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

Western Australia

June 2009

SIGNED FOR AND ON BEHALF OF THE GOVERNMENT OF WESTERN AUSTRALIA, DEPARTMENT OF HEALTH BY

(Signature)

Hon. Dr. KIM HAMES
DEPUTY PREMIER
MINISTER FOR HEALTH

___ June 2009

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ABBREVIATIONS

The following abbreviations are used extensively in the following planning documentation.

ACCHO Aboriginal Community Controlled Health Organisations
AHCWA Aboriginal Health Council of WA
CAHS Child & Adolescent Health Service, WA Health
DCP Department of Child Protection
DCS Department of Corrective Services
DOH Department of Health
DPC Department of Premier and Cabinet
DTF Department of Treasury and Finance
KEMH King Edward Memorial Hospital
NMAHS North Metropolitan Area Health Service, WA Health
PHU Public Health Unit
PMH Princess Margaret Hospital
OAH Office of Aboriginal Health, WA Health
AHPF Metropolitan and Regional Aboriginal Health Planning Forums
RAESP Remote Area Essential Service Program
RPH Royal Perth Hospital
SMAHS South Metropolitan Area Health Service, WA Health
TICHR Telethon Institute for Child Health Research
WACHS WA Country Health Service

1 BACKGROUND AND CONTEXT

Indigenous Australians experience the worst health of any one identifiable cultural group in Australia. This is also the case in Western Australia, as underlined by statistics which show Aboriginal people in this State can expect to live 15–20 years less than other Western Australians and have infant mortality rates 3 to 5 times higher than the general population.

On 2 October 2008, COAG agreed to six ambitious targets for closing the gap between Indigenous and non-Indigenous Australians across urban, rural and remote areas:

(a) to close the gap in life expectancy within a generation;
(b) to halve the gap in mortality rates for Indigenous children under five within a decade;
(c) to ensure all Indigenous four years olds in remote communities have access to early childhood education within five years;
(d) to halve the gap in reading, writing and numeracy achievements for Indigenous children within a decade;
(e) to halve the gap for Indigenous students in year 12 attainment or equivalent attainment rates by 2020; and
(f) to halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade.

In signing a *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes*, the Commonwealth and State and Territory governments committed to undertaking substantial expenditures over the next four years (2009/10 – 2013/14). The Western Australian Government commitment is to undertake new expenditures totalling $117.43 million over the four years. According to recent Federal Treasury figures, the Commonwealth will also spend an additional $117.4m over four years on own purpose expenses in WA as part of the Closing the Gap in health initiative.

Western Australia Government Plan for Closing the Gap in Indigenous Health Outcomes

In accordance with the COAG Agreement, this Implementation Plan presents the strategies to be pursued using the additional funds committed by the Western Australian Government under the National Partnership Agreement (NPA). As per the delegation arrangements set out in the NPA, the WA Minister for Health through the WA Department for Health is responsible for the implementation of the NPA and the Implementation Plan.

Consistent with the priorities identified in the National Partnership Agreement, the initiatives in this Plan target five priority areas:

- tackling smoking;
- providing a healthy transition to adulthood;
- making Indigenous health everyone's business;
- delivering effective primary health care services; and
- better coordinating the patient journey through the health system.

The initiatives are intended to complement the range of services already in place aimed at improving the health status of Indigenous people and are consistent with broader State and Commonwealth policy directions for Indigenous health.

In Western Australia, Aboriginal people access a range of health services, including both mainstream services designed for the broader population and services that more specifically targeted to meeting the needs of Aboriginal people. The initiatives in this plan aim to improve the ability of mainstream services to meet the needs of Aboriginal clients and to enhance Aboriginal-specific services.

The Western Australian Government recognises that achieving improvement in Aboriginal health status is one of the most complex and challenging tasks it faces. Significant improvement in health outcomes will only be achieved if better and more relevant health services are delivered and accompanied by actions in other key service areas such as housing, education, employment and economic development.

It is also important that there is complementarity between the new Commonwealth and State commitments through the "Closing the Gap" Agreement and other National Partnership Agreements both within Health and in other functional areas such as sub-acute, preventative, housing, education etc. In developing the detail of initiatives for this plan, there will be close liaison and involvement by relevant Commonwealth and State Government agencies to ensure a high degree of complementarity is achieved.

The Government also recognises that the initiatives it implements will not succeed unless pursued in partnership with the Aboriginal community. The Government is committed to ensuring Aboriginal community involvement is central to the development of this plan.

In developing the detail of the initiatives presented in this plan, it is recognised that there will be a need for broad ranging consultation with the Aboriginal community and, for WA Government internal processes, a need for consultation and relevant approvals by central agencies, including the Department of the Premier and Cabinet and the Department of Treasury and Finance.

Benefits Realisation

WA will contribute to implementing the following National reforms under this NPA, namely: National Minimum Service Standards, improved quality of Aboriginal identification, accountability framework, infrastructure to support transitions and linked records, workforce and cultural competency in health service delivery.

The underpinning principles and values of the WA Implementation Plan are:

- Area based planning (regional and metropolitan)
- Value adding by building on existing policy, structures and services
- Sustainability through best use of, and capacity building of mainstream and Aboriginal dedicated services to facilitate joint service delivery
- Aboriginal engagement at all level of the decision making process and implementation
- Improved access to health care
- increasing the numbers of Aboriginal people employed in the health workforce..

WA Health will improve health outcomes for Aboriginal Western Australians [1]: by:

- Increasing access to mainstream and dedicated Aboriginal health programs and services across the state
- Establishing a coordinated, systemic approach to Aboriginal engagement and health reform through the Aboriginal Health Partnership Group and Planning Forums
- Establishing an improved governance and accountability structure to ensure transparency in funding, planning and implementation of Aboriginal health reforms
- Improving reporting and accountability measures
- Provide integrated care pathways across primary, secondary and tertiary care providers that are appropriate to Aboriginal health consumers in Western Australia

2 SERVICE DELIVERY PRINCIPLES FOR INDIGENOUS AUSTRALIANS

The initiatives in this implementation plan will advance all of the Service Delivery Principles for Indigenous Australians detailed in the COAG National Indigenous Reform Agreement. The implications of the initiatives for the Service Delivery Principles are outlined below.

