Hearing for Learning Initiative Stakeholder Workshop Report

Monday 8th April 2019

Centre for Remote Health, Alice Springs

Executive summary

The Hearing for Learning Initiative Stakeholder Workshop brought together 23 professionals from the health, education, Indigenous employment and research sectors to:

- Provide an overview of the Hearing for Learning Initiative;
- Understand different perspectives on ear disease and hearing health in the Northern Territory (NT) among key stakeholders; and
- Discuss key constraints, needs and opportunities that may affect the program's success.

The Hearing for Learning Initiative is an innovative community-based service enhancement model, which will also operate as a stepped-wedge cluster randomised trial. It aims to improve the ear and hearing health of Aboriginal children in the NT by funding employment, delivery of Certificate II training in ear and hearing health, and mentoring and integration of community-based ear health workers within existing health and education services.

The program has received $7.9 million over five years from The Balnaves Foundation, the NT Government and the Commonwealth Government. The Menzies School of Health Research is the administrative organisation, but the success of the program depends on a collaborative partnership with communities, health, education, and the Aboriginal Community Controlled Health sectors.

The workshop was opened with a Welcome to Country provided by Arrernte Elder Aunty Margaret Furber.

Presentations during the morning session covered the study's design and data considerations and an overview of the training package being developed with units of competency from the HLT20113 Certificate II in Aboriginal and Torres Strait Islander Primary Health Care.

Invited speakers shared experience from various perspectives in health, education and workforce development, including the perspectives of Aboriginal Health Practitioner coordinators, Central Australian Health Service staff, the General Manager of the Central Australian Remote Health Development Services (CARHDS), a Registered Training Organisation specialising in Aboriginal Primary Healthcare, the Chief Medical Officer of the Central Australian Aboriginal Congress, and AMSANT.

During the afternoon session workshop participants broke into three groups to discuss three key considerations: how to integrate the training with existing services; the training curriculum requirements for the community-based ear health workers; and how best to engage communities in delivering the program.

Key themes emerging across the three topics were that:

- The project presents a significant opportunity to build career pathways within Aboriginal Primary Healthcare, confidence, and empower people and communities.
- It is unclear where funding for participants will come from in the long-term.
- Ear and hearing health will need to be a priority of the community if the project is to succeed. Community ownership of the project is seen as a critical success factor.

- 0.25FTE may not allow enough time for the person to carry out the breadth of tasks expected of the position – flexibility on job-sharing arrangements and FTE is needed.
- The community-based workers will need day-to-day support in their roles for the initiative to work. The supervision and mentoring aspects of the project are very important.
- The workers could fill a significant health promotion and service gap in their communities, and act as 'case managers' for clinics and schools.
- Clear delineation of roles and communication about what the community-based workers are responsible for is critical, and high-level leadership to support them.
- The timing and location of the training will need to be considered in the context of cultural obligations and acceptability. Providing lunch and transport is also important.

At the end of the workshop the proposed governance structure was introduced with opportunities for feedback and questions.

Workshop attendees:

Nerida Nettelbeck	Facilitator
Aunty Margaret Furber	Welcome to Country
Denyse Bainbridge (by videoconference)	Department of Education
Liz Moore	AMSANT
John Boffa	CAAC
Claudia Griffiths	CAAC
Joanna Nixon	CAAC
David Reeve	CAHS
Scott Weily	CAHS
Gwen Paterson-Walley	CAHS
Raelene Beale	CARHDS
Anne Hazel (by videoconference)	ltyentye Apurte CEC
Sandra Nelson	TEHS
Amanda Leach	Menzies
Amy Kimber	Menzies
Kristal Chapman	Menzies
Cherie Cameron	Menzies
Victor Oguoma (by videoconference)	Menzies
Jiunn-Yih Su (by videoconference)	Menzies
Mary Woolcock	CAHS
Jenifer Hampton	CAPHC
Deborah Fearon	CAHS
Deborah Rogerson	CAHS

Welcome to Country – Aunty Margaret Furber, Arrernte Elder

Aunty Margaret Furber welcomed participants on behalf of the Arrernte people. She highlighted the importance of coming together to discuss this issue and thanked the audience for acknowledging the Arrernte people, wishing participants a safe journey on their country.

Introductions and Welcome – Nerida Nettelbeck, Workshop Facilitator

Following the Welcome to Country, Nerida opened the workshop by introducing herself and highlighting the importance of the workshop in enabling everyone to have a voice. General housekeeping was discussed, and participants gave consent to having photos taken during the workshop. Individuals were asked to introduce themselves by sharing their name, organisation and one thing that comes to mind when thinking about ears. Ground rules were established to provide safety and boundaries for participation. Suggestions from the participants included:

- Talking up in loud voices
- Respecting and acknowledging that we all come from different places and have things to contribute
- Encouraging each other to input
- Presenters to use pauses to let people think and digest thoughts.

An Aboriginal Health Practitioner's perspective - Sandra Nelson, Aboriginal Health Practitioner Coordinator for Top End West, Top End Health Service

Sandra explained that ear and hearing is not just a profession for her, but also a very personal issue, having had ear disease and suffered hearing loss herself. Sandra's sons without hearing loss have excelled in their career, one son commenced his school-based apprenticeship in Year 12 and gained employment with the company and still works for them. The other son graduated with two university degrees in education and science. Sandra observed that community hearing health workers employed during 'the NT Intervention' had a major impact on improving hearing health, and the size of perforations decreased. With the right people and the right training, Sandra believes we can close the gap on this issue.

