TAKING CARE OF BUSINESS:

Corporate Services for Indigenous Primary Health Care Services

OVERVIEW REPORT

Kate Silburn, Alister Thorpe and Ian Anderson

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Incorporating the Cooperative Research Centre for Aboriginal and Torres Strait Islander Health

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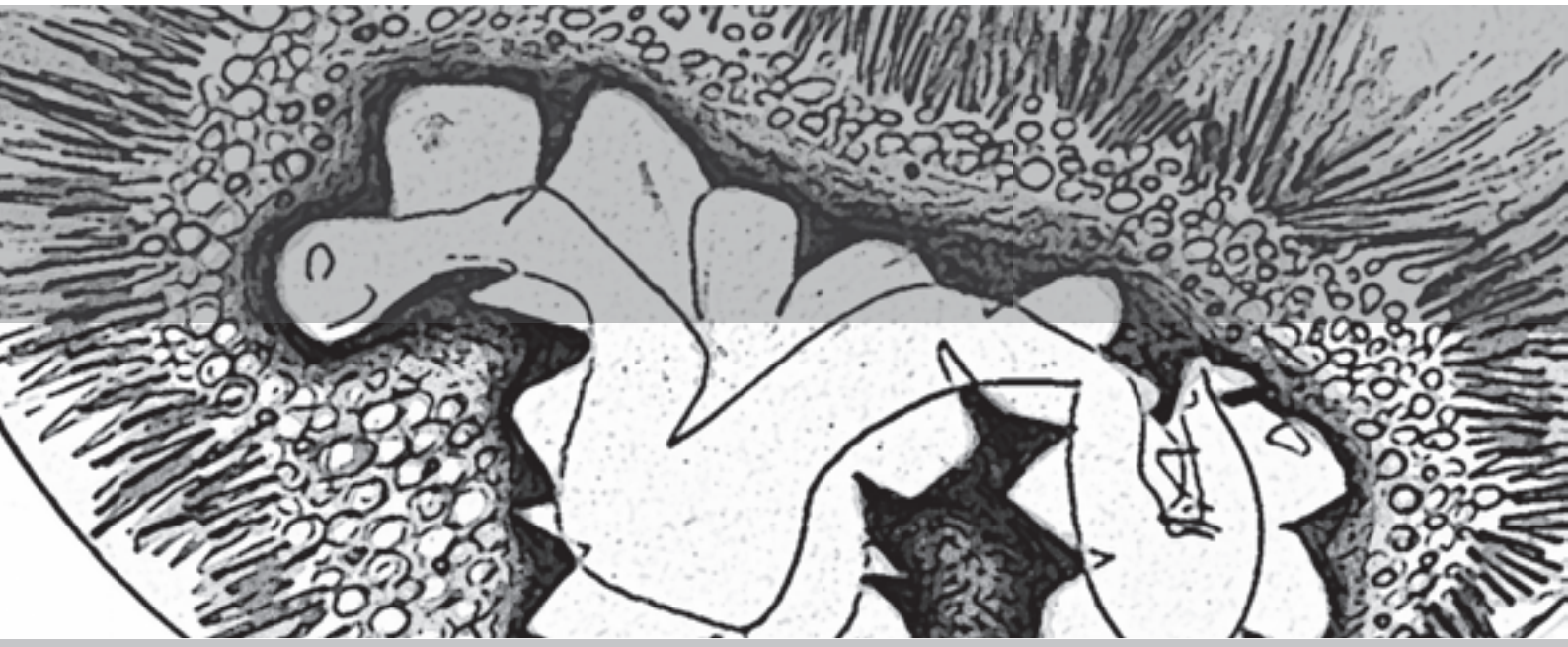

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Contents

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Without the contribution of everyone involved, this work would not have been possible.

It's like a tricycle – you have three wheels – cultural safety, supportive systems, health care provision – without the balance of these three it doesn't work well (Katherine West Health Board key informant).

Abbreviations

ABCD	Audit and Best Practice in Chronic Disease
ACCHS	Aboriginal Community Controlled Health Service
CAAC	Central Australian Aboriginal Congress
CQI	continuous quality improvement
CRCAH	Cooperative Research Centre for Aboriginal Health
KAMSC	Kimberley Aboriginal Medical Services Council
KWHB	Katherine West Health Board
NACCHO	National Aboriginal Community Controlled Health Organisation
OATSIH	Office of Aboriginal and Torres Strait Islander Health
QAIHC	Queensland Aboriginal and Islander Health Council
SDRF	Service Development and Reporting Framework

Some terms used in this report

Corporate functions

By 'corporate functions' we mean those functions that maintain the business side of an organisation – these include things like governance, general management, human resources, finances, organisational development, data management, and evaluation and quality improvement systems.

Core business

We use the term 'core business' to refer to the activities directly related to the reason the service exists. In the case of Aboriginal Community Controlled Health Services (ACCHSs) the core business is likely to be to provide holistic, comprehensive primary health care services to communities. Corporate functions therefore support the core business of an organisation.

Support structures/models/frameworks

This project looked at a range of ways ACCHSs obtain support for corporate functions where necessary. In many cases organisations get direct support from one or more providers (such as accountants, lawyers etc). However, the main focus of the work is on how ACCHSs have moved beyond one-on-one arrangements and developed ways to obtain corporate support for multiple functions in organised or structured ways. We refer to these means of getting support as support structures, models or frameworks.

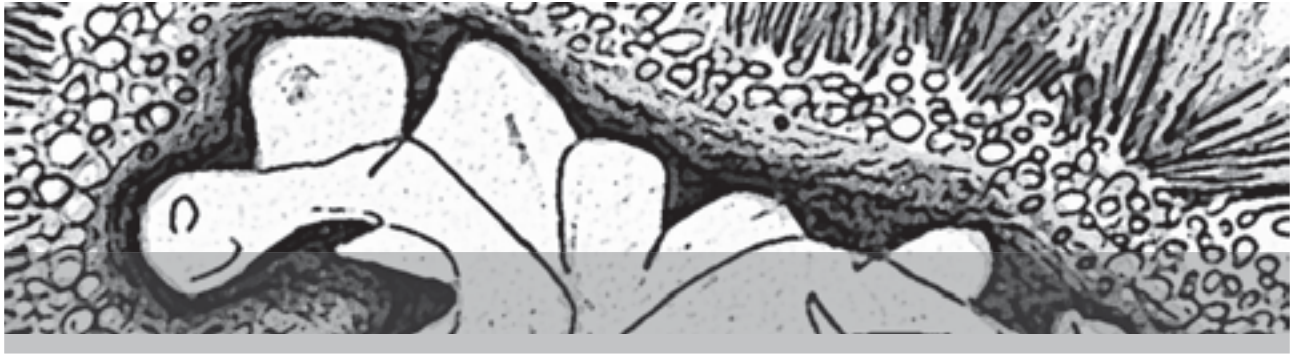
It was noted that in 'mainstream' organisations (and, indeed, in many ACCHSs), obtaining corporate support is viewed as a necessary part of the organisation's corporate services activity. That is, organisations see obtaining support as a normal component of their business operations rather than as something that is only required if they are facing a crisis or difficulty. In this sense corporate support is the same as corporate services – however, we have used the term 'corporate support' to refer to externally provided corporate services and to delineate them from those provided internally by employees. We have also tried to pay attention to issues that may create specific issues for ACCHSs in relation to corporate support, such as (1) the relationship between community control and accessing corporate support and (2) the role of ACCHSs within their communities (for example, in many cases ACCHSs are significant employers and may be one of the few mechanisms through which community members can gain entry-level positions within organisations and/or further develop certain types of skills). Issues like these will clearly inform the ways ACCHSs consider the issue of corporate support and influence the ways they engage with it.

Supporter, support provider, support accessor or service accessing support

We note there are many complex sets of organisational, individual and community relationships involved in the area of corporate support. Therefore it is not easy to develop terms that are easily definable. However, at the risk of over simplification, and to make this discussion simpler to follow, we have adopted the following terms to indicate different stakeholders in the support provider – support accessor relationship. These are:

- 'supporter 'or 'support provider' are used to refer to the structure through which support is provided
- 'support accessor' or 'service accessing support' are used to refer to those accessing services provided by the supporter or support provider.

An example of how this language can overlook complexity is in a peer support network, where those who provide support also access support, so it is not really appropriate to talk of participants as either support providers or accessors. However, for ease of discussion, when their role is support provision they are called 'supporters' or 'support providers' and when their role is accessing support they are referred to as 'support accessors'.



Executive summary

The Cooperative Research Centre for Aboriginal Health (CRCAH), (now known as the Cooperative Research Centre for Aboriginal and Torres Strait Islander Health), in collaboration with people from the Aboriginal health sector, identified corporate support systems as an area requiring more research to inform ongoing development; hence, the Support Systems for Indigenous Primary Health Care Services Project (hereafter, the Support Systems Project) was conceived.

The Support Systems Project focused on corporate support for Aboriginal Community Controlled Health Services (ACCHSs). The aim of the project was to contribute to improving the viability and sustainability of ACCHSs as corporate entities through developing knowledge about:

- the range of corporate functions for which ACCHSs might require external support
- the factors that influence the support required
- the support structures that currently exist
- the lessons that can be learned from existing models
- ideas about what needs to be done in the future.

The project examined the corporate support needs of ACCHSs, the issues associated with obtaining appropriate support and existing support structures used by these services.

The key research questions were:

- what is the nature (scope and characteristics) of the support needs of ACCHSs as corporate entities, taking into account differential organisational capacity and contexts?
- how do ACCHSs, as corporate entities, access the different kinds of support they require in each area (taking into account the diversity of services, differential organisational capacity and the contexts in which they operate)?
- what frameworks (organised support structures) are required for the provision of adequate corporate support for organisations with different organisational capacity operating in different contexts, and what are the barriers to implementing and accessing such frameworks?

The project was conducted in two parts. Part 1 focused on support needs and issues associated with obtaining support. Part 2 focused on existing models for corporate support and the lessons learned through developing and implementing these structures. Each part included reviewing literature, consulting with key informants (with case studies being developed in Part 2), developing a discussion paper and holding a national roundtable.

The project findings are reported in *Taking Care of Business: Corporate Services for Indigenous Primary Health Care Services*, which comprises three documents:

- *Overview Report* (this document)
- *Case Studies*, which provides full details of the four case studies conducted for the project
- *Summary Report*, which briefly presents the main points.

Background

The first ACCHSs were established in the 1970s to enable Aboriginal people to obtain services they could not access through mainstream services. Since then, ACCHSs have become an important provider of health and wellbeing services to Aboriginal people. However, they generally receive very little funding to support the corporate functions of their services because many of their funding allocations are program- or project-based.

ACCHSs exist within a continuously changing policy environment. Many have experienced significant growth and change and have increasingly complex funding arrangements, which result in high administrative and reporting loads. Changes to business practices and developments in technology also increase the complexity of the way organisations operate, but the skills and the significant resources required to manage services are not accessible in many communities.

The extent to which all services (both mainstream and community controlled) can perform optimally is generally related to their capacity in areas of corporate functioning, such as governance and the management of organisational and capacity development, human resources, finances, risk and information. One means of strengthening the viability and sustainability of services is to establish structured ways for them to access effective and appropriate external support – either so they can build internal capacity or have specific functions delivered for them. Towards this end, considerable effort has gone into developing external systems to support the corporate functions of Aboriginal primary health care services in some regions/jurisdictions. This effort is the focus of the Support Systems Project.

Corporate functions

Structuring the delivery of corporate functions to best support core business is an ongoing challenge for all types of organisations. This report examines the different ways that corporate services have been organised in the past, and the different types of arrangements through which organisations can collaborate to share corporate services. It also looks at the lessons that have been learned.

The project identified areas where ACCHSs might require corporate support. Areas most regularly noted were governance, finances and human resources. ACCHSs also need to consider which types of corporate support need to be carried out within an organisation and which can be provided externally.

Many factors influence how individual ACCHSs consider their corporate support functions. These fall into the three main areas – the broader environment in which they operate, organisational factors and community factors. Issues associated with getting support were also identified, as were the features of 'good' support.