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

The proposed initiatives will contribute most directly to meeting two COAG *Closing the Gap* targets:

(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.

The initiatives will also assist with meeting other *Closing the Gap* targets as good health is a prerequisite for social participation. The initiatives have been selected for their relevance to WA Aboriginal communities and further consultation will ensure they are delivered in the way most appropriate and effective for meeting local needs.

Detailed regional plans and strategies will be developed, monitored and reviewed by metropolitan and regional Aboriginal Health Planning Forums (AHPFs).

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

[1] WA Health Strategic Intent and Operational Plan 2009/10, Foundations for Country Health Services, WA Health Promotion Strategic Framework 20007-2011, WA Aboriginal Primary Care Action Plan 2007, WA Cultural Respect Implementation Framework, WA Aboriginal Health Impact Statement and Guidelines, WA Aboriginal Maternal and Child Health Action Plan 2009, and WA Clinical Services Plans and health networks Models of Care.

The approach involving AHPFs will ensure Aboriginal engagement is a central theme to service design and delivery. The AHPFs will undertake extensive consultation with relevant communities in determining local priorities and developing services.

This implementation plan provides a framework for implementation that will guide more detailed project plans and strategies including costs, performance measures, evaluation methodologies and risk assessments, The detailed project plans will require extensive consultation , collaboration and transparency with Indigenous communities and agencies to ensure the most effective and efficient service delivery models are implemented which satisfactorily address identified community need.

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

In the first year of implementation, the emphasis is on building effective relationships, developing the skills and capacity of the Aboriginal workforce, and ensuring that program targets are achievable in the plan's timeframe.

The detailed implementation plans will include building capacity for continuation of health improvements beyond the four years of this plan. Sustainability will form a key component of the reporting to the departments of Premier and Cabinet and Treasury and Finance. .

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

As noted above, AHPFs will be responsible for developing, monitoring and reviewing regional plans and strategies. This approach will ensure initiatives are physically and culturally accessible to local Indigenous people. For example, under *"Primary Health Care that Can Deliver"*, specific strategies will be developed for providing access to services for the 90 approved Remote Area Essential Infrastructure Program (RAEIP) WA Aboriginal communities.

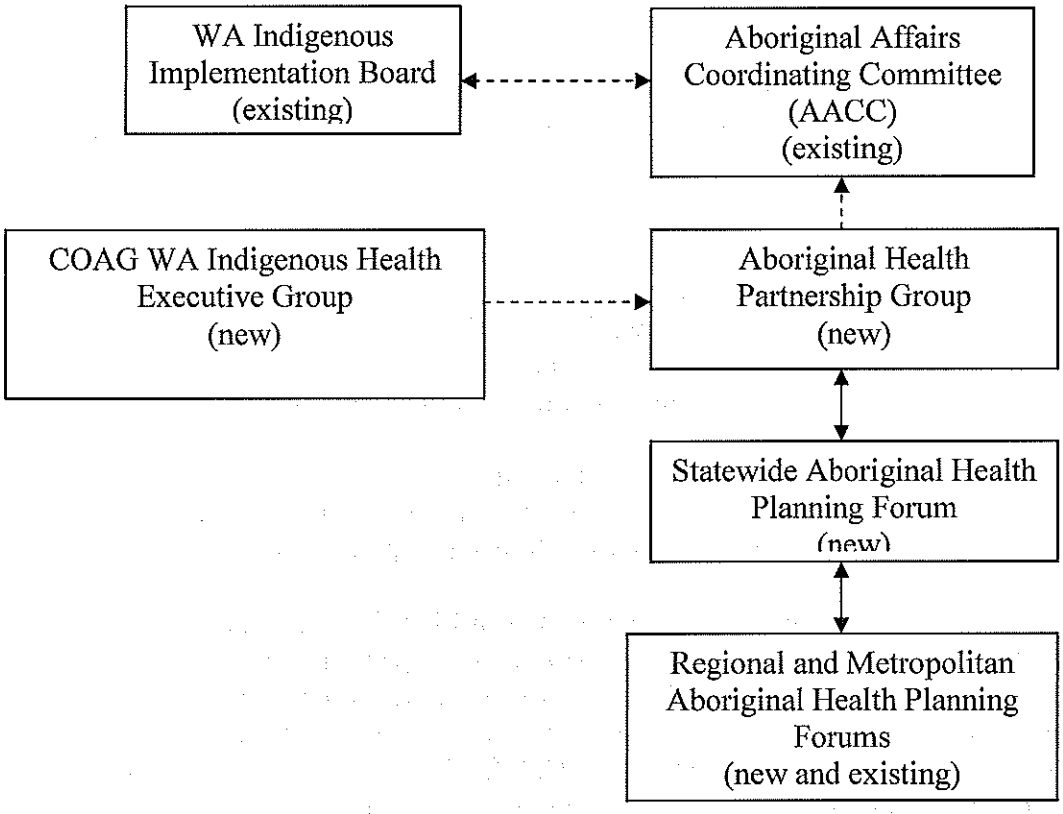
Integration - ***There should be collaboration between and within Governments at all levels and their agencies to effectively coordinate programs and services***

The oversight of the plan by the WA Aboriginal Affairs Coordinating Committee ensures that Government agencies take into account the health impact of their activities, and then develop initiatives which positively affect Aboriginal health improvement. The governance framework described below ensures that initiatives under this proposal are integrated with other WA Government and GOAG initiatives to ensure good coordination and minimal duplication.

Accountability - ***Programs and services should have regular and transparent performance monitoring, review and evaluation***

To encourage greater transparency and reduce risks, the DOH will submit six monthly reports on implementation progress to DPC/DTF to ensure central agencies are satisfied with the progress being made and the allocated resources are being used appropriately. Confirmation of the effectiveness of the implementation will be a condition for the release of state funding. DPC and DTF, will provide a template and timeline for the provision of reports by DOH.

