# National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes: Implementation Plan

Jurisdiction: Northern Territory

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## BACKGROUND AND CONTEXT

Evidence and existing NTG policy recognise that without timely intervention Aboriginal disadvantage accumulates across the lifecourse.

The initiatives covered within the NATIONAL PARTNERSHIP AGREEMENT ON CLOSING THE GAP IN INDIGENOUS HEALTH OUTCOMES (CTG NP) are all significant pressures in the Northern Territory. Current need in these areas contribute to early death, antisocial behaviour, and dysfunction in individuals, families and communities, leading to poor health outcomes, offending, ineffective health servicing and increased cost. These outcomes are plainly evident in the behaviour and circumstance of many Aboriginal people, families and communities not just in remote areas but also in Territory cities and towns.

Failure to deal with these challenges will put at risk gains made through other investments, drastically impair the likelihood of meeting CTG NP objectives, and continue to add cost. Planned and more recent investment decisions have provided scope to address some of the health and development needs of Aboriginal Territorians by improving capacity, coverage and scope of primary health care and family support services. Relevant policies and frameworks that will guide this implementation plan include:

- Cultural Security Policy
- Aboriginal and Torres Strait Islander Strategic Workforce Plan (2008 – 2011)
- Aboriginal Health and Families - A Five Year Framework for Action
- Building Healthier Communities
- Closing the Gap – Generational Plan
- Pathway to Community Control Framework
- Little Children are Sacred Report
- Framework Agreement on Aboriginal and Torres Strait Islander Health

## IMPLEMENTATION PLAN

Total commitment for the CTG NP is $175,682,241. This does not include funding commitments for the financial year 2008-9. Attachment I: Letter of Verification from Chief Finance Officer.

Measuring the plan's implementation will be based on a range of performance benchmarks and indictors contained in the CTGNP as well as others more specifically related to the activities the Plan outlines. The NT Aboriginal Health Forum will provide a useful mechanism to assist the implementation of the Plan.

## Key for Performance Benchmarks and Indicators from CTG NPA

| Priority Area | Key | Performance benchmarks | Performance indicators |
| --- | --- | --- | --- |
| **Smoking** | **S1** | Number and key results of culturally secure community education/ health promotion/ social marketing activities to promote quitting and smoke-free environments. | *Relevant indicators:*<br>Incidence/prevalence of important preventable diseases and injury.<br>Proportion of babies born of low birth weight.<br>Teenage birth rate.<br>Risk factor prevalence.<br>Immunisation rates for vaccines in the national schedule.<br>Cancer screening rates (breast, cervical, bowel).<br>Number of women with at least one antenatal visit in the first trimester of pregnancy.<br>*Additional indicators:*<br>Tobacco smoking during pregnancy.<br>Social and emotional well-being.<br>Health promotion. |
| | **S2** | Key results of specific evidence based Aboriginal and Torres Strait Islander brief interventions, other smoking cessation and support initiatives offered to individuals. | |
| | **S3** | Evidence of implementation of regulatory efforts to encourage reduction/ cessation in smoking in Aboriginal and Torres Strait Islander people and communities. | |
| | **S4** | Number of service delivery staff trained to deliver the interventions. | |
| **Primary Health Care services that can deliver** | **P1** | Number of Indigenous specific health services meeting national minimum standards. | **PHC:**<br>*Relevant indicators:*<br>Access to GPs, dental and primary health care professionals.<br>Proportion of diabetics with HbA1c below 7%.<br>Life expectancy (incl. gap b/w Indigenous & non-Indigenous).<br>Infant/young child mortality rate (incl. gap b/w Indigenous & non-Indigenous).<br>Potentially avoidable deaths.<br>Selected potentially preventable hospitalisations.<br>*Additional indicators:*<br>Time between GP/specialist visits.<br>Chronic disease management<br><br>**Sustainability:**<br>*Relevant indicators:*<br>Indigenous Australians in the health workforce.<br>*Additional indicators:*<br>Expenditure on health services (including mainstream vs. Indigenous -specific).<br>Aboriginal and Torres Strait Islander people in tertiary education for health related disciplines.<br>Recruitment and retention. |
| | **P2** | Number of Aboriginal and/or Torres Strait Islander people receiving a MBS Adult Health Check | |
| | **P3** | Number of new allied health professionals recruited. | |
| | **P4** | Increased effort to refocus own purpose outlays in primary care to prioritise core service provision and evidence-based Indigenous health regional priorities. | |
| | **P5** | Improved patient referral and recall for more effective health care, and in particular, chronic disease management. | |
| | **P6** | Improved/new IT systems operational to support interface between systems used in primary health care sector and other parts of the health system. | |
| | **P7** | Evidence of implementation of cultural competency frameworks across the applicable health workforce. | |
| **Fixing the gaps and improving the patient journey** | **F1** | Number of new case managers/ Indigenous liaison officers recruited and operational. | **Hospital and hospital-related care:**<br>*Relevant indicators:*<br>Waiting times for services.<br>Selected adverse events in acute and sub-acute care settings.<br>Unplanned/unexpected readmissions w/in 28 days of surgical admissions.<br>Survival of people diagnosed with cancer (5 year relative rate). |
| | **F2** | Number of culturally secure health education products and services to give Indigenous people skills and understanding of preventative health behaviours, and self management of some chronic health conditions. | |

| Priority Area | Key | Performance benchmarks | Performance indicators |
| --- | --- | --- | --- |
| | **F3** | Key results of strategies to improve cultural security of services and practice within public hospitals. | Rates of services provided for public and private hospitals per 1,000 weighted population by patient type.<br>*Additional indicators:*<br>Rates of discharge from hospital against medical advice.<br><br>**Patient experiences:**<br>*Relevant indicators:*<br>Access to services by type of service compared to need.<br>Nationally comparative information that indicates levels of patient satisfaction around key aspects of care they received.<br>*Additional indicators:*<br>Barriers to accessing care. |
| | **F4** | Increased percentage of Aboriginal and/or Torres Strait Islander people with a chronic disease with a care plan in place. | |
| | **F5** | Percentage of Aboriginal and Torres Strait Islander people participating in rehabilitation programs intended to reduce hospitalisation of people with chronic disease. | |
| | **F6** | Increased number of culturally appropriate transition care plans/procedures/best practice guidelines to reduce readmissions by (percentage/proportion). | |
| | **F7** | Improved quality of Aboriginal and Torres Strait Islander identification in key vitals and administrative datasets. | |
| **Healthy Transition to Adulthood** | **H1** | Number of additional health professionals (including drug/alcohol/mental health/outreach teams) recruited and operational in each 6 month period. | *Relevant indicators:*<br>Incidence/prevalence of important preventable diseases and injury.<br>Proportion of babies born of low birth weight.<br>Teenage birth rate.<br>Risk factor prevalence.<br>Immunisation rates for vaccines in the national schedule.<br>Cancer screening rates (breast, cervical, bowel).<br>Number of women with at least one antenatal visit in the first trimester of pregnancy.<br>*Additional indicators:*<br>Tobacco smoking during pregnancy.<br>Social and emotional well-being.<br>Health promotion. |
| | | | |
| **Making Aboriginal Health Everyone's Business** | | | *Relevant indicators:*<br>Incidence/prevalence of important preventable diseases and injury.<br>Proportion of babies born of low birth weight.<br>Teenage birth rate.<br>Risk factor prevalence.<br>Immunisation rates for vaccines in the national schedule.<br>Cancer screening rates (breast, cervical, bowel).<br>Number of women with at least one antenatal visit in the first trimester of pregnancy.<br>*Additional indicators:*<br>Tobacco smoking during pregnancy.<br>Social and emotional well-being.<br>Health promotion. |