The reform of government funding processes was considered by key informants to be one way that the viability and functioning of organisations could be enabled, because multiple funding and reporting streams create a corporate support need, competitive tendering processes do not facilitate capacity building across the sector, and organisations with the least capacity are often the least likely to be able to obtain funding in submission-based processes.

This report also looks at the issues that arise when services consider developing shared support models. The sharing of corporate support services between organisations is potentially beneficial, but also has risks.

Each ACCHS exists within a broad system that includes regional structures (in some States and Territories), State-based peak bodies and organisations (such as affiliates), national organisations, and government and other funders. Each level might have some role in creating supportive systems and developing agreements about what should be provided at which level.

Case studies

ACCHSs deal with the factors impacting on their operational and management functions in varying ways and various mechanisms have been established by the sector to address corporate support needs. Case studies of four different models were conducted and various aspects of their establishment and operation were examined. The four models were:

- Queensland Aboriginal and Islander Health Council, which is a State-based peak body with a Sector Development Unit that provides member support through a fee-for-service model
- Bila Muuji Health Services Incorporated, which began as a peer support network for Chief Executive Officers and operates across western New South Wales
- Katherine West Health Board, which is a regionalised health service operating in the Northern Territory
- Central Australian Aboriginal Congress, which auspices a number of remote health services in its surrounding area.

The case studies illustrate some of the significant thinking, work and effort invested in developing a range of models for supporting the corporate functions of ACCHSs in Australia over many years.

In thinking about the kinds of support that might be obtained from external sources and the kinds of corporate functions that need to be undertaken internally, we group corporate functions into three main categories – the foundational aspects of a health service (those required on a regular basis for ongoing functioning); where expert skills or advice are required relatively infrequently but over a long period; and where one-off changes occur. Generally, only large services have the internal capacity to undertake many of these functions in-house, although they may choose not to do so.

The project also considered:

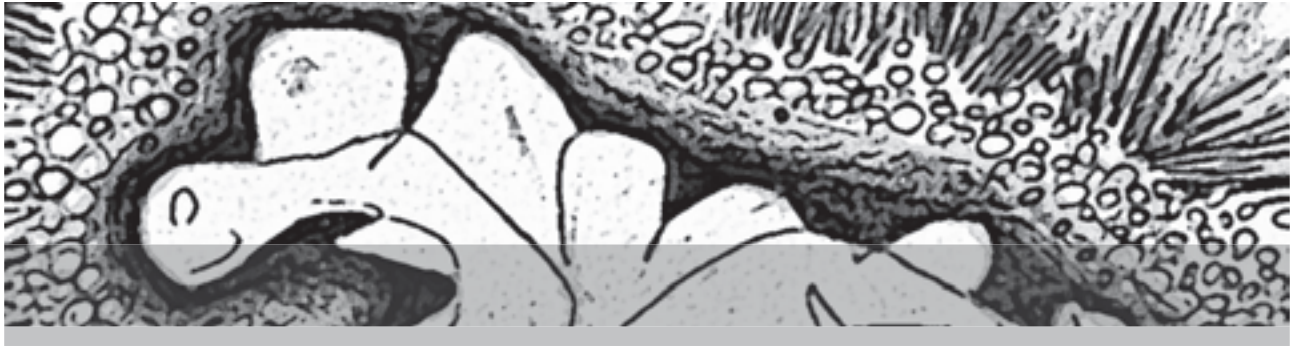
- the critical issue of how organisations identify their support needs
- how models incorporate a capacity building approach (some had a commitment to developing skills of local Aboriginal people to work in ACCHSs)
- the variety of ways in which models were funded
- the main ways support providers were accountable to support accessors
- indicators of corporate support success and how they can be measured – these are grouped as 'process indicators' (those that indicate the quality or extent/reach of a program or service function) and as 'impact indicators' (those that indicate the changes that have occurred as a result of program or service activity)
- benefits and risks of support structures
- key issues for further work.

Conclusion

The process for developing models appears to be more important than having a specific model or structure to apply at the outset. This means that the initial costs of developing shared approaches to delivery of corporate services is likely to be significant (particularly when both the consultation and infrastructure development needs are considered).

Corporate support systems also need to have capacity for ongoing monitoring, review and evaluation so that they can evolve over time.

The work outlined in this report highlights the capacity of the ACCHS sector to develop innovative solutions to difficult issues while working in a quickly changing environment. Additional resources to facilitate ongoing action by the sector in developing appropriate models to support corporate services is likely to enable further innovation in this area. Such work should contribute to stronger and more viable health services for Aboriginal communities.



Introduction and context

Aboriginal Community Controlled Health Services

Aboriginal Community Controlled Health Services (ACCHSs) are important providers of health and wellbeing services to Aboriginal people in Australia. ACCHSs are ideally placed to work with their local communities to develop and implement health services and programs that effectively meet community needs. They are generally run by an elected Board, and vary considerably in scope, organisational composition and geographic location. They range from large, complex multifunctional services that employ doctors and other clinicians in urban and regional settings to small remote clinics that may have some resident clinical staff and/or rely on fly-in fly-out clinical support.

The first ACCHSs were established in the early 1970s to enable Aboriginal people to obtain services they could not access through mainstream services. Many mainstream services were not accessible to Aboriginal people, were culturally inappropriate or were unable to provide the health care required. Most of these early services were in urban or town settings and were built up by Aboriginal leaders and activists in an environment of strong political activism by Aboriginal people and communities. These services were run and funded by the communities and provided culturally safe and accessible health services to their people. Fundamentally, these services aimed to give communities more control over their own health and wellbeing.

These services were strongly supported by Indigenous communities and provided the impetus for Indigenous leaders to lobby for government funding and support. They also provided inspiration for other communities to establish their own Indigenous health services, and in 2008, 145 ACCHSs provided primary health care to communities across Australia (Dwyer et al. 2009:24). Whether they are in metropolitan, rural or remote areas, ACCHSs are now an important component of the health system, particularly in providing and/or facilitating the delivery of culturally accessible and responsive services. In some communities in remote Australia they are the primary providers of health services, and in some areas they also provide care to significant numbers of non-Aboriginal people. Consequently, their viability and sustainability is critical.

Over time ACCHSs have obtained funding from government departments (in particular from the Commonwealth Government). The nature of these funding arrangements has become increasingly complex and uncoordinated, resulting in more reporting and more complicated bureaucratic processes, something that Dwyer et al. (2009) describe as an 'overburden' on services. Alongside changes associated with funding, changes to business practices in general and developments in technology have increased the complexity of the way organisations operate. This often means that significant skill levels beyond those accessible to many community members are required to manage services, which creates a dependency on people from outside communities (Palmer 2005). The increase in complexity of operation, management and functioning of ACCHSs is compounded by a relative lack of resources flowing to the sector compared to the health needs of Aboriginal populations (Palmer 2005).[1] ACCHSs reported to us that they generally receive very little funding to support the corporate functions of their services because many of their funding allocations are program- or project-based.

1 There has been debate about the extent of under-resourcing.

The broader context for ACCHSs

ACCHSs exist in a continuously changing policy environment. Currently, the health and wellbeing of Aboriginal people is a key issue for governments, and a range of policies impact on the sector and consequently on organisations and their operations. For example, at the national level the *National Strategic Framework for Aboriginal and Torres Strait Islander Health* (NATSIHC 2003) specifies the importance of comprehensive primary health care, and *Closing the Gap* (Australian Government 2009) is establishing a new set of governance and administrative structures focusing on partnerships, as well as increased funding to the sector. Similarly, each State and Territory has its own policies and strategies, such as the Northern Territory Government's regionalisation strategy for Aboriginal health services, or the Queensland Government's commitment to transitioning State-run services to community-controlled services. In addition, the Commonwealth is able to target specific policies to Territories, and the Northern Territory 'Intervention' (the Northern Territory Emergency Response) is an example of this.

Each State/Territory has a peak body for ACCHSs.[2] The functions of the peak bodies generally include (at least) advocacy, policy development and sector support of varying kinds. The way these peak bodies are organised and the extent to which they undertake various functions depends on their history and factors specific to the State/Territory in which they operate. Each State/Territory peak body is affiliated with the national peak body – the National Aboriginal Community Controlled Health Organisation (NACCHO).[3]

Overall, the range of challenges to the viability of ACCHSs include the fact that:

- many ACCHSs are relatively small[4] and provide a wide range of services with multiple funding sources[5]
- services are largely dependent on government funding
- there are high and sometimes competing demands from governments and communities
- clients often have complex needs
- there can be tension between mainstream public administration and government requirements and Aboriginal culture and values
- recruiting Board members with appropriate skills can be difficult
- there are many workforce issues
- there is a high level of demand from government and other organisations to participate in consultations (Effective Change 2007; Dwyer et al. 2009).

Consequently, some ACCHSs experience difficulties in maintaining optimal functioning, which can result in less effective service provision to communities.[6]

2 These peak bodies are governed by representatives from their membership. Membership is voluntary and not all ACCHSs are members of their State/Territory-based peak body.

3 An individual ACCHS can be both a member of its own State/Territory-based peak body and a member of NACCHO.

4 Dwyer et al. (2009:2) reported that more than half the agencies in a representative sample of 21 ACCHSs obtained between $1 and $2 million dollars per annum.

5 In the same sample cited above, Dwyer et al. (2009:2) reported that the ACCHSs reported between six and 51 separate funding grants per annum with an average of 22 grants per ACCHS.

6 Despite the significant difficulties outlined here, Bartlett (2007, pp2-3) warned against the danger of 'overstat[ing] the endemic nature of the problem' and reminds us that many remote Aboriginal community-controlled services in the Northern Territory have sustained service delivery despite significant issues with their governance and management. He suggests that this indicates that 'support solutions need to be flexible enough to allow the (often undocumented) ways of working in the community to be creative and appropriate'.

In relation to corporate functioning, the extent to which all services (both mainstream and community controlled) can perform optimally relates to many factors, in particular their capacity in areas such as:

- effective governance
- management support
- risk management
- human resource management
- education and training/workforce capacity development
- information systems management
- financial management
- program development, evaluation and quality improvement.

One means of strengthening the viability and sustainability of services is to establish mechanisms through which they can access effective and appropriate external support to build internal capacity and/or to have certain corporate functions provided externally (particularly for small services with limited access to the resources required for effective corporate functioning). Towards this end, considerable effort has gone into developing external systems to support the corporate functions of Aboriginal primary health care services in some regions/jurisdictions. This effort is the focus of this project.

Thinking about structuring corporate services

The key purpose for organisations engaging in structures or models for organising corporate support is to strengthen their capacity, or to 'unlock value', so that the core business of the organisation (in this case delivery of health services) can benefit (Kaplan & Norton 2006). This has been a challenge for organisations across the world and is not a simple activity. Much thinking, negotiating, restructuring and learning from mistakes has occurred as organisations have sought to maximise the capacity of their corporate functions to most effectively support core business. The main models for organising corporate services,[7] which have developed sequentially over the past two centuries, are:

- centralisation of corporate functions (also known as centralisation by function models), which allowed for significant economies of scale
- the creation of separate business units that provide corporate functions for units producing particular products or located in geographic locations (also known as 'decentralised by product and region' models), which enabled tailored strategies to meet specific needs with some reductions in economies of scale
- the 'matrix model', which was a combination of the previous two models and aimed to maintain flexibility and adaptability to meet local needs as well as produce economies of scale
- organisation around business processes rather than functions, products or geographical boundaries
- total quality management systems
- virtual or networked organisations, which work across organisational boundaries (Kaplan & Norton 2006 p1).

7 Although these models are generally discussed as if they are internal to an organisation, the same structures may be applied to shared or joint services.

Whichever type of arrangement is used to structure corporate services, there are additional considerations when corporate functions are shared between independent organisations. Peppin (referenced by QAIHC 2008a) suggested these can be described along a continuum of collaboration – networking group, short-term arrangement, long-term arrangement and permanent structure. The further along the continuum the arrangement sits, the more the participants in the arrangement need to contribute (both in terms of input into development and funding).