Overview of the Hearing for Learning Initiative - Amanda Leach, Co-Chair, Menzies School of Health Research

Nerida introduced Amanda and the Initiative's other Co-Chair Associate Professor Kelvin Kong, a Worrimi man from the Newcastle area and Australia's first Aboriginal surgeon (ENT). Amanda highlighted the power of stories in building people's understanding of this issue. Amanda's daughter had ear disease at an early age and the insertion of grommets changed her entire demeanour. Ear disease is very common and affects many Australians – the Hearing for Learning Initiative presents a great opportunity to address the issue among Aboriginal children in NT communities, with $7.9m over four years. Ear disease impacts a child's health and education outcomes, their school readiness, and can have flow on effects to the justice system and workforce sustainability if left untreated. Ear disease is difficult to detect and manage – as part of the Healthy Under 5 checks only about 30% of children have ear assessments at scheduled visits compared to 80% for height, weight, blood test etc. Our evaluation of under 3-year-olds in our vaccine trials shows that of around 2000 cases of AOM or CSOM which require follow-up at 7 days post diagnosis, only 13% are followed up within 10 days, and 50% of these have appropriate treatment. The independent evaluation of the Australian Government's Indigenous Ear and Hearing Health Initiatives recommended a greater focus on building and maintaining the capacity of primary health care in Aboriginal Community Controlled Health Organisations to provide effective assessment, referral and follow up. Amanda also cited Watson, Young & Barnes who found that while Aboriginal and Torres Strait Islander health workers

are known to significantly contribute to the overall acceptability, access and use of health services, they require support to do this important role.

Study Design: The Hearing for Learning Initiative is a four-year intervention in 20 communities, which aims to employ forty 0.25FTE workers, who will screen 5,000 children.

The PICOT research question:
Population: In urban, rural and remote Aboriginal communities in the NT, does
Intervention: employment, training, and integration of local Ear and Hearing Clinical and Education Support Officers into health and education services (the Hearing for Learning initiative),
Comparison: compared to current practice (annual half day OM workshop),
Outcome: increase the proportion of Aboriginal and Torres Strait Islander children who receive an ear assessment,
Time: during the intervention period?

It is a workforce innovation model which aims to build the sustainability of Aboriginal community-controlled primary healthcare. A steering group will be established in participating communities, and this group will decide who will be the mentors, supervisors, and health and education champions to support the ear health workers. The roles & responsibilities of the workers will be:

- To undertake Certificate II training in Aboriginal Primary Healthcare tailored to include specific training in ear and hearing clinical and education support;
- Clinical – undertake ear assessments for all children using otoscopy and tympanometry, assist case management and follow-up;
- Education – assist the teaching of children with hearing problems; and
- Families – educate families about the impact of ear and hearing problems in children and what they can do about it.

The benefits to families, workers & communities are a community-based expert in ear and hearing health to:

- Provide safe, culturally appropriate, reliable and expert clinical and education services for children who have ear and hearing problems;
- Explain how ear and hearing problems can affect their child's behaviour, listening, talking, playing and learning;
- Explain how to detect, treat and manage ear and hearing problems; and
- Link the family with services to get the best help from the clinic, specialists and school.

The benefits for the community-based expert in ear and hearing health are:

- Employment;
- Opportunity to play an important and respected role in their community;
- Professional workforce development training to improve workforce readiness; and
- Certificate II training in ear and hearing checks, how to use equipment, write up and discuss results with the child's doctor, nurse or Aboriginal Health Practitioner, inform the child's family and teacher of their ear and hearing needs, and make follow-up appointments.

The benefits for the community are:

- Each community can have a say about how to best run the program through workshops and membership of the Community Steering Group of the Hearing for Learning Initiative;
- Culturally safe, reliable, efficient, effective ear and hearing services for children;
- Employment, training, mentoring and support of community members as ear and hearing health experts;
- Intensive in-service training for health service providers, teachers and others; and
- Community data on how many children have ear and hearing problems, how many children receive a care plan, how many improve or need ongoing help (and more).

The Otitis Media Guidelines app will be an important resource, as will innovative ways of testing. Amanda provided an outline of the research pathway and summarised concerns of stakeholders raised to date being:

- Employer, integration, transition beyond the project
- Champions, supervision, support (mentoring)
- Literacy and numeracy
- Clinical competency
- CDP
- 0.25 FTE – case load, scope of practice
- Other ear programs
- Other programs including Health Coach, Rheumatic Heart Disease, education assistants

Study design and data considerations - Victor Oguoma, Biostatistician & Jiunn-Yih Su, Data Analyst, Menzies School of Health Research

Victor explained the benefits and rigour of a randomised controlled trial. The Hearing for Learning Initiative will use an open cohort stepped-wedge design, with eight sequences or steps across 20 communities over four years. The intervention (training) is delivered in groups of communities (clusters) and all 20 communities must consent before the study can begin. Repeated measurements of the study outcomes will occur over time with the same individuals, and baseline data will be collected for six months before the intervention begins, subsequently rolling out on a six-monthly basis.

Study sites have not been determined yet – an example might be as follows:

> Communities will be stratified in pairs based and randomised into eight different starting periods e.g. Wurrumiyanga and Pirlangimpi; Maningrida and Gunbulanya; Milingimbi and Gapuwiyak; Wadeye and Palumpa; Beswick and Ngukurr; Ali Curung and Mungkarta; Yuendumu and Willowra; Hermannsburg and Papunya; Kaltukatjara and Mutitjulu; Engawala and Harts Range. Communities will not know when they will join the intervention until about 6 months before starting.