# PRIORITY AREA: Tackle smoking

## Plan Period: July 2009 – June 2013

| What are we aiming to do? | How will we do it? | Why are we doing it? | Who will do it? | When will it be done? | How will we check progress? | What is the cost? |
|---|---|---|---|---|---|---|
| Improve life expectancy by reducing smoking related mortality<br><br>Advocate stronger regulation to prevent uptake and create other incentives to stop smoking.<br><br>Encourage Aboriginal individuals, families and communities to pursue substance abuse reduction as a health goal | New alcohol and other drug intervention and treatment programmes<br><br>Increase access to Nicotine Replacement Treatment<br><br>Establish and implement a non-smoking policy in Hospitals/ Health /Community Centre<br><br>Strengthen regulatory effort to support changes to social and cultural norms<br><br>Provide a more diverse range of culturally appropriate smoking cessation services that are proactive in engaging clients when they are most receptive to health messages.<br><br>Increase support for NGOs, community, sporting and cultural institutions through provision of grants to support the social marketing effort.<br><br>Develop researched and targeted social marketing tools and initiatives that build resilience at an individual, family and community level | Tobacco smoking is responsible for 12.1% of the total burden of disease and 20% of Aboriginal deaths<br><br>52% of Aboriginal and Torres Strait Islander mothers smoke during pregnancy.<br><br>Tobacco smoking directly causes a third of all the cancer and cardiovascular disease burden<br><br>Stronger prevention measures through the expansion of culturally appropriate education campaigns and resources specifically targeting school aged students<br><br>Half of all Aboriginal and Torres Strait Islander adults are smokers<br><br>Values triggers will inform the development of a targeted package of prevention and intervention strategies.<br><br>Research suggests that an approach that pursues cessation of both smoking and alcohol use has merit as a clinical strategy. | Aboriginal Policy Branch (NT DHF) will facilitate coordination across DHF's Divisions.<br><br>NTAHF will be the body to coordinate across various elements of the CTG NP.<br><br>Include CTG NP as a standing item at Forum meetings.<br><br>NATSIHON include CTG NP as a standing agenda item to discuss progress on reforms, sharing of information and development of solutions.<br><br>See Attachment A for operational arrangements | **Over the life of the agreement.** | **S1** Number and key results of culturally secure community education/ health promotion/ social marketing activities to promote quitting and smoke-free environments<br><br>**S2** Key results of specific evidence based Aboriginal and Torres Strait Islander brief interventions, other smoking cessation and support initiatives offered to individuals<br><br>**S3** Evidence of implementation of regulatory efforts to encourage reduction/ cessation in smoking in Aboriginal and Torres Strait Islander people and communities.<br><br>**S4** Number of service delivery staff trained to deliver the interventions. | **Costings are consolidated**<br><br>Yr 09/10<br>$558,360<br><br>Yr 10/11<br>$573,540<br><br>Yr 11/12<br>$588,720<br><br>Yr 12/13<br>$603,900<br><br>**Total:**<br>**$2,324,520** |

# PRIORITY AREA: Tackle smoking

## Joint Initiatives.

| What are we aiming to do? | How will we do it? | Why are we doing it? | Who will do it? | When will it be done? | How will we check progress? | What is the cost? |
|---|---|---|---|---|---|---|
| Reduce the Indigenous smoking rate and the burden of tobacco related chronic disease for Indigenous communities. (Joint Initiative) *This initiative will be implemented in partnership with the Commonwealth government measure (A1) and the Northern Territory Government initiatives.* | Northern Territory Government to work with the Commonwealth and NGOs to:<br>▪ Establish a national network of tobacco action coordinators.<br>▪ Implement local strategies including media placement.<br>▪ Consult and engage with local communities.<br>▪ Sponsor community events and establish quit smoking role models and ambassadors.<br>▪ Provide workforce training and support units.<br>▪ Enhance Quitline to provide culturally sensitive services.<br>▪ Train health and community workers to deliver tobacco action programs.<br>▪ Implement targeted tobacco cessation programs. | If the smoking rate among Indigenous Australians was reduced to the rate of the non-Indigenous population, the overall Indigenous burden of disease would fall by around 6.5%, and save around 420 Indigenous lives per year. This equates to an additional four extra years of life expectancy.<br><br>Evidence from New Zealand in reducing Maori smoking rates and national formative research commissioned under the Indigenous Tobacco Control Initiative will inform this priority area. | Northern Territory Government in partnership with Mental Health and Chronic Disease Division and Business Group (DoHA), Indigenous and non-Indigenous health and community organisations. | **2009-10:**<br>Partnership, program and funding arrangements agreed with Commonwealth.<br><br>Refer to Commonwealth implementation plan for detail. | The following benchmarks will be part of the Australian Government Performance Measures<br><br>**Benchmark: S1**<br>*Measurement*: Number of tobacco action coordinators.<br><br>*Measurement*: Number of Indigenous participants in smoking cessation and support activities.<br><br>**Benchmark: S4**<br>*Measurement*: Number of health workers and community educators trained in smoking cessation | This measure will be funded by the Australian Government. |

# PRIORITY AREA: Tackle smoking

| What are we aiming to do? | How will we do it? | Why are we doing it? | Who will do it? | When will it be done? | How will we check progress? | What is the cost? |
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| Assist Indigenous Australians to reduce their risk of chronic disease and better manage their conditions and lifestyle risk factors through the adoption of healthy lifestyle choices (A2).<br><br>Joint initiative with Australian and Territory governments.<br><br>This element forms a continuum with *Helping Indigenous Australians improve their self management of established chronic disease* (B4) to effectively reduce the impact chronic disease. | Northern Territory Government to work with the Commonwealth and NGOs to:<br><br>Recruit and train over 100 (Nationally) Indigenous healthy lifestyle workers to deliver activities and programs that target the key lifestyle contributors to chronic disease.<br><br>Deliver lifestyle risk reduction sessions to 25,000 (Nationally) individuals and families, particularly targeting those who are considered to be at high risk of developing a chronic disease. | Many chronic diseases can be prevented or delayed through intervention, effective management and lifestyle change.[1].<br><br>Access to affordable chronic disease lifestyle risk reduction programs is a barrier to good health outcomes for Indigenous Australians. Significant ongoing personalised support is needed to encourage self management of lifestyle risk factors and prevent chronic disease.[2]. | Northern Territory Government in partnership with Mental Health and Chronic Disease Division (DoHA), Indigenous and non-Indigenous health and community organisations. | **2009-10:**<br>Partnership, program and funding arrangements agreed with Commonwealth.<br><br>Refer to Commonwealth implementation plan for detail. | *Measurement*:<br>Number of healthy lifestyle workers funded and trained.<br><br>Number of healthy lifestyle sessions and activities conducted.<br><br>Number of participants in healthy lifestyle sessions and activities.<br><br>**Benchmark: S4**<br>*Measurement*:<br>Number of healthy lifestyle workers funded and trained. | This measure will be funded by the Commonwealth. |
| Improve Indigenous Australians' awareness of, and access to, health measures to better promote their health and wellbeing. *This initiative will be implemented in partnership with the Commonwealth government measure (A3) and the* Northern Territory Government *initiative.* | Northern Territory Government to work with the Commonwealth and NGOs to:<br><br>Partner with communities to develop local-level information and communication activities.<br><br>Implement local strategies, including media placement. | The World Health Organization's Ottawa charter recommends a five pronged approach for health promotion, including public awareness campaigns.[3]<br><br>Health promotion is an important factor in reducing risk factors at the population level.[4] | Northern Territory Government in partnership with Business Group (DoHA), Indigenous and non-Indigenous health and community organisations. | **2009-10:**<br>Partnership, program and funding arrangements agreed with Commonwealth.<br><br>Refer to Commonwealth implementation plan for detail. | **Benchmark: S1**<br>*Measurement*:<br>Number and type of targeted activities undertaken<br><br>Number and type culturally appropriate information resources develop<br><br>Description of dissemination of information undertaken. | This measure will be funded by the Commonwealth. |

# PRIORITY AREA: Tackle smoking

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| Support Indigenous Australians to better manage or self-manage their chronic disease. *This initiative will be implemented in partnership with the Commonwealth government measure (B4) and the Northern Territory Government initiative.* This element forms a continuum with *Assisting Indigenous Australians to reduce their risk of chronic disease and better manage their conditions and lifestyle risk factors through the adoption of healthy lifestyle choices (A2)* to effectively reduce the impact of chronic disease. | Northern Territory Government to work with the Commonwealth and NGOs to:<br><br>Fund the delivery of 400 (nationally) healthy lifestyle/self management workforce training programs.<br><br>The training will provide the competency-based skills appropriate to support lifestyle change and self management skills in Aboriginal and Torres Strait Islander people who have established chronic disease or who are at risk of developing a chronic disease.<br><br>The trained workforce will deliver sessions and activities to 50,000 (nationally) Indigenous individuals and families with established chronic disease or who are at high risk of developing a chronic disease. | Many chronic diseases can be prevented and its progressed delayed through intervention, effective management and lifestyle change.[5].<br><br>Access to affordable chronic disease risk reduction/self management programs is a barrier to good health outcomes for Indigenous Australians. Significant ongoing personalised support is needed to encourage self management of lifestyle risk factors to prevent chronic disease or to slow its progression.[6]. | Northern Territory Government in partnership with Mental Health and Chronic Disease Division (DoHA), Indigenous and non-Indigenous health and community organisations. | **2009-10:**<br>Partnership, program and funding arrangements agreed with Commonwealth.<br><br>Refer to Commonwealth implementation plan for detail. | **Benchmark: P5**<br>*Measurement*:<br>Number of workers provided with training on supporting healthy lifestyle change and self management.<br><br>Number of participants, activities and sessions. | This measure will be funded by the Commonwealth. |

