but a package was almost complete and will be rolled out throughout 2014.
- The Centre for Education and Workforce Development (CEWD) is driving implementation in the LHD and hosts a dedicated “Cultural Respect Trainer”, employed by the LHD for a two-year period, who has helped develop the package and will be the primary trainer for Respecting the Difference.
- Training will focus initially on areas of high frequency Aboriginal client contact which have direct potential impact on health outcomes – Emergency Department, Admissions, specific clinical streams such as Mental Health and Obstetrics.
- The workshop is 4 hours in duration, not 6, and the LHD plans to deliver 4 workshops per week – 80 people per week in all. The Cultural Respect Trainer will lead the training supported, where possible, by an Aboriginal Health Worker (ideally from the unit being targeted) and another trainer from CEWD.
- Wherever possible, the LHD plans to deliver training to whole operational units – developing the cultural competence of whole team, including Aboriginal and non-Aboriginal staff is considered more likely to change behaviours and get results than training individuals from disparate operational areas.
- The LHD remains committed to achieving the 80% completion target but considers it to be very challenging given the size of the workforce and tight time frames.

Background

The Sydney Local Health District covers the centre and inner-west of Sydney and includes the Local Government Areas of City of Sydney, Leichhardt, Marrickville, Ashfield, Burwood, Strathfield, Canada Bay and Canterbury. It was previously part of the Sydney South West Area Health Service, along with the current South Western Sydney LHD. The population of the area is around 580,000, but the LHD services a large number of people who live outside its boundaries. The LHD employs around 10,000 staff with over 7,000 employed as doctors, nurses or in allied health and complementary roles. 1.8% of staff are Aboriginal or Torres Strait Islander people and there is a large Aboriginal population living in the LHD, especially around the Redfern-Waterloo area, in the City of Sydney and in Marrickville.

The Centre for Education and Workforce Development (CEWD) is responsible for delivering a comprehensive range of clinical and non-clinical education and training programs across the Sydney LHD and it is driving the implementation of Respecting the Difference. CEWD maintains the Learning Management System for the LHD and can provide detailed reporting on training completion.
Progress

**eLearning Component**

As at the end of November 2013, 5,733 staff (55%) had completed the eLearning component of *Respecting the Difference*. CEWD provided additional data on participant roles. Of note was the high number of clinical staff:

- Around 70% (3,244) were nursing staff;
- Around 15% (202) were medical and other staff.

The LHD appears to be well on track to achieve 80% completion of the eLearning component by the end of 2015. Staff consulted in the evaluation reported that the nature of the package made it possible to readily build it into existing training schedules – for example, by requiring all staff to complete it during their initial three-month orientation period in the LHD.

**Face-to-Face Component**

As at end December 2013, a small pilot face-to-face workshop of 8 staff had been delivered under *Respecting the Difference*. The local package is now complete, including local Aboriginal community-specific content, and will be rolled out from February 2014 (see Moving Forward below).

**Barriers**

**Challenging Target**

Respondents indicated that the sheer size of the task of delivering 6 hours of face-to-face training to more than 10,000 staff made achieving the targets very challenging within the set timeframe. The package had taken time to develop and roll-out to this number of staff was not viable in the timeframe. The view was also expressed that setting targets too high could be counter-productive and lead some people to simply give up. With so many things that must be done and against which a service is accredited, such targets can lead people to give other training a low priority – especially if they believe they are likely to not meet the expected targets anyway. The LHD indicated that they gave this feedback to the Ministry very early on in the planning of the program.

**Resources**

The LHD identified lack of resources as being a perennial problem in training. Sydney LHD may have been in a somewhat better position than others because it had funded a full-time “Cultural Respect Trainer” for a two-year period initially. The Cultural Respect Trainer is based in CEWD, has developed the face-to-face training package and will be the primary trainer.

**Resistance of Some Staff**

As has been the case in some other locations, staff indicated that there has been resistance from some staff about the need for and value of Aboriginal cultural awareness training. This included people from other cultural groups who could not see the reason for focusing on Aboriginal cultural differences. The training, of course, explains this, but people need to complete it – ideally, both eLearning and face-to-face – before such attitudes can be addressed. It may be worthwhile to also include something in the promotion of the training that might help to overcome such resistance.
Quality and Appropriateness of the Training

Respondents all considered the eLearning package to be very good with only one person suggesting that it might have slightly too much focus on history at the expense of work-based situations. The broad content was seen to be covered well and, it was suggested by one respondent, there may be many staff who, because of their roles, would only need the eLearning – at least initially.

Like other parts of NSW Health, Sydney LHD was affected by the eLearning package’s technical glitches (sign off of completion), but these are now resolved. The view was strongly expressed by all of those consulted at the LHD that delivery required a targeted approach that focused on specific areas of need and engaged with services to determine how best to respond to Aboriginal client needs in their circumstances. It would be far more powerful and effective to work on cultural competence on a team by team basis. As one person put it: “We want people to go away from the training able to change what they do in the workplace. If you’re trained as an individual in a generic group, you’ll have no support back in the workplace to change anything.”

Moving Forward

The LHD wants to ensure that this training has a real impact, but measuring the impact of cultural competency programs can be very difficult. Only one of the existing KPIs relates to Respecting the Difference in the Good Health – Great Jobs Aboriginal Workforce Strategic Framework and this is a process indicator when, ideally, it should be somehow linked to measurable clinical results. Measuring Aboriginal clients’ access to services and their satisfaction with them is one approach, but many other factors contribute to this that are not related to cultural competency of the service.

There is a need for some kind of tool or diagnostic instrument that might look at such things as experience in waiting rooms, the mix of staff involved in delivering services, and the appropriateness of programs and services being delivered (both general and Aboriginal-specific). It may be the other jurisdictions in Australia have developed such tools or diagnostics and these could be adapted (see Recommendation 6.2.10, for example).