Implementation of COAG funding will occur through the following structure which will be reviewed progressively to ensure it does not create an administrative burden that detracts from the actual delivery of services and programs but is strategically structured to maximise transparency, collaboration and effective and efficient use of resources:



The WA Indigenous Implementation Board, which reports to the Minister for Indigenous Affairs, and works in partnership with AACC, is establishing a WA Government Indigenous governance framework to improve coordination and management of service delivery at a regional level in WA. The Board, chaired by the Governor of WA, will ensure that Government agencies are aware of how their services and programs fit within the State Indigenous governance framework and will monitor and report on the progress of Government agencies in meeting their outcomes centrally, regionally and in local areas.

Aboriginal Affairs Coordinating Committee (AACC). The AACC is comprised of the Directors General of State Government Departments. This group will have oversight of the plans to ensure coordination of strategies across State Government departments, and to ensure that the goals and priorities across departments contribute to the *Closing the Gap* goals.

Aboriginal Health Partnership Group

The overall management and oversight of the delivery of the health implementation plan will be through the Aboriginal Health Partnership Group. This group is currently being established to oversee and coordinate Aboriginal health strategies across the State, and across all programs including the COAG initiatives.

This group will comprise high level representatives from the Aboriginal Health Council of WA, the three Area Health Services, the Child and Adolescent Area Health Service and Office of Mental Health, other Aboriginal community organisations, State, Commonwealth and local governments, and Divisions of General Practice. The essential travel and accommodation expenses of regional ACCHO representation to this group will be met from within the funds allocated under this plan.

A **Statewide Aboriginal Health Planning Forum** is being established which will include WACHS planners, and representatives from the Aboriginal Health Council of WA, Senior State and Commonwealth Health agency representatives and other Statewide health service providers and planners where relevant. This group will provide planning and technical support to metropolitan and regional Aboriginal health planning forums.

COAG WA Indigenous Health Executive Group

The COAG WA Indigenous Health Executive Group is an informal group to monitor and provide cultural security into the overall planning process and statewide plans.

Metropolitan and Regional Aboriginal Health Planning Forums

Detailed regional plans and strategies will be developed, monitored and reviewed by metropolitan and regional Aboriginal health planning forums. These include Perth metropolitan forums (North and South metropolitan forums) and country regional forums (Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, Great Southern and South West). Membership of the regional planning forums includes the relevant WA Area Health Service and Office of Mental; Health, Aboriginal Community Controlled Health Services, State and Commonwealth Health agency representatives and other health service providers where relevant. A portion of the management and administrative costs of developing the plans will be contributed from within the funds allocated under this plan, although as an existing entity, the quantum of funding will be subject to determining the extent of new requirements and functions.

The role of the planning forums is twofold:

1. Agree on Statewide and regional Aboriginal health priorities, based on epidemiological data and other evidence, to determine health risks and prevalence/incidence for key health conditions compared to the state average.
2. Agree on Aboriginal health service delivery models and coordinate health service delivery systems between the respective health providers within the region to ensure more effective services and outcomes for Aboriginal people.

From these functions the planning forums are able to develop State-wide and regional Aboriginal health plans, for consideration by funding agencies, incorporating both evidence of health need in the region and service delivery plans to ensure no duplication in services occurs.

The Aboriginal health planning forums will become the vehicle through which the COAG objectives will be developed in detail to achieve regional objectives in *closing the gap* for Aboriginal Western Australians.

Included in the plans will be regular reviews of the allocation of existing resources to ensure they are being used effectively and fairly and to allocate resources to areas of greatest need. Detailed plans developed by the metropolitan and regional Aboriginal health planning forums will be submitted to DPC and DTF for approval prior to implementation. An agreed standard format for the plans will ensure that they contain the required level of detail.

3 NATIONAL PRINCIPLES FOR INVESTMENTS IN REMOTE LOCATIONS

National principles for investments in remote locations include:

- remote Indigenous communities and remote communities with significant Indigenous populations are entitled to standards of services and infrastructure broadly comparable with that in non-Indigenous 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, reduce dependence on welfare where possible and promote personal responsibility, engagement and behaviours consistent with positive social norms; and
- priority for enhanced infrastructure support and service provision should be to the 90 Remote Area Essential Service Program (RAESP) communities, allowing for services outreach to access by smaller surrounding communities, including:
  - recognising Indigenous peoples' cultural connections to homelands (whether on a visiting or permanent basis) but avoiding expectations of major investment in service provision where there are 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.

These principles will be included in the selection criteria for the identification of specific regional strategies to be implemented under this agreement.

4 IMPLEMENTATION PLAN

PRIORITY AREA: Tackling Smoking

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	How will we check progress?	When will it be done?	What is the cost?
Reduce prevalence of smoking targeting – persons aged 15 years + – pregnant women – smoking at home indoors – smoking related illnesses (long term) Reduce the incidence of smoking related illness (long term) Reduce burden of tobacco related disease.	• Develop and monitor a statewide tobacco strategy, with particular focus on tackling smoking in Indigenous health. • Develop and implement culturally sensitive and relevant tobacco education strategies and information in partnership with priority population groups. • Implement brief Intervention programs across hospital and health services. • Support the implementation of culturally appropriate marketing campaigns targeting tobacco.	• In WA in 2004-05, 43% of Indigenous men and 52% of Indigenous women aged 18 and over were current smokers. • Aboriginal mothers were almost 4 times as likely as non-Aboriginal mothers to report smoking during pregnancy. • Tobacco smoking was responsible for 12.1% of the total burden of disease and one-fifth of deaths in Indigenous Australians in 2003. • Tobacco smoking directly causes a third of all the cancer and cardiovascular disease burden among Indigenous peoples (Vos et al., 2007).	▪ A working party will be established comprised of key stakeholders advised by research and best practice; ▪ Culturally appropriate local strategies will be developed through the metropolitan and regional Aboriginal health planning forums.	Regular monitoring and review of the state-wide tobacco strategy An evaluation framework will be developed which includes : • Numbers of AHWs with credentialed competency in smoking cessation • Number of people seeking support • Evidence of reductions in prevalence of tobacco use in persons 15 years+, and pregnant women, reduction in hospitalisations for tobacco related disease. • Number and key results from marketing campaigns.	2009/10 Establish the working group and statewide strategy and evaluation framework Develop and implement regional actions plans through the Aboriginal health planning forums 2010/11 review and refine plans 2011/12 implement 2012/13 implement and evaluate.	2009-10 $1,400,000 2010-11 $1, 600,00 2011-12 $1,950,000 2012-13 $2,000,000 **Total** **$6,950,000**

