

The Katherine West Health Board

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¹Katherine West Health Board

Robyn Williams: Please come up, the guys from Katherine, and you'll introduce yourselves and hold forth for the next 20 minutes, please.

Joseph Cox: Hello. Good afternoon, ladies and gentlemen. I would like to acknowledge the traditional owners of Cairns and the organisers, as well, for the conference. I might introduce ourselves. I'm Joseph Cox. I'm the chairperson of Katherine West. Jack Little is the boss man. Andrew Bell is the primary health care. David Lines is the community development officer, a local bloke from Kalkaringi. And Sean Heffernan, who was just here—executive officer, Katherine West.

You can see there—just to talk about the map there—this area we cover would like cover Tasmania twice—the size of Tasmania and, yes—Katherine West—no slides? This is a model of providing premier health care across a large region controlled by the communities. We want to develop a health service that serves the community that work out—want it to work. This is a picture of the community area we cover. All right. I've finished my speech. Now I'd like to introduce Jack Little.

Jack Little: Thank you very much, Joseph. Good afternoon, ladies and gentlemen. Good to be here this afternoon. And I'm from Bulla community. I'm (inaudible 0.02.44) tribe. I'll give you a bit of a background of myself. I been born in a cattle station. I been working as a ringer until I was about 30. I decided to train to be a Aboriginal health worker; and I went to Darwin 1958 and trained to be a health worker, and then I went to Katherine, working in Katherine with one of the nurses. We usually go round to each community; but I'm really come from Bulla. Bulla is my community, but I been born in Humbert River. Regarding a (inaudible 0.03.32) mean that one shield for all of us. Doesn't matter what colour we can be, the shield to stop the sickness that we can use; and I can say thank you very much, government, for giving us a funding to run our own affair because this is my community. That's where I come from, Bulla. That two road, it very important for me, from my heart and from my spirit. That two road, the narrow road is a government road. The wide, broad road is for Aboriginal road because we didn't know how to handle, how to walk hand in hand together, black and white.

Now, I decided to put that up just to have a relationship with black and white, and so why I put that up, you can see part of my culture side there and government culture, government law, Aboriginal law. That's what we do. We test the ways. That road, two road, heading to better health; and so you can see two hand and two little people running across. You can see white man run to my road, we black man run to their road; give experience and knowledge to each other so that we can work together; and you can see before we hit the road, at end of the road we walking hand in hand. We are partner. We are fighting something that we cannot see. Thank you very much.

Andrew Bell: I'm going to give you a very brief history—because we're all cramming into our spot—of Katherine West from a health service management perspective, and where we've come from. This is a picture of Jack and one of our long-term GPs, Tim Hannah, who's now retired, again at a community meeting telling the story of our health service. We can probably best describe the original Katherine West proposal as a trojan horse in that we found that this was a co-ordinated care trial proposal, and we took a model for the development of a regional community controlled health service for a per capita funding model, which included cashing out of Medicare entitlements, a guidelines development process; and we rolled all that into a thing and made it look like a co-ordinated care trial, and we pushed it through the gate and we got the proposal up. So that's where we came from. That all

started back in 1995, and as Fred was saying, one of the key success factors, I think, was the realistic timeframe in which we were able to do this.

So in 1995 and 1996 a process of consultation started with the remote communities, and many of our board members, including Jack and Joseph, were involved in actually developing a health service. We went to every community, every family in every community, and got consents for the access to medical records that was necessary to evaluate the proposal. So every person in our region of over 3000 was consulted. So there was a process of proposal development, community consultation, governance training for our new interim board.

In 1998 we were actually incorporated as the funds holder and purchased all the health services for the region; and this is the public health, the population health, as well as acute clinical services. Then between 1999 and 2001, in a slow transition, we took over management of both population health and clinical services. So we took over two clinics, we developed our management capacity around managing those two clinics, and then we took over a couple more community health centres; and by 2001 we were running the eight or nine community health centres plus programs like environmental health, child health, nutrition, etcetera. And this year, now, we've been delivering services on the ground for 10 years.

It was a transitional change process which involved investing a lot of extra money, and we probably have about three times the budget now in real terms compared with what was spent in the health service we took over. One of our health services for Lajamanu, for instance, has 1000 people and its health staff was two nurses, one and a half health workers and a doctor every second week at the time we took it over. We now have a staff of six nurses, a couple of health workers at the moment, administrative support plus a resident GP. So it's really been a huge expansion of services; but it was a transitional change process where we had a clear goal, and we had a three phase plan of health service development.