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| **Internal Governance and Management** | NT DHF will coordinate and manage the implementation of this plan in this Priority Area through an overarching internal coordination committee. The group will comprise of Departmental officers (Chair System Performance and Aboriginal Policy, Health Services Division, Health Protection, Acute Care Services Division and Families and Children Division) who will meet regularly to ensure effective internal coordination, monitoring and reporting. |
| **Linkages and Coordination** | The NT Aboriginal Health Forum (NTAHF) will provide advice on priorities and opportunities for integrated activity at regional and Territory wide levels. Membership of the NTAHF currently includes Commonwealth, state and territory government and the Aboriginal community controlled health sector.<br>Coordination across governments will be provided through existing government arrangements, including the engagement with Australian governments through NATISHON, AHMAC and AHMC. |
| **Community/ Stakeholder Involvement** | Aboriginal Territorians will be involved in the development, implementation and monitoring of the Tackle Smoking initiatives through participation in technical reference groups as required advising on the development and implementation of initiatives under this priority area. Membership will include representatives of Aboriginal and non-Aboriginal health organisations, subject matter experts. Aboriginal community participation is also promoted through the engagement of the NTAHF. |

# PRIORITY AREA: Tackle smoking

[1] Lorig, K and Holman, H. *Patient self-management: a key to effectiveness and efficiency in care of chronic disease.* Public Health Rep, 2004 119(3).
[1] Lorig, K and Holman, H. *Patient self-management: a key to effectiveness and efficiency in care of chronic disease.* Public Health Rep, 2004 119(3).
[1] Laugesen M, Swinburn B, New Zealand's tobacco control programme 1985-1998, *Tobacco Control* 2000, 9: 155-162
[1] Commonwealth of Australia 2007. *Changing Behaviour: A Pubic Policy perspective.*
[1] Lorig, K and Holman, H. *Patient self-management: a key to effectiveness and efficiency in care of chronic disease.* Public Health Rep, 2004 119(3).
[1] Lorig, K and Holman, H. *Patient self-management: a key to effectiveness and efficiency in care of chronic disease.* Public Health Rep, 2004 119(3).
[1] Lorig, K and Holman, H. *Patient self-management: a key to effectiveness and efficiency in care of chronic disease.* Public Health Rep, 2004 119(3).
[1] Lorig, K and Holman, H. *Patient self-management: a key to effectiveness and efficiency in care of chronic disease.* Public Health Rep, 2004 119(3).
[1] Laugesen M, Swinburn B, New Zealand's tobacco control programme 1985-1998, *Tobacco Control* 2000, 9: 155-162
[1] Commonwealth of Australia 2007. *Changing Behaviour: A Pubic Policy perspective.*
[1] Lorig, K and Holman, H. *Patient self-management: a key to effectiveness and efficiency in care of chronic disease.* Public Health Rep, 2004 119(3).
[1] Lorig, K and Holman, H. Patient self-management: a key to effectiveness and efficiency in care of chronic disease. Public Health Rep, 2004 119(3).

# PRIORITY AREA: Primary health care services that can deliver

**Plan Period: July 2009 – June 2013**

| What are we aiming to do? | How will we do it? | Why are we doing it? | Who will do it? | When will it be done? | How will we check progress? | What is the cost? |
|---|---|---|---|---|---|---|
| Secure improvement in life expectancy and quality of life for Aboriginal Territorians.<br><br>Ensure effective and efficient deployment of available staffing resources.<br><br>Build an integrated platform of services shared by public and NGO providers that more effectively delivers outcomes across the lifecourse.<br><br>Improve Aboriginal and Torres Strait Islander engagement in health policy development, delivery and evaluation. | Develop, adopt and monitor compliance against an agreed set of Core Services that promote best opportunity for health development, treatment, recovery, maintenance and gain across the lifecourse. See Attachment E<br><br>Improve access to quality PHC through improved coordination across the care continuum<br><br>Contribute to increased uptake of best practice standards and CQI.<br><br>Electronic linking of PHC centres to ensure quality control, best practice and efficient care.<br><br>Pursue staff training and support appropriate to the maintenance of core services competence.<br>Development of multi-disciplinary team approach at a local and regional level<br><br>Enhance PATS Scheme<br><br>Build an integrated Eye Health Program<br><br>Increase child ear health programme. | Evidence shows that how people's life unfolds across time is influenced by whether or not they are born and live in a family and community that is capable, whether they have access to health and family development services at the right time throughout their lives.<br><br>Research has shown that culture and the social behaviours surrounding it influence Aboriginal peoples' decisions about when and why they should seek services, their acceptance or rejection of treatment, the likelihood of adherence to recommendations and follow up and the likely success of health prevention and health promotion strategies, the clients assessment of the quality of care and their views about the facility and staff providing care.<br><br>Research demonstrates that remote and rural Territorians access MBS services at a lower level that other Australians and significantly less than health needs indicate.<br><br>Research demonstrates that community engagement has the potential to improve the quality of services supplied and also improve the opportunities and capability of those who rely on services, so lessening their need for them. | Programme Divisions will implement relevant improvements.<br><br>Community Midwifery Programme<br>(See Attachment B)<br><br>Disability services programme<br><br>Remote Health and Centre for Disease Control will expand programmes targeting chronic disease<br><br>Health Services and Families and Children's Services Divisions will jointly expand child safety and wellbeing staff and program integration.<br><br>Aboriginal Policy Branch (NT DHF) will facilitate coordination across DHF Divisions.<br><br>NTAHF will coordinate across the sector to strengthen various elements of the CTG NP. Include CTG NP as a standing item at Forum meetings.<br><br>NATSIHON include CTG NP as a standing agenda item to discuss progress on reforms, sharing of information and development of solutions. | **Over the life of the agreement.** | **P1** Number of Indigenous specific health services meeting national minimum standards<br><br>**P2** Number of Aboriginal and/or Torres Strait Islander people receiving a MBS Adult Health Check<br><br>**P3** Number of new allied health professionals recruited<br><br>**P4** Increased effort to refocus own purpose outlays in primary care to prioritise core service provision and evidence-based Indigenous health regional priorities.<br><br>**P5** Improved patient referral and recall for more effective health care and in particular, chronic disease management.<br><br>**P6** Improved/new IT systems operational to support interface between systems used in primary health care sector and other parts of the health system. | **Costings are consolidated**<br><br>Yr 09/10 $ $15,979,248<br><br>Yr 10/11 $16,761,272<br><br>Yr 11/12 $19,797,271<br><br>Yr 12/13 $20,307,739<br><br>**Total $72,845,530** |

# PRIORITY AREA: Primary health care services that can deliver

| What are we aiming to do? | How will we do it? | Why are we doing it? | Who will do it? | When will it be done? | How will we check progress? | What is the cost? |
|---|---|---|---|---|---|---|
| | Improve medical evacuation services for Aboriginal people outside major service centres<br><br>Implementation of Cultural Security policy<br><br>Implementation of Pathways to Community Control Framework. | | | | **P7** Evidence of implementation of cultural competency frameworks across the applicable health workforce<br><br>Number of cultural secure initiatives successfully implemented<br><br>Establishment of measures and benchmarking of cultural competence of the PHC workforce | |
| **Internal Governance and Management** | NT DHF will coordinate and manage the implementation of this plan in this Priority Area through an overarching internal coordination committee. The group will comprise and Families and Children Division) who will meet regularly to ensure effective internal coordination, monitoring and reporting. | | | | | |
| **Linkages and Coordination** | The NT Aboriginal Health Forum (NTAHF) will provide advice on priorities and opportunities for integrated activity at regional and Territory wide levels. Membership of the NTAHF currently includes Commonwealth and Territory government and the Aboriginal community controlled health sector.<br>Coordination across governments will be provided through existing government arrangements, including the engagement with Australian governments through NATISHON, AHMAC and AHMC. | | | | | |
| **Community/ Stakeholder Involvement** | Aboriginal Territorians will be involved in the development, implementation and monitoring of the Tackle Smoking initiatives through participation in technical reference groups as required advising on the development and implementation of initiatives under this priority area. Membership will include representatives of Aboriginal and non-Aboriginal health organisations, subject matter experts. Aboriginal community participation is also promoted through the engagement of the NTAHF. | | | | | |