Governance/ Management	The Aboriginal Health Partnership Group will have overall governance and oversight of the implementation. The WA Indigenous Implementation Board will monitor achievement of intended outcomes through the state government's Indigenous

	Governance Framework. Delivery and reporting on the plan will be the responsibility of the Aboriginal Health Partnership Group. The Statewide Aboriginal Health Planning Forum will coordinate the development of a State-wide implementation strategy . Regional action plans, including risk management plans, will be developed by the AHPFs, with leadership from the Area Health Services and will be endorsed by the Statewide Aboriginal Health Planning Forum. Strategies will be coordinated with other COAG funded initiatives to avoid duplication.
Linkages/Coordination	The 'Tackling Smoking' reform will coordinate with, and be informed by: WA Health Area Health Services and Public Health Division (including contractors and KPI Working Group; Environmental Health Branch; Respiratory Health Network OAH: Trans-Tasman Agreement; Men's Health Strategy; Indigenous Early Childhood Development National Partnership NGO projects: *Beyond the Big Smoke* Randomised Control Trial – AHCWA/KAMSC; *SmokeCheck* – SIDS and Kids (WA) DoHA/OATSIH programs: *A Reduction in tobacco use among Indigenous communities* (Professor Mike Daube, Curtin University)
Community/Stakeholder Involvement	Community /stakeholder consultation will occur through the governance arrangements outlined above. Initial and ongoing consultation with key stakeholders (including campaign target groups, and via research /evaluation)

PRIORITY AREA: Primary Health Care Service That Can Deliver

Develop a comprehensive chronic disease management strategy

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	How will we check progress?	When will it be done?	What is the cost?
• Improve access to primary care treatment services to Aboriginal people and communities that currently have poor access. • Review WA Health primary health care services and prioritise evidence based regional priorities. • Expand access to allied health and acute services and increase referrals for coordinated care by primary care providers. • Improve screening and follow up of chronic disease	• Work with AHPFs to identify regional Indigenous health priority areas and programs on the basis of epidemiological data and service gaps, including ear and eye health, antenatal care, youth health access, and men's health. • Develop an agreed state-wide framework for the delivery of primary care services across service providers including minimum levels of service to be provided by location and care coordination systems. • Develop multi-disciplinary chronic disease management services to provide screening, education and treatment to Aboriginal communities across WA. • Develop specific strategies for providing access to services for the 90 RAESP communities	For the Aboriginal population the burden of disease is significantly greater than non Aboriginal people. There is a higher incidence of: • Low birth weight babies (In 2006 - 16.5% of 1697 babies of Aboriginal mothers had low birth weight compared to 6.5% of babies born to non-Aboriginal mothers); • Infant mortality • Child deaths 0-4yrs • Hospitalisation of 0-4 years; and • Higher rates of sexually transmitted infections. • Aboriginal life expectancy is 17 years less than for non Aboriginal people. • Aboriginal child mortality rate almost 3 times the state total • 80% of WA Aboriginal communities have no access to an obstetrician-gynaecologist, 74% of communities had no access to an ENT	• Services delivered by country and metropolitan area health services, AMSs and GP Divisions.	• Monitor the development and implementation of the strategy through the Aboriginal Health Partnership Group and the State and metropolitan and regional Aboriginal Health Planning Forums. • Develop an evaluation framework including: • Number of communities serviced. • Number of allied health professionals recruited • Number of people screened/ occasions of service provided. • Hospital admissions for ambulatory care sensitive conditions	**2009/10** • Develop an agreed framework, work plan, reporting framework and clinical protocols in consultation with AHPFs. • Develop and implement a workforce plan. • Commence regular visits to priority communities **2010/12** Full implementation to all 90 communities. **2012/13** Implementation, review and evaluation.	**2009/10** $4,050,000 **2010/11** $8,350,000 **2011/12** $9,450,000 **2012/13** $10,832,500 **TOTAL** $32,682,500

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	How will we check progress?	When will it be done?	What is the cost?
in the WA Aboriginal population.		specialist, and 57% of communities had no access to an eye specialist.				
Provide access to primary care services in priority locations	• Enhance partnerships with education services and develop a model for a school health clinic in priority locations that do not have an AMS, through establishing a demonstration project in the Rockingham-Kwinana area. • This service will be integrated with local primary care services to ensure good systems for patient referral and treatment.	The Rockingham-Kwinana area is an outer metropolitan area of Perth with a relatively high Aboriginal population and no access to Aboriginal Medical Services. A regional needs assessment has identified this area as a priority for the development of a service which will respond to the needs of young people at school.	• OAH, in partnership with the Department of Education and the local GP Division to develop the strategy.	• monitor development and implementation of service model. • Develop evaluation criteria including performance measures, to include numbers of people screened an monitored. • Evaluate the model for effectiveness and applicability in other locations.	**2009/10** Consult with relevant stakeholders and Develop service model, and recruit staff **2010/11** Implement. **2011/12** Review and refine strategy **2012/13** Evaluate strategy and applicability for other settings	**2009/10** $80,640 **2010/11** $80,640 **2011/12** $80,640 **2012/13** $80,640 **TOTAL** $322,560

Ensure primary care services have the capacity to deliver coordination and continuity of care

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	How will we check progress?	When will it be done?	What is the cost?
Improve coordination and continuity between providers and	• Develop and implement processes and protocols for capturing and sharing data on Aboriginal patients in order	Aboriginal people have high rates of chronic disease. For example: • 17% of Aboriginal people have diabetes;	• Area Health Services and Pathwest will implement, in coordination	▪ Monitor and review implementation of the plan. ▪ Number of health	**2009/10** Develop protocols across service providers. Develop systems for sharing data.	**2009/10** $86,235 **2010/11** $86,235

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	How will we check progress?	When will it be done?	What is the cost?
across the continuum of care	to improve patient follow-up and recall systems. • Develop communication protocols and care pathways to improve care coordination, referral and recall. • Increase access to specialist services through enhanced use of E-health technologies.	• 13% of Aboriginal females, and 17% of Aboriginal men have high blood pressure. Lack of coordination and communication between service providers across the continuum of care Indigenous people have higher rates of communicable diseases when compared with the non-Indigenous community	with AHPFs.	services to endorse the protocols, agree to shared data and implementing the IT system. ▪ Number of Aboriginal patients with shared care plans.	**2010/11** Implement protocols and data systems **2011/12** Monitor and progress implementation **2012/13** Review and evaluate.	**2011/12** $86,235 **2012/13** $86,235 **TOTAL** $344,940.

