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Centre for Health Equity Training, Research and Evaluation (CHETRE)

Centre for Primary Health Care and Equity

Population Health, South Western Sydney Local health District

Ingham Institute

Learning by doing: Building workforce capacity to work in locational disadvantage

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Background

- Locationally disadvantaged communities
  - High levels of concentrated disadvantage, unemployment, poor educational outcomes
  - Poor access to services and infrastructure
  - Poor health outcomes
    - » Challenges to the public health workforce

- Capacity of the health workforce to work in areas of locational disadvantage?
  - Needs assessment conducted by the Public Health Education and Research Program in 2006
    - » Limited understanding of how to identify and implement effective interventions

Background (2)

- Development of Learning by doing program
  - CHETRE developed the Working in Locationally Disadvantaged Communities (WiLDC) program in response to this needs assessment
  - Lbd is the process of acquiring knowledge and skills through active involvement with practical real-world experience
  - Often applied to public health projects that build leadership capacity, evaluation, and health promotion
  - The WiLDC program
    - » Workforce development
    - » Focus on enhancing problem solving capabilities of organisations and communities

Project Aim

- To identify and describe best practice for a learning by doing (Lbd) program and assess CHETRE's WiLDC program against what is known about best practice

  - What are the components of the WiLDC Lbd program?
  - What is known about best practice for Lbd programs in the literature?
  - Does the WiLDC program align with best practice?
  - What are the gaps and opportunities for the WiLDC program?

Design, method and analysis

- 3 stages
  - Program description
    - » Documentation review
    - » Examination of literature on theories underpinning the program
    - » Informal reviews with CHETRE staff
  - Literature review of current Lbd programs
    - » Identify key components
    - » Develop set of criteria for best practice
  - Comparison of WiLDC to best practice
    - » Systematic comparison the program to each of the 6 criteria identified
    - » Commonalities identified as program strengths; differences identified as gaps or opportunities for improvement

WiLDC program: theoretical underpinnings

- Empowerment-oriented education model (Baker & Wallerstein, 1998, p.2). Adults:
  - are self-motivated, expect practical tools to help them solve problems
  - learn best by building on what they already know, learning should encourage reflection on their knowledge base.
  - learn in different ways, will learn best if they can engage in multiple learning modalities.
  - learn best when actively engaged, when they “learn by doing”
  - learn best when participatory methods are used that involve interaction between participants

- Social action, development of critical thinking and strategic planning skills

- Learning AND transfer of knowledge to practice

Purpose

- Capacity building and community engagement
- Support and mentoring members of health organisation to:
  - Carry out community projects
  - Learn about causes and consequences of locational disadvantage
  - Develop and practice skills in program design and delivery
- By program completion participants are able to:
  - Describe features of locationally disadvantaged communities
  - Undertake community assessment needs
  - Design and implement plan for improving health in a disadvantaged area
  - Evaluate, review and report on projects

Participants

- SWSLHD health workforce
- Invitation to submit proposals that aim to:
  - Increase access to specific health service or program
  - Address one or more risk factors of chronic disease
  - Improve opportunities for health start to life
- Projects assessed on seven key criteria
  - Locational disadvantage focus?
  - Who will come to training? Is their commitment?
  - Project piloted?
  - Feasability within 12 months?
  - Priority population?
  - Based on need?
  - Could it get done without the program?

Program components

- 7 Workshops
  - Theory of locational disadvantage, Health promotion planning, Approaches to working in disadvantaged communities
  - Regular Speakers - specific workshops on Community engagement, social determinants of health, evaluation, report writing
  - Participants work on team projects, practically apply theory and skills
- Site visits/excursions organised by allocated facilitator
  - To project location and or other community projects
  - Based on relevance to development of teams project
- Help desk support
  - Advice, assistance, referrals, validation, learning dialogue
- Funding

Literature review – Criteria for best practice

- 255 articles initially identified
- 43 included substantive discussion of Lbd
- 16 identified essential components of LbD

- Six key criteria for Lbd best practice
  - Practical skills
  - Authentic problems
  - Active reflection
  - Social collaboration
  - Support
  - Program structure

Criteria for best practice (2)

- Practical skills
  - Core purpose of Lbd program
  - Opportunities to apply lessons learned immediately
  - Transfer of knowledge from theory to practice
  - Continued professional development

- Authentic problems
  - Context specific problems - stimulus for project development
  - Meaningful environments with both positive and negative consequences
  - Real life problems provide stimulus for reflection and collaboration
    - Develop problem solving process
  - Passion for project and topic, considered to be high priority in community
    - Motivational context – purpose and reason for learning

Criteria for best practice (3)

- Active reflection
  - Important to learning process
    - » Peer to peer reflective practices
    - » Personal journalising
    - » Reflection on past experiences and skills
    - » Feedback mechanisms: action → feedback → corrective action
  - Facilitates transformational learning
  - Method of creating a workplace learning community
    - » Enhances communication and improves organisational learning structure
  - Enhances workforce development, increases leadership capacity, and employability