The Sydney LHD will begin rolling out the face-to-face training early in 2014. Key elements of this roll-out include:

- Targeting the Executive and the Board first. All were keen to do it and the LHD expected that this will help reinforce the message from the top of the importance of doing the training. This includes getting clinical staff, in particular, to do the training, as they are often hard to engage;
- Adopting a highly targeted approach. Rather than pursue 80% coverage at all costs, the LHD is focusing initially on areas of high frequency Aboriginal client contact which have direct potential impact on health outcomes – Emergency Department, Admissions, specific clinical streams. A targeted approach will maximise effectiveness of the training. As one person said: “This is what we should be about rather than ‘tick the boxes’”.

It would be far more powerful and effective to work on cultural competence on a team by team basis. As one person put it: “We want people to go away from the training able to change what they do in the workplace. If you’re trained as an individual in a generic group, you’ll have no support back in the workplace to change anything.”
Wherever possible, delivering training to whole operational units. Focusing on developing the cultural competence of whole team, including Aboriginal and non-Aboriginal staff is more likely to change behaviours and get results than training individuals from disparate operational areas. If whole team isn’t possible, maybe split into smaller groups. This approach would also allow community engagement to discuss specific service issues relating to the team or unit – not just a collection of people drawn from across various units. This approach will enable relationships to be improved both internally and externally;

Delivering the face-to-face over 4 hours, not 6. Looking at delivering through a 4 hour session run 4 times per week – 80 people per week in all. The Cultural Respect Trainer will lead the training supported, where possible, by an Aboriginal Health Worker (ideally from the unit being targeted) and another trainer from CEWD. In terms of scheduling, the LHD is still scoping the actual numbers within the targeted areas. Pilot courses will be run unit by unit including, for example, Renal, Acute, Psychiatric, Obstetrics and Respiratory. The first pilot will be with Midwifery in February 2014;

Focusing on real workplace scenarios and case studies;

Requiring all participants in the face-to-face training to do the eLearning first;

Not using existing operational staff (Aboriginal Health Workers) as the primary trainers – this approach has too many risks including burn out. Such workers will, of course, support the process of improving cultural competence in their own unit, particularly if the training is delivered to the unit as a whole. The training will also establish ground rules that ensure the “cultural safety” of trainers is maintained (e.g. to protect against behaviours that are an assault on identity);

Measuring impact at an individual and team level. Individuals might go through a before and after process – targeted questions on knowledge of the Barriers and how they might handle situations differently. As one person said: “We want to focus as much as possible on health care, focusing on the social determinants of disparity in health outcomes. Progress is being made and this needs to be highlighted too – to show that a positive difference can be made”;

The LHD stressed the importance of delivering this training in a way that gets people to start to think about results. A tool or diagnostic, as described above, would help this. It would help to identify practical, real things that reflect Aboriginal experience of the health system.

The training will also establish ground rules that ensure the ‘cultural safety’ of trainers is maintained (e.g. to protect against behaviours that are an assault on identity).
4.6 Northern NSW Local Health District

Background

Key Points

- Progress to date in rolling out the training has been relatively modest, with 668 staff (13%) completing the eLearning by the end of 2013 and 179 staff (3.1%) completing workshops which, like Mid North Coast LHD, are based on its long-standing “Cultural Awareness Program” (CAP).
- The existing package is currently being redeveloped and the intention is to offer a 2-hour local eLearning component in addition to the existing generic eLearning package.
- The current face-to-face training is delivered over 6 hours by Aboriginal health staff and includes presentation from a local Elder and focuses on the analysis of service scenarios.
- Feedback on training quality has been very positive and there are waiting lists.
- The LHD plans to run 9 face-to-face sessions per year – 3 in each sub-region. At best, this would see another 250 people complete this mandatory training per year.
- The 80% target is regarded as unachievable and the LHD has its own more modest target of putting “at least 100 staff per year” through the training.

Northern NSW Local Health District covers the Local Government Areas of Tweed, Byron Bay, Lismore, Kyogle, Ballina, Richmond Valley and Clarence Valley and the suburb of Urbenville in the Tenterfield LGA. It has a resident population of around 290,000 of whom over 4% are Aboriginal or Torres Strait Islander people. It administers 13 regional hospitals and 20 community health centres and employs 5,786 staff of whom around 3% are Aboriginal or Torres Strait Islanders. Before 2012, this LHD was part of the North Coast Area Health Service along with what is now the Mid-North Coast LHD.

Overall coordination of Respecting the Difference implementation in the LHD is the responsibility of the Manager of Aboriginal Health, a role which also has significant other duties. As was the case with Mid-North Coast LHD (see 3.1), prior to the splitting of the former Area Health Service, there had been a long history of providing Aboriginal Cultural Awareness training to staff in this region. This has continued while the LHD has worked on revising the content to bring it more into line with the Respecting the Difference model.

Progress

eLearning Component

Data collected from LHD reports and from HETI records indicate that 668 (around 13%) staff have completed the eLearning component. This includes an estimated 480 staff who completed the training while registered as North Coast Area Health Service staff.

Face-to-Face Component

From 2012 to the end of 2013, 179 staff (3.1%) were reported to have completed face-to-face training. Like Mid-North Coast LHD, which was previously part of the same Area Health Service, Northern NSW LHD has continued to deliver its longstanding Cultural Awareness Program (CAP).
The current face-to-face training is delivered over 6 hours and includes presentation from a local Elder, analysis of service scenarios and is led by Aboriginal health staff. Training is delivered in a variety of locations in the LHD including Lismore, Ballina, Casino, Kyogle and even Bonalbo (a small town with a population of 100). Participants are not targeted and groups of up to 30 people attend who are drawn from across the organisation – “cleaners, executives and medical specialists” in a broad mix. Courses are administered and delivered in 3 sub-regions in the LHD – Richmond, Tweed and Clarence. In recent times, no training has been delivered in the Clarence area.

The existing training package is currently being re-developed. The plan is to develop the LHD’s own 2-hour eLearning package that would be used to cover the local content requirement. In other words, the training would have three and not two components:

- Generic eLearning component (2 hours);
- Local eLearning component (2 hours); and
- Face-to-Face Component (4 hours)

**Barriers**

**Lack of resources**

The LHD said that lack of resources makes it impossible to reach the 80% completion target for the face-to-face delivery. That would require a team of trainers working full-time on the roll-out – not a team of Aboriginal Health staff who run courses in addition to an already busy operational workload.