Minimum Service Standards

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	How will we check progress?	When will it be done?	What is the cost?
Improve clinical governance and cultural security of clinical service provision across health services	We will work with ACCHOs, and public hospitals to identify priority clinical governance issues and develop and implement a clinical governance program which will improve medical governance in ACCHOs, and improve cultural security in WA public hospitals. This will be achieved through: • Developing an agreed set of service standards; • Assisting ACCHOs to meet national minimum service standards • Education and training; • Medical staff rotation between the two settings.	▪ There is no consistent standard of medical governance across providers of health services to Aboriginal people, and poor governance in some instances. ▪ Aboriginal people often feel insecure in hospital settings resulting in non-compliance with treatment. ▪ There are many cases where Aboriginal people are afraid of and reluctant to go to hospital, which results in situations where a patient does not present to a hospital until an illness is at an acute stage ▪ Language barriers that contribute to a lack of understanding and increase the chance of non-compliance.	- Program to be developed through the state-wide and AHPFs. - ACCHOs and Area Health Services to implement.	Monitor the development and implementation of a medical governance program. Develop an evaluation plan which will include: o Number of staff trained in clinical governance measures, and cultural security; o Implementation of clinical governance standards and national minimum standards in ACCHOs o Implementation of cultural security policies in hospital; o Number of registrars rotated through ACCHOs.	**2009/10** Consult with key stakeholders and develop the program Commence staff training **2010/11, 2011/12** Implement the medical governance program; Commence staff rotations **2012/13** Evaluate and refine programs.	**2009/10** $500,000 **2010/11** $500,000 **2011/12** $500,000 **2012/13** $500,000 **TOTAL** $2,000,000

Governance/ Management	The Aboriginal Health Partnership Group will have overall governance and oversight of the delivery of the health implementation plan process. The WA Indigenous Implementation Board will monitor achievement of intended outcomes through the State government's Indigenous Governance Framework. Delivery and reporting on the plan will be the responsibility of the WA Department of Health. The Statewide Aboriginal Health Planning Forum will coordinate the development of a state-wide implementation strategy . Regional action plans, including risk management plans, will be developed by the AHPFs, with leadership from the Area Health Services and will be endorsed by the Statewide Aboriginal Health Planning Forum. The following groups will be used to provide advice and expertise or coordination as appropriate: • Primary Care Health Network, via WA Aboriginal Primary Health Care Advisory Group • WA Aboriginal Chronic Disease Screening Committee • Aboriginal Maternal and Child Health Partnership State Executive Group • Western Australian Aboriginal Women's Maternal and Child Health Governance Group • WA Aboriginal Men's Health Reference Group
Linkages/Coordination	Inter-governmental and inter-departmental links will be managed through the state-wide Aboriginal Affairs Coordinating Committee Strategies will be coordinated with other COAG funded initiatives to avoid duplication. Development and implementation of the strategy will require broad consultation and coordination across health and related providers. These will include: • Aboriginal Community Controlled Health Organisations • State-wide, metropolitan and regional Aboriginal Health Planning Forums • DoH: Area Health Services; Public Health Division (including contractors and KPI Working Group); Environmental Health Branch; Health Networks • Divisions of General Practice • Cultural competency strategy • Indigenous Early Childhood Development National Partnership • NGOs • Local Government • Education Department • DoHA/OATSIH Programs
Community/Stakeholder Involvement	• Community /stakeholder consultation will occur through the governance arrangements outlined above, and will include regional and metropolitan ACCHOs, GP Divisions and Area Health Services. • Existing established planning forums will be used to identify priorities and develop local strategies to achieve the outputs and outcomes identified.

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?	• How will we check progress?	When will it be done?	What is the cost?
• Ensure hospitals and primary health care services have the capacity to deliver the coordination and continuity of care necessary to meet the needs of Aboriginal and Torres Strait Islander clients. • Improve coordination and follow up care of patient journey between hospitals and primary care settings. • Develop culturally competent hospitals program	**Needs Analysis** We will consult with health providers through the AHPFs, and collate Aboriginal patients' experiences to identify key issues. **Employ joint staff** Aboriginal Liaison officers (ALO)s and Aboriginal Health Workers (AHW)s will be jointly employed and trained to work across the hospital and ACCHO system to enhance access and transition between settings for Aboriginal people. ALOs and AHWs will form part of a multidisciplinary team established to link clients with best fit existing services, find the best illness prevention and intervention path for clients. **Discharge planning** Improve discharge planning of Aboriginal patients from hospitals, patient tracking and patient recall systems. **Patient centred focus** Adapt DoH's *Patient First* consumer package to provide culturally secure health system for Indigenous health consumers that will assist them better navigate the health system. Implement WA Health's Culture	• To reduce rates of self-discharge, reduce medical complications due to inappropriate follow-up and maintenance of care post discharge. • Failure of compliance with treatment post-discharge. • Inadequate patient follow-up and care post discharge. • Poor attendance for specialist or outpatient clinic appointments. • Patient and provider dissatisfaction. • Lack of referral networks across all regions of the state for Indigenous patients. • Difficulty in attending outpatient clinics and specialist appointments due to transportation issues.	• Needs analysis will be undertaken by AHSs with oversight from RAHPSs. • AHSs to take primary responsibility for implementation.	• Regular monitoring, review and formal evaluation. • Completion of needs analysis. • Number of ALOs and AHWs recruited, trained and operational. • Development of measures likely to include: – discharge against medical advice, readmission rates, increase in percentage of Aboriginal patients with a car plan in place, – Percentage of Aboriginal patients participating in chronic disease programs. – Results of implementation of cultural security programs – Provider and patient satisfaction surveys.	**2009/10** Needs analysis establish teams and train staff. Commence implementation. **2010/2012** implement program across the state. **2012/13** Evaluate and refine	**2009/10** $3,550,000 **2010/11** $6,170,000 **2011/12** $5,490,000 **2012/13** $5,370,000 **TOTAL** $20,580,000

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	• How will we check progress?	When will it be done?	What is the cost?
	Security framework across the public health system. **Transport and accommodation** ALOs will assist Aboriginal patients to get to and from hospital appointments. Hospitals will provide culturally welcoming space for Aboriginal families who are visiting patients, and are/or patients in transit.					