# PRIORITY AREA: Fixing the gaps and improving the patient journey

**Plan Period: July 2009 – June 2013**

| What are we aiming to do? | How will we do it? | Why are we doing it? | Who will do it? | When will it be done? | How will we check progress? | What is the cost? |
|---|---|---|---|---|---|---|
| To improve the efficacy of health and wellbeing interventions involving transition between levels of care and locations of service.<br><br>To improve outcomes associated with cases involving referral services.<br><br>To improve the patient's perspective and experience of the quality and effectiveness of interventions involving transition.<br><br>To improve staff satisfaction with services provided to referred clients.<br><br>To improve the morbidity and mortality outcomes for clients that requires more complex or referral services away from their community.<br><br>To improve the cultural security of services that involves care or service away from the client's community | Increase compliance, fewer people not presenting for services, and decrease discharge against medical advice. Implement Cultural Security initiatives. See Attachment F<br><br>Increase the patient's awareness and understanding of treatments and procedures. Attachment C<br><br>Increase the capacity of hospitals to accommodate expected increase in admissions from better PHC<br><br>Improve specialist services (ENT Cardiac) to remote areas of NT by improving coordination and appropriateness of services.<br>See Attachment D<br><br>Introduce culturally secure admission and discharge processes for Aboriginal clients the NT health system. Attachment F<br><br>Improve level of engagement between Aboriginal patients, referred care providers and primary level providers to deliver better follow up and referral outcomes. Attachment F<br><br>Improve coordinate of access (transport, accommodation, appointments, follow-up care etc), coordinating the transfer of patient information between providers<br><br>Expand 'Hospital in Home' | In the NT the unadjusted costs associated with discharge against medical advice (DAMA) were estimated at $38m over 5 years.<br><br>Coronial findings point to areas requiring improvement in the patient journey.<br><br>Research has shown that culture and the social behaviours surrounding it influence Aboriginal peoples' decisions about when and why they should seek services, their acceptance or rejection of treatment, the likelihood of adherence to recommendations and follow up and the likely success of health prevention and health promotion strategies, the clients assessment of the quality of care and their views about the facility and staff providing care.<br><br>Research has shown that improving communication between levels of care including the assigning of specific responsibilities about patient needs in an organised manner can lead to improvements in outcomes.<br><br>Research shows that | Primary and referral level staff will reform primary and secondary care services to effectively engage with and support new service models.<br><br>Operational Divisions will take on specific tasks including:<br><br>Acute Care: DAMA, implementation of cultural security elements, adoption of improved discharge and admission protocols.<br><br>Health Services: improve patient journey though implementation of improved communication arrangements.<br><br>Families and Children: improved engagement with at risk clients and specific trial new approach to improve co-ordination of services across traditional lines at a family level<br><br>Corporate Reporting branch will establish | **Over the life of the agreement.** | **F1** Number of new case managers/ Indigenous Liaison Officers recruited and operational.<br><br>**F2** Number of culturally secure health education products and services to give Indigenous people skills and understanding of preventative health behaviours, and self management of some chronic health conditions.<br><br>**F3** Key results of strategies to improve cultural security of services and practice within public hospitals.<br><br>**F4** Increased percentage of Aboriginal and/or Torres Strait Islander people with a chronic disease with a care plan in place.<br><br>**F5** Percentage of Aboriginal and Torres Strait Islander people participating in rehabilitation programs intended to reduce hospitalisation of people with chronic disease.<br><br>**F6** Increased number of culturally appropriate transition care plans/procedures/best | **Costings are consolidated**<br><br>Yr 09/10<br>$8,217,621<br><br>Yr 10/11<br>$8,258,542<br><br>Yr 11/12<br>$17,026,050<br><br>Yr 12/13<br>$17,465,063<br><br>**Total: $50,967,275** |

# PRIORITY AREA: Fixing the gaps and improving the patient journey

| What are we aiming to do? | How will we do it? | Why are we doing it? | Who will do it? | When will it be done? | How will we check progress? | What is the cost? |
|---|---|---|---|---|---|---|
| | programme in selected urban areas.<br><br>Implement the approved outcomes from the Cultural Security Territory wide consultations and negotiations in areas relevant to the patient journey, by reducing the barriers, addressing gaps in knowledge or systems' operations. | minorities use referral services at lower rates than others and that this lower rate is in part attributable to provider and client communication issues, preferences, systems orientation and previous experience. | and monitor the implementation of the CTG NP arrangements across the agency and provide a centralised reporting mechanism. Aboriginal Policy Branch (NT DHF) will facilitate coordination within DHF.<br><br>NTAHF will be the body to coordinate across various elements of the CTG NP. To include CTG NP as a standing item at Forum meetings.<br><br>NATSIHON include CTG NP as a standing agenda item to discuss progress on reforms, sharing of information and development of solutions. | | practice guidelines to reduce readmissions by (percentage/proportion).<br><br>**F7** Improved quality of Aboriginal and Torres Strait Islander identification in key vitals and administrative datasets<br><br>Number of Did Not Show (DNS) in Outpatients and for other referral services<br><br>Quality of Aboriginal and Torres Strait Islander identification in key vitals and administrative datasets<br><br>Percentage of people participating in rehabilitation programs intended to reduce hospitalisation of people with chronic disease | |
| **Internal Governance and Management** | NT DHF will coordinate and manage the implementation of this plan in this Priority Area through an overarching internal coordination committee. The group will comprise of Departmental officers (Chair System Performance and Aboriginal Policy, Health Services Division, Health Protection, Acute Care Services Division and Families and Children Division) who will meet regularly to ensure effective internal coordination, monitoring and reporting. | | | | | |
| **Linkages and Coordination** | The NT Aboriginal Health Forum (NTAHF) will provide advice on priorities and opportunities for integrated activity at regional and Territory wide levels. Membership of the NTAHF currently includes Commonwealth and Territory government and the Aboriginal community controlled health sector. Coordination across governments will be provided through existing government arrangements, including the engagement with Australian governments through NATISHON, AHMAC and AHMC. | | | | | |
| **Community/ Stakeholder Involvement** | Aboriginal Territorians will be involved in the development, implementation and monitoring of the Tackle Smoking initiatives through participation in technical reference groups as required advising on the development and implementation of initiatives under this priority area. Membership will include representatives of Aboriginal and non-Aboriginal health organisations, subject matter experts. Aboriginal community participation is also promoted through the engagement of the NTAHF. | | | | | |

# PRIORITY AREA: Healthy transition to adulthood

**Plan Period: July 2009 – June 2013**

| What are we aiming to do? | How will we do it? | Why are we doing it? | Who will do it? | When will it be done? | How will we check progress? | What is the cost? |
|---|---|---|---|---|---|---|
| Reduce morbidity and mortality by reducing risk taking and improving health promoting behaviour in adolescents particularly Aboriginal men.<br><br>Improve the efficacy of intersectoral efforts for this group of young Territorians by linking institutional settings such as school, family, training and employment settings.<br><br>Reduce the onset of chronic disease and other health risks/conditions by improving the clinical and other service platforms addressing health and development issues for young Aboriginal and Torres Strait Islander Territorians.<br><br>Improve the health and development settings and environment for young people especially Aboriginal men. | Promote school and juvenile justice settings as health promoting institutions.<br><br>Expand and integrate mental health and substance use services particularly for this age group.<br><br>Establish effective and value forming initiatives through peer modelling leadership and engagement with cultural and other valued social institutions.<br><br>Improve the network of family based and other treatment, rehabilitation and support services for alcohol and drug related abuse.<br><br>Provide appropriate services and facilities for young people with complex needs | This is the period in life when most risk taking behaviours form as youth; particularly males disengage from their communities and other support structures such as government services.<br><br>For females aged from 15 to 24 the most common reason for admission was a pregnancy related condition.<br><br>In NT, 42.2% Aboriginal males complete Year 12 compared to non Aboriginal counterparts at 70.9%. For females 41.5% and their non Aboriginal counterparts at 79.0%.<br><br>For males and females aged from 5 to 24 years the most common reason for hospital admissions was injury and poisoning.<br><br>Undertake research to elicit the drivers and inhibitors affecting your peoples risk taking behaviours and apply it to program design and evaluation | DHF Operational Divisions will pursue specific strategies.<br><br>Aboriginal Policy Branch (NT DHF) will facilitate coordination within DHF's Divisions.<br><br>NTAHF will be the body to coordinate across various elements of the CTG NP. To include CTG NP as a standing item at Forum meetings.<br><br>NATSIHON include CTG NP as a standing agenda item to discuss progress on reforms, sharing of information and development of solutions.<br><br>Corporate Reporting branch will establish and monitor the implementation of the CTG NP arrangements across the agency and provide a centralised reporting mechanism | **Over the life of the agreement.** | **H1** Number of additional health professionals (including drug/alcohol/mental health/outreach teams) recruited and operational in each 6 month period.<br><br>Hospital separation rates for injury including force, violence, by Aboriginal and non Aboriginal status; (AIHW) 15-24 year old<br><br>Internal performance measures will be utilised and reported on using the normal reporting mechanisms.<br><br>Rates of sexually transmissible infections<br><br>Excess mortality and morbidity among Aboriginal men<br><br>NTAHF - Report on quality improvement systems including the use of best practice guidelines<br><br>Homicide death rate by Aboriginal status and age -15-24 years old group (ABS unpublished ROGS Indigenous Compendium) | **Costings are consolidated**<br><br>Yr 09/10 $7,374,476<br><br>Yr 10/11 $11,507,624<br><br>Yr 11/12 $9,008,085<br><br>Yr 12/13 $9,240,356<br><br>**Total: $37,130,541** |