Even the current rate of delivery is proving difficult to maintain with one respondent saying that it takes up 16 to 20 weeks of her time per year in planning, organising and delivering the training. As trainers all have other duties, “something has to give” and this is often their own personal and family time.

As the training also needs the participation of local Elders, the limits on their time need also to be acknowledged. Finding a suitable way of paying the Elders for their time is also an issue.

**Getting people to attend**

Although the training has a good reputation and has waiting lists of people wishing to do it, getting clinical staff to attend can be a challenge. In some locations in particular, backfilling staff is very difficult and this is a barrier to a rapid roll-out of the training.

**Quality and Appropriateness of the Training**

The LHD stressed that there is a clear need for this kind of training and that staff continue to get feedback from the Aboriginal community about the need for a more culturally responsive service – for example, service access issues and situations involving Aboriginal people which should be handled better by Health staff. Although the number of courses run is limited, demand for the training is strong and there is a waiting list.
The trainers themselves have a strong commitment to the program and believe it makes a difference. As one person put it: “I absolutely love doing this training. It has a profound effect on me to see what it does to people.”

Staff involved in the training believes that the follow-up calls they get after running the training shows that the training is having an effect on workplace behaviour and that it has prompted participants to think about how they might do things differently when providing service to Aboriginal clients.

Only a limited number of course participants were consulted in the evaluation, but feedback was positive. Comments included:

- “Every day something comes up and I think about your program. I use it every day – one of the most useful and helpful training programs.”
- “There were 4 presenters including 3 Aboriginal Health people and an Elder. They gave answers to a lot of things I had long questioned – how Aboriginal people are focused on the group not the individual; how when someone is sick their whole community comes. Their sharing culture.”
- “A lot of young people just starting in Health need to get this message at the start.”
- “I learned that speaking to one Aboriginal group in the community doesn’t mean you’ve spoken to everyone. There are divisions in the community which means you need to establish a number of relationships to reach the community as a whole.”
- “Regarding the eLearning, I imagine there are some people who just click through it. They need face-to-face follow up. The training would lose potency if it relied too much on eLearning. Need to have face-to-face contact with other health practitioners and Aboriginal people.”
- “The informal time – breaks in the course – were also helpful. People lined up to ask questions.”

Moving Forward

In the future, the LHD intends to run 9 face-to-face sessions per year – 3 in each sub-region. At best, this would see another 250 people complete this mandatory training per year. The 80% target is regarded as unachievable and the LHD has its own more modest target of putting “at least 100 staff per year” through the training.

To measure impact, the LHD could potentially use a number of consultative mechanisms. It has an Aboriginal Health Council with representatives from 4 local Aboriginal nations and they can provide feedback from community. The LHD also conducts regular community forums to get direct feedback from local people.
4.7 Hunter New England Local Health District

**Key Points**

- Hunter New England LHD has made relatively good progress in implementing the Framework. Around 7000 staff (55%) of staff have completed the eLearning component and 773 (5.4%) have completed face-to-face training during 2012 and 2013.
- The LHD is focused on linking Aboriginal Cultural Respect training to Closing the Gap goals and has therefore focused on developing mechanisms to ensure that training is applied in the workplace. This includes structured “conversations” between staff members and their managers before and after participation in the face-to-face training.
- Training is delivered by two TAFE facilitators at TAFE premises (in Newcastle, Lower Hunter and Tamworth), away from everyday work distractions. They are professional Aboriginal trainers and are skilled and experienced in delivering training of this type.
- A range of local resources have been produced to help explain and promote the program including guidelines, templates and videos.
- The LHD stresses that this training should not be “a numbers game” in which the organisation just “hopes for outcomes”. A holistic approach is required that includes workforce development and an ongoing organisational commitment to improving services for Aboriginal clients.

**Background**

Hunter New England Local Health District covers a very large area encompassing 25 Local Government Areas including larger population centres such as Newcastle, Tamworth, Armidale, Taree, Maitland, Cessnock, Lake Macquarie and Port Stephens as well many smaller rural communities. The total resident population is around 880,000 of whom about 35,000 (4%) are Aboriginal or Torres Strait Islander people. Total staffing is 14,445.

Hunter New England was the only LHD to experience no change when Area Health Services were broken up to form LHDs. Its boundaries remained the same, shared administrative units and their resources were not split and its Learning Management Systems remained the same. This relative continuity in its administration may have assisted the LHD in its roll-out of Respecting the Difference.

The LHD described cultural awareness training as a key organisational strategy in the LHD and a program has been running for around 7 years with some 1500 staff completing this training. Aboriginal employment and cultural redesign have been a particular focus of the Organisational Capability and Learning Unit (within the broader Workforce portfolio. This unit has had overall management responsibility for both Respecting the Difference and the Aboriginal Cultural Respect program. There is also a Strategic Leadership Committee that oversees the Progress of all Closing the Gap initiatives in Hunter New England LHD.

The LHD learned some important lessons from previous ventures into cultural awareness training. A two-day program was developed by a South Australian organisation in 2007, but the LHD decided to review...
and relaunch the program to ensure that participants were able to better engage with the educational content and to understand the importance of Closing the Gap. This included ensuring that staff left the training with a clear understanding of the reasons for focusing on Aboriginal cultural differences in service delivery, of their responsibilities under Closing the Gap, and the strategies they could use in their workplace.

The new program includes 4 modules:

- Module 1: Completion of the NSW Health Respecting the Difference online training
- Module 2: A conversation between the staff member and manager about their service’s priorities regarding Closing the Gap (prior to attending the one-day face-to-face workshop)
- Module 3: Participation in the one-day “Aboriginal Cultural Respect Education” (ACRE)
- Module 4: A conversation between the staff member and manager to debrief and to agree on a personal Action Plan to contribute towards Closing the Gap.

**Progress**

**eLearning Component**

7,046 staff (49%) have completed the eLearning. Hunter New England has not had the same problems as other LHDs which have needed to introduce new Learning Management Systems and which have had difficulties in tracking and reporting completions. Its well-established system can track and report on completions for each of the LHD’s 4 Respecting the Difference modules.