Similarly, Dollery and Johnson (2007), in their work with local government, suggested classifying models based on their political and operational levels of control by participating organisations and levels of centralisation. The models identified have varying levels of sharing services or resources between organisations, and the organisations participating in them also have varying levels of control over and input into how resources are shared. They note that increasing centralisation generally results in reduced autonomy and control by those participating. They suggest seven types from highest level of control to lowest level of control:

1. small independent councils
2. councils having voluntary arrangements to share resources when required
3. formalised arrangements between councils and usually funded by a fee (regional organisations of councils)
4. creation of a shared service governed by a Board of participating councils (area integration or joint Board model)
5. creation of a shared service centre or shared contractors who carry out service provision as directed by councils
6. all service functions being funded and run by government agencies (agency model).

Aside from locus of control, other perspectives can be taken into account when working out how corporate services could best be structured. Kaplan and Norton (2006 p3) suggest that to maximise the benefit obtained from such structures it is also important to consider different perspectives and the balance between them. They suggest considering the following areas:

- *financial*, which is about processes that allow organisations to 'create financial synergies' (that is, to maximise financial benefit from collaboration); it includes processes around resource allocation, corporate governance, and negotiations with funders, suppliers and other outside organisations
- *customer*, which is about organising systems and processes to deliver the best service for clients
- *process*, which is about sharing resources and common processes between multiple areas within a service (or between organisations); this might include purchasing and research, and other functions
- *learning and growth*, which relates to activities around capacity development, both for people and organisations; an example of the latter might be how the organisation manages knowledge and learns from best practice.

These authors also suggest a range of lessons and challenges for organisations today:

- advantages can arise from putting more emphasis on 'intangible assets' (such as knowledge of workers, research and development, and information technology) than on management of physical and financial assets; in the Aboriginal health sector this might translate to an improved focus on the knowledge, expertise and development of community and the maintenance of a range of types of relationships
- as many organisations have sites in various locations, they have to reconsider issues of control and management and ensure staff members at all sites are able to maximise local operations while contributing to broader organisational goals

- one of the mistakes some organisations have made in attempts to better align their operations is to go through ongoing cycles of organisational restructure, which can create new problems and result in employees leaving and taking valuable knowledge (an intangible asset) with them
- any new structure requires time for people to adapt (and this has a cost)
- using finances and budgets as the primary management tool can result in long-term strategic goals being overlooked because of short-term financial considerations (Kaplan & Norton 2006 p2).

To overcome some of these issues, Kaplan and Norton (2006) suggested that a guiding principle should be to focus on developing a management system that aligns with an organisation's strategy while at the same time creating as few conflicts as possible with the existing structure. They suggested that organisations do not need to fund the 'perfect structure'; rather, they need to create one that provides good value for all participants. A similar argument is made by Dollery, Akimov and Byrnes (2007). In their work with local government, they suggested that aligning existing structures might create better value than significant restructuring. In this case they suggested creating shared services as an alternative to amalgamation to improve the operational effectiveness of local government. They also stressed that one model will not fit all organisations.

Critical success factors for development of shared corporate services models in the Aboriginal health context in Australia have been suggested. These include that structures should:

- be carefully planned at the outset, including the development of a sound business plan and a risk assessment
- have the support of senior management and leaders
- have identified achievable and clear goals
- serve the community's interests, stay connected with the community's preferences and values, and discharge strategic corporate responsibilities effectively
- equalise power so that decision-making reflects all stakeholder groups
- have a process for determining which services to move into a shared service arrangement
- balance business process redesign and reshaping of roles and technology
- have the commitment and support of member organisations
- build a new culture (QAIHC 2008a).

An additional requirement described in the local government setting was the need to have an effective governance arrangement, including representation of the services participating in a shared service model on the Board of Directors of the shared service and negotiated performance agreements (Allan cited by Dollery, Akimov & Byrnes 2007 p12).

At the operational level, success also involves monitoring and managing costs, ensuring accountability, using service-level agreements and monitoring performance (QAIHC 2008a). It can also be important for any model to consider other factors such as employment of local people and support for local suppliers of goods and services rather than only focusing on financial considerations (QAIHC 2008b). Further, a model should enable a community or community members to operate, maintain and control it (Palmer 2005). This could mean, for example, using older technology that a community has the ability to use in the first instance, while capacity is developed to use newer technologies.

A further issue is deciding what to share. For local government it has been suggested that services that could be shared or outsourced are those with one or more of the following characteristics: 'low core capability'; a high number of suppliers who can compete; 'low task complexity' (although some suggest that some high complexity tasks may be suitable for sharing or outsourcing); and high economies of scale. Where highly specialised technology is required (e.g. information technology) in some cases 'low asset specificity' may also be a criterion for deciding whether to share a function where an expensive or specific asset is required to complete a task (Allan cited by Dollery, Akimov & Byrnes 2007 p12).

Some of these 'critical success factors' represent significant challenges for services: for example, people management issues could arise if staff aren't committed to the transition of a new model, or tension could arise if roles and responsibilities have changed. The role of technology in new systems could be quite difficult to implement, especially in rural and remote locations.

Why we did this study

The Cooperative Research Centre for Aboriginal Health (CRCAH), in collaboration with people from the Aboriginal health sector, identified corporate support systems as an area requiring more research to inform ongoing development, hence the Support Systems for Indigenous Primary Health Care Services Project (hereafter, Support Systems Project) was conceived. This project was one of three priority projects in the Comprehensive Primary Health Care, Health Systems and Workforce Program of the CRCAH. The other two projects focused on quality standards in Aboriginal and Torres Strait Islander health and funding and regulation of ACCHSs.

The aim of the Support Systems Project was to contribute to improving the viability and sustainability of ACCHSs as corporate entities through developing knowledge about:

- the range of corporate functions where ACCHSs might require external support
- the factors that influence the support required
- the support structures that currently exist
- the lessons that can be learned from existing models
- ideas about what needs to be done in future.

How we did this study

The project was conducted in two parts. Part 1 focused on support needs and issues associated with obtaining support, and Part 2 focused on existing models for corporate support and the lessons learned through developing and implementing these structures.

Part 1 included establishing an advisory group, conducting a brief literature review (unpublished) about different areas of corporate support, conducting interviews with key informants about support needs and issues, writing the findings into a discussion paper, and holding a national roundtable to discuss and build on these findings and obtain advice for the second part of the project.

Part 2 included conducting a brief literature review on thinking about corporate support, identifying four sites that demonstrate different models for organising corporate support for ACCHSs, reviewing background documentation about each site, conducting onsite interviews with those who were involved in the provision of corporate support and those who worked in organisations that accessed this support, using this information to develop case studies, writing a second discussion paper, and holding a second national roundtable focusing on the provision of corporate support and suggestions about action for the future. Two additional models were presented at this roundtable.

More detailed information about the method is provided in Appendix 1.

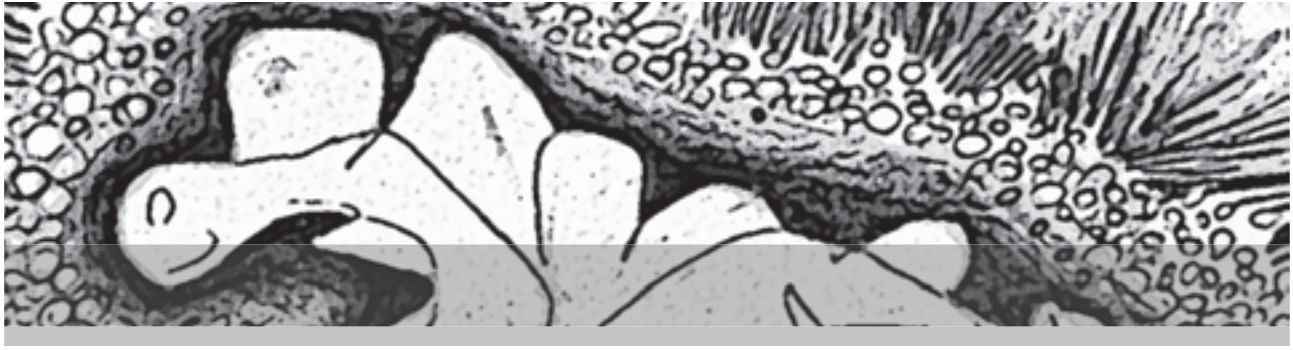
Organisation of this report

The first part of this report outlines a range of areas where ACCHSs indicated they might require support, as well as a set of issues pertaining to the provision of such support. This is meant to be an illustrative, rather than an exhaustive, list.

The report then describes some models developed from within the ACCHS sector for strengthening the corporate support available to services, and discusses some of the emerging themes and lessons from this work and from the experience of others participating in project activity.

This *Overview Report* is supported by two other *Taking Care of Business: Corporate Services for Indigenous Primary Health Care Services* documents:

- *Case Studies*, which provides full details of the four case studies conducted for the project
- *Summary Report*, which briefly presents the main points.



Corporate functions where services might need support

This chapter provides a brief discussion of the main areas where ACCHSs might need support in corporate areas. The information about priority areas comes from consultations with key informants and from the literature.[8] We have kept this section brief because it became clear early in our consultation process that although there are many potential areas where organisations need support, often these depend on the organisation and its context. However, there were some areas where support was identified as being required by most informants – the top three being governance, finances and human resources.

When considering the issue of corporate support, each main area needs to be broken down into sub-areas and further consideration given to which sub-areas need to be carried out within an organisation and which could be provided externally to sustain well-functioning organisations. For example, when considering human resources, a range of functions might be contracted out or shared with others, such as high-level legal and industrial advice, advertising and marketing, and development of up-to-date templates for job descriptions. However, it is likely that organisations will want to maintain or develop the internal capacity for other human resources functions, such as making final recruitment decisions.

Informants spoke about the support needed for individual organisations, as well as support that might be required for the sector generally or that could be provided across regions. This means that when thinking about corporate support it could be useful to consider functions that might be provided nationally, on a State/Territory basis or at a regional/area level, as well as support that could be provided to individual or groups of organisations. Examples of support required are provided in the following section.

Governance

Although some ACCHSs are very sophisticated in their understanding of governance (and may understand it in a way that mainstream organisations do not), many require support in this area. There was significant interest in examining governance models and processes further, particularly the development of processes that are relevant to Boards where most members will have concurrent complex relationships and obligations in their communities. A further topic suggested for examination was establishment of skills-based Boards.

The most commonly identified aspects of governance where support, guidance and/or training might assist included:

- criteria for who can be on the Board and processes for election of the Board
- roles and responsibilities of Boards, especially about the delineation between governance and management roles, understanding the constitution and succession planning
- the relationship between the Board and the Chief Executive Officer (CEO): this might include work around the Board's role in directing/managing the CEO, establishing a structured way for the Board to relate to the CEO and identifying performance measures for the CEO; Boards might need additional support when the CEO is the problem (Dwyer, Shannon & Godwin 2007)
- Board processes (for example, goal setting, performance management, problem-solving and dispute resolution)

8 We have only referenced information sourced from printed documents.

- appropriate mechanisms for the Board to access support in relation to business functions (for example, finances); this might be through advisory mechanisms or ensuring people with relevant skills are on the Board
- supporting Boards to manage community expectations and balance cultural expectations with their legal and fiscal obligations (Effective Change 2007)
- training in language for staff working with Boards, particularly when communities come from very remote locations and where their first or second language is a language other than English
- resourcing training and capacity building and community development to increase the numbers of community members able to take up Board positions (Effective Change 2007).

General management

Management support was considered important for some services, particularly when a new CEO (or other senior manager) was recruited (and especially if they had not previously been a CEO and/or had not worked in a similar organisational context before), and/or if managers worked in small services with limited organisational support and/or if they were in very remote areas. A different issue for managers occurred when they worked in larger services with flat organisational structures and limited middle management. This resulted in CEOs having a significant number of direct reports, with very high demands being placed on them from staff, communities, the sector and government.

Some other aspects of general management where support and/or capacity development might be useful included risk management (identifying and managing risk and risk mitigation), program management, business development, business support and project management.