Criteria for best practice (4)

- Social collaboration
  - Allows for the exchange of ideas, mutual encouragement and support
  - Lbd involves interpersonal interactions as a “social experience positioned within practice”
  - Shared experience and knowledge of diverse members helps
    - » Inter-professional dialogue
    - » Inter-disciplinary methods of teamwork and learning
  - Participants manage change, negotiate and lead
  - Builds leadership capacity
  - Encourages partnerships
  - Smaller groups of 2-7 create environments that instill confidence, increase discussion and contemplation

Criteria for best practice (5)

- Support
  - Mentoring
  - Facilitation
  - Resources
  - Guidance from professionals and experts
  - Facilitates deep level learning

- Program structure
  - Proposal and approval processes
  - Structured courses
  - Project deliverables
  - Contributes to high level learning and project success
  - Mechanism to support progression

Strengths and gaps of the WiLDC program

Criteria	Strengths	Opportunities
Practical Skills	Provided participants time and guidance to apply theory and skills to their own project Skills were transferable to the health workforce	Understanding participant skill level prior to commencement can assist program planning and ensure program speaks to participants needs
Authentic Problems	Projects were chosen and proposed by participants for their own communities	No key opportunities identified
Active Reflection	Collaborative nature of workshops provided opportunity for participants to reflect on their experiences and facilitated group reflection.	Individual level reflection could be explored further. Strengths and gaps of the WiLDC program

Criteria	Strengths	Opportunities
Social Collaboration	There was enhanced capacity within groups to achieve set goals when there were diverse members. Collaborative process enabled participants to utilise and share past experiences and knowledge.	Course participation could be widened to include workers in more non-health sectors such as urban planning and employment.
Support	Support was provided through the provision of resources, talks from experts in the field, guidance in the workshops, the utilisation of site visits, the help-desk as well as funding.	Mentoring from someone from population health could be a valuable opportunity for participants and could be revisited.
Program structure	Structure needed to be adaptable to varying participant needs, project needs and availability.	Lack of program deliverables leads to projects progressing at different speeds, favouring proactive and highly autonomous participants. Information on participant's knowledge and skill level prior to commencement of program can inform workshop design and ensure adherence to program structure.

WiLDC in the Broader Capacity Building Context

- The NSW Capacity Building Framework was used as a lens to help identify areas for improvement and development in the WiLDC program
- 5 key intervention areas
  - Organisational, workforce and resource development
  - Partnerships
  - Leadership
- 3 dimensions
  - Health infrastructure or service development
  - Program maintenance and sustainability
  - **Problem solving capability of organisations and communities**
- WiLDC program just one aspect of a larger capacity building strategy
  - multi-strategic, multi-level, system wide comprehensive approach
  - intervention at local, meso (usually regional) and macro level (state level).

Intervention Type	Local	Meso	Macro
Organisational development	Organisational support for participants in Lbd program for locational disadvantage	Lbd programs developed as mandatory training programs for organisations working in locational disadvantage	Incorporate Lbd program as part of graduate and university training State wide training programs
Workforce development	Staff participation in Lbd courses and training for working in locational disadvantage	Projects implemented in communities to solve real-world problem, transference to participants communities and organisations	Establish workforce standards/requirements for working in locational disadvantage
Resource development	Written resources and funding for training programs and projects in locational disadvantage	Access to resources and funding for all LHDs with high areas of disadvantage, transference of resources to develop communities	Consistent funding to support course, worksheets and seminars for working in locational disadvantage readily available state-wide
Partnerships	Inter-organisational Lbd projects	Establish ongoing inter-organisational and inter-professional collaboration	Establish training for locational disadvantage across disciplines and organisations Identify opportunities for Lbd within other sectors
Leadership	Increased understanding of working in locational disadvantage	Problem solving capacity of organisations and communities in locational disadvantage	Self-sustained communities Community capacity building

Recommendations

- WiLDC program
  - Short term
    1. Increased incorporation of reflective practice
    2. Incorporate Pre-course survey
    3. Incorporate structure based on pre-course survey and introduce program deliverables

  - Long term
    4. Formal review and evaluation of program
    5. More non-health sector participation
    6. Advocate and promote higher level system and governance changes that address the continued education of health workforce in locational disadvantage

Recommendations (2)

- System wide
    7. curriculum for locational disadvantage as part of Continued Professional Development (CPD) or Mandatory Training for staff working in health in disadvantaged areas
    8. courses on locational disadvantage as part of training for new graduates across disciplines within health
    9. increased partnerships between the Local Health District and local communities to facilitate projects that are community led and authentic to individual community needs

Conclusion

- The WiLDC program aligns with Lbd best practice with a few key opportunities for improvement.
- CHETRE could consider conducting a formal evaluation to understand the impact and effectiveness of the program
- A system wide comprehensive approach to working in and addressing locational disadvantage is required at the local, meso and macro levels
- Readily available training for working in locational disadvantage to the health workforce and the non-health sector workforce working in these areas.