**Face-to-Face Component**

A total of 773 staff have completed face-to-face training between 2012 and 2013. This includes 414 staff who completed the old two-day program in 2012 and 359 staff who completed the revamped package in 2013. By February 2014, a total of 22 face-to-face courses will have been delivered to 550 staff through the new package. Estimates for 2014 and 2015 are that another 1600 staff will have completed the training. Participants in the face-to-face training generally need to do the online component first and the message is reinforced that the program needs to follow the sequence outline above. Those who do the eLearning can generally enrol in a workshop fairly quickly. The philosophy underpinning the training is that it is all about improving health outcomes and Closing the Gap. As such, training is very much aligned with the organisation’s 8 KPIs in health. On average, two face-to-face sessions, each with around 25 participants, are delivered per week. The program is actively promoted and managers are held accountable if enrolments from individual units are low – i.e. there is follow up by the Executive overseeing that particular area.

The training is delivered by two TAFE facilitators at TAFE premises (in Newcastle, Lower Hunter and Tamworth), away from everyday work distractions. They are professional Aboriginal trainers and are skilled and experienced in delivering training of this type. The cost of delivery of training by TAFE was $90,000 (for 20 courses and 500 staff). The LHD targets participants from areas that have the potential to “Close the Gap” in health outcomes – that is, frontline staff in operational “hot spots” like
The LHD focuses on local content in the program that links to local Closing the Gap initiatives and improved health outcomes for Aboriginal and Torres Strait Islander people e.g. babies born at a healthy weight; mothers not smoking during pregnancy; people feeling welcomed and cared for in LHD facilities and services.

While acknowledging that backfilling staff to attend training can sometimes be a challenge, the LHD said that it does not accept this as an excuse: “It’s up to the units to work out how to get people there.” However, the LHD does recognise that the whole organisation must be unified in its resolve to get people trained. It is easy to “cave in” to resistance justified by arguments of operational need. The LHD’s holistic approach to Aboriginal health service improvement means that it has benefited to some extent from external funding, especially funding under the Australian Government’s Indigenous Employment Program. The LHD’s effective use of such funding has helped it to grow its Aboriginal workforce numbers and to create an environment for the roll-out of the training program.

Quality and Appropriateness of the Training
The LHD reports that it has had nothing but positive responses from staff to the new face-to-face training program – “rave reviews”.

Moving Forward
The LHD said that it is very important to understand that this should not be “a numbers game” in which the organisation just “hopes for outcomes”. A holistic approach is required that includes workforce development and an ongoing organisational commitment to improving services for Aboriginal clients. The LHD believes that its model could be applied in other regions and has already attracted interest from other LHDs. In terms of funding options, the LHD posed some questions about existing funding that could be used. For example, where Aboriginal identified positions are not filled, for whatever reason, there is a case to invest these funds in activities that relate to the improvement of Aboriginal health outcomes, such as Respecting the Difference. Similarly, funding from the Centre for Aboriginal Health to fund cultural activities could also be drawn on to some extent.
5.1 Resources

Of the organisations examined in the evaluation’s Case Studies, most were attempting to roll out the Face-to-Face Component of Respecting the Difference by using existing Aboriginal staff as part-time facilitators and trainers. These staff spent considerable time and effort in organising the courses as well as in their delivery. The time available to them to perform their usual roles – including workforce development or frontline health service delivery – was therefore reduced.

It seems very unlikely that this approach to implementing the framework can achieve anything like the scale required by the Ministry without compromising other important results associated with the usual roles of the staff involved. For example, maximising the number of Aboriginal people employed in an organisation would itself have the potential to improve cultural competence within that organisation, but these results are likely to suffer if the Aboriginal Workforce Manager is preoccupied with Respecting the Difference training.

It also needs to be recognised that using Aboriginal staff in this way risks burn out. The Aboriginal staff engaged in training that were interviewed in the evaluation were all passionate about the program and derived personal satisfaction in delivering it. However, the training does require Aboriginal staff members to share personal history and emotions with participants and this can be far more draining than, say, the delivery of purely technical content. Insensitive or hurtful responses from participants are possible and these can be personally draining. Increasing the amount of training delivered by these staff is therefore risky – as one trainer put it: under current part time arrangements, “expansion would kill me”.

Finding the funds to expand face-to-face delivery was a common complaint in the consultations. No additional funds were provided by the Ministry of Health to implement the program and organisations were expected to find the funds from existing resources. The cost of delivery (including external training consultants to expand numbers) and the cost of backfilling staff who are participating was estimated to cost “millions” by some senior managers consulted in the evaluation and this was considered unreasonable in the context of current budgetary constraints.

Two LHDs (Sydney and South Western Sydney) have received funding through a pilot “Cultural Respect Training” program and this has provided a dedicated resource which has helped them to develop and run training under Respecting the Difference. Others are exploring the possibility of external funding, at least as a means of kick starting an increased effort, improving operational effectiveness and, hopefully as a result, winning Board approval for continued support. Mid North Coast LHD, for example, is seeking external funding10 to support the establishment of a

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10 Through the Elsa Dixon Aboriginal Employment Program funded and managed through the Department of Education and Communities.
new role that would help in organising courses and in transferring learning back in the workplace through service redesign.

As for other available funding options, questions were asked by some staff consulted in evaluation about what LHDs do with unspent funds that are allocated to Aboriginal programs and positions. Some mentioned that they were aware of funded Aboriginal identified positions which, for whatever reason, had remained unfilled for significant periods of time. Given the critical importance of achieving Closing the Gap targets, they wondered if there was potential to use these unspent funds on expanding Respecting the Difference.

5.2 Trainers

In addition to the staff capacity issues described above, there is also the issue of the capability of staff to facilitate this training. The program’s Facilitator Guide indicates that “it is vital that you have a strong background in facilitation and Australian Aboriginal cultural awareness.” Given the nature of this type of training – designed to challenge (and, in many cases, ultimately change) participants’ long-held assumptions, attitudes and values as well as their workplace behaviours – a background in facilitation is vital.

Instead, in some cases, Aboriginal staff with little previous experience in training delivery have been asked to lead the training, including using advanced training techniques (such as games designed to result in effective learning). If less experienced trainers are used in training delivery, organisations need to provide appropriate support, including an experienced co-facilitator, appropriate training for the trainers and content that is does not require more advanced training skills than those available.