Financial management

The complexity of the funding environment in which ACCHSs operate means there is a need for sophisticated financial management skills. At the same time many ACCHSs have grown quickly, compounding the need for effective financial services. However, many ACCHSs are not able to employ specialist finance staff for a number of reasons, including that their organisation may not be large enough or may have limited availability of qualified personnel. In some ACCHSs finance workers without accounting qualifications do the work required to maintain records, and expert accounting support is obtained from external providers who may also support and/or train finance workers. In larger organisations, financial and other reporting to funders was said to require at least one full-time equivalent position.

Particular areas in which finance support might be required include:

- managing a complex set of accounts (due to multiple funding sources)
- dealing with recurrent and non-recurrent funding
- billing (for example, making sure Medicare is billed for all relevant services provided) and practice management (for example, assisting general practitioners to use billing facilities)
- financial reporting
- payroll
- fringe benefits tax and salary packaging
- money management to improve the efficiency and effectiveness of services and to improve the overall use of resources
- goods and services procurement (medical, office, capital equipment)
- purchasing clinical services (for example, allied health).

Human resource management

Human resources management was an important area, and most key informants identified this area as requiring support. This might include support for:

- a Board when selecting a CEO – some Boards will have limited skills in recruiting to such a critical and high-level position and without assistance they might employ someone they know or trust rather than make a selection based on skill set; in organisations experiencing change, such as rapid growth, the Board may not be aware of the skills required by the CEO of their larger organisation
- improving the workplace environment; for example, support for how to build a healthy organisation, how to build trust among workers, how to promote team work, how to deal with issues like bullying and harassment, and how to manage staff effectively
- staff recruitment, including advertising, marketing and developing position descriptions (in some cases position descriptions do not reflect current practice)
- grievance procedures, staff termination practices and other industrial matters (for example, enterprise bargaining processes)
- staff orientation (for example, cross-cultural training), staff support (for example, counselling) and staff development, training and continuing education
- development of consistent and standardised pay rates, either within organisations or across organisations – this might include doing an assessment of position descriptions and identifying appropriate pay for different types of roles
- assistance with drawing up standard contracts that specify how service providers such as general practitioners and other health care providers will work (for example, that they will work in a team, the models of care they are expected to contribute to and how they will work with other staff such as Aboriginal Health Workers). Further to this, it might help ACCHSs to work together to develop standard rates of payment for general practitioners, and to identify some strategies for negotiating effectively with general practitioners and other health care providers in high demand.

Workforce

Workforce is a significant issue for most health services and ACCHSs often a have high staff turnover. Although there is a Health Workforce National Strategic Framework (AHMAC 2002), there are still many areas where support might be required, including at regional and local levels, particularly in developing recruitment, retention and professional development strategies. Further, short-term contracts and project-based funding can work against maintaining a stable staffing structure. Some specific issues raised by informants about where support might be required include:

- development and provision of lifetime professional development for managers to keep them in management positions and in the sector
- having a regional or area level locum service to cover staff leave, particularly for CEOs, senior managers and clinicians because it is very difficult for individual services to attract short-term staff
- a service to provide cultural awareness training to new (non-Indigenous) staff early in employment periods
- developing ways to share resources that might help attract staff (for example, in a town with a number of ACCHSs, there could be a shared child care service, or capacity to share infrastructure such as housing)

- joint workforce planning and development of regional or shared workforce strategies (including for recruitment and retention): such a strategy might include a focus on improving the way services operate and their reputations as good places to work to attract qualified workers into the sector; developing ways to cater for partners and families; coordinating recruitment across a region; enabling (and organising for) staff to work in different organisations in the sector; seconding staff for skill development; coordinating training across a region; and standardising practice across services so that it is easier for staff if and when they transfer between organisations.

Information technology, information management and telecommunications

Information technology (IT) was a significant area identified by informants as requiring support. Well-functioning IT systems can enable provision of enhanced support in other areas, and can provide the platform for other aspects of service functioning. It is also an area where bulk purchasing could result in significant savings. Sharing intelligence about IT and associated deals might also produce savings; for example, one State/Territory peak body identified that not-for-profit organisations could get free software from Microsoft.

Support in this area could include:

- facilitation of server hosting arrangements
- procurement of IT assets
- establishment of ACCHS communication networks and a carrier service for this
- technical support and help-desk services
- standard clinical data collection and reporting protocols across platforms (Brailsford 2006)
- development and maintenance of service websites.

Legal services

Most services need support for legal issues. Even large ACCHSs are unlikely to have in-house lawyers and are likely to require expert legal services at some times. Matters about which services might require legal support include constitutions, industrial relations, contract formulation, dispute resolution, risk mediation and changes to legislation or regulations.

Data collection, management and analysis

Many organisations do not have comprehensive data about their communities or service delivery. As a consequence it is difficult for these organisations to develop a strong evidence base about client impacts and outcomes, accountability for funding received, how the sector is making a difference, and effective service models and practices (Effective Change 2007). Key informants generally considered that services need support to develop their capacity to collect and manage their own data so that they could be used to identify emerging issues and assist planning and development, as well as evaluation and reporting purposes. It was also noted that being able to see how data could be used was likely to be an incentive to ensure accuracy of data.

Planning

It is important that organisations have the ability to undertake good strategic planning, health planning and business planning and are able to use and revisit these plans. In a period of fast growth it can be difficult for a service to review its current position and whether it is delivering what the community wants.

However, the way services are funded means they often do a lot of short-term planning to meet funding requirements, and do not undertake long-term strategic planning – nor are they rewarded for having longer-term plans. This can result in organisations tending to 'look one year down the track' and focus efforts on reporting rather than planning.

Informants considered a range of supports for planning could be useful, including for:

- development of strategic plans (including processes for promoting staff ownership, knowledge and use of the plans)
- development of population health plans (including technical tools for needs assessments and gap analyses, as well as access to epidemiologists to assist with collecting and analysing data)
- development of business plans
- use of service data to inform planning and service delivery
- engagement/support of communities so that they can participate in making planning and service delivery-related decisions
- well-presented information about effective interventions to guide service development
- training on concepts of health economics (such as opportunity cost) so that services can set up processes and systems to make the best decisions about how to maximise the use of (very limited) resources to address needs.

Organisational change and organisational development

The sector experiences a continuous process of change. High levels of expertise and experience are generally required by managers to manage change well. This creates a lot of challenges, particularly when services grow quickly and people within the organisation might not have the experience or resources required to administer larger organisations. Key informants considered that managing change was an important capacity to have within organisations and that it wasn't just a matter of getting 'someone to fly in and write a policy for us'. Constant change creates support needs for services around:

- identifying how to change and develop in relation to new initiatives (for example, what will service-level governance look like in a regional structure?)
- how to effectively restructure organisations or grow organisations
- managing staff through periods of change
- working with external evaluators, who can assist organisations by giving independent perspectives on what is working or not working during periods of change
- sustainability – so that organisations can create stable services in a difficult environment.

Administration and systems development

Services often get very limited funding for administrative functions and systems development. Support needs might include assistance with:

- development of policies and procedures
- development of central filing systems and document and data management systems (the latter might include development of sector-wide systems and processes such as patient information, reminder and recall systems, and Medicare processing systems)
- general administration support.

Community engagement and developing local community members

Community consultation and engagement is critical for community-controlled organisations; however, doing it properly can be resource intensive. Support might include:

- developing effective methods for consultation
- providing support to Board members to hold events to seek community views
- improved mechanisms for providing ongoing information to communities and getting their feedback.

Support for development of local community capacity was considered important in relation to increasing the numbers of local people who could be employed in services, who could participate on Boards and who could become community advocates. Related to this was establishing a more systematic approach within organisations for employment and development of local people.

Research

Health services are often sites for extensive research by universities and they are often unable to negotiate well with researchers about what the service needs are. This means that although services provide sought-after settings for research, they are often subject to the researcher's agenda and do not benefit according to their own service needs. This can create a range of support needs, including:

- how to identify research questions and priorities
- how to negotiate with researchers
- how to make sure researchers give useable feedback.

Continuous quality improvement and accreditation

Building capacity for continuous quality improvement (CQI), including in areas relevant to corporate functioning, requires capacity for regular organisational reflection, review and problem-solving. Key challenges for CQI are related to many of the other domains described above. Further issues specific to CQI include having to deal with multiple CQI frameworks, inconsistent indicators across jurisdictions, fragmented reporting systems, and limited clinical and other education and training in CQI (Sibthorpe, quoted in Bailie et al. 2008).

Accreditation can be seen as a part of CQI because it is the formal process organisations go through to have their functions measured against a set of standards. A confounding factor is that in order to be comprehensively accredited, many comprehensive primary health care organisations require accreditation by more than one accrediting body (CRCAH 2008).

Significant work is being done across the ACCHS sector on accreditation. Support needs include:

- undertaking accreditation assessment plans (this is usually done by licensed providers as part of their registration and verification process, and in the community-controlled sector the Office of Aboriginal and Torres Strait Islander Health (OATSIH) employed a panel of experts to assist with this work)
- developing and implementing accreditation work plans
- understanding how accreditation (and dual accreditation) affect organisations
- building expertise among Aboriginal staff to be accreditation surveyors
- managing accreditation of different aspects of a service which requires working with multiple accreditation agencies
- developing documents and tools, such as consumer feedback surveys in remote communities, to support accreditation (and CQI).

There were some questions as to whether accreditation fitted within corporate services because it is often focused on clinical capacity. However, we have noted it here because there are significant administrative requirements associated with accreditation, as well as domains related to business functions (see Appendix 2).

Public affairs, media and marketing

Aboriginal issues have become prominent in some jurisdictions, so organisations are constantly asked to provide media content and comment. Support to deal with the media can be critical in ensuring that the perspectives of the sector or service end up being presented to the public in a constructive and considered fashion.

Funding sources, applications and reporting

Many services, including those in small communities, get funds from multiple sources, and/or under multiple programs from the same funder. This creates a number of support needs, including:

- submission writing
- reporting on programs and projects (progress and financial)
- project management
- human resources issues associated with different types (and periods) of contracts.

In addition, assumptions built into the way mainstream services (such as the Medicare Benefits Schedule and Pharmaceutical Benefits Schedule) are developed can make obtaining and managing income from these funding streams more difficult for ACCHSs. Support needs to deal with these might include:

- assistance with developing systems and processes for Medicare billing
- how the service should deal with co-payments (as many people can't afford these).

Infrastructure/asset management

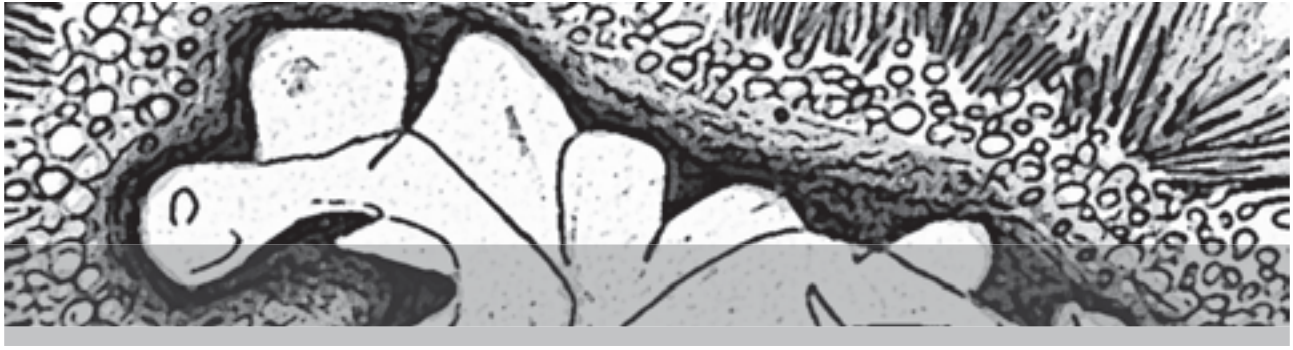
There are significant limitations to the capacity of ACCHSs to take on additional activity caused by insufficient infrastructure. Support needs related to infrastructure and its management include:

- capital planning (in particular related to service expansion)
- asset management and infrastructure maintenance support (including cars and fleet management, housing)
- tenancy management (this might include developing processes for managing the occupiers of a house and potentially developing a system so that services in the same town might be able to have short-term access to vacant housing belonging to other services).