# PRIORITY AREA: Healthy transition to adulthood

| | |
|---|---|
| **Internal Governance and Management** | NT DHF will coordinate and manage the implementation of this plan in this Priority Area through an overarching internal coordination committee. The group will comprise of Departmental officers (Chair System Performance and Aboriginal Policy, Health Services Division, Health Protection, Acute Care Services Division and Families and Children Division) who will meet regularly to ensure effective internal coordination, monitoring and reporting. |
| **Linkages and Coordination** | The NT Aboriginal Health Forum (NTAHF) will provide advice on priorities and opportunities for integrated activity at regional and Territory wide levels. Membership of the NTAHF currently includes Commonwealth and Territory government and the Aboriginal community controlled health sector. Coordination across governments will be provided through existing government arrangements, including the engagement with Australian governments through NATISHON, AHMAC and AHMC. |
| **Community/ Stakeholder Involvement** | Aboriginal Territorians will be involved in the development, implementation and monitoring of the Tackle Smoking initiatives through participation in technical reference groups as required advising on the development and implementation of initiatives under this priority area. Membership will include representatives of Aboriginal and non-Aboriginal health organisations, subject matter experts. Aboriginal community participation is also promoted through the engagement of the NTAHF. |

# **PRIORITY AREA:** Making Aboriginal Health Everyone's Business

Plan Period: July 2009 – June 2013

| What are we aiming to do? | How will we do it? | Why are we doing it? | Who will do it? | When will it be done? | How will we check progress? | What is the cost? |
|---|---|---|---|---|---|---|
| Reduce mortality among disenfranchised Aboriginal families and individuals.<br><br>Improve the efficacy of intersectoral efforts for this group of Aboriginal Territorians by linking institutional settings such as school, family, training and employment settings.<br><br>Improve the efficacy of services accessible by this group of Territorians | Create programs and services that significantly improve the contribution from social and cultural institutions to prevention and health promotion outcomes. Attachment F<br><br>Improve the detection and engagement with disenfranchised Aboriginal families and individuals through improved intersectoral networks.<br><br>Develop and implement programmes to improve the capability of social and cultural institutions to become health promoting institutions<br><br>Improved multi-agency/programme and intersectoral collaboration and coordination to meet the needs of families and communities.<br><br>Develop specific strategies that target people disengaged from health system | Research has shown that the determinants of ill health found in other sectors make significant contribution to ill health and premature death.<br>Research shows that reform of non health public sector institution to adopt a health promoting policy and service framework can have a significant impact on disease rates and mortality outcomes as well as contributing to outcomes<br>Research has shown that targeted strategies addressing the lack of co-ordination for the most disenfranchised members of the community can produce significant outcomes for this group.<br>Research has shown that case coordination for high needs families can produce effective outcomes and a substantial | DHF operational Divisions will undertake specific related strategies.<br>Aboriginal Policy Branch (NT DHF) will facilitate coordination within DHF' Divisions.<br>NTAHF will be the body to coordinate across various elements of the CTG NP. To include CTG NP as a standing item at Forum meetings.<br>NATSIHON include NP as a standing agenda item to discuss progress on reforms, sharing of information and development of solutions.<br>Corporate Reporting branch will establish and monitor the implementation of the CTG NP arrangements across the agency and provide a centralised reporting mechanism | **Over the life of the agreement.** | Expansion of sexual assault services completed<br><br>Number of occasions of service<br><br>Frequency and compliance of identified families with the planned services<br><br>Fewer unplanned emergency deliveries among Aboriginal women<br><br>Other indicators currently being developed | **Costings are consolidated**<br><br>Yr 09/10 $2,569,725<br><br>Yr 10/11 $2,932,875<br><br>Yr 11/12 $3,411,900<br><br>Yr 12/13 $3,499,875<br><br>**Total: $12,414,375** |

| | |
|---|---|
| **Internal Governance and Management** | NT DHF will coordinate and manage the implementation of this plan in this Priority Area through an overarching internal coordination committee. The group will comprise of Departmental officers (Chair System Performance and Aboriginal Policy, Health Services Division, Health Protection, Acute Care Services Division and Families and Children Division) who will meet regularly to ensure effective internal coordination, monitoring and reporting. |
| **Linkages and Coordination** | The NT Aboriginal Health Forum (NTAHF) will provide advice on priorities and opportunities for integrated activity at regional and Territory wide levels. Membership of the NTAHF currently includes Commonwealth and Territory government and the Aboriginal community controlled health sector. Coordination across governments will be provided through existing government arrangements, including the engagement with Australian governments through NATISHON, AHMAC and AHMC. |
| **Community/ Stakeholder Involvement** | Aboriginal Territorians will be involved in the development, implementation and monitoring of the Tackle Smoking initiatives through participation in technical reference groups as required advising on the development and implementation of initiatives under this priority area. Membership will include representatives of Aboriginal and non-Aboriginal health organisations, subject matter experts. Aboriginal community participation is also promoted through the engagement of NTAHF. |

## RISK MANAGEMENT

Risk in the Agency is assessed using a tool that considers both a five-point scale assessing consequence and a five-point scale assessing likelihood of occurrence. These two factors are combined to determine risk rating.

(Risk assessment is incomplete at this stage)

**Risk identification and control**

| Risk | Risk rating | Origin/cause/source of risk and trigger point for deploying strategies | Risk mitigation/control strategies |
|---|---|---|---|
| Failure of deliver optimal allocative efficiency across NTG and AG decision making | Medium | Failure of joint planning to conclude successfully<br><br>Failure of co-ordination of implementation | Maintain evidenced based approach to bilateral discussions<br><br>Maintain a flexible approach to implementation within approved parameters.<br><br>Be prepared to seek modification of NTG and AG position where appropriate<br><br>Maintain sound monitoring of inputs and outputs |
| CTG NP Implementation conflicts with existing EHSDI reforms | Low | Potential for conflict emerges | Establish clear association between reform agendas and use the existing EHSDI platform as basis for implementation |
| Ensure appropriate and timely performance | Medium | Risk emerges when the following are unplanned or inadequately monitored:<br><br>Specific Outcomes:<br>• Output specific with links to Cost Codes<br>• Specific PI outputs<br>• Monitor outcomes<br>• Regular reports between NTG, AG and Executive Leadership Group | Measuring of outcomes; output measures will need to be developed. Specific activities included in the Business Plans and that they are measured. A focus on gaining baseline information/data and then ensure there is measuring and reporting occurs. |

## REVIEW AND EVALUATION

The implementation of the NP will:

- Provide new priority services to Territory towns and remote communities, contributing to gains in health, family violence, alcohol abuse, offending, smoking and social order outcomes;
- Provide tangible evidence of the NT partnership with the AG;
- Provide tangible demonstration of the NT partnership with Aboriginal Territorians;
- Establish new targeted efforts to engage and improve outcomes for Aboriginal men, including the key areas of antisocial behaviour, family violence and child protection;
- Establish highly targeted services to identify and work with disengaged dysfunctional families and individuals to improve social, household and personal order and capability;
- Remedies identified gaps and improve coordination of the patient journey, including the cultural security of Aboriginal patients.

This integrated model requires clear measurement of commitments under the CTG NP. The DHF will put in place specific new arrangements to manage these accountabilities based on use of performance benchmarks, clear outputs specification and measurement. Performance frameworks, centralised management of key performance data and reporting responsibilities under the NP will be established.

## KEY PERFORMANCE INDICATORS

As mentioned previously, a range of indicators will be used in the monitoring of this CTG NP. These will be drawn (inter alia) from the Northern Territory Key Performance Indicators, Aboriginal and Torres Strait Islander Health Performance Framework and the HAWG Aboriginal Health Sub Committee work. An agreed subset of these sets of indicators will be used in monitoring the implementation plan. The process for identifying the final Performance Indicator regime will involve AMSANT and other relevant internal stakeholders.