There are advantages in having Aboriginal staff involved in training delivery. They understand the culture of the organisation, can develop connections with participants that can assist transfer of learning back in the workplace (e.g. advice on how to handle a particular issue) and are passionate about the training and understand why it is so important. However, to increase delivery beyond the current levels, the resource of full time skilled facilitators are needed to help with course organisation and logistics. The approach adopted by the Hunter New England LHD, which uses skilled Aboriginal facilitators provided by TAFE NSW, is an option that could be investigated by other LHDs and health organisations.

5.3 Organisational issues

Planning and monitoring

Achieving the framework’s ambitious targets would seem to demand some kind of local implementation plan, but only about half of the Chief Executives who responded to the survey indicated that they had in place a detailed implementation plan that included completion targets and milestones. To monitor the program State-wide, it may be useful if LHDs and other health organisations provide not just a report on past delivery every six months, but a forecast of planned delivery as well.

11 For example, the game “My Island Home” has been used in some locations. This game aims to give participants a personal experience of dispossession and the emotions it evokes.
It should also be noted that *Respecting the Difference* training should be incorporated into each health service’s Aboriginal Workforce Strategy implementation plan for *Good Health – Great Jobs*. This is reinforced by the KPIs for both *Good Health – Great Jobs* (KPI 16) and *Respecting the Difference* (KPI 10). Both strategies require six-monthly reports to the Ministry and Chief Executives’ responsibilities may need to be re-emphasised. Similarly, Chief Executives have Service Agreements with the Director-General that include six-monthly monitoring of Progress against both sets of KPIs and this should also be re-emphasised. (See Recommendation 6.2.14).

**Facilities**

Different types of training facilities were used by the organisations examined in the Case Studies. Some used LHD training rooms or TAFE facilities, while others, attempting to immerse participants in an Aboriginal cultural experience, used offsite facilities (e.g. Mid North Coast LHD used Sea Acres Rainforest Centre in Port Macquarie and the Botanical Gardens in Coffs Harbour and had Elders lead the group through sites of cultural significance). There are advantages and disadvantages in these different approaches in terms of cost, effectiveness and scale. For example, running regular workshops in an LHD training room is likely to be cheaper and to allow greater throughput of participants but may not allow them as easily to step away from their day-to-day routine and to experience a different mindset. On the other hand, attending a site with cultural links might make it easier to directly experience some aspects of Aboriginal culture, but might limit the number of people who can realistically be trained.

**Promotion and management**

While the responsibility of staff to complete the mandatory eLearning component of the training can be promoted using a variety of methods, line managers and senior managers need to regularly monitor completion rates and to remind staff of the importance of the training. Getting staff into face-to-face training – particularly frontline staff – can be difficult and line managers can, in practice, resist releasing staff unless senior managers make it clear that they need to find a way to do so.

The approach adopted by Hunter New England LHD, which requires the eLearning component and Face-to-Face Component to be supplemented by structured interviews between staff and their managers is worth highlighting in this respect. Not only does it encourage greater take up of the training, but it provides a mechanism to plan the application of the learning in the workplace.

**Institutional commitment**

The slow pace of roll-out of *Respecting the Difference* in some locations may suggest that not all organisations are equally committed to its implementation. Not all have large Aboriginal populations to service but even those that do are unlikely to embrace the framework unless there is clear direction from the top and down through line management that it is important and is directly linked to local priorities and key performance indicators.
Health organisations have many pressures to deal with including many demands relating to mandatory training of different types. In this context, some may see the training as a lesser priority – even as just another administrative impost by “those people in the Ministry”. Some may question why Aboriginal cultural awareness should be singled out when awareness of so many other cultural differences may also be important.

The basic reason for improving Aboriginal cultural awareness – why it is a major issue and specific to Aboriginal people – needs therefore to be continuously reinforced: it is about closing the enormous gap in health outcomes between Aboriginal and non-Aboriginal people. The ways this training can directly achieve these outcomes need also to be continuously reinforced – including, as the NSW Aboriginal Health Plan puts it, correcting the situation where “the prevailing attitudes and level of understanding, particularly by non-Aboriginal people in the system, directly affected the experience Aboriginal people had, and indeed whether they would enter the system at all to receive help”.

**Monitoring**

The evaluation was hampered by difficulties in obtaining even the most basic data on the framework’s implementation across NSW. Organisations are theoretically required to provide six-monthly data against the ten key performance indicators, but none have done so. What is more, the hotchpotch of different learning management systems currently used across the state, the legacy issues associated with the splitting of LHDs from the old Area Health Services, and the apparent proliferation of duplicate training records in the limited reports that have been provided, make it extremely difficult to reliably ascertain the number of completions. The new centralised “HETI Online” system will hopefully resolve these difficulties, at least for future training delivery, but the Ministry’s Aboriginal Workforce Development Unit (and future evaluations) will still rely on organisations’ existing training records for training delivered prior to the commissioning of the new system.

At a local level, some LHDs have Aboriginal health advisory committees that advise their Boards on a range of issues including service delivery and workforce development. Some have had a direct role in overseeing the development of Respecting the Difference course content and in setting delivery targets and monitoring performance. These committees may be able to help to reinforce the importance of Respecting the Difference training and the need to provide adequate resources.

Patient Journey interviews are a possible regular opportunity to investigate patient experiences and build evidence of outcomes for Aboriginal clients.

**5.4 Training Structure and Content**

Not all health organisations have any history of delivering Aboriginal cultural awareness training, at least not to the extent envisaged by the Respecting the Difference framework. Those that did have such a history were able to build on existing programs, reviewing them to ensure they complied with the framework – the Cultural Awareness Program (CAP) run in the Mid North Coast LHD and Northern NSW LHD is an example, as is the Aboriginal Cultural Respect Education (ACRE) run in the Hunter New England LHD.
Others have had to develop their face-to-face packages from scratch (e.g. Illawarra Shoalhaven LHD, Sydney LHD, South Eastern Sydney LHD, Central Coast LHD, Justice Health and Forensic Mental Health Network) but have commenced training delivery. Others, including Nepean Blue Mountains LHD and the Ambulance Service of NSW are still in the early stages of developing their face-to-face packages.