Jiunn-Yih outlined the data requirements for the project, which will include collecting administrative data on primary and secondary outcomes of the intervention.
The **primary outcome** is the proportion of children aged 0-16 who receive an ear assessment in the last 6 months.

The secondary outcomes include:

- The number of ear and hearing clinical and education support workers
- The number of children receiving specific types of ear assessments
- The proportion of children having an episode of Acute Otitis Media
- The proportion of children who have had an episode of Chronic Suppurative Otitis Media and the proportion that received appropriate treatment, a hearing test, a care plan, and appropriate follow up within 10 days of diagnosis.
- The project also seeks to monitor workforce data from the NT Department of Health and participating Aboriginal Medical Services, and clinical data from PCIS, Communicare, and NT Hearing Health Services. Data retrieval will occur at six-monthly intervals, and a dummy record will be generated for unit record data.

John noted that a specific query for the SQL needs to be written so data can be extracted remotely from Communicare, otherwise there will be a cost associated.

Overview of the Certificate II training options- Kristal Chapman, Senior Clinical Training Research Officer, Menzies School of Health Research

Kristal opened with an Acknowledgement of the Traditional Owners, the Arrernte people. Kristal is a proud Aboriginal woman from the Mitakoodi and Gangalidda nations and has been nursing for over 16 years. The life expectancy of Indigenous Australians remains appalling, which is why she is passionate in her belief for this project and the changes it can make. The training for the community-based ear health workers consists of three Accredited Units and will be delivered on country in the community by two experienced and certified trainers. One of the trainers is required to be Aboriginal and/or Torres Strait Islander. The key aims of the training is to ensure that the community-based workers are competent in their roles and in the use of ear health screening technology and equipment, which will improve their ability to screen for abnormal ear health or hearing.

In previous consultations many people have expressed interest in providing input and being part of a group that oversees the development of the content and training. A Training Working Group of sector leaders and partners will be established to provide guidance and feedback on the training. Industry leaders will include Aboriginal and Torres Strait Islander professionals from the clinical, education and work readiness fields. Key topics to be covered in the training include Primary Health Care, Ear Health, Infection Control, Workplace Health & Safety, PCIS, EA Communicare, Communicare, Technology and Equipment.

The Clinical Research Training Officers will have a strong educational and/or clinical background**.** All staff will:

- Undergo Cultural Competency/Awareness training
- Be experienced in working with Aboriginal & Torres Strait Islander people
- Be committed to empowering and hearing the voice of Aboriginal people
- Have a good understanding of how to apply Aboriginal methodologies for learning such as ‘Both Ways’ and the 4MAT methodology
- Demonstrate the value of transparency, being open and honest in communications.

The three key roles/responsibilities of the Clinical Research Training Officers will be designing, developing, and delivering the training in consultation with industry stakeholders and communities. Apart from leading the training program, they will also provide support to the community-based workers, mentors and champions, and develop a tailored mentoring program. Research into Indigenous employment and training programs has identified seven key success factors. Hearing for Learning aims to address and implement these to ensure good outcomes at all stages of the project, placing an emphasis on relationships with community and key stakeholders.

Jenifer asked for further information about support for mentors and what training might be available.

Ear disease from an educational perspective - Denyse Bainbridge, Senior Education Advisor – Hearing, Department of Education

Denyse introduced herself and thanked Menzies for the opportunity to present at the workshop. She paid respect to the elders past and present on which the land we were meeting on. The presentation was titled hearing and ear disease from an educational perspective which is embedded in what the Hearing for Learning Initiative is all about. Denyse provided an overview of the NT Department of Education Hearing Team 2019 which sits within Student Wellbeing and Inclusion. There are two smaller teams comprising Wellbeing and Student Behaviour and Inclusive Practice. The Hearing Team sits within the Student Inclusive Practice team and includes the NT-wide Darwin team of Denyse (Senior Education Advisor), Rachel Brindal (Education Advisor), Meaghan Arundell (Education Advisor), and Tammy Simmons (Education Advisor CHL). The Education Advisor position for Alice Springs is currently being advertised.

Denyse described the Nationally Consistent Collection of Data (NCDD) – all schools need to be able to contribute. There are four key categories, being cognitive, physical, sensory (hearing and vision), and social/emotional. There are four levels of support offered: quality differentiated teaching practice (QDTP), supplementary, substantial, and extensive. QDTP means a student has a diagnosed conductive hearing loss in the mild range – specific pathways and recommendations are provided e.g. improve classroom acoustics. Supplementary means the student is offered QDTP, has a hearing loss and needs to wear a hearing hat or head band.

The ear health workers proposed by the Hearing for Learning Initiative may be able to support the Department of Education's program and will need to be aware of these recommendations. The program uses a bottom up and top down approach and provides reminders for teachers. A spreadsheet is provided to teachers with the student's name and strategies suggested by audiologist and possible NCCD intervention, but it is up to the teacher to determine the best approach and to make the final decision of which level of adjustments they are making for the reporting process. A cheat sheet is also provided to progress suggested actions e.g. 'Ensure the student is facing speakers with their better ear' or, 'Support referral to Australian Hearing for consideration of hearing aids' or, 'Support referral to an ENT surgeon in view of ongoing ear disease'. The ear health workers need to be aware of these recommendations, and to feel part of the school environment, i.e. not just a visitor.