Following are the agreed Northern Territory Key Performance Indicators; all members of the NTAHF have agreed and endorsed them:

**Domain 1: Health Services**

**1.** Number of episodes of health care and client contacts.

**2.** Timing of first antenatal visit for regular clients delivering Aboriginal babies.

**3.** Number and proportion of low, normal and high birth weight Aboriginal babies.

**4.** Number and proportion of Aboriginal children fully immunised at 1, 2 and 6 years of age.

**5.** Number and proportion of children less than 5 years of age who are underweight.

**6.** Number and proportion of children between 6 months and 5 years of age who are anaemic.

**7.** Number and proportion of clients aged 15 years and over with Type II Diabetes and/or Coronary Heart Disease who have a chronic disease management plan.

**8.** Number and proportion of resident clients aged 15 years and over with Type II Diabetes who have had an HbAIc test in the last 6 months.

**9.** Number and proportion of diabetic patients with albuminuria who are on ACE inhibitor and/or ARB.

**10.** Number and proportion of Aboriginal clients aged 15 to 55 years who have had a full adult health check.

**11.** Number and proportion of Aboriginal clients aged 55 years and over who have had a full adult health check in the past 12 months.

**12.** Number and proportion of women who have had at least one PAP test during reporting period.

**Domain 2: Management and Support Services**

**13.** Report on unplanned staff turnover (where possible by occupation) over each 12 month period.

**14.** Report on recruits (excluding locums) completing an orientation and induction program, including cultural awareness.

**15.** Report on overtime workload.

**16.** Report on quality improvement systems including the use of best practice guidelines; eg CARPA.

**Domain 3: Linkages, Policy and Advocacy**

**17.** Report on service activities (position papers, collaborative meetings and services, published papers, policy submissions, participative research).

**Domain 4: Community Involvement**

**18.** Report on community involvement in determining health priorities and strategic directions through any of the following: health boards; steering committees; advisory committees; community councils; health councils.

**19.** Show evidence of appropriate reporting to community on progress against core PIs.

## Attachment A: Remote Tobacco Cessation Project

The Project aims to deliver smoking cessation and education services in remote communities through a dedicated team of cessation workers that will deliver targeted education, brief intervention and cessation services in remote communities.

The Project will:

- Identify smoking cessation needs within individual remote Aboriginal communities,
- Work with communities using a community development framework increase community knowledge about smoking related harm and to develop a response to the high levels of smoking within remote Aboriginal communities,
- Adapt best practice Brief Intervention Resources for use in Northern Territory Communities, and
- Deliver brief interventions to smokers in remote Aboriginal communities Provide a link with hospital based smoking cessation interventions for patients/ clients going to hospital; and
- In line with the new DHF smoke-free Policy, provide seamless continuation of cessation support for patients/ clients leaving hospital and returning to their community.

### Governance

The Project will be auspiced by the Alcohol and Other Drugs Program. A Working Group will be convened to ensure linkages with chronic disease management and prevention initiatives and hospital-based interventions for tobacco across the DHF. The following branches will be invited onto the working group:

  - Alcohol and Other Drugs Program
  - Preventable Chronic Diseases
  - Acute Care
  - Remote Health
  - Health Promotion Strategy Unit

## Attachment B: Integrated continuity of care for pregnant women

To create an integrated, quality and sustainable service delivery model for improving the continuity of care for remote women, and subsequent birth outcomes, using a Midwifery Group Practice (MGP) model. The model will provide antenatal, birthing and postnatal services, in collaboration with other maternity service providers, for women from remote areas for the time they are in town. Each woman will be assigned a primary midwife who will work closely with an AHW to provide individualised continuity of care.

The expected outcomes of this model include:

- Increased antenatal education available for remote women with a particular emphasis on young women and first-time mothers.
- Improved cultural security for women accessing this service.
- A reduction in the number of remote women missing appointments (due to better communication with remote and ANC, transport arranged).
- Fewer ANC appointments required at the outpatient department, reducing current waiting times, as majority of care provided by assigned midwife and AHW.
- With Group Practice Midwives providing the majority of care, we could expect to see better streamlining and throughput between services, with women being seen by an Obstetric Registrar or specialist only as required and not routinely, resulting in better use of specialist services.
- Access to the Birth Centre (only applicable in Darwin) for remote Aboriginal women (equity of access). Currently these women have no access and improving care coordination and quality through a case management model such as the proposed GMP could facilitate use of the Centre by women with uncomplicated antenatal profiles (i.e. fit the birth centre criteria).
- Women cared for by this team who meet the criteria for early discharge, would have the choice to return to the hostel with daily domiciliary care by their midwife and AHW. This has the potential to relieve pressure on acute beds.
- Increased access to and support from other agencies (eg Family and Community Services, Mental Health Services, Social and Emotional Wellbeing Services, Social Work Services, Quit Smoking initiatives, Domestic and Family Violence Services).

## Attachment C: Multidisciplinary Specialist Outreach Services

Acute Care Division has developed a population-based model and funding requirements to achieve minimal level of access of rural and remote Territorians to specialist services. This is supportive of the Universal Core Services model. The underpinning assumptions are based on the following:

- Development of a population based model to determine a minimum number of visits per year by the essential specialist groups to rural and remote areas
- Nurse, AHW and allied health staff support
- Equipment and resources required to facilitate minimum satisfactory service levels.
- Refine and simplify the funding and reporting arrangement across existing Specialist Outreach (NTG, SOS $3.7m pa) , Medical Specialist Outreach Assistance Program ( AG, MSOAP $1.4m pa) and additional specialist funding under NT Closing the Gap (NTG, $0.8m pa) and potential CTG NP funds
- Work with acute, remote health, NGO providers and other stakeholders on models of care

### Administration Arrangements

Northern Territory Multidisciplinary Specialist Outreach Steering Committee (NTMSOS) is to be established to oversight and provide strategic leadership for outreach services in the Northern Territory provided under multiple funding streams. Membership will include stakeholders and partners including AMSANT, GPNNT, Health Consumers of Rural and Remote Australia, Allied Health, Nursing and Specialist representatives. Key aims would be to:

- Centralise and coordinate from one locale
- Web based coordination
- Across divisional coordination

### Service Planning and Delivery

- A manager (NTG funded) will be appointed to establish central coordination of outreach services (remote experienced Nurse). The current MSOAP funded administrative position will support this coordinator. A client tracking and coordination mechanism for visits to the communities will contribute to improving the Patient Journey.
- Planning of service priorities to enable workforce and resource planning and coordination.
- A panel contract for flights is proposed to enable long term scheduling of trips and coordination with other areas who may wish to access available flights.
- MSOS will have overarching general principles and specialty teams will develop principles specific to their requirements. (contribute to the Patient Journey)
- Regular review of needs assessment and development of recommendations through the analysis of data will be conducted and tabled at the Regional committees and NTMSOS steering committee.
- Regular review, flexibility and improved liaison with remote clinics or AMS on timing of scheduled trips
- Develop a plan for patients for treatment, education and, as appropriate, follow up to occur in the community. MSOS maintain' engagement as required. Follow up and checking systems in new model (contribute to the Patient Journey)
- Information systems used in the clinics (PCIS etc)
- Ease of transport to hubs

## Attachment D: Heart Health Plan

In August 2008 the Northern Territory Government committed $45 million over ten years for a '*Heart Health Plan'*. This includes cardiac rehabilitation and to deliver specialist equipment and major equipment upgrades to Royal Darwin and Alice Springs Hospitals.

This is in response to the increasing number of Territory patients with cardiac conditions requiring treatment, of which some treatments are currently only available interstate. The cardiac development will be based on the Frommer and Harris report '*Cardiac Services in the Northern Territory 2006-2015',* which was released in February 2007.

In August 2007, the Preventable Chronic Disease Clinical Reference Group (CRG) was established to develop an implementation plan from the Report recommendations. The recommendations have been grouped as short, medium and long term with estimated costings. Some activities under the short term priorities are being progressed using existing resources and development work is commencing to plan the ten year priorities and estimated costs.

The CRG is oversighting this work. Representatives on the CRG are from Acute Care, Community and Remote Health, Heart Foundation, Aboriginal Medical Services Alliance of the Northern Territory and the General Practice Network NT. The professional groups represented include cardiologists, physicians, nurses, allied health, policy officers and access others as required e.g. information technology and workforce experts.

## Attachment E: Universal Core Services

Universal Core Services are based on life stages, targeting services that will give the largest impact for the service provided. Core Services do not target any one disease but have the potential to impact on many areas of ill health and health by providing a standard set of services to all residents. The generic basis for providing these services is that they are evidence based and are provided to all, this ensures the access and management of clients is achievable.

Fundamentally, the model is based on the development of an appropriate level and type of service delivery for the consumer of the services rather than historical or the supplier of services. This then predicates what levels and type of staff are required to provide these Universal Core Services to the whole population.

Core Services have been agreed between public and community controlled services and have been based on evidence, have broad support and seen as best practice.