A detailed content analysis of the training packages developed and delivered by health organisations was not part of the evaluation’s terms of reference, but among the organisations examined in the course of the evaluation, there does appear to exist considerable variation from the standard model in content and approach to delivery. Rather than the standard model of 2 hours eLearning, 4 hours face-to-face (local content) and 2 hours face-to-face (generic content), examples of variations include:

- Northern NSW seeking to develop its own 2-hour eLearning package to cover local content;
- Illawarra Shoalhaven LHD delivering a 4-hour face-to-face workshop that focuses on generic content. The LHD is still considering how it might deliver an additional 2 hours of local face-to-face content;
- Hunter New England delivering a 6 hour face-to-face (mostly generic content) and adding two structured interviews before and after the completion of the eLearning and Face-to-Face Components;
- The Ambulance Service gaining approval to develop and deliver a 2 hour face-to-face workshop and to supplement this by developing Aboriginal cultural “fact sheets” covering 45 Aboriginal nations in NSW for use by its staff.

The unique operational challenges of some organisations do make it necessary to consider alternative approaches. The Ambulance Service, for example, would find it almost impossible to strictly adhere to the model outlined in the framework given its decentralised operation, the amount of local content it would need to deliver, the small number of operational staff based in some locations and the costs involved in fully complying. However, although one size clearly does not fit all, a process is needed to ensure that local variations do not lead to the omission of essential content or to the reduced likelihood of improved and more effective practices in the workplace.

5.5 Effectiveness

Application of Learning – Change Management and Cultural Redesign

Training evaluation is currently limited to the participant reaction level (gathering feedback on what participants thought and felt about the training) and, to a lesser extent, demonstration of learning (mostly through completion of the eLearning package). These are important, but what is missing is a mechanism to evaluate the transfer of learning back to the participant’s workplace and the results that flow from this.

Transfer of learning to the workplace should not be assumed. For example, a participant may believe that the services and procedures in place in the workplace require review to better meet the needs of
Aboriginal clients, but he or she is unlikely to bring about change without management and peer support. Even at an individual level, participants need to quickly apply what they have learned – practice new behaviours in their jobs – or they risk forgetting it.

Some LHDs are taking steps to address this issue. For example, Sydney LHD wants to deliver face-to-face training to whole operational units wherever possible. This would engage the whole work team in improving members’ awareness of Aboriginal service issues and allow them to collectively consider and implement operational changes. Similarly, Mid-North Coast LHD is seeking to establish a role that will provide a type of internal consultancy service to support change and service redesign. Hunter New England LHD has also addressed this issue through the conversations it requires between participants and their supervisors. These review workplace service issues and seek out opportunities for participants to apply what they have learned.

**Targeting**

It was pointed out many times in the evaluation that often the most difficult people to get to do the face-to-face training were the frontline, clinical staff – the very people who come into most contact with Aboriginal clients. While the framework identifies four target audiences for the training,12 frontline staff obviously have the most potential to directly influence the Aboriginal client’s experience of the service and the health outcomes they derive from it.

Some of the LHDs consulted are now focusing on targeting key staff and units (e.g. Emergency Departments and specific clinical streams that have a high Aboriginal client base). The alternative “numbers game” or “tick the box” approach needs to be avoided – that is, where back office or administrative staff are trained to keep the numbers up because backfilling frontline staff is harder to organise. The program will only be truly effective if frontline staff are trained and behaviours are changed in the workplace.

**Other evidence of effectiveness**

Mid-North Coast LHD reported that the number of enquiries the Aboriginal Health Unit received from operational units increase after staff complete face-to-face training. They saw this as an indicator of training effectiveness because the enquiries typically sought advice on improving services and outcomes for Aboriginal people. For example, an Aboriginal child did not report for a scheduled operation and, rather than just ‘put him back at the bottom of the queue’, the unit sought advice on how to follow up an issue in the community that may have prevented his attendance.

LHDs and other health organisations would benefit from advice on how to collect data that provide a measure of program effectiveness. This would also provide a baseline for a future impact evaluation of the framework.

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12 Senior Executives (“Lead the Change”), Program and Service Managers (“Plan the Change”), Frontline Staff (“Make the Change”) and all other staff (“Make and Support the Change”).
SECTION SIX

Conclusion and Recommendations

6.1 Conclusion

Although an accurate NSW-wide assessment of Progress is difficult to make because of continuing problems in collecting training completion data, the implementation of Respecting the Difference training does appear to have been much slower than anticipated when the framework was launched in late 2011. Delivery of the eLearning component was initially hampered by technical difficulties with software which were not resolved until August 2013 and around 30% of staff have completed it to date – though this figure varies considerably across organisations. Delivery of the Face-to-Face Component had not commenced in 3 of the 15 Local Health Districts by the end of 2013 and that training numbers were very low (1% or less of total staff) in another 4. Even where face-to-face training has commenced and is being delivered regularly, too few courses are being run to ensure that 80% of staff complete the training in the foreseeable future.

With the bugs in the eLearning component software now eliminated, it should be possible for LHDs and other NSW Health organisations to get most of their staff to complete this part of the compulsory training by the end of 2015 – provided it is actively promoted by management and supervisors. However, the eLearning component was intended to be delivered as part of a package that also includes the Face-to-Face Component – these “ideally should be completed close together or within six months.” Unless the number of face-to-face training opportunities offered by LHDs are significantly increased, staff who complete the eLearning over the next two years are likely to wait much longer than this.

While there are LHDs that have a history of providing Aboriginal cultural awareness training and have adapted existing courses in line with the Respecting the Difference framework, others are only just beginning to develop course material and are still many months away from conducting their first workshop. For other organisations in NSW Health, only limited data were available, such as Progress in eLearning completions. The number of people in these organisations who have completed the Face-to-Face Component has generally not been reported.