Governance/ Management	The Aboriginal Health Partnership Group will have overall governance and oversight of the delivery of the health implementation plan process. The Statewide Aboriginal Health Planning Forum will coordinate the development of a state-wide implementation strategy . Regional action plans, including risk management plans, will be developed by the AHPFs, with leadership from Area Health Services and will be endorsed by the Statewide Aboriginal Health Planning Forum. The WA Indigenous Implementation Board will monitor achievement of intended outcomes through the state government's Indigenous Governance Framework. • WA Health will have responsibility for good governance and accountability of this priority area including the management of high risk areas. • Management will occur through the established WA Health management and reporting framework. • Strategies will be coordinated with other COAG funded initiatives to avoid duplication.
Linkages/Coordination	Consultation and coordination with service partners will occur through established forums including • Office of Aboriginal Health • State-wide, metropolitan and regional Aboriginal Health Planning Forums • Primary Care Health Network, via WA Aboriginal Primary Health Care Advisory Group • Aboriginal Community Controlled Health Organisations • DoHA/OATSIH Programs
Community/Stakeholder Involvement	• Community /stakeholder consultation will occur through the governance arrangements outlined above, and will include regional and metropolitan ACCHOs, GP Divisions and Area Health Services. • Existing established planning forums will be used to identify priorities and develop local strategies. • Indigenous involvement in existing District Health Advisory Councils will be strengthened, and these Councils will be consulted on consumer needs and experiences.

PRIORITY AREA: Making Indigenous health everyone's business

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	How will we check progress?	When will it be done?	What is the cost?
• Develop and implement an evidence-based suite of responses to improve Aboriginal men's health and wellbeing, which can be adapted to meet local needs. • Improve Aboriginal peoples' health in custodial settings and after release.	• Consult with Aboriginal communities through the State-wide and AHPFs to identify priority groups. Current research suggests that Aboriginal men in prison are a priority group. • Work in partnership with other government agencies to provide primary health in reach and outreach services to disadvantaged groups of people currently engaged with child protection, youth justice, corrective services, drug and alcohol and mental services to ensure the primary health needs of these groups are being met. • Establish referral protocols between agencies to ensure early identification and referral of clients requiring treatment. • Employ locally contracted Aboriginal Health (including Mental Health) and Welfare Workers to provide a state-wide Aboriginal health In-reach and Through Care Program at the interface between prison and community health services. • Develop culturally and locally appropriate health promotion messages and strategies to increase knowledge and understanding.	Evidence indicates delays in treatment and poorer health outcomes for patients who have the following: • have fewer years of education • have lower income • are too embarrassed or afraid to ask for assistance. • Indigenous imprisonment in WA at June 2007 was 21 times the rate of non-Indigenous persons • Released Indigenous prisoners have an increased risk of death and suffer greater rates of ill-health and injury compared to general Indigenous population	Services to be developed through AHPFs	• Regularly monitor and evaluate the progress against the implementation plan • Develop performance measures to include: – Staff employed, trained and retained in the service. – Proportion of Indigenous persons in the target group having health and wellbeing checks and care plans. – Number of referrals for treatment services. – Number and percentage of clients who have care plans provided to their designated health service.	**2009/10** Consult and develop a prioritised implementation plan. Recruit and train staff Implement program **2010/2012** Monitor and continue implementation. **2012/13** Implementation and evaluation of program	**2009-10** $2,336,000 **2010-11** $2,406,086 **2011-12** $2,481,269 **2012-13** $2,556,645 **Total** **$9,780,000**

Governance/ Management	• The WA Aboriginal Affairs Coordinating Committee will have overall governance and oversight of the delivery of the health implementation plan process. • The WA Indigenous Implementation Board will monitor achievement of intended outcomes through the state government's Indigenous Governance Framework. • Delivery and reporting on the plan will be the responsibility of the WA Department of Health. • The Statewide Aboriginal Health Planning Forum will coordinate the development of a state-wide implementation strategy . • Regional action plans, including risk management plans, will be developed by the AHPFs, with leadership from the Area health Services and will be endorsed by the Statewide Aboriginal Health Planning Forum. • Strategies will be coordinated with other COAG funded initiatives to avoid duplication.
Linkages/Coordination	The following groups will be used to provide advice and expertise or coordination as appropriate: • WA Aboriginal Men's Health Reference Group • Primary Care Health Network, via WA Aboriginal Primary Health Care Advisory Group • WA Aboriginal Chronic Disease Screening Committee. • Aboriginal Community Controlled Health Organisations • Government departments including child protection, corrective services, juvenile justice and education. • Outcare Existing resources will be utilised including: • Health of Prisoner Evaluation (HOPE) survey: commenced 2008, ongoing; *Promoting, sustaining and evaluating health programs for Aboriginal men* – Brian McCoy project being completed • DoHA/OATSIH Programs
Community/Stakeholder Involvement	• WA health will ensure engagement of key stakeholder groups, including Indigenous health groups and other Government departments to ensure that this most vulnerable group of people have access to the services they require. • Indigenous people will be consulted through existing mechanisms.