Sector development

Sector-wide strategies are required to ensure the sector as a whole is developed effectively. This may require development of a stronger capacity to participate in, influence and drive government policy development. This could require capacity for development of policies/policy frameworks by the sector to base negotiations with government on, and would require resources such as research and policy workers (Effective Change 2007).

Similarly, some of the support needs identified above may be most effectively dealt with through sector-wide activity or structures. Examples of areas in which this might be useful include managing growth, developing multiple sourcing strategies, quality improvement, accreditation and dealing with regionalisation in jurisdictions where this is occurring (QAIHC 2007).



Factors influencing the support required

Factors for ACCHSs to consider if they are planning to implement a new corporate support system or build upon and strengthen current systems include:

- the preferences, capabilities and needs of the community
- demographics and geography
- organisational strength
- leadership
- funding
- workforce
- public policy settings (QAIHC 2007).

A further consideration might be local needs and the capacity development requirements of services, something that might need to be factored into the cost of new structures since developing local capacity can be costly and time consuming (QAIHC 2007). Some factors identified by informants for this study are described in this section. These factors have been grouped into three key areas: the broader environment, the organisation and community factors.

The broader environment

ACCHSs operate within a national policy environment and also sit within separate State/Territory jurisdictions. Clearly, this broader environment influences the way services develop and operate and will therefore influence the support required by organisations at different times. This broader environment is characterised by health system reform processes, increasing administrative complexity, the number and range of services in a region, and workforce issues.

Health systems reform, change and transition, and differences between jurisdictions

Systems reform (or at least consultation about it) to increase effectiveness and efficiency of health services and to create integrated and coordinated health systems is occurring across Australia – this will affect all health services, whether mainstream or community controlled. National-level reform includes the Council of Australian Governments processes for health and hospitals reform and for 'Closing the Gap'. Further, there has been a change in how governments view health services over the past decade or so, and most have moved from historically determined methods of funding towards viewing health services as businesses operating in a competitive environment. The funding and regulatory context for Australian Aboriginal community-controlled organisations and the problems and issues associated with this is comprehensively described by Dwyer et al. (2009).

As well as national-level reform, most States/Territories have engaged in (or are pursing) their own reform processes (and it is not yet clear how national reform will intersect with these). For example, in some jurisdictions, such as the Northern Territory, reform processes are associated with work to create regionalised service systems and in others there is a move towards establishing formalised partnerships between mainstream and community-controlled organisations (an example of this is the Aboriginal Health Promotion and Chronic Conditions Partnerships in Victoria). Some jurisdictions, such as the Northern Territory and Queensland, have policies of transitioning government-run services in predominantly Aboriginal communities to community-controlled services and in some cases existing ACCHSs are working with services on these transitions. While the focus of these reforms is (rightly) being driven by the need to provide enhanced services

and good practice health care (in its clinical and broader sense), there is a need to ensure that services (and service systems) are well supported by effective corporate functions.[9] It is our observation from evaluation of previous work, that to be effective these reforms also require significant system-level capacity development (for example, through jurisdiction-level development of tools, practices, protocols and training) to support joint activity (Silburn et al. 2010).

In addition to these broader system-level reform processes, the health sector is generally subject to change associated with both State/Territory and national policy and program development – this includes changes to program rules, introduction of new initiatives (which may be focused in specific health areas like chronic illness or mental health) and competitive funding rounds.

In a study conducted in Victoria, many ACCHSs indicated that there was often lack of clarity and many unknowns in relation to policy affecting their organisations and communities (Effective Change 2007). This can make it extremely difficult for organisations to work out what support they might need, as this will be influenced by the types of changes they are required to make.

As a result, ACCHSs are often in a period of continual change and some informants noted that 'reform was exhausting services'. When service reforms take place, organisations might need support to make decisions about the proposed changes and to work out what it means for them and how to deal with this. For example, in the Northern Territory, where work is being done on regionalisation and transition of services to community control, there will be a facilitated process for organisations to work out how they will make the associated changes.

It was noted that regionalisation could refer to provision of health services and provision of corporate support, and that the model for regionalisation of health services would influence the corporate support required and the way this is best delivered. In the Northern Territory there has been recognition of the need for regionalisation based on factors like the size of the population required to make a health service viable and the services that can be provided locally and those that can only be provided from larger centres. There are different ways that regionalisation can be established, including having a lot of small services operating independently with access to regionalised corporate support or having larger regionalised services that provide most of their corporate support internally (such as Katherine West Health Board). Similarly, regionalisation can be developed through a process of consultation so that the needs of all those engaged are considered, or it can be imposed with the assumption that the 'one size' seen to work in one context will fit the needs of all types of services and locations. There was concern among key informants that in the 'rush to regionalise' the latter approach would prevail.

How small services and communities maintain their identities within a larger regional model was a further issue. For some, this was seen as a challenge in that it required 'thinking about community control in a bigger way'; that is, focusing on maximising the advantages of community control (such as being able to identify and meet community health needs) and then being able to 'let go' of some aspects of service functioning that support delivery of core business but aren't really necessary to maintain control over the service:

> Some people have the idea that if things (such as payroll) aren't done locally then they don't have community control.

Some informants also considered that there are major differences between the States/Territories, including in relation to the kinds of support that might work best; for example, although regionalisation might be the most appropriate approach to both service delivery and provision of corporate services in some jurisdictions, it might not be the best approach in others.

9 It is noted that some health services have contributed to significant health improvements in their communities at the same time as experiencing difficulties with governance and management (Bartlett 2007).

Increasing administrative complexity

Increasing complexity of the business of health and health administration also influences support needs (AMSANT n.d.). ACCHS often have many funding agreements with a range of entities, including governments. Generally each funding entity is unaware of the other funding entities or their reporting requirements (and, indeed, different reporting requirements are often imposed by the same government departments). This often creates a scenario where services need additional funds (and therefore feel compelled to apply for or accept them) but cannot keep up with the reporting and administrative requirements that arise as a consequence. The pace at which new funds are rolled out was considered likely to increase with the additional funding becoming available through the Council of Australian Governments. It was acknowledged by informants from both the community-controlled and government sectors that there needs to be some reform in relation to this situation, and this is further discussed by Dwyer et al. (2009).

Some informants identified a critical issue as flowing on from the way government departments are organised internally, noting that as these departments grow and their internal arrangements become more complex, there appears to be 'expansion without coordination', which results in 'more rules and reporting requirements'.

Allocation of primary health care service delivery resources by government to non-government organisations, which operate in the same communities as community-controlled services, was also considered to create a number of issues for ACCHSs, including increased work required to engage with external providers and provide training to them to ensure services are appropriate. This could also be seen to undermine the potential to develop a solid foundation for delivery of comprehensive primary health care. Similar issues were created by the increasing numbers of non-government organisations working in Aboriginal communities.

The number and range of services in a region

The number and range of ACCHSs in an area, particularly if organisations are willing to collaborate, can influence the amount and type of support required because there can be capacity to build partnerships or networks, share resources, or develop town or regional support structures.

Similarly, having other local mainstream organisations willing to collaborate/work in partnership can facilitate support provision (on the downside, this may require significant effort to ensure this is done in an appropriate and respectful way, and some organisations in metropolitan areas might have many mainstream providers to deal with, which can create a high burden). Each approach is likely to need a good agreement or memorandum of understanding.

However, where an ACCHS is the only Aboriginal-controlled organisation in a town, it can be asked to take on a lot of issues and provide a lot of services, which can increase its corporate function support needs.

Community control

Strengthening the operationalisation of community control was considered important by many key informants when thinking about corporate support services. This was because they considered that well-functioning community-controlled services were the most likely service types to be able to identify and meet local needs. Some noted growing tensions between community control and the increasing complexity of the environment.

Specifically in relation to corporate support, maintaining a commitment to community control means considering how corporate support structures are developed, how decision-making processes operate, and which parts of corporate services need to be retained internally and which can be provided from external sources.

It was also noted that developing shared or joint support services might require changes to the way organisations and senior people think about community control. Some key informants gave examples of how they had been reticent to consider outsourcing some of their corporate functions for fear of losing control over

the organisation and how doing this had required a change in attitude. One informant, a CEO of an ACCHS, indicated how, after going through a process with other organisations in the same region, he/she identified that if the organisations pooled their resources they could get access to improved support functions:

> we could get top IT people, top governance people, top people from the corporate world.

This meant that pressure was eased in some areas, enabling more focus on the organisation's core business:

> As a CEO I was required to be everything, the [human resources] expert, be able to deal with community stuff etc... but now having a service hub has taken away things that we didn't really need to focus on and has allowed us to focus on service delivery.

In a similar vein another key informant noted:

> community control should be about client/patient satisfaction; that is, about making sure services meet the needs of clients.

By this definition, the informant considered that models for corporate support that enabled ACCHSs to function well could be considered to be strengthening community control.

Therefore, the way ACCHSs think about community control and how best to strengthen their operationalisation will influence the way services are developed and the way corporate support functions are obtained.

Workforce

Workforce is a critical issue. Workforce availability and the capacity of organisations to attract and retain staff is clearly a factor that will determine the support the organisation might need to obtain from external sources. Key issues here are the availability of a local workforce and the capacity of the service to attract and retain workers. Related to this is poor access to education for many Aboriginal people over many years. This can make it difficult to find local staff with adequate education for senior roles, such as a CEO or finance manager. To address this, significant training and support might be needed for people to undertake these positions.

One informant noted that although there is a big push towards training more Aboriginal clinicians, there is not the same focus on training Aboriginal health administrators (and that, in fact, many people do not know what health administration is and can therefore not elect to pursue a career in this area).

A consequence of having organisations with high rates of staff turnover, which is the case in many ACCHSs, is that corporate memory is continuously lost, potentially creating a need for ongoing support or for having to deal with similar sets of issues over and over again.

The organisation

A range of factors influence the support needs of individual organisations, including:

- size
- type and complexity of the organisation
- location
- level of demand compared to resources and administrative complexity
- internal capacity and approach to capacity building
- whether the organisation is itself a support provider.

These are discussed briefly in the following pages.

Size of the organisation and organisational change or growth
The size of an organisation was identified as a critical determinant of the corporate support required, especially in that smaller organisations are unlikely to have the critical mass for employment of staff to perform many (particularly specialist) functions (such as a human resources manager, an accountant, an operations manager).

As described previously, many ACCHSs have experienced periods of significant change, including in size or in how the service operates, and this creates changing support needs. Some informants considered that it would be useful to do some modelling work to identify the types of arrangements required for different-sized organisations so that when organisations grow they have access to information about the structures that need to be put in place. This might include things like a list of issues organisations need to consider as they grow, templates for effective organisational structures, and guidance around the number and type of corporate support staff required in different-sized organisations.

Some key elements of support for organisations in transition identified by participants at the second national roundtable include a need for:

- good planning for the short, medium and long term
- adequate resources for change processes
- good governance and leadership
- community buy-in and stakeholder engagement
- good communication processes (between the organisation and its staff, its community and its funding bodies)
- identified champions to support change processes
- matching the strengths of different staff members to the range of required tasks during planning and change process
- realistic timeframes for transition and change
- building in processes for regular monitoring and review.

It was also considered important to be outcome focused and to have identified milestones to indicate when short, medium and longer term objectives have been reached.

Related to the above is that organisations with capacity might need assistance to get funds to grow (and get new staff and additional space), and other organisations might need assistance to develop the capacity required to grow.

Informants also warned that in this environment it is important to avoid setting up permanent (inflexible) support service organisations on the assumption that organisation needs will stay the same over time.

Type and complexity of organisation
The type of service, service model and organisational structure will influence the organisation's function and the corporate support required. For example, a homelands resource service in the Northern Territory will look after a range of things, including roads and rubbish, employment, health etc. In Victoria Aboriginal cooperatives also deal with a broad range of issues that affect their communities. A level of expertise is required for *each of these portfolios* and the specific level of expertise required for the health service part of the organisation might not be covered in the organisation's Board or management.