The target that 80% of all health staff complete the training by the end of 2015 does not feature prominently in the Framework documentation or in the associated policy directive. It is included, somewhat ambiguously, among the framework’s Key Performance Indicators (KPI-7) and its exact meaning may need to be clarified. Although the evaluation’s survey of Chief Executives suggests that more than three-quarters of respondents were confident that the target would be reached, it would take a very substantial and increased effort, particularly in the delivery of the Face-to-Face component, for most LHDs to actually do so.
To illustrate the magnitude of the task, an LHD with 10,000 staff commencing face-to-face delivery in 2014 would need to run three workshops per week for two years, each with 25 participants to achieve target (ignoring staff turnover). The cost and human resource implications of this are significant, not to mention the difficulty in ensuring a high level of Aboriginal community involvement (e.g. local Elders) in delivery.

The face-to-face training component is mandatory and, if implemented in a targeted and outcomes-focused way, can have a real impact on the quality and cultural responsiveness of health services and on the achievement of Closing the Gap goals. However, this is not like some types of mandatory training that are primarily about communicating technical or procedural information. It is not, as one person put it, the type of training where people can sit at the back of a large auditorium and “nod off or do their knitting”.

Rather, Respecting the Difference training requires a high level of personal engagement from participants, trainers and community representatives. It requires participants to question their attitudes and beliefs. It challenges organisations and operational units to critically evaluate how they are engaging with Aboriginal people and communities and to make real changes in the workplace that can ultimately improve health outcomes. While a focus on numbers must also be maintained, quality training delivery and application of learning in the workplace is what this is really all about.

6.2 **Recommendations**

6.2.1 **Improve data collection**

The implementation of HETI Online is an urgent priority. The effective monitoring of implementation of the Respecting the Difference framework cannot be carried out without accurate and timely data on training completions and the current reliance on the submission of reports that draw data from a hotchpotch of learning management systems has proven to be not working. HETI Online promises to provide instantaneous access to data that has been entered on this new organisation-wide database.

6.2.2 **Improve other reporting**

Until HETI Online is fully implemented, LHDs and other health organisations should continue to submit six-monthly reports, but these should be as simple as possible, outlining just the total number trained in each component. The most recent report request (made in December 2013) was in this simple format, yet some organisations were still unable or reluctant to comply or to do so in a timely manner.

*Reports should in future also include a forecast of numbers expected to be trained face-to-face in the next 6 month period.* This should continue even after HETI Online is implemented and would help reinforce the need for a planned approach to implementation.
6.2.3 *Re-publicise the program*

NSW Health has undergone many organisational and personnel changes since the framework was first launched and it is possible that some of the key messages now need to be reinforced – such as why the program is crucial and how cultural competence is such an integral part of *Closing the Gap*. If NSW Health remains committed to the 80% staff completion target by the end of 2015, this also needs to be emphasised as does the need to especially target frontline staff.

6.2.4 *Re-consider the 80% completion target for the Face-to-Face Component*

The requirement that 80% of all NSW Health employees complete both the eLearning and Face-to-Face Components by the end of 2015 is unrealistic given current resource constraints. Even those LHDs that have dedicated substantial resources to implementation, are unlikely to get anywhere near 80%.

Moreover, the training should not be considered as a project that will finish at some point in the future. *The message needs to be reinforced that Aboriginal cultural respect training is a permanent, mandatory requirement for all staff working in NSW Health*. An implementation target should be considered that reflects this ongoing requirement and can be achieved without risking the quality and organisational impact of the training. This should be negotiated with each NSW Health organisation based on their individual circumstances and should include an action plan, a reporting framework and realistic targets for the next three years (2014 to 2016).

In addition, a KPI might also be set for “percentage of current staff who have completed *Respecting the Difference* training (eLearning and face-to-face)” with an expectation that this should, over time, reach a specific minimum. To encourage better targeting of training, this minimum might be higher for frontline staff.

6.2.5 *Encourage LHDs to appoint a senior executive to take responsibility for implementation*

Some LHDs seem to have assigned responsibility for *Respecting the Difference* to people or operational units that might struggle to command the attention to implementation that the Framework needs. *Where Tier 2 Executives have been assigned responsibility and are actively involved, more Progress is evident.*

6.2.6 *Establish a clear process for approving variations of the training model*

Although one size does not fit all, there is a risk that locally developed variations of the recommended training model and content do not meet the full range of learning outcomes outlined in the framework. LHDs and other health organisations should be required to *seek the input and approval of the Aboriginal Workforce Unit before setting out to significantly vary the model*. HETI will also need to play a role in this, including by ensuring that the coding of training elements remains consistent.
6.2.7 Encourage and support the application of learning in the workplace – Change Management & Cultural Redesign

What really matters is how Respecting the Difference training can bring about changes in workplace systems and behaviour that meet the specific needs of Aboriginal clients and lead to better health outcomes for them. This requires training participants to be able to apply what they learn and for organisations and operational units to be open to change. Health organisations implementing the framework need to consider mechanisms to support such change and monitor their impact. Some LHDs are already doing this in different ways (see 6.5).

6.2.8 Establish an impact evaluation framework

The current evaluation focuses on the first of the Framework’s three key evaluation areas – “Evaluation of the Development and Implementation of the Training”. Ultimately, however, it is the third evaluation area that is most important – “Effectiveness”. To do this, work needs to be done now to establish an “impact evaluation framework” for Respecting the Difference. This will require LHDs and health organisations to collect a range of data that will allow them to measure the impact on service delivery and health outcomes from changed staff behaviours, service systems and procedures and better linkages with Aboriginal communities.

Clearly, this is a far more complicated task than compiling a list of training completions. It might be necessary to develop some kind of diagnostic tool to help organisations to define and collect these data. Without them, program evaluation will be largely restricted to a review of process. This might include a role for Epidemiology and Evidence in developing and implementing mechanisms to collect Aboriginal client data in key areas, such as:

- analysing numbers of patients being discharged against medical advice;
- monitoring unit levels of contact with Aboriginal Health before and after training;
- analysing ‘did not wait’ statistics

6.2.9 Link Respecting the Difference to accreditation

Link Respecting the Difference to Accreditation elements as per Health Service Standards and Accreditation. Elements include:

- Patient and Consumer Centred Care
- Patient Identification
- Patient Safety in Primary Health Care.