One was to raise acute clinical care to a level of safety, where it was safe for people in communities and it was safe for staff from an occupational health and safety perspective. To develop well structured and well engaged population and preventative health programs, and at the same time a community development component concentrating on better cultural integration of our health services with the communities; and this is the area where we're really working one now, 10 years down the track.

So in 2009 we're the provider and employer of all the primary health care and population health services to the whole population. 3300 people, 90 per cent of that are indigenous. We also have a mobile team that visits the pastoral properties and the stock camps because we're in the heart of cattle country. I think one of the ongoing reasons for our success has been the really close relationship between our governing board, our management team and our communities; very high level of community input which is getting richer with time; the cultural oversight and management of service delivery; and—but—really important, a secure funding model. We know where we're going to be for the next three years, and that's really important.

I think the real success stories—factors—to learn from Katherine West are: you have to have extensive community consultation to make this work; you need to be developing a model which is what the communities want, not a one-size-fits-all model transplant from somewhere else; you need realistic core funding, and the funds pooling model has worked very well for us where, initially, we had both the commonwealth and the state government funding and we purchased our services and then gradually developed our own health service.

We're a size, as a region, that's large enough to have the capacity to have expertise and stability, but small enough to be very focused on our communities. We've got a very integrated leadership model now, which Sean will talk about, between our population health and our clinical services. We have multi-disciplinary teams, and they're lead by a multi-disciplinary management team; and I think that's really important.

I think the key factor in making multi-disciplinary teams work in the bush is to have your relationships right at management level. We've got a very strong emphasis on systems and quality, and we have a fully networked electronic health record across our whole region. We're not alone now. There's a second health service, Sunrise Health Service, which looks after the east side of the Katherine region—there's a few Sunrise people here, somewhere; but what's really exciting in the Territory at the moment is—and this was part of the response to the emergency intervention—it was a joint response between our (inaudible 0.12.06) and Northern Territory Department of Health and Families, and we have 100 million dollars to invest over two years to do system-wide primary health care reform across the whole of the jurisdiction, which is really exciting.

So there's new funding based on a virtual funds pooling model. We've developed an adjusted per capita funding model that factors in varying degrees of costs and remoteness. We're developing regional health services across the whole of the Northern Territory with steering committees which will have the options to progress to being boards. We have a definition of what core primary health care services we want to deliver in every one of those regions. We've got a document pathways to community control which gives the communities a framework where they can progressively take more control of their health service delivery over time, and we've got a lot of other system-wide reforms that we're driving, such as a system-wide reports approach to quality improvement to performance indicators, workforce, etcetera; so it's a very exciting time in the Territory, and that's my bit.

I'd just like to thank Simon and the musicians for that introduction, too. There couldn't have been a more appropriate song to introduce our story—Kalkaringi, Wave Hill, Daguragu, that song's about. It's right in the heart of our country.

David Lines: I originally come from Kalkaringi. I'm a Mudburra man, so pretty impressed with the song From Little Things Big Things Grow; so very relevant and set the mood for us at Katherine West. My background is I've worked as an Aboriginal health worker for Aboriginal medical services over the last few years and I'm currently with Katherine West which is relevant, I guess, with my work. The one thing good about it is I get to go home on a regular basis and keep in touch with family.

The two things that I'm going to touch on are cultural safety and community engagement. One thing that our board's really strong on is engaging at the grass roots level with health service delivery. I guess what ensures that we have cultural safety is we've got a few things at Katherine West that the board's been really strong on delivery, and I guess those processes are, one, our board members. All of our board members are representatives from each of our communities. So they get to have—they're elected by the community and they're a part of that decision making with health service delivery. Basically, with Katherine West, they have the final say with health service delivery; how we do it, how we deliver it.

The other thing that we've got that we've recently implemented is what we call our (inaudible 0.15.54) reference group. That's our Aboriginal reference group. Now, what the reference group does; every new program that's about to start at Katherine West, that is screened for cultural sensitivities and how that's delivered out in the community. All our health service delivery, all our information and education resources that go out, they're all screened by our (inaudible 0.16.27) reference group to make sure that cultural sensitivities are taken care of so we don't upset our people. We're starting programs out

at our communities that don't work. We want programs to be meaningful when they go out there; we want them to have an impact, not starting up programs that don't have any effect, don't have any impact. So that's what the (inaudible 0.17.03) reference group is about.

The other thing that we do; we regularly go out to open community meetings—out to communities to have open consultations. So once every year, a group of us as management, all our program staff and our board, will go and visit each of our communities for a week, and we'll sit down at the grass roots level and have an open discussion about what we're trying to do. We'll get our staff to present to the community what they're trying to achieve; what they've done. Also it's a vehicle, I guess, to have two-way communication. We get to hear what we're doing well, also where our challenges lie; so we have that open discussion about how we can change it to make it appropriate for each community.