The Now Hear Continuum was designed specifically for the NT to support children with hearing loss. It is a tool that provides schools with a guide to maximise the learning environment for all students

with conductive hearing loss. The process of developing the continuum identified the need for an integrated approach across health and education. Under this approach, the school does an audit, creates an action plan, then reviews and evaluates. This process clearly identifies the state of not knowing, compared to the optimal state across five domains. The key take home measures for teachers are: increase hand and face washing; and reduce background noise. Teachers tend to see behaviour changes first, as pain may not be present, then delays with speech and language. Throughout that process is the child's social and emotional development, which may be more difficult to monitor.

John would like to see evidence of what the most effective interventions to prevent ear disease in school-age children are, as hand washing at this age may be far too late and this cohort is likely to have already had multiple ear infections.

AMSANT perspective - Liz Moore, Public Health Medical Officer, Aboriginal Medical Services Alliance of the NT

Liz noted that the ACCHO sector is bigger than government. AMSANT has several research projects funded by the National Health and Medical Research Council. They have had some engagement with Hearing for Learning and are aware that the concepts are still being mapped out. A letter of support has not yet been provided as the project's plan is still evolving. AMSANT would like clarification on:

- Support for the community-based workers.
- How they will be integrated with existing services.
- What will happen to the positions at the end of the project.
- Data sovereignty.

Liz believes the 0.25FTE proposed is inadequate and could be a concern in Central Australia due to communities being smaller and people preferring full-time work. It would be best if the project leads to ongoing employment and the positions should not be linked to CDP. The project should adopt a strengths-based and continuous quality improvement approach. Liz emphasised the importance of ensuring the job is attractive to avoid barriers finding staff to do the work and shared examples of this being an issue in previous projects. It is recommended that Aboriginal Primary Healthcare services are the main employer to ensure success. It is positive to see a focus on the Aboriginal Health Practitioner workforce and identifying/creating alternative pathways for staff. It will be important to work together through networks such as the NT Aboriginal Health Forum to explore other workforce initiatives. When addressing the impact of hygiene on ear health, the wider context of social determinants needs to be considered to avoid sending the message that washing hands can solve everything.

Workforce Development Perspective – Raelene Beale, General Manager of the Central Australia Remote Health Delivery Services

Raelene commenced her presentation by stating as a workforce development, Hearing for Learning Initiative is a good start. There are small amounts of funding around for training, however if we do Hearing for Learning carefully as discussed by Kristal, we can make a start to ensure staff in communities are accredited. CARHDS has found the workforce wants to learn more IT skills, currently they share as much as they can via touch screens and apps. Many Aboriginal people don't have access to this or are last to see it. CARHDS found there is a high risk with the training and has

moved away from the original model. Most recently they have trained in Tennant Creek full certifications. In Central Australia they have delivered a full qualification Cert II and in Wadeye Cert II which is a progression for them.

Raelene shared some examples of workforce strategies and suggestions for working in remote settings. These included the following:

- To address challenges in language barriers - Design a tool kit that is wide enough and deep enough. Stretch as an educator.
- Accredited training will assist your clinic. Having Aboriginal workers will help the accreditation process and can change what happens internally for people.
- Within the workforce we can impact the person on the day and provide the information. It's about telling the story to share onto other families. There is no illusion that training will change everything.
- Using a zoom in zoom out approach: Consider how other Indigenous communities fit together to create a real focus in primary health care. The HfLI is a great opportunity to create pathways.

Raelene also provided an insight to what might happen once the training is finished and how the training packages are designed to suit a range of opportunity in communities. It is about keeping communities alive, not just about culture and language but by creating a great start for people. This approach has great legs.

Panel discussion – **David Reeve, Liz Moore, John Boffa, Raelene Beale**

Nerida opened the panel discussion by explaining this session would begin to explore the constraints, needs and opportunities of the project before the afternoon session where these themes would be considered in small groups. Two initial issues for discussion:

1. Who the employer should be; and
2. How to tailor the 0.25FTE positions appropriately, noting this is an average across the project.

Liz recommended the employer should be the primary healthcare service. There was a workshop with Menzies, TEHS, CARHDS and AMSANT in November 2018 – concern that the Hearing for Learning workers might be ignored and not supported if they weren't part of the clinic team, due to a high turnover of staff and the high-pressure environment. The training sounds fantastic but resident support is needed to make it sustainable. David agreed that if there is a clinical component to the role they should be part of the primary healthcare team because the workers will be using the space and equipment and workplace health and safety needs to be considered. Appropriate line management within the clinic is needed for them to get the support they need. Regarding the 0.25FTE, David suggested there may already be staff within clinics that would like to undertake the training and take on this role as part of their other responsibilities.

John noted that at any given time, 9% of Congress patients under 5 years of age have pussy ears (80 kids in Alice Springs and 40 in remote communities). A recently published study has shown 6 out of 10 children can be cured with treatment. With ciprofloxacin drops, tissue spears and co-trimoxazole about 60% can be cured – therefore long-term support and intensive case management for 130 kids

is needed each year. There is evidence that none of the surgical interventions work – adenoidectomies and grommets do not make a difference, so the focus needs to be on primary healthcare. John would like to see the treatment pathway that will be used because if a child in school has pussy ears, it's gone beyond hand hygiene and they need to be seen by the clinic. 0-5 year olds should be the target cohort. Getting hearing assessments organised for this age group and getting disadvantaged kids to appointments requires work. There is clear evidence now about what works, and it is important that any new evidence is incorporated into the care pathway. Kathy Currie's research demonstrated that an ear health case worker in primary healthcare is what's effective, and with a caseload of 130 kids per year, 0.25FTE will not be enough. Amanda noted that where there is a large burden of disease, the FTE will be adjusted accordingly. John was interested to know what the algorithm is for that. The NTG Hearing Health Service has offered to share their data. David pointed out that if there is more than 0.25FTE in one community there will be even less in others – Amanda noted the project will work with the community-based workers to determine the priority. For example, the OM Guideline states that 0-3 year olds are the priority. The 0-16 age range determined for the study is to ensure that every child gets an ear and hearing check once every 6 months – the Guideline states that all children should have regular surveillance. John noted that of 900 children 0-5, 57% got a health check last year, and about 60% of them got an ASQ-TRAK. The proportion of children aged 5-15 having a child health check is much lower. With these figures in mind, Hearing for Learning will need to do ear and hearing checks in schools if the project is targeting 0-16 year olds. The group agreed 0-3 year olds should be the priority, meaning they will need to be seen in clinics. A universal hearing check in schools may be one option to identify school-age children with hearing problems – HearScreen will be a good tool for this.