For organisations in transition to community control, the service model and the level of community control will also influence the kinds of support an organisation needs. For example, *Pathways to Community Control*, developed by the Northern Territory Aboriginal Health Forum (2008), describes the responsibilities and functions of the public and community sectors across a number of levels of community control. Capacity development will be required on both the public sector and community sides to enable successful transitions. For example,

on the community side there needs to be the capacity for good governance, and on the public sector side for community engagement and ensuring services are culturally secure. The support required for implementing transition to community control is currently being identified.

Depending on the function and model of the organisation, there will also be a range of systems and standards that services need to deal with. These include accreditation standards, clinical standards, financial management standards, human resources standards, criteria for best practice, patient management systems, case management systems and management of multidisciplinary teams.

Having multiple sites and keeping sites integrated and part of a bigger organisation may create particular support requirements. In addition, services with multiple sites have to work out how to ensure all their communities have control and make decisions about addressing their needs.

Location of the service
Geographical location is obviously important, in that services located in metropolitan or regional centres will generally have access to more internal and external corporate support than those in rural and remote settings (although some informants said that organisations in the former settings still experienced difficulties in obtaining support).

Level of demand compared to resources and administrative complexity
ACCHOs face many challenges associated with the high and often complex needs of clients and the limited resourcing, which generally does not support the demand for services (Sullivan, cited in QAIHC 2007). This means that it can be difficult to prioritise development of corporate services when this activity is seen as competing for resources with direct health service delivery. The extent to which services have been able to balance these different aspects of their operation might influence their current support needs, as well as their current capacity to carry out corporate functions internally.

This is not assisted by the high administrative loads associated with burdensome reporting and accountability requirements and lack of financial support for administrative processes (Sullivan, quoted in QAIHC 2007; Dwyer et al. 2009). As a service gets larger it is likely to have a higher reporting burden and this is likely to influence the need for corporate support in this area.

Although many ACCHSs have grown, particularly in their clinical service delivery areas, many have not had the resources to increase their skill base or staff numbers to manage the larger service.

Capacity within the organisation and approach to capacity building
The approach taken to the way support is sought and/or the way support structures are developed depends on the existing organisational capacity and the extent to which organisational capacity building is required. The extent to which the organisation focuses on employment of Aboriginal staff also informs this. For example, if an ACCHS is the main employer in a town, or if it has identified that a certain percentage of staff should be Aboriginal, it might focus on building internal capacity. In this case it might also look externally for mentors.

Generally, it was considered that building capacity within the sector was critical and that (where possible) external support should be provided in a way that facilitates internal capacity building (particularly so that the organisation does not experience the same problems or issues repeatedly). However, there was some discussion about trying to identify 'non-core' corporate type functions that could be delivered by an external provider so that the community-controlled organisation could focus on 'core services' (likely to be those associated with clinical and other service provision).

Some informants also considered the tension between the provision of support by OATSIH for organisations in crisis and the potential for organisations to become reliant on this support. It was considered that 'getting the balance right' between external support and capacity building (so that organisations could 'seize control of their own destiny') was important. However, it was also noted that the extent to which organisations can build capacity depends on the support available (either externally or within communities) for that capacity building.

Work on CQI and accreditation was seen as important in a process of capacity building, especially if organisations can take ownership of the CQI process. Ownership was considered important because once people see that they can identify problems and work out how to address them, they are more likely to take control over this than if a solution is imposed upon them. The access to funds to support ACCHSs to prepare for accreditation was also seen as an opportunity for the development of support structures (either within affiliates and/or through developing regional hubs/peer support networks or regional accreditation teams) for relevant organisational functions.

Several services described strategies for building capacity among staff, including:

- having succession plans, on-the job training and mentoring, and being able to act in other positions
- two-way mentoring where each person respects what the other has to teach (particularly where Indigenous staff have skills and knowledge about their communities and non-Indigenous staff have higher-level technical or clinical skills)
- grouping people with similar roles so they can learn from each other
- having an external consultant to support a finance worker or human resources worker (this can be hindered in rural and remote communities if IT systems are not well-enough developed to allow the external support provider to have remote access to service records).

One informant warned of the danger of multitasking as a way of building capacity but recognised that workforce shortages meant this was the only option for some. The informant considered that as all jobs have become more specialised, most people can't just cover for other people, and that this is unfair and doesn't pay due respect to skill areas.

When the organisation becomes a support provider

A number of ACCHSs indicated that because of their leadership roles they were becoming support providers either to other Aboriginal community-controlled organisations or to mainstream organisations. Sometimes these were mainstream organisations that employed Aboriginal people to work on specific programs:

> [but they find] big conflicts between the way the Aboriginal staff want to operationalise programs compared to the way the mainstream organisation might want to do this.

One CEO identified a lot of time was spent trying to work with these organisations to:

> develop a framework that everyone is happy with... otherwise the Aboriginal managers will just leave, or get frustrated and get sick and depressed.

It was noted that in many areas the mainstream is not servicing the needs of Aboriginal clients:

> [It is] a big ask for the service that is meeting these needs [ACCHSs] to then work with the service that isn't.

This was especially the case when:

> you are being told that firstly services will be competitively funded, then that you will have to shore up other players in the market place, then that you have to work in partnership.

Some informants thought that mainstream organisations are not held accountable for how they work with Aboriginal clients and that the onus falls on community-controlled services (which are already under resourced) to address the issues that mainstream organisations are not dealing with well.

Community factors

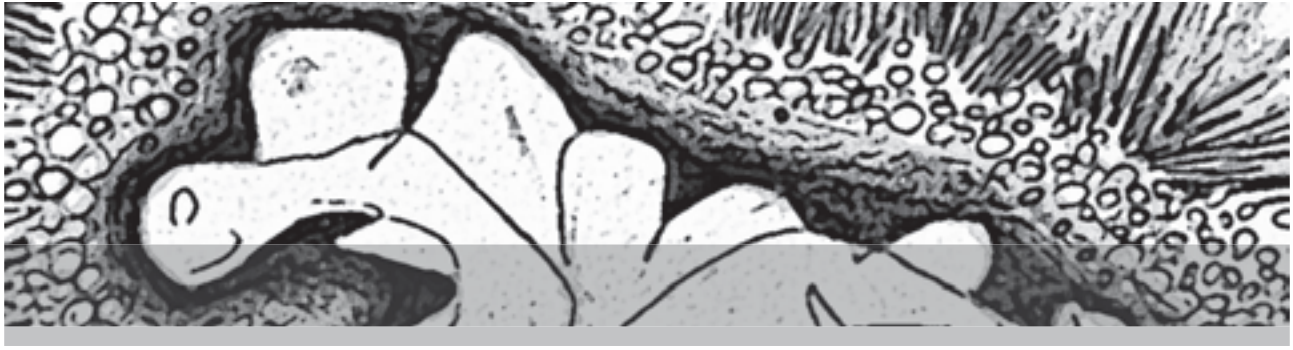
ACCHSs aim to meet the primary health care needs of their communities. They are governed by community members and are accountable to their communities. Therefore community capacity to participate in the service in a range of ways (including in governance, in planning processes and as employees in providing services), as well as community expectations about local services, are important aspects of well-functioning services. Associated support needs relate to developing community capacity and dealing with community expectations.

Community capacity

People living in communities are often dealing with many different issues. Finding people with the time and capacity to participate in governance structures is critical, but can be difficult. Communities might also need support to participate in active decision-making about priorities and direction of their local service.

Community expectations

The number of clients a service has (or the size of the community) influences the support required for community engagement activities. Generally, as organisations provide services to more clients there is an increase in the number of people wanting input into the service. Prioritising, managing and meeting these expectations requires a significant level of consultation and planning skill.



Issues associated with getting support

This chapter focuses on some of the issues identified by informants and in the literature associated with getting support. The first items are relevant for all forms of support. Those discussed later pertain to issues associated with developing shared or joint models for obtaining corporate support.

Support has come to be associated with organisations in crisis

For some in the ACCHSs sector obtaining corporate support has become associated with organisations in crisis, rather than simply being seen as a (potentially) necessary or normal part of obtaining corporate services in today's complex organisational environment. Some considered that ensuring a focus on business improvement and on excellence in business operations may assist in changing this perception.

How do organisations know they need support?

Informants stated that organisations often found it difficult to identify when they might need support or where they need to build capacity. Related issues include:

- CEOs and senior managers may not discuss internal organisational issues with others (especially with funding bodies) for fear that negative action will be taken
- funding bodies (in particular OATSIH) may see indicators that organisations are experiencing difficulties but not have processes for intervening until the organisation is in crisis
- in periods when system changes are occurring, organisations can be very 'caught up' in the changes and are often 'being their own evaluators' – this means it can be difficult to identify areas where support is required; at these times, having independent, external people/evaluators to reflect on what is happening can be helpful because they can offer alternative perspectives on issues and highlight areas where additional work is required
- sometimes the 'symptoms' occurring within organisations are indicative of broader issues – addressing the symptoms only might not enable the organisation to build capacity in a way that will prevent the issues arising again
- the process of accreditation could assist with identifying areas where support is needed, but it does tend to focus on 'the here and now' and on process issues – if processes of CQI could be implemented to enable a process of ongoing self-reflection and joint problem-solving (in a similar way to the way the Audit and Best Practice in Chronic Disease (ABCD) approach works for service delivery), this is more likely to be effective; however, this approach can be difficult to sustain
- some organisations report doing issue identification well through having structured and regular meetings with the different kinds of stakeholders in their service (for example, a senior leadership group, senior clinicians and public health doctors, Aboriginal Health Workers, and through community meetings and Board meetings) – one informant commented that for these structures to be useful in issue identification, people in management positions need to be able to actively identify emerging or likely issues and think through what the consequences of any actions might be

- some organisations indicated that issue identification can be facilitated through Service Development and Reporting Framework (SDRF) planning and through reporting on programs – related to this, the OATSIH Risk Assessment[10] was seen by some as a useful tool and by others as having limited usefulness.

A number of informants indicated that a tool to assist organisations do 'diagnostic work' about the health of their organisations would be useful. Such a tool would need to reflect the different types of organisations in the sector.

What do you get? Knowing how to access support, assess support providers and manage risk

Once organisations know they need support, working out how to identify support providers is often difficult. There are also issues associated with:

- availability of high-quality support providers
- being able to assess the quality of those support providers
- the timeliness of the support provided
- managing risk associated with external support
- knowing how to get the best from the support provider for the organisation.

The quality of support provided

Services can find themselves buying in expertise that is not 'expert expertise' and consequently not having the relevant issue dealt with, or ending up in a worse position than they started. Recruiting consultants is similar to recruiting employees and includes describing the tasks required (that is, developing a 'job' description), interviewing potential providers, setting out performance targets, developing a contract and getting reports on progress.

There is also a set of issues around responsibilities of those engaged to support services. Currently, if a consultant has been working with a service and the service continues to experience difficulties in the area where the consultant was meant to facilitate solutions, there is no examination of, or responsibility allocated to, the external support provider. Informants also reported instances of poorly performing consultants continuing to obtain work in the sector because references were often not requested and there was no mechanism for sharing 'intelligence' between agencies about the work quality of support providers.

The focus of support provided

Although support might address symptoms in organisations, there might be underlying problems that need to be identified and addressed, and sometimes consultancy-type arrangements do not facilitate this level of activity. Consequently, having a narrow focus in the provision of support does not always result in development of longer-term solutions to issues or foster a CQI approach (Brailsford 2007; Bartlett 2007). This means that services might either need to get support for the same issue on many occasions, or might develop a reliance on ongoing intervention (for example, one informant reported a case of a service that had an administrator in place for many years).

10 The OATSIH Risk Assessment is designed to identify risks to OATSIH (the funding body) rather than risk for ACCHSs. Clearly, there will be overlap in areas of risk.

Cost

The cost of getting external support or training, either through consultants or industry bodies, can be prohibitive and organisations have to be in a reasonably good financial position to be able to afford this. One informant noted that some suppliers tried to take advantage of the organisation because of the perception that there are 'bucket loads of money available to assist Aboriginal organisations'.