Though we're one region, all our communities are unique in their own right. We've got different language groups in our communities, different cultural sensitivities in each of our communities. They are all addressed in a different way in consultation with our (inaudible 0.18.32) people at that grassroots level.

I guess I'll end with the most important thing with cross-cultural communication: in our communities our people—with English, English is a second and a third language so we often have a lot of challenges with a lot of our non-aboriginal staff with program delivery, health service delivery. By getting out and being open at that grass roots level, our communities call us (inaudible 0.19.14); that's open communication. This communication, I guess, encourages open discussion, positive discussion; but also that it's fair between each other. I shall leave you with that. Thank you.

Sean Heffernan: Thanks a lot, everyone. The problem with working with Katherine West hospital is it's too radical a model; the CEO goes last and he's got to be the shortest amount of time. I guess the main wrap-up for this one is, you know, the Katherine West model, what use could it be for other parts of remote Australia? When thinking about that I just come up with two or three points, I guess, and I was steered in that direction by conference organisers.

The main thing about a regional model that we have is that we get funds pooling; we're able to recruit and retain quality staff because of that great resourcing; and I think the main thing hasn't quite come in through totally in such a short presentation, but the flexibility of what Katherine West are able to do means we can tailor our programs, even our basic service delivery, to meet our client's needs through community consultations. The actual fact of the community elections, even though it's varied from community to community—one community, an old lady got up and said, "Okay, everybody, who wants to nominate for the health board," and had a chat about why they wanted to do that, put them all in heads of lines and then people had to stand behind the person they wanted to represent them. If one line got too long, they then matched up the other line with it just so that there was no shame job—so we really do do things differently. But all that stuff makes sure that there's cultural safety and there's respect amongst our staff to see those processes.

Because of that flexibility we could have—bring in earlier than other health services in the Territory—a clinical quality program. We can bring in an integrated model of staffing which means we bring nurses, health workers, board members together regularly to discuss issues. We make sure that the predominant voice is (inaudible 0.21.37), or Aboriginal. With other quite flexible in issues we've been able to bring in under Andrew's leadership and some of our head nurses, are the collaborative processes. Every Friday we have collaboration across our whole region with our senior health workers and our nurses around what are the important things to watch that week. Quite often those things that the health staff are looking at are quite small things; it might be the one percenters, but it means they're talking about those issues—whether it's around nutrition, chronic disease management, or

health promotional program priorities that week so there's also a dialogue, and we create lots of sites of dialogue.

So we got away from a total solo mentality to—from a corporate stream, you know, public health stream, clinical stream. We work very hard at cross-flows and thatching that underpins our organisation, and that's the main lesson that (inaudible 0.22.35) brother Jack has taught us about how everyone needs to know what everyone's doing. It doesn't mean you're not a specialist in your area; it means you have to know something about what another person who's part of your team is doing; but that might not be your special area. But there's a discussion about it, as David said, there's a (inaudible 0.22.52) around those things, and that's part of our cultural safety.

You can also construct the model to suit your needs, and that's what we've been able to do at Katherine West Health Board. It means turning away money sometimes. Even though we have good healthy commonwealth funding and NT government funding, we've actually turned away a lot of other resource streams because—simply for what Fred has said: it has to be brought on in a really good way, in a way that our mob really can understand and own it. If our health workers and the people that David works with closely in the (inaudible 0.23.24) reference group do not understand it, it's our crude test; it doesn't get up, there's more work to be done.

So I guess it's the Katherine West Health Board. We're now working on helping other health boards get across the line in the NT. Andrew's doing some of that work through AMSANT and that's about trying to help some of the other smaller services up to the benchmark per capita funding rate we now have. Right now, the next phase of our development—we've brought our model to a certain point, and now our board and (inaudible 0.23.57) reference group want us to re-look at our vision again; so we're going to spend a six to 12 month process doing that; again, taking our time around the vision and this will take strategic plan.

Just like to thank NRHA for inviting us to come here today. I've forgotten to press the mouse, so I might flick through some of these. I won't talk about this one, this is a (inaudible 0.24.21) ceremony for making (inaudible 0.24.25). That's basically the stuff I've touched on. That's just out at Lingara. That's really near (inaudible 0.24.33), Jack's country, Humbert River. When we go there, that's the place of his heart.

That's the board involving governance training, we've had that been going now for at least three or four years; we've had it always ongoing. That's also a good—it's very useful to have other people coming into your board, talking about what's happening outside. We open up the board to lots of input; we're not afraid of that. And that's (inaudible 0.25.02) I forget. Anyway, thanks very much.