PRIORITY AREA: Healthy transition to adulthood

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	How will we check progress?	When will it be done?	What is the cost?
• Re-establish positive social norms among young Aboriginal people to support healthy life options and reduce risk-taking behaviours. • Improve referral and access to clinical and other services to address health problems • Improve access to health services for young people leaving the justice system. • Increase Aboriginal teenage girls' resilience and coping skills. • Increase early intervention in young people's mental health and alcohol and other drug issues.	**Needs analysis** We will work with existing Aboriginal health forums to develop a comprehensive analysis of the priority needs of Aboriginal young people, and to develop a range of local strategies to address those needs. It is envisaged that specific strategies may include: • **Sexual health** • Develop a community based program to improve sexual health and protective behaviours for Aboriginal girls, in partnership with Aboriginal matriarchs, DCP and the eduction department. • **Juvenile justice** • Work with Aboriginal groups, mental health and juvenile justice services to ensure that young people leaving the juvenile justice system are linked into health services that meet their needs. • **Nutrition** • Work with remote communities to develop programs to increase awareness of and access to nutritious food. • **Education/training** • We will sponsor and support local Indigenous people to undergo Certificate IV and university training to develop the capacity of community leaders. • **Develop culturally appropriate materials/programs**	During the period 2004-06 STIs and hepatitis C were more common among ATSI people than others in WA. In 2005 those aged 15-19 were 104 times more likely have gonorrhoea and 15 times more likely to have Chlamydia. In 2004-05 in WA approx 28% of Indigenous males and 26% of Indigenous females aged 15 years were a victim of physical or threatened violence in the last 12 months (AIHW analysis of 2002 National ATSI Social Survey).	AHPFs will develop regional implementation plans.	• Completion of the needs analysis. • Completion of a detailed implementation plan. Progress will be regularly reviewed against the implementation plan. • Number of communities involved in providing programs. • Number of Indigenous people recruited and trained to deliver programs. • An evaluation plan will be developed with performance measures, including: • Numbers of young people accessing services • Prevalence of STI diseases • Prevalence of teenage pregnancies.	**2009/10** Completion of needs analysis and detailed implementation plan **2010/11** Recruitment and training of staff. Development of program materials. **2011/13** Implementation and ongoing review. **2012/13** Evaluation.	**2009-10** $5,750,000 **2010-11** $4,500,000 **2011-12** $6,060,000 **2012-13** $6,000,000 **Total** **$22,310,000**

Statewide Indigenous Mental Health Service (SIMHS)

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	How will we check progress?	When will it be done?	What is the cost?
Improve Aboriginal people's mental health by a whole of family approach to supporting access to mainstream services, and increasing services' capacity to better meet Indigenous people's needs.	Consult with AHPFs to establish a statewide Indigenous mental health service. This service will work with mainstream services to provide: • Shared client assessment and management • Participation in treatment and discharge planning for inpatients to ensure seamless transition back to their community • Brokering elders to participate in particular clinical cases and/or contracting traditional healers • Clinical services for Indigenous patients in custody or presenting for parole • Increase focus on primary health to address co morbidities affecting mental health. Staff will be trained to provide services by: • Sponsoring key workers from Certificate IV to University courses • Seconding AMS Aboriginal Health Workers for professional development	• From July 2004 to June 2006 in WA Indigenous males and females were hospitalised for mental health related conditions at a higher rate than non-Indigenous males and females (AIHW analysis of National Hospital Morbidity Database). This was higher than the national rate. • Lack of culturally appropriate Indigenous mental health services in all regions of the State. • Severe lack of Indigenous mental health workers when compared to the rate of Indigenous people that present with mental health issues. • Lack of follow up care provided to the patient post discharge in many cases due to the patient living too far away from mental health services. • Lack of service Indigenous specific support services throughout the state that cater to assisting a patient when they do not need acute mental treatment. e.g. counselling.	Mental Health Division in consultation with AHPFs.	• Number (rate) of hospitalisations and emergency presentations for mental health conditions • Number of key workers sponsored to undertake University courses • Number of AHWs undertaking professional development	**2009/10** Develop service model, prepare service policy, procedures, documentation, Recruit and train staff, establish service, **2010/2012** Implement service **2012/13** Evaluate and refine services.	**2009-10** $2,000,000 **2010-11** $7,400,000 **2011-12** $6,300,000 **2012-13** $6,770,000 **Total** **$22,4700,00**

Governance/ Management	• The Aboriginal Health Partnership Group will have overall governance and oversight of the delivery of the health implementation plan process. • The WA Indigenous Implementation Board will monitor achievement of intended outcomes through the state government's Indigenous Governance Framework. • Delivery and reporting on the plan will be the responsibility of the WA Department of Health. • The Statewide Aboriginal Health Planning Forum will coordinate the development of a state-wide implementation strategy . • Regional action plans, including risk management plans, will be developed by the AHPFs, with leadership from the Area Health Services and will be endorsed by the Statewide Aboriginal Health Planning Forum. • Strategies will be coordinated with other COAG funded initiatives to avoid duplication.
Linkages/Coordination	Programs will be coordinated with existing strategies to ensure that there is no duplication, and that strategies are aligned with State and National priorities and goals, and identified best practice. This will include coordination with: • WA Health Networks Models of Care • WA Aboriginal Primary Health Care Advisory Group • WA Aboriginal Chronic Disease Screening Committee • Aboriginal Maternal and Child Health Partnership State Executive Group • Western Australian Aboriginal Women's Maternal and Child Health Governance Group • WA Aboriginal Men's Health Reference Group Aboriginal Community Controlled Health Organisations • Cultural competency strategy • Outcare • WA Indigenous Sexual Health Advisory Committee • Indigenous Early Childhood Development National Partnership • NATSINSAP • DoHA/OATSIH Programs:
Community/Stakeholder Involvement	• WA health will ensure engagement of key stakeholder groups, including Indigenous health groups and other Government departments to ensure that the health needs of young Aboriginal people are identified and addressed. • Indigenous people will be consulted through existing mechanisms.

5 RISK MANAGEMENT

The Department of Health has a specific risk management process. All managers are responsible and accountable for effective risk management within their areas of responsibility (see risk matrix in appendix A).

All operational planning documentation will include identification and assessment of risks. It will be accompanied by appropriate management plans for treatment, monitoring and review of those risks. Managers will be expected to periodically review their risk management and include its status with commentary on any significant risk issues in their regular management reporting.