- An integration of a range of historically separate services into a cohort of services that will progressively be provided from all NTG Health Centres.
- Targeted services that are based on life stages.
- Core Services provided, to an agreed standard by competent staff.
- Regional Hub service sites will support the Health Centre services
- IT linking of all NTG Health Centres

**Life Course Approach:** Evidence-based approach that focuses on the planning, delivery and performance monitoring of services on the cumulative nature of disadvantage and the particular risks and opportunities to health and wellbeing that present at key stages and transitions of life.

**Universal Core Services:** Divided into five main age cohorts. Each cohort addresses the essential primary health services required to tackle the major risk and needs for that age group, while paying attention to the impact on later life of these outcomes. A comprehensive health and family wellbeing information system, which would include population register, case records and a recall system to support health activities and social interventions; a chronic disease register and recall system to support the management of chronic diseases; and data collection to enhance evaluation and quality assurance and in-servicing is required. Also a linked information system, this can be through HealthConnect or other IT system; enabling all centres to be linked to an electronic data system.

The importance of effective and efficient electronic communication between all service providers can not be understated. Georgeff (2007) summarises this by stating that

*The figures for this lack of information-sharing and co-ordination are starkly worrying.*

- Georgeff (2007) further quotes figures of "more than 50% of doctors do not follow best practice guidelines. Between 30 and 50% of patients with chronic disease are hospitalised because of inadequate care management. Fewer than 14% of people with chronic disease are placed on care plans and less than one per cent of patients are tracked to see if they adhere to care plans. Thus, all but a tiny portion of those plans created are all but useless". Many of the indicators and disease rates are alarming, these are often much more prevalent in the Aboriginal and Torres Strait Islander population. The benefit to that particular section of the population can and would be so much more than the general population if a comprehensive implementation of e-health services were implemented.

Georgeff M 2007, *E-Health and the Transformation of Healthcare*, Australian Centre for Health Research Limited, Melbourne Victoria.

## Attachment F: Cultural Security

Culture as a social function creates obligations and responsibilities and establishes an order that binds individuals, families and communities together. Culture and identity is central to health and ill health. How Aboriginal people view wellness and illness is in part based on cultural beliefs and values. At the service interface these perceptions and the social interaction surrounding them influence when and why Aboriginal communities access services, their acceptance or rejection of treatment, the likelihood of compliance and follow up, the likely success of prevention and health promotion strategies, the client's assessment of the quality of care and views of health care providers and personnel.

Cultural security is a commitment that the construct of effective clinical care, public health, health systems administration and the provision of services offered by the health and wellbeing system will not compromise the legitimate cultural rights, views and values of Aboriginal people. The crux of the move to Cultural security is a shift in emphasis from attitude to behaviour, ensuring that the delivery of health services is of such a quality that no one person is afforded a less favourable outcome simply because they hold a different cultural outlook. Cultural security recognises that a more respectful and responsive health system will contribute to improved outcomes and greater efficiency.

Increasingly the medical profession has recognised that 'health care belief systems are critical to the patient's healing processes and overseas studies have shown that the practice and advice of traditional healers is often valued more highly than the advice from western medical practitioners. Cultural security in health service provision is also emerging as a risk minimisation and cost containment issue with some overseas providers adopting this approach in an effort to improve market share, contain costs, improve outcomes and improve quality. Some overseas malpractice insurers offer premium discounts to doctors who take cultural security or competence into their practice. Cultural security enriches the competence of practitioners and administrators in the design, delivery and evaluation of health services. Key target areas are:

- Implementation of the Cultural Security policy
- Cultural Security Guidelines for Managers
- Aboriginal positions employed in the health and wellbeing system including promotion of Aboriginal staff into senior positions
- Cultural leave
- Patient journey
- Admissions protocol
- Gender issues in service delivery
- Building designs and standards
- Measure of cultural competence of staff
- Interpreter solutions

Achievement of the outcomes under this policy will involve the establishment of high level cross department collaboration and continuing, effective, engagement with professional peak bodies.

## Attachment G: NPA Service Delivery Principles for Indigenous Australians:

Service Delivery Principles for Aboriginal Australians are detailed within the COAG National Indigenous Reform Agreement. Implementation of this Plan will advance these Service Delivery Principles as described below:

**Priority**
The National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes aims to make considerable progress on improving health outcomes and reducing inequities between Aboriginal and non-Aboriginal Australians by focusing on five priority areas: tackling smoking; providing a healthy transition to adulthood; making Aboriginal health everyone's business; primary health care service that can deliver; and fixing the gaps and improving the patient journey.

The programmes and services developed as part of the NP are all evidence based and complement existing effort. A critical feature of the NP implementation in addition to the health gains is the clear intersectoral benefit. The successful implementation of this NP will deliver significant gains to other sectors including Justice, Education, Families and Children and Child Protection. Evidence clearly demonstrates the benefits to these areas from the work proposed in the NP. DHF plans to establish an interdepartmental reference group to optimise health and intersectoral outcomes.

**Aboriginal engagement**
The Northern Territory and Australian Governments and the Aboriginal Medical Services Alliance of the NT have signed an Aboriginal Health Framework Agreement. That Agreement created the NT Aboriginal Health Forum (NTAHF), a collaborative forum that promotes the objectives of the Agreement and provides regular and constructive opportunities for reform, discussion and development of strategies that improve the health and wellbeing of Aboriginal people in the Northern Territory. The NTAHF meets regularly and feeds back to its members; as a member of the NTAHF, AMSANT is the peak Aboriginal Organisation that attends and represents Aboriginal Community Controlled Organisations. Some successful outcomes of the forum include Pathways to Community Control document, agreed Northern Territory Key Performance Indicators and provide the ability to use the NTAHF as the principle vehicle for consultation.

**Sustainability**
The NP implementation plan is to direct the efforts of the NT applied to the achievement of the objectives of the NP. The general approach taken in building this Plan is to use the agreed reform platform of the Enhanced Health Services Delivery Initiative (EHSDI). This approach will ensure that the additional effort brought to bear through this plan will be used optimally to improve Aboriginal health, mindful of the directions being advanced under EHSDI.
EHSDI will establish and deliver a suite of essential core primary health care services to Aboriginal people in the Territory, the key element is that the NP will further enhance and improve the types of services delivered. The NP goes further than supporting and enhancing Primary Health Care services, and addresses issues surrounding client journey, cultural secure service delivery, and engagement with those groups that do not normally have access to appropriate services. The NP is a critical element of building and maintains a strong and sensitive continuum of care for Aboriginal Territorians.
Funding identified in the NP will be directed at initiatives complementary to EHSDI. They will add to the EHSDI effort by focusing on education, engagement and early detection to prevent the establishment of chronic disease (particularly in young people) and management of existing chronic disease in adults. In the long term this will increase the life expectancy and well being of Aboriginal Territorians, and decrease the dependence on health care services, particularly high cost medical interventions. The flow on reduction in demand growth (especially preventable instances of chronic disease) for health services may serve to reduce future cost pressures.

**Access**
The DHF Cultural Security policy is a commitment to further strengthen Aboriginal people's access to health and community services and the benefits they derive from them by making sure that the system recognises the role that culture plays in delivering successful outcomes.

It is essential that Government services can meet the needs of all Territorians. Aboriginal and Torres Strait Islander people are almost one third of our population and have the greatest health and welfare needs of any group of Territorians making up over 60% of services provided. It is important that the DHF delivers services in a way that is both effective for Aboriginal people and that protects and respects their cultural rights and values. The Cultural Security policy is a commitment that the services offered to Aboriginal Territorians by the DHF will respectfully combine the cultural rights and values of Aboriginal people with the best that health and community service systems have to offer.

Providing culturally secure services requires health and community service providers to:

- *Identify* those elements of Aboriginal culture that affect the delivery of health and community services in the Northern Territory
- *Review* service delivery practices to ensure that they do not unnecessarily offend Aboriginal people's culture and values
- *Act* to modify service delivery practices where necessary
- *Monitor* service activity to ensure that services continue to meet culturally safe standards. By providing services this way we can ensure that all Territorians have access to safe and effective services.

This implementation plan seeks to build greater cultural security and thereby boost the access of Aboriginal people to health services in the NT. The implementation plan also delivers a range of improvements that will fill service gaps and discontinuities in the service model.