Comments from the audience:

- A model that is flexible will be needed, on the FTE, where screening will occur etc. One size will not fit all.
- People involved in the Australian Nurse-Family Partnership Program may be interested in taking on a 0.25FTE role, because they work when the outreach team fly in, and they are keen to learn more.
- A minimum of 0.25FTE per community is a good start and can be further built upon – this was the FTE used for hearing community workers as part of the Intervention.
- These workers were originally supervised by the Aboriginal Health Practitioner coordinators but then were supervised by non-Indigenous people and much of the workforce was lost.
- Even with an MOU in place with clinic managers, there have been instances of community-based workers being asked to do work outside of their position description in previous programs. Nowadays AOD workers are seen manning reception.
- Support from higher up within the Department is needed to protect and support the roles of the community-based workers, along with a strict MOU.
- Clear pathway of AO1, AO2, AO3 etc is needed, and the program can be flexible in terms of the level attained by each individual.
- It will be important to educate health centre managers on what the role is, its purpose, and what the health centre manager's role is in helping them fulfil their role. There is also a lack of clarify about what the outreach services are doing.
- A clear work plan with a flow chart will assist.
- ASTIWAG is working on a culturally appropriate work plan and the training team will be available to support the worker, follow up on issues, and clarify their role with managers.

John noted that Certificate II trainees cannot be absorbed into the day-to-day work of the clinic, and that clinics are much better resourced nowadays. Careful consideration of the role is needed, for example part of their role will be driving, and they could collect children for health checks so long as an ear and hearing assessment is done as part of this. Tympanometry and otoscopy need to become a routine part of child health checks.

Community engagement workshop session

Key themes	Audience rating
The program can be community owned with a local steering group	••••
Workshopping community engagement	••
The program presents an opportunity to work with people on the ground	•
Funding being ongoing seen as a constraint	•••••••
HfLI not being a priority for the selected communities and could this create a constraint	•••••
Knowing who to approach in each community and being clear on the right pathways for community engagement (Traditional Owners, LAG, LHAG's, Elders, clans and family groups).	•
Perception of workloads	•
Time and having realistic time frames	•
Service providers viewed as a constraint	•
The gatekeepers of community/blockers controlling inappropriate influences	
Lack of support in health an engagement constraint.	
Staff cultural inappropriate/lack of cultural awareness.	
Opportunities to work with communities to explain the project and offer support as required.	
Community engagement with TO's, Reps, Elders, council, key people, clans according to community cultural protocols.	
Central land council could be utilised as a support/advisory.	
NLC for support/advisory.	
Opportunity for community endorsement/approval	
Using interpreters and pictures for community engagement.	
Plan community BBQ's, movies, activities as engagement approaches	
Community needs to be respected and acknowledged to ensure efficient consultation	
Take time to get to know the people/community. Build rapport by planting the seed and give them time to think.	

Integrating training with existing services workshop session

Key themes	Audience rating
The trained workers can play a key health promotion role.	•••••
Workers can assist with finding families that are on outreach lists.	••
Opportunities to provide appropriate support to child health RN/AHP.	•
Workers will help clinics meet their CARPA requirements.	•

There needs to be a clear communication plan with all staff about the roles/meetings.	●●●●●●
Constraints for too little in too many locations/places.	●●●
There needs to be a health clinic understanding of the roles of the workers	●●
Medico-legal issues may need to be very well defined/explained.	●
Funding constraints	●
People will leave the job because .25 is not enough work	●
An opportunity to provide appropriate accredited mentor training.	
Utilise existing AHP mentors and co-ordinators.	
Workers will be able to help clinics and can obtain informed consent.	
Mentors can be non-clinical	
Under-utlised mentors may put their hand up to mentor a worker.	
Hearing for Learning trainers can offer support to clinic staff.	
Kids get crossed off wait list with too many DNA's.	
There needs to be a buddy system	
Mentors need to be compensated otherwise it will stop.	
The mentor needs to be trained/accredited.	
Integrate the training into existing clinic programs.	
Mentors must be good role models and well respected.	
Ear health workers need to be able to ensure other services are doing their job.	
A correct referral pathway is required	
There needs to be a high level mandate and clear description of the role.	
There needs to be a clear understanding of what the supervisor/mentor/champion roles are.	
All clinic staff must support, not just the mentor/champion.	
Vehicle required/drivers license.	
Good mentors are already time poor/busy.	
Mentors can identify new mentors	
The broad nature of the role could be too much to get across and too much responsibility/expectation for Cert II.	
Cultural obligations and avoidance could be a constraint.	
Cultural safety, security and non-Indigenous awareness	
Continuity of care a constraint	
Mentors needs to be registered within their agency.	
Continuity of staff and staff being able/unable to obtain an OCHRE card	
Lack of AHP support an issue, including the support for AHP's could be improved.	
Scope for ongoing work if they don't want to be clinical/AHP.	