It was also noted that to be effective within ACCHSs, many mainstream processes need to be adapted to be appropriate and effective and that ACCHSs (or those providing support, such as State/Territory peak bodies) were generally not funded for this aspect of their work. One informant suggested that funders should learn from international development agencies that require those they fund to provide support to engage with in-country communities and organisations as part of the process of developing/adapting their programs in those countries.

Choices about resource use

There needs to be a balance between funding service delivery and capacity development (Grogan & Thomann, cited in QAIHC 2007), as well as consideration of the balance between developing capacity among local communities to undertake corporate functions and having such functions provided externally.

Related to the issue of capacity building is whether internal capacity to provide corporate functions should be a priority, or whether these functions could just as readily be obtained from an external source. Originally, the Support Systems Project was to investigate the areas where it might be reasonable to obtain external support and the areas where functions really had to be done internally. However, over the course of the project it became clear that it might be more useful to identify some principles that organisations could consider when thinking about this question, rather than providing specific advice about it.

Key points from a discussion about how organisations might think about internal or external capacity include:

- there are some decision-making processes or functions that cannot be outsourced – these might be those specified in funding agreements or constitutions under administrative law
- it is important to work out what is core and non-core business (generally, ACCHSs consider the provision of health services to communities as being their overall core business) – the next step might be to work out what support services the organisation needs to control in order to deliver its core business, and then identify what functions can be provided externally; functions that can be externalised might differ depending on what the core business is and may also change if the vision or business of the organisation changes (when developing regional models it might be that organisations which are to be 'clustered' may need to have similar core businesses)
- a consideration of the critical components to maintain community control (for example, an organisation might look at where decisions need to be made to maintain control, and which decisions these are – an example of this is that while some human resources functions might be provided externally, the organisation will still need to be able to make decisions about appointments)
- what is outsourced needs to be based on choice and an assessment by the organisation of its strengths and weaknesses – to assist with this, a framework for making decisions about what support services are needed (or about organisational capacity) would be useful; one rule of thumb could be to ask how much governance or management time particular issues are taking
- there could also be a principle around making sure the focus is on the best quality for clients (for example, will outsourcing IT result in enhanced or decreased capacity for good client management?).

What underpins good support?

In the first part of the project informants noted a number of general features that underpin good support. These include the support provider:

- having an understanding of the cultural and geographic context in which the organisation exists
- having the capacity to work in a culturally appropriate way and respect cultural differences
- having high levels of technical expertise in the relevant discipline and providing support in a timely way
- understanding the importance of consultative processes with the Board and community, so that any recommendations they make are more likely to be beneficial and appropriate for the organisation
- providing support in a way that facilitates development of local capacity
- working in structures where there are multiple organisations, creating mutual benefit for all members (for example, economies of scale, shared workforce, good expertise)
- having a shared understanding with the organisation about the support required
- having defined roles and responsibilities (with outcomes and progress indicators)
- having clarity about the boundaries for decision-making (so that support providers do not take over making decisions that should be made by the ACCHS) and a robust contract that articulates these
- being clear about where their accountabilities lie (for example, a government funder or a local health service) and discussing this with the organisation
- keeping a focus on the needs of the organisation or organisations they are serving, rather than 'developing a life of their own' – if this is not done, corporate support services can be in danger of responding inappropriately to health service provider issues (or can make decisions related to their area of technical expertise without understanding the broader service delivery objectives).

Government processes

Some informants considered that reform of government funding processes could make a big difference to the viability and functioning of organisations. First, having multiple funding streams and associated reporting processes creates a support need (which is often not funded) around submission writing, project administration, project management, and financial and project reporting. Second, competitive tendering processes often do not enable capacity building across the sector. Third, those organisations with the least capacity (and possibly the greatest need) are often unable to develop submissions.

Sometimes the rules around provision of support structures by government do not allow enough flexibility for organisations or a group of organisations to develop their own solutions and get support for this. Further, the way the support is rolled out is not always planned well and this can limit the capacity of organisations to obtain maximum benefit from it.

Another issue is that government intervention may occur long after crises have occurred and that more discussion is needed about how to improve protocols so that intervention can be timely and effective (Bartlett 2007:13).

Developing shared models

Skills needed to facilitate establishment of support structures

People establishing joint support structures for a number of agencies need to have a wide range of skills, including:

- leadership, vision, capacity to facilitate longer-term strategic thinking and an ability to identify opportunities for systems development when they arise (possibly in a crisis situation), as well as the ability to identify how to develop long-term solutions to crises rather than focusing on the development of a short-term fix for an immediate issue
- advocacy, strategy development and skills in managing politics, which might include identifying processes for working with the sector to develop strategies and also how to present the case to funders – in situations where there is an immediate problem to be solved, this might include presenting a solution to the problem and laying out a plan for what could be done in the future
- consultation and negotiation skills (in establishing consortium/partnership arrangements with members, in assessing potential support providers and in establishing service arrangements with support providers) with companies that might provide aspects of the support
- capacity to learn about unfamiliar content quickly (for example, if one area of support required is IT, becoming familiar with IT terms is critical when facilitating negotiations).

Community control

Maintaining local community control when participating in regionalised or shared support (and service provision) structures was an issue that was often raised, as was the related issue of how to develop models that provide business support that reflects or strengthens community governance. Ensuring that community control is not tokenistic (and that there is not a divergence between espoused values and actual behaviour) was also raised. Questions about the contemporary nature of community control might also fit here:

the current community control model has seen us through the past 30 years, but it's time to re-evaluate and develop a new model that will take us through the next 30 years (participant at QAIHC Business Conference 2007).

How to manage differences between communities and services when developing models

When developing regional or shared models there might be many different communities and organisations wanting to participate. This creates a series of issues around community and creating structures that can take into account the differing needs and resource levels of different-sized services and managing potential inequities between communities and organisations.

Funding support structures

Establishing good support systems can be very costly and take a lot of time. Getting funding to do this is difficult and establishment may rely on services participating at their own cost. There are also issues about longer-term funding of these structures once they have been established (that is, will services pay fees or subsidise them, will government provide funding)?

At what level could support be provided?

Individual health services and their associated corporate support structures operate within a broader system that includes regional structures (in some States and Territories), State-based peak bodies and organisations (such as affiliates) and national organisations, as well as government and other funders. Each type of organisation might have some role in creating supportive systems in which services can operate. In our experience of evaluating health service reform initiatives, it is often critical for the balance between what is done at a State-wide level and what is done at local and regional levels to be carefully negotiated so that there is system-level development along with local-level autonomy. In discussions of support systems, it might be useful to consider the potential roles for each of these types of organisations, as well as for individual services and support providers.

Some types of support might be best provided locally, while some could be provided regionally and others on a State/Territory or even national level. Obviously, developing agreements about what should be provided at which level requires a process of discussion and negotiation. One informant considered that there should be formal agreements between the Commonwealth and State/Territory governments around the provision of support and that 'preventive, pre-emptive' support should be written into funding agreements. Another informant suggested that part of organising different levels of support would include developing improved funding agreements, management and expectations.

> If there was a suite of nationally agreed (by all service providers and funders) indicators for health outcomes, there could be a national minimum data set which could be used to track work over time (to close the gap) and which services could also use to track their own progress. Instead, there are changing requirements every year and as a result the services don't trust the funders and are less likely to value reporting, let alone expect any meaningful results back from the funders.

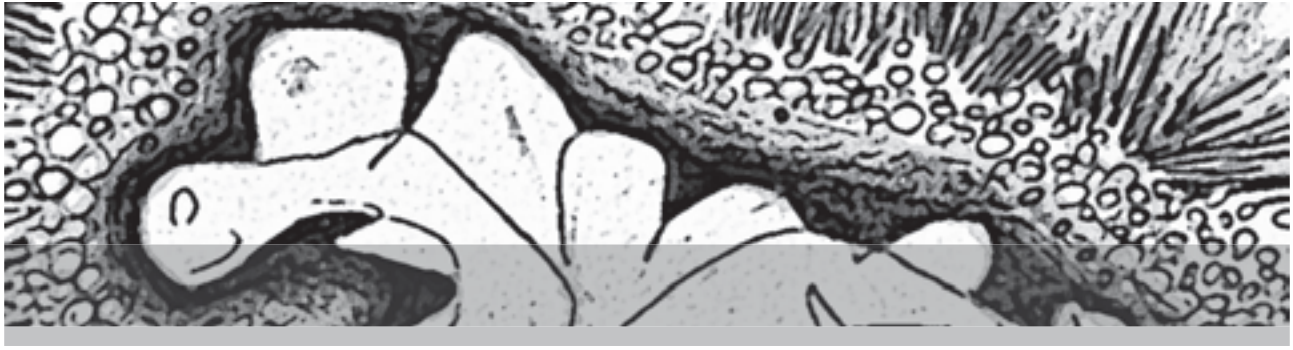
Concern about centralisation and mainstreaming

Although the second part of this project aimed to look further at models for the provision of support, one concern that has been raised on a number of occasions is that outlined by Brailsford (2006, p1) about issues of centralisation and mainstreaming. To paraphrase: some issues relating to the stability and operation of ACCHSs have resulted in suggestions that these services should be 'mainstreamed' or that a centralised 'one size fits all' solution should be adopted. Critics of this position have argued that returning to 'an authoritarian, centralised system' is unlikely to lead to improvements in Aboriginal health outcomes and that given workforce shortages and a concern about the capacity for some mainstream sectors (such as general practice) to meet the needs of Aboriginal clients, it would be unwise to disband these services.

It sounds good in theory, but...

Although there might be support in theory for the development of a range of shared support structures, successful implementation of these will 'depend on the ability of all stakeholders to move beyond a theoretical model and realistically asses the practical challenges of implementation and maintaining a successful operation' (Brailsford 2006, p18).

It was also noted by key informants that sometimes the potential benefits of shared services (such as economies of scale through joint outsourcing) have not been delivered, and when this occurs services often revert to 'doing their own thing', which then results in the support service failing.



Shared models for corporate functions: benefits and risks

In principle, the sharing of corporate support services between organisations has potentially excellent benefits (some of these are described below). However, these need to be weighed against the potential challenges of a shared services model (discussed in the following section). Some informants thought that it was important to be able to assess and balance the benefits and costs and ensure that, overall, benefits outweigh costs; for example, while there may be increased functionality, this might come at a cost of a reduction in community control, or there may a reduction in the functions undertaken by the organisation for the benefit of increased economies of scale.

Potential benefits and advantages

For some communities, creating shared or regionalised services is considered to offer the potential to:

> secure greater authority and control... over the things that matter to them, and to create a strong voice that could influence government funding and service delivery to the region securing greater authority and control considered to provide opportunities (Smith 2007:1).

The advantages of having some kind of model of shared services, as identified by a number of authors (Brailsford 2006, 2007; QAIHC 2007; Dollery, Akimov & Byrnes 2007) and by key informants, include:

- achieving economies of scale and increased purchasing power (including through sharing resources and joint procurement and potentially leveraging off investments in technology to achieve cost savings and improved service delivery)
- having access to more (pooled) funds, which enables purchase of better quality goods, services and resources; similarly, pooling skills provides a means of increasing access to resources
- reduced duplication of effort and facilitation of enhanced business practices, which results in efficiencies (similar to above); for example, this can occur through sharing knowledge about successful practices, streamlining business processes, developing standardised templates and policies that can be used across a sector and adapted for individual organisations, and mentoring
- standardisation, consistency, coordination and CQI of practices
- improved channels of communication and information flow across services
- the development of a formal capacity within a network or group of ACCHSs to facilitate/enable change and improve effectiveness – this includes working jointly to build on and strengthen the things that work well and to identify how to change things that don't work well (this can include developing responses to issues common to a group or network of organisations and advocating for means to have these issues addressed)
- the potential for coordinating aspects of employment/workforce organisation, such as placement of students, volunteer professionals, staff who want to return to the sector after an absence, or staff who want to stay within the sector but work in other services or work in more than one service at one time
- the development of a 'united front', which can lead to a stronger bargaining position when wanting to access further funds
- the provision of a framework to support the development and operation of smaller organisations or organisations operating under difficult circumstances

- building a capacity for increased revenue generation
- maximising value for each dollar spent – this might be through developing consistent recruitment and workforce strategies that might result in improved career options for those working in the sector, as well as increased staff retention
- greater scope to focus on core business and strategic outcomes through having more efficient or streamlined business practices (and therefore less need to focus on them)
- assisting with early identification of problems and facilitation of access to additional and specialist skills where required (this could include through accessing skills of those working in other services within a shared service model).