**Integration**

The need for integration of services is a delivery issue that has been building in momentum during the last decade. This momentum has in part been fed by the weakening of the service continuum caused by a combination of an increasing number of providers that organisationally work in isolation of each other and geographic and political and rhetorical differences. These issues have at times manifested themselves as serious impacts on client outcomes. Some key reforms that relate to service integration include:

- Commitment to the goal of an integrated, equitable, effective and responsive health and family wellbeing system for Aboriginal people that respects Aboriginal culture and values best practice care and support, including the promotion of Aboriginal community control;
- Recognise the need for services to take into account local circumstances and need including informed consultation;
- Hold a shared commitment to co-operative approaches between sectors and services and maintaining and strengthening effort to address Aboriginal health and family wellbeing;
- Committed to cultural security as a central tenet of an integrated system. Aboriginal culture influences people's choice and view of services, client's assessment of the quality of care and their views about the facility and staff;
- Aboriginal community engagement with the health and family wellbeing sector and services in a manner consistent with their positioning on the pathways to community control is fundamental as is Aboriginal participation in high level policy decision making;
- Building the capacity and capability of communities and Aboriginal people to engage is necessary to ensure the equitable and effective functioning of services and communities;
- Aboriginal health and family wellbeing is core business to all parties;
- Development of greater complementarily in service standards, delivery, planning and monitoring, accountability, sound and appropriate evaluation and reporting;
- Appropriate sharing of information and experience and to the promotion of best practice in the design, delivery and evaluation of health and family wellbeing services;
- Recognise that trust and honest dialogue along with a commitment to finding solutions is an essential starting point to building an integrated health and family wellbeing system for Aboriginal people in the Northern Territory.

**Accountability**

In keeping with the undertakings at COAG the NT approach includes attention to effective monitoring and evaluation of the implementation of the NPA. At the front end of implementation planning is the intention to

adopt specific business processes that provide capacity to link the strategic aims of the NPA to activity and funding to outputs and reporting. This will enable the department to meet its reporting obligations effectively. This is a specific risk management strategy that seeks to deal with the heightened expectations of the NTG, Commonwealth Government and COAG for performance related monitoring associated with this NPA. This will also include consideration of the monitoring, reporting and evaluation requirements of other current and relevant reforms such as the NTG Closing the Gap and the Enhanced Health Service Delivery Initiative.

**NATIONAL PRINCIPLES FOR INVESTMENTS IN REMOTE LOCATIONS**

In addition the following principles have also been considered in the development of the implementation plan. National principles for investments in remote locations include:

- remote Aboriginal communities and remote communities with significant Aboriginal populations are entitled to standards of services and infrastructure broadly comparable with that in non-Aboriginal communities of similar size, location and need elsewhere in Australia;
- investment decisions should aim to: improve participation in education/training and the market economy on a sustainable basis; and reduce dependence on welfare where possible; and promote personal responsibility, engagement and behaviours consistent with positive social norms;
- priority for enhanced infrastructure support and service provision should be to larger and more economically sustainable communities where secure land tenure exists, allowing for services outreach to access by smaller surrounding communities, including:
- recognising Aboriginal peoples' cultural connections to homelands (whether on a visiting or permanent basis) but avoiding expectations of major investment in service provision where there are a few economic or educational opportunities; and
- facilitating voluntary mobility by individuals and families to areas where better education and job opportunities exist, with higher standards of service.

## Attachment H: Service Delivery Principles for programs and services for Indigenous Australians:

### Purpose

B1 These principles draw upon the National Framework of Principles for Government Service Delivery to Indigenous Australians agreed to by COAG in 2004. These principles are to guide COAG in the:

(a) design and delivery of Indigenous specific and mainstream government programs and services provided to Indigenous people; and

(b) development and negotiation of National Partnership agreements, National Agreements and reform proposals.

### Principles

B2 *Priority principle*: Programs and services should contribute to Closing the Gap by meeting the targets endorsed by COAG while being appropriate to local community needs.

B3 *Indigenous engagement principle*: Engagement with Indigenous men, women and children and communities should be central to the design and delivery of programs and services.

B4 *Sustainability principle*: Programs and services should be directed and resourced over an adequate period of time to meet the COAG targets.

B5 *Access Principle*: Programs and services should be physically and culturally accessible to Indigenous people recognising the diversity of urban, regional and remote needs.

B6 *Integration principle*: There should be collaboration between and within Governments at all levels and their agencies to effectively coordinate programs and services.

B7 *Accountability principle*: Programs and services should have regular and transparent performance monitoring, review and evaluation.

### Principles in Detail

B8 *Priority principle*: Programs and services should contribute to Closing the Gap by meeting the targets endorsed by COAG while being appropriate to local community needs. The COAG targets are:

(a) close the 17 year life expectancy gap within a generation;

(b) halve the gap in mortality rates for children under five within a decade;

(c) halve the gap in reading, writing and numeracy within a decade;

(d) halve the gap in employment outcomes and opportunities within a decade;

(e) at least halve the gap for Indigenous students in Year 12 or equivalent attainment rates by 2020; and

(f) within five years provide access to a quality early childhood education program to all Indigenous four year olds in remote Indigenous communities.

B9 *Indigenous engagement principle:* Engagement with Indigenous men, women and children and communities should be central to the design and delivery of programs and services. In particular, attention is to be given to:

(a) recognising that strong relationships/partnerships between government, community and service providers increase the capacity to achieve identified outcomes and work towards building these relationships;

(b) engaging and empowering Indigenous people who use Government services, and the broader Indigenous community in the design and delivery of programs and services as appropriate;

(c) recognising local circumstances;

(d) ensuring Indigenous representation is appropriate, having regard to local representation as required;

(e) being transparent regarding the role and level of Indigenous engagement along a continuum from information sharing to decision-making; and

(f) recognising Indigenous culture, language and identity.

B10 *Sustainability principle:* Programs and services should be directed and resourced over an adequate period of time to meet the COAG targets. In particular, attention is to be given to:

(a) service system orientation, particularly:

(i) using evidence to develop and redesign programs, services and set priorities;

(ii) recognising the importance of early intervention; and

(iii) including strategies that increase independence, empowerment and self management;

(b) ensuring adequate and appropriate resources, particularly:

(i) setting time-frames for meeting short, medium and longer-term targets and outcomes;

(ii) considering flexibility in program design to meet local needs;

(iii) considering workforce supply and future planning;

(iv) considering sustaining or redesigning services to best use existing resources, as well as the need for programs and services to meet the COAG targets;

(v) minimising administrative red tape to enable greater integration of program and service delivery;

(vi) ensuring that programs and services are efficient and fiscally sustainable; and

(vii) ensuring that infrastructure is appropriate and adequately maintained;

(c) building the capacity of both Indigenous people and of services to meet the needs of Indigenous people, particularly:

(i) developing the skills, knowledge and competencies, including independence and empowerment of Indigenous people, communities and organisations;

(ii) supporting Indigenous communities to harness the engagement of corporate, non-government and philanthropic sectors;

(iii) building governments' and service delivery organisations' capacity to develop and implement policies, procedures, and protocols that recognise Indigenous people's culture, needs and aspirations;

(iv) ensuring that programs and services foster and do not erode capacity or capability of clients; and

(v) recognising when Indigenous delivery is an important contributor to outcomes (direct and indirect), and in those instances fostering opportunities for Indigenous service delivery.

B11 *Access Principle:* Programs and services should be physically and culturally accessible to Indigenous people recognising the diversity of urban, regional and remote needs. In particular, attention is to be given to:

(a) considering appropriate and adequate infrastructure and placement of services (including transport, IT, telecommunications and use of interpreter services);

(b) minimising administrative red tape that may be a barrier to access; and

(c) providing adequate information regarding available programs and services.

B12 *Integration principle:* There should be collaboration between and within Governments at all levels, their agencies and funded service providers to effectively coordinate programs and services. In particular attention is to be given to:

(a) articulating responsibilities between all levels of government;

(b) identifying and addressing gaps and overlaps in the continuum of service delivery;

(c) ensuring services and programs are provided in an integrated and collaborative manner both between all levels of governments and between services;

(d) ensuring services and programs do not set incentives that negatively affect outcomes of other programs and services; and

(e) recognising that a centrally agreed strategic focus should not inhibit service delivery responses that are sensitive to local contexts.

B13 *Accountability principle:* Programs and services should have regular and transparent performance monitoring, review and evaluation. In particular, attention is to be given to:

(a) choosing performance measures based on contribution to the COAG targets and report them publicly;

(b) ensuring mainstream service delivery agencies have strategies in place to achieve Indigenous outcomes and meet Indigenous needs;

(c) clearly articulating the service level to be delivered;

(d) ensuring accountability of organisations for the government funds that they administer on behalf of Indigenous people;

(e) periodically measuring/reviewing to assess the contribution of programs and services to the above, and adapting programs and services as appropriate;

(f) clearly defining and agreeing responsibilities of government and communities;

(g) supporting the capacity of the Indigenous service sector and communities to play a role in delivering services and influencing service delivery systems/organisations to ensure their responsiveness, access and appropriateness to Indigenous people; and

(h) evaluating programs and services from multiple perspectives including from the client, Indigenous communities and government perspectives and incorporating lessons into future program and services design.