Training curriculum workshop session

Key themes	Audience rating
Creating opportunities for pathways to other training	●●●●●●●
Training curriculum creating a means of empowerment and confidence	●●●●
Creating opportunities to build LLN capacity	●●
Providing night school as a study option	●
How will applicants be supported?	●●●●●●●
Possible constraints with finding space for training and considering gender for cultural needs.	●●

The training curriculum creates an opportunity for certificates to improve competency and respect for the role/self respect.	
Training is an opportunity to develop language resources.	
Possible constraint being unrealistic expectations of getting a job.	
Issues with people not being in community for training.	
Constraints with applicants getting OCHRE card and Police checks	
Levels of computer literacy/LLN	
Timing of training a constraint	
Considerations for number of applicants and challenges choosing who will get the training.	
Accessing staff in thin employment markets means smaller numbers.	
Training competing with co-morbidities, life and distractions.	
Will on the job training and space be available in PHC?	
Constraints with internet/wifi access when it comes to Hearscreen.	
Workers will require constant support	
Who can the hearing workers go to when CRTT isn't in the community?	
Communication with CRTT?	
LLN support during training a need	
Create a video to demonstrate how clinic work occurs on the job.	
Needs to be clear roles and responsibilities, including medico-legal positioning.	
Training needs for PCIS and Communicare	
Thinking about the need for lunch, transport to/from training.	

Governance Structure – Amy Kimber, Hearing for Learning Program Manager, Menzies School of Health Research

Amy introduced and discussed the proposed governance structure for the Hearing for Learning Initiative. The current proposal includes 7 key groups consisting of the following:

- Partner Advisory Board: Objective is to maintain an overview of the program's progress, risk mitigation, and finances. Advocate on behalf of the program and facilitate linkages with other Commonwealth, NT, or Balnaves strategic programs or priorities. Membership includes representatives from funding bodies. Proposed meetings 3 times annually.
- Indigenous Leaders Coalition: Objective is to provide high level strategic advocacy and advice. Support Aboriginal and Torres Strait Islander members of the program and identify and advise on any cultural risks associated with the program. Identify collaboration opportunities. Membership includes senior Aboriginal and Torres Strait Islander leaders. Proposed meetings 3 times annually.
- Stakeholder Steering Committee: Objective is to provide operational advice on integrating the program with existing services. Encourage member services to participate. Membership includes TEHS/CAHS Primary Health Care, Dept of Education, Catholic Education, ACCHO representation, Australian Hearing. Proposed meetings 3 times annually.
- Research Executive Committee: Objective is for overall responsibility for the design, conduct and reporting of the study. Membership includes Amanda Leach, Kelvin Kong, Peter Morris and Alan Cass. Proposed meetings 3 times annually.

- Community Reference Groups: Objective is to provide advice on implementation of the Hearing for Learning initiative in a specific community. Membership includes Community Elders or leaders, community members working in the health and education sectors who are nominated as 'champions' by the community. Proposed meetings 3 times annually.
- Data Safety and Monitoring Board: Objective is to provide objective advice to the Hearing for Learning Co-Chairs on the study's safety and efficacy, by reviewing and evaluating accumulated study data for participant safety, study conduct and progress. Membership includes Menzies researchers from other divisions, ear health researchers from other institutions. Proposed meetings 2 times annually.
- Training Working Group: Objective is to provide input and guidance on the learning program. Membership includes Clinical – Audiologists, nurses, surgeons, Education – Department of Education hearing advisors, FaFT, Catholic Education, Work readiness – experts including Raelene Beale, Sandra Nelson. Proposed meetings - Several in 2019.

Next steps

- Thank you for participating.
- A report will be circulated.
- Please complete an evaluation form.

The workshop closed at approximately 4.12pm.

Appendix 1 - APRIL, 2019 STAKEHOLDER WORKSHOP EVALUATION RESULTS

ATTENDANCE

The following are the accumulated results from the evaluations completed by workshop participants. A total of 23 people attended over the course of the full day workshop. Four participants attended via video conference.