6.2.10 Collect and analyse Patient Journey data

Explore the roles of the Bureau of Health Information and Agency for Clinical Innovation to review Patient Journey interview data collection processes and other data collection and evaluation opportunities which reflect patient care outcomes. A number of measures have the potential to be reviewed at regular intervals to test the impact of the training on clinical outcomes.
6.2.11 Link Respecting the Difference to Continuing Professional Development

A number of clinical roles require demonstration of Continuing Professional Development (CPD) to ensure currency of registration. For example nurses must accrue 20 points per year with 1 hour of training achieving 1 point. Line Managers could consider this option in their regular CPD discussions with clinical staff.

6.2.12 Explore funding opportunities

Funding opportunities do not seem to be well known or understood across all services across the state. Funding opportunities, which have been sourced by some services and not others, should be workshopped to share knowledge among NSW Health services representatives. This would aim to overcome Barriers to development and delivery of the training.

6.2.13 Responsibly apply the Code of Conduct

The evaluation uncovered some examples of inappropriate behaviour by staff participating in Respecting the Difference training. Consistent management of such behaviour – whether in the training room or not – requires strong leadership and capable trainers. It also requires consistent messages from the executive leaders through to Human Resource services regarding acceptable and unacceptable behaviours.

6.2.14 Strengthen Chief Executive reporting requirements

Good Health – Great Jobs links to the Respecting the Difference KPIs through the six-monthly reporting requirements.

Chief Executives sign on to a Service Agreement with the Secretary of the Minister for Health (formerly the Director General NSW Health). The Service Agreement is also monitored on a six-monthly basis and seeks to review a raft of performance indicators including Progress on Good Health – Great Jobs and Respecting the Difference.

Attention needs to be given in this reporting to the agreed Respecting the Difference KPIs, including the KPIs relating to implementation planning (KPI 6), evaluation of learning outcomes and impact (KPIs 7 and 8) and linking the training to Aboriginal recruitment and retention strategies (KPI 10). This will require more clearly articulating what local Respecting the Difference activities are being implemented or are planned, how the local executive team are driving implementation and ensuring that training has an impact on frontline service delivery to Aboriginal clients.
ATTACHMENT A

Statement of Requirements

Requirement
The NSW Ministry of Health are seeking the services of experienced consultancy firms to provide quotes for the Respecting the Difference Evaluation Proposal.

The NSW Ministry of Health has commenced a project to review the 1st year of implementation of the Respecting the Difference: An Aboriginal Cultural Training Framework for NSW Health and requires the assistance of an experienced consultancy firm to undertake this project that will assess the reach and uptake of the training and explore the potential impact on the cultural competence of health service organisations.

Context
“Respecting the Difference: An Aboriginal Cultural Training Framework for NSW Health” (the Framework) has been developed to ensure that health staff are empowered to deliver more respectful, responsive, and culturally sensitive services to Aboriginal people, their families, and communities.

The Framework outlines the nominal training requirements for all staff working in NSW Health. There are three components to the delivery of the Framework:

1. eLearning (2 hours online)
2. Generic Subject Content (2 hours face-to-face) and
3. Local Content (4 hours face-to-face).

The eLearning component is a two hour self-directed online learning experience. The face-to-face training is a day-long training comprising generic content (2 hours) that supports the eLearning training, and local content (4 hours) that is specific to the local context of Aboriginal health.

Local Health Districts and other NSW Health organisations determine their individual Aboriginal Cultural Training Programs in accordance with the Policy Directive (PD2011_069) associated with the Framework.

The eLearning package has been developed by the Aboriginal Workforce Unit at the NSW Ministry of Health, and is available for all NSW Health employees through the Ministry of Health, the Health Education and Training Institute (HETI), Local Health Districts, and other NSW Health Organisations online Learning Management Systems (LMS). In addition, resources to support the development of the Generic Subject Content and Local Subject Content face-to-face training at a local level have also been developed and are available. In many cases these may be used to complement existing local cultural training programs of Local Health Districts and other NSW Health organisations.

Implementation Review
The review will describe the first year of implementation of the Framework, assess the reach and uptake of the training, and explore the potential impact on the cultural competence of individuals and organisations.

The review will:
- Produce and deliver a written Survey of Chief Executives of LHDs and key NSW Health organisations
- Organise and convene Qualitative Interviews with Key Stakeholders of selected LHDs and NSW Health organisations
- Produce and deliver Participant Survey: eLearning Component
- Produce and deliver Participant Survey: Face-to-Face Component

Data Analysis and Reporting:
- Analyse data to assess the level of compliance with the Framework and the reported outcomes of training
- A draft report of the findings of the review of the implementation of the cultural training in the first year
- A final report that identifies recommendations and implications for the ongoing implementation of Respecting the Difference Aboriginal Cultural Training.
### ATTACHMENT B

## Schedule of Consultations

<table>
<thead>
<tr>
<th>ORGANISATION/GROUP</th>
<th>DATES OF CONSULTATIONS</th>
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<tbody>
<tr>
<td>Aboriginal Health Worker Forum</td>
<td>December 10, 2013.</td>
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<tr>
<td>Health Education and Training Institute</td>
<td>October 24; November 5, 2013; February 18, 2014.</td>
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<tr>
<td>Illawarra-Shoalhaven Local Health District</td>
<td>October 28; November 26, 2013.</td>
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<tr>
<td>Managers, Aboriginal Workforce Development</td>
<td>December 12, 2013.</td>
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<td>Mid-North Coast NSW Local Health District</td>
<td>October 25; November 13-14, 2013.</td>
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<td>Nepean-Blue Mountains Local Health District</td>
<td>November 4; December 19, 2013.</td>
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<tr>
<td>Northern NSW Local Health District</td>
<td>December 18-19, 2013.</td>
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<tr>
<td>NSW Health Workforce Executive</td>
<td>October 14, 2013.</td>
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<tr>
<td>NSW Ministry of Health</td>
<td>October 1, 8, 31; November 15, 29, 2013; January 30; Feb 21; March 13, 2014.</td>
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<tr>
<td>Sydney Local Health District</td>
<td>November 27-28, 2013.</td>
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References


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