Key risks include workforce shortages, lack of data collection systems, the need for community ownership and engagement, the need to demonstrate equity in service provision and resource distribution, and the need for good coordination across the sector in order to ensure well targeted services and reduce duplication of effort. Addressing these issues will be a key responsibility of the governing bodies and program managers, and will form an essential component of the reporting requirements.

Workforce

Workforce availability is the key risk in the successful implementation of these initiatives and a comprehensive workforce strategy will be required across Government Agencies including education and housing to address issues of workforce supply, and the infrastructure to support the required workforce in remote locations.

The increase in Aboriginal participation in the health workforce is a key strategy. WA Health will work with the Department of Educating and Training and tertiary education institutions to develop pathways into health careers for Aboriginal people. Linkages will be made with the NP on Indigenous Economic Participation and Skills and Workforce Development to maximise opportunities for the health workforce through those strategies.

6 REVIEW AND EVALUATION

To ensure accountability, a 'Closing the Gap' monitoring an evaluation framework will be developed to provide a valid and reliable assessment of programs. This will be developed by the CAOH sub-committee of the Aboriginal Health Partnership Group.

Western Australia will review its performance against the National Health Performance Framework and COAG targets and indicators. Evaluation will include process and outcome targets, and will utilise both quantitative and qualitative methods.

The lack of consistent data collection systems across providers is recognised as a significant risk in the successful implementation and ability to report on this initiative.

The ability to share electronic records, and development and implementation of protocols and shared data systems is therefore a priority strategy.
Over the last few years, Area Health Services have collated and analysed regional datasets to establish baseline data for the purpose of developing and monitoring regional clinical service plans. This data will be shared with, and supplemented by the data from other health service providers to develop common priorities and shared plans. In addition, WA Health will work with ACCHOs, and other providers in providing targeted training on data recording, identification of Indigenous status and management to improve data collection.

Additionally the Commonwealth will formally and independently evaluate the Indigenous Health National Partnership in 2012/13.

Appendix A: Risk identification and control

Risk	Risk rating	Origin/cause/source of risk and trigger point for deploying strategies	Risk mitigation/control strategies
{Financial}			
Management of cost centres	High	Lack of expertise	Enforce accountability through auditing, financial and service reporting requirements
Potential for budget over-runs and underspends	Med	Insufficient system controls and validation	Review and improve effectiveness of system controls and validation mechanisms.
Adequacy of financial management systems and reporting, and available expertise	Med	System not able to meet reporting needs. Support may not be available.	Implement and monitor quarterly performance reports
Delay in expenditure of funds	Med	Procrastination or other inaction	Revise management expenditure approval process to include deadlines and enforce accountability
Governance			
The capacity and capability of the leadership team	Med	Limited resources	Establish routine performance monitoring. Develop and implement succession planning processes.
Independence from management and governance	Med	Lack of understanding of the role and responsibilities	Determine priorities and establish suitable improvement mechanisms
Lack of skills to govern available	High	Insufficient practical knowledge and expertise	Target training programs to improve skills and continue monitoring
Representative of the community	High	Limited resources	Ensure consultation and build relationships with the community
Potential interpersonal conflict and breaches of confidentiality	High	Inadequate practical knowledge	Target specific training on confidentiality and conflict
Capacity to deliver within the health sector demands	High	Limited work experience and knowledge of health sector	Initiate training programmes targeted at increasing health knowledge Establish COAG processes with appropriate leadership

Managerial Competing SHEF priorities compromises initiatives	Med	Demand of predetermined priorities	Regular reporting on progress of initiatives
Variations between Commonwealth and State approaches	High	Lack of connectivity and alignment	Regular meetings to ensure clear understanding of joint needs and processes.
Cultural Acceptability of provider to target groups and local Aboriginal communities	High	Lack of culturally appropriate provider Misinformation to Aboriginal community	Ensure community engagement
The delivery model is not sensitive to cultural diversity	High	Lack of cultural understanding towards Aboriginal	Ensure provider has appropriate cultural programs Implement Cultural Respect Framework
Contractual Potential for contractual failure/non-compliance	High	Failure to perform due diligence checks	Rigorous due diligence checks prior to awarding contract Develop a Contract management plan Perform a SWOT analysis on potential provider.
Ability to comply with reporting requirements	Med	Inadequate systems and accountability reporting requirements	Establish quarterly reporting template
Skills and expertise in managing contracts of the same size and scope	Med	Inadequate skills and expertise	Ensure clear understanding of delivery requirements
Capacity to effectively monitor the project/service	Med	Inadequate monitoring systems	Ensure scope of project is orientated to delivery requirements
Political High profile or sensitive project or service (COAG)	High	COAG goals not achieved as they are not feasible or acceptable Under resourced Critical success factors not identified or ignored	Ensure rigorous evaluation and control mechanisms are established Continue active participation with Working Group Maintain ongoing two-way communication to ensure alignment with initiatives
Loss of political confidence	Med	Poor implementation outcomes	Progress meetings with key personnel Prepare briefings on

			contentious issues
Staffing Capacity to recruit/retain staff	High	Inadequate selection and recruitment of staff	Review appointment processes
Skills and experience of available staff	High	Lack of experienced skilled Aboriginal staff available	Target Aboriginal workforce through building capacity in AMS Trial alternative workforce options
Loss of staff confidence	Med	Pressure to deliver in a different environment	Provide regular information on performance and change
Industrial relations issues	Med	Inadequate disputes solving procedures	Enforce accountability and processes
Occupational health and safety issues	Med	Unsafe place or system of work	Compliance for safe places and systems of work
Project Management Cost overrun	High	Inexperienced project team	Establish rigorous project planning and management methodology
Project delay and time slippage	High	Inadequate project planning and project management Changes to specifications or deliverables	Recruit experienced project managers and leaders with established records of success in budget and timely delivery.
Operational Plan Loss of key staff	High	Promotion or separations	Develop a process to ensure succession planning. Target retention and training programs to retain critical personnel
Information Systems Lack of Management Information systems	High	Insufficient system controls and validation	Establish routine performance monitoring and feedback processes