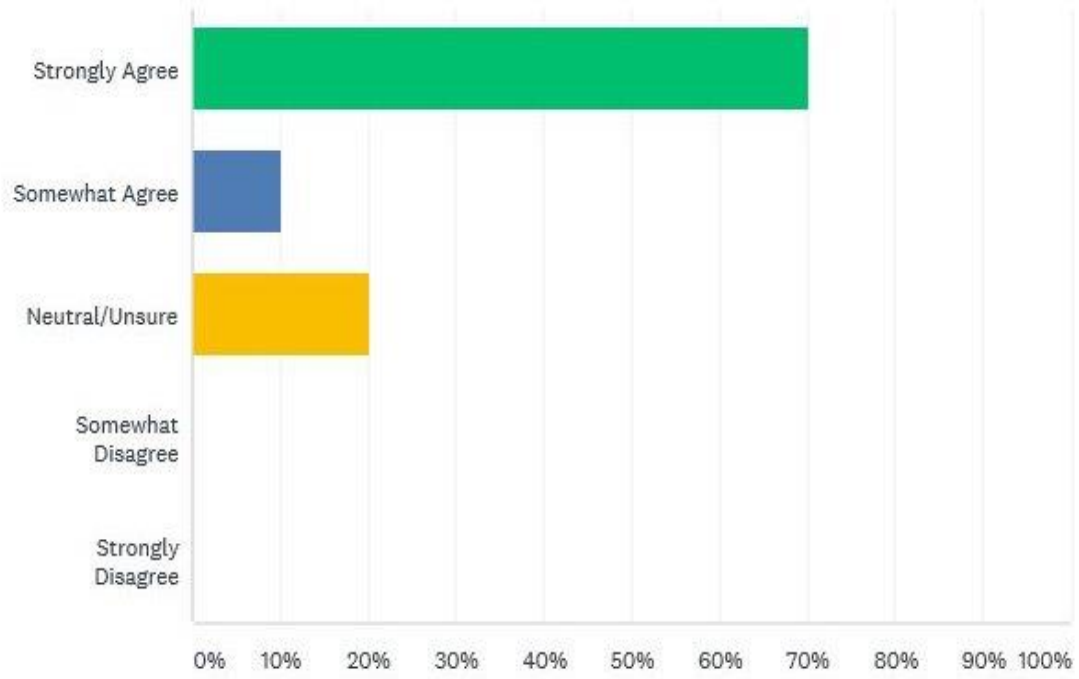
WORKSHOP EVALUATION

The Workshop Evaluation had ten questions which allowed for collection of suggestions, comments and feedback on the workshop and the Hearing for Learning Initiative. Ten of the 23 participants completed the hardcopy evaluation form.

STAKEHOLDER WORKSHOP EVALUATION RESULTS REPORT

QUESTION ONE. Today's presentations were informative

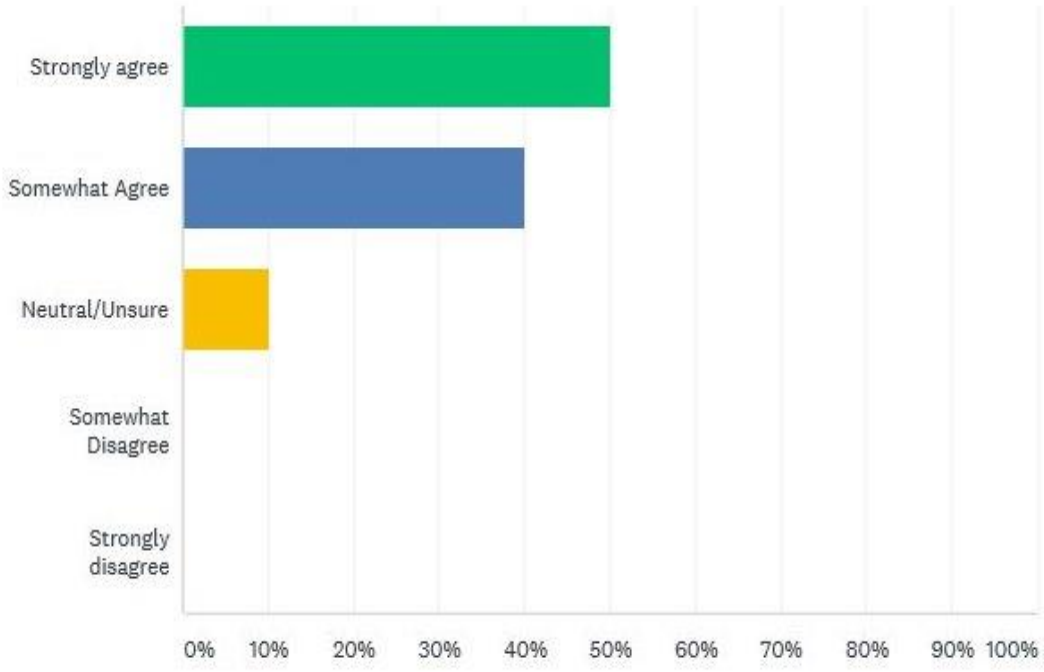
Answered: 10 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly Agree	70.00%	7
Somewhat Agree	10.00%	1
Neutral/Unsure	20.00%	2
Somewhat Disagree	0.00%	0
Strongly Disagree	0.00%	0
Total Respondents: 10		

QUESTION TWO. I have an increased understanding about the Hearing for Learning Initiative

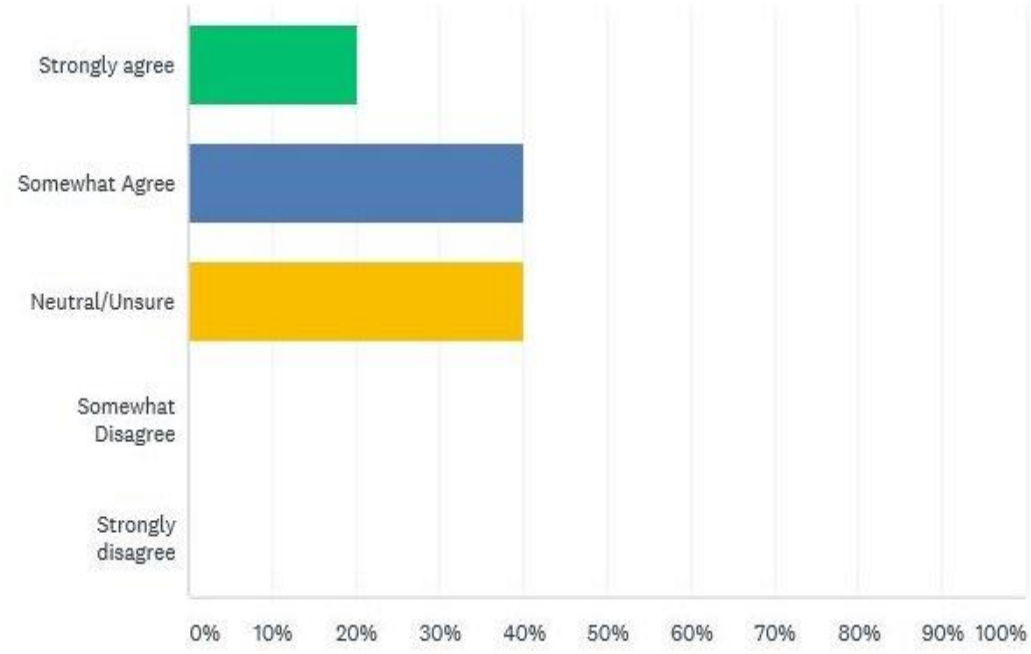
Answered: 10 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly agree	50.00%	5
Somewhat Agree	40.00%	4
Neutral/Unsure	10.00%	1
Somewhat Disagree	0.00%	0
Strongly disagree	0.00%	0
Total Respondents: 10		

QUESTION THREE. The information provided today demonstrates that the Hearing for Learning Initiative will be engaged with the Community

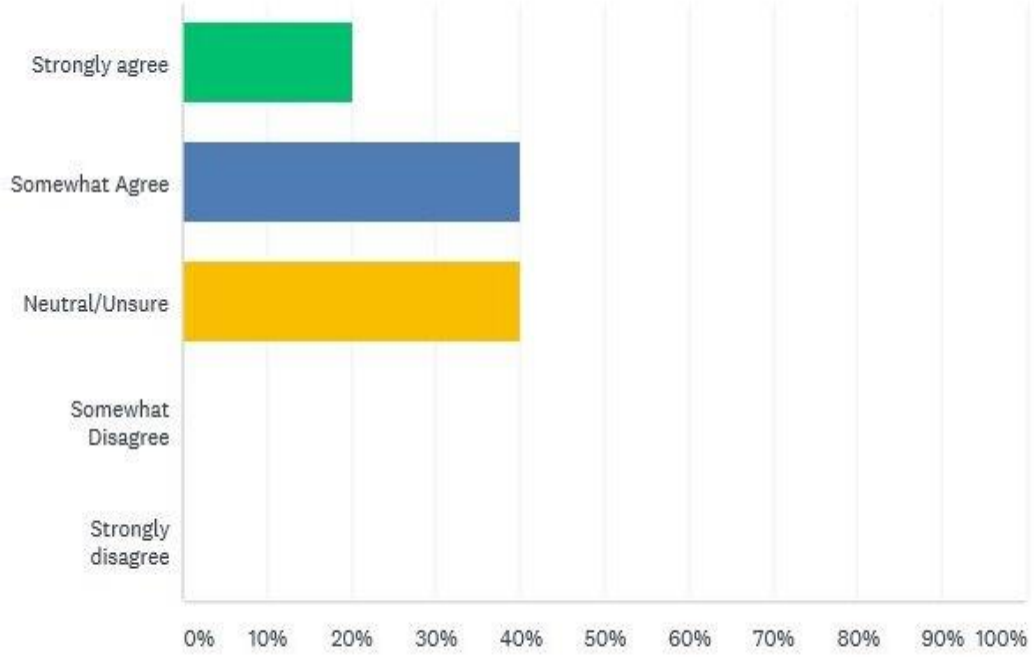
Answered: 10 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly agree	20.00%	2
Somewhat Agree	40.00%	4
Neutral/Unsure	40.00%	4
Somewhat Disagree	0.00%	0
Strongly disagree	0.00%	0
Total Respondents: 10		

QUESTION FOUR. I feel confident that the Hearing for Learning Initiative will improve employment for people living on country

Answered: 10 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly agree	20.00%	2
Somewhat Agree	40.00%	4
Neutral/Unsure	40.00%	4
Somewhat Disagree	0.00%	0
Strongly disagree	0.00%	0
Total Respondents: 10		

QUESTION FIVE. What was the most worthwhile thing you will take away from attending the workshop?

7/10 responses - 3 Did not give a response

1. More aware of the varied views on the project.
2. A greater understanding of what is wanted from the program.
3. Learning how complex it will be to manage the research.
4. All the input and questions raised.
5. People are still unclear of the role and responsibility of this position.
6. About the program, other organisations view points.
7. That hearing is back on the agenda.

QUESTION SIX. What do you see as the major benefits of the Hearing for Learning Initiative?

7/10 responses - 3 Did not give a response

1. Up Skills/Aboriginal employment.
2. Possible improvement with case management.
3. Employment.
4. Pathways for employment and training.
5. Improved treatment of ear infections.
6. Improved ear health, education and benefits overall.
7. May be an improvement in ear health.

QUESTION SEVEN. Is there any information about the Hearing for Learning Initiative that you would like to learn more about or other topics you would like to hear about in future sessions?

5/10 Responses - 5 Did not give a response

1. Employment, Medico-legal risk, Written descriptions.
2. Sample Job description.
3. Actual tasks of community workers needs to be sorted out.
4. Governance – process.
5. Just progress of project.

QUESTION EIGHT. Do you have any suggestions to improve future sessions?

4/10 Responses – 6 Did not respond

1. No, it was well designed.
2. Always good to hear different opinions.
3. Greater understanding of the challenges.
4. More time to discuss as very important issue.

QUESTION NINE. Are there better/other ways of sharing information about the Hearing for Learning Initiative?

1/10 Responses – 9 Did not respond.

1. Conversations with ACCHS sector. Services need to ask their own questions.

QUESTION TEN. Are there any further comments?

2/10 Responses – 8 Did not respond.

1. Very informative.
2. Great initiative but concerns that it's not ready for implementation or road blocks.