Risks, issues or potential disadvantages of developing shared services (corporate functions)

Aside from the potential for benefits, there are also considerable challenges in setting up, organising and developing shared service arrangements. These challenges can be associated with different phases of working in joint structures: (1) development or transition to shared services; (2) management and coordination; and (3) outcomes, performance and accountability.

Development or transition

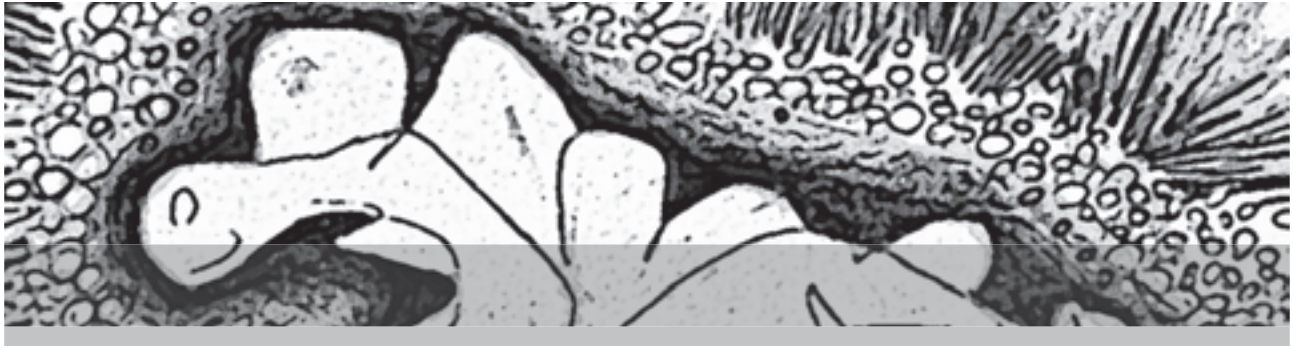
There are many barriers to overcome before a shared services model can even be developed. Opportunities for sharing services need to be identified by the participating organisations and, as Dollery, Akimov and Byrnes (2007:19) state, 'some services are more amenable to a shared service arrangement than others'; for example, organisations with excellent internal corporate support functions may not want to share services. Barriers in the development stage may be identifying the causes, defining need, identifying the right solutions (BIG 2007), the potential for loss of identity (or loss of autonomy or community control or loss of assets), conflicting objectives and the uncertain benefits of entering into a shared service agreement (Dollery, Akimov & Byrnes 2007; QAIHC 2008b). Other challenges include the amount of time required and the cost of establishing a shared services model; securing funding for it; the uncertainty associated with working in collaboration; issues with developing a shared vision, managing change processes and overcoming cultural differences between organisations; setting up new systems or adapting existing ones; and getting commitment from services, Boards, workers and communities already operating in high stress environments (QAIHC 2008b).

Management and coordination

Once shared service arrangements have been developed other challenges arise. For example, within a shared services arrangement there can be increased complexity associated with working in collaboration (including developing relationships of trust and making decisions together with others); introducing and implementing new management and administrative arrangements; and maintaining systems for linking services (including with new technology or with existing and limited technology) (QAIHC 2008a, 2008b; Smith 2007). These changes can be difficult for organisations and their staff to coordinate, and therefore become challenging – particularly when there may be different skill levels and infrastructure available across organisations (QAIHC 2008a, 2008b). Fostering staff ownership of joint models and ensuring there are clear processes for conflict management so that disputes are (ideally) prevented (or, if not, then managed and resolved) are also critical issues, as is maintaining privacy and confidentiality of information (including potentially sensitive information) (QAIHC 2008b).

Outcomes, performance and accountability

Ensuring the support model performs well for participating organisations, is accountable to them and produces outcomes is also important to maintaining support for it. Although measuring success might be a significant challenge (BIG 2007), a clear process for doing this is important to enable benefits for participating services to be measured and to assist with CQI of business functions. Over time, shared models need to protect against: the creation of power bases of groups of people who are not necessarily representative of the communities or organisations they are working with; pressure on or coercion of some (especially smaller) services working within a shared model; inequities between participating organisations; the creation of complex solutions to simple problems; repatriation of savings to funding bodies (rather than re-investment in local services); and disputes resulting in members opting out (Dollery, Akimov & Byrnes 2007; QAIHC 2008a, 2008b; Brailsford 2006, 2007).



Existing models for providing corporate support

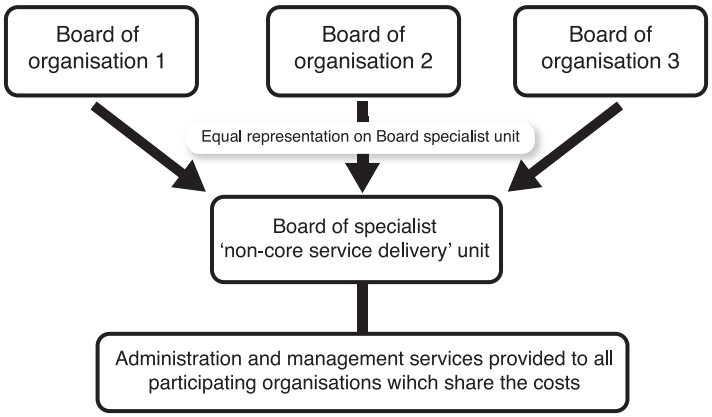
ACCHSs have dealt with the factors impacting on their operational and management functions in varying ways. These include significant work currently going on to establish support structures for their corporate functions. We identified a broad range of mechanisms through which ACCHSs currently obtain support and these are described in the first section below. We then identified four sites where significant work has been done to create organised structures for corporate support and developed case studies on each of these. A short summary of each case study is provided. The full case studies can be found in the companion document, *Taking Care of Business: Corporate Services for Indigenous Primary Health Care Services – Case Studies.*

Mechanisms for organising corporate support

The following points illustrate the different types of mechanisms through which ACCHSs currently obtain support. In many instances services might obtain different types of support through a number of these mechanisms.

1. **Organisation-owned shared service provider or service centre,** which can be a separate organisation from its member services but owned and governed by them. This type of service brings together and provides business functions previously performed by business units within member organisations.

Figure 1: Organisation-owned shared service provider or service centre model

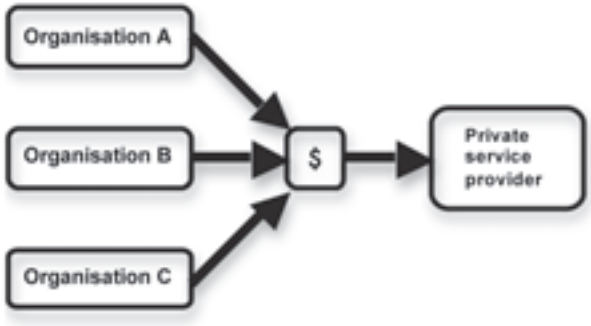


2. **Provision of corporate support services by a large or peak organisation.** In this model specialist support is provided either by individuals within the service or by a specialist unit created within a *single* large organisation that has sufficient administrative capacity to provide support to others.

Figure 2: Large or peak organisation model

3. **Joint outsourcing to the private sector,** in which organisations pool funds to jointly purchase goods or services from the private sector.

Figure 3: Joint outsourcing model

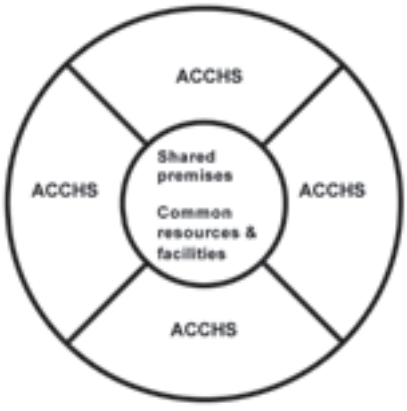


4. **Peer support networks,** in which a group of organisations (or specific staff within organisations, such as CEOs or finance workers) form a network to provide support to each other.

Figure 4: Peer support model

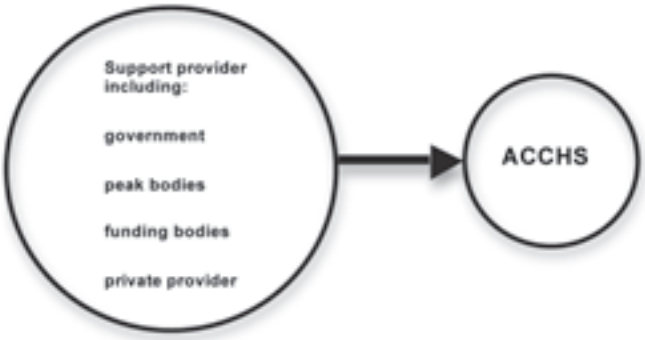
5. **Co-location models,** in which a number of organisations share premises and common resources and facilities.

Figure 5: Co-location model



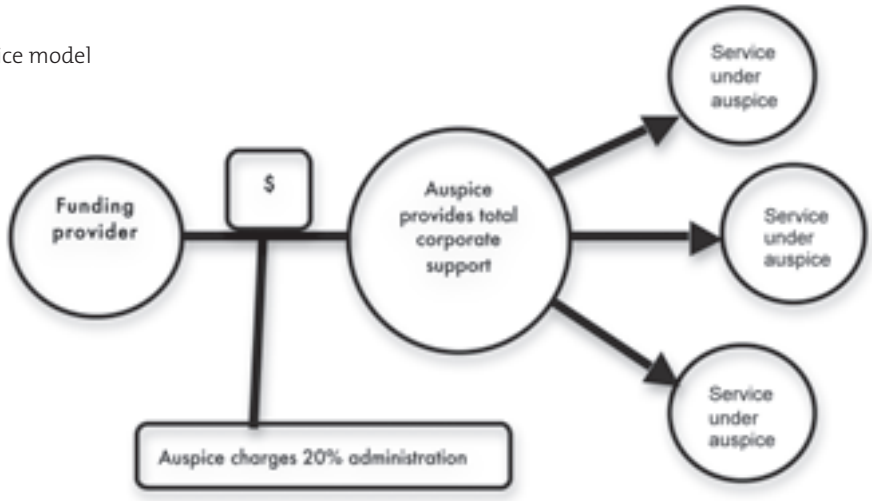
6. **Partnerships,** in which individual organisations coordinate relationships with external support providers, peak body organisations, larger services etc. on a one-to-one basis.

Figure 6: Partnership model



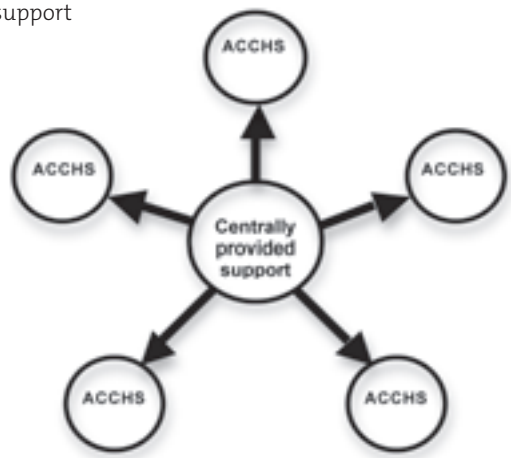
7. **Auspice arrangements,** in which a small organisation enters into an arrangement under the auspices of a larger one. These arrangements are often expected to be temporary.

Figure 7: Auspice model



8. **Regionalised or central support,** in which a number of services agree to work together as a regionalised service. Sometimes in this model corporate support is centralised.

Figure 8: Regionalised or central support model



9. **Organisational arrangements with consultants,** in which organisations outsource particular functions, or obtain advice from, consultants.

Figure 9: Consultants model

Four case studies

In Part 2 of the project we examined case studies of four of these different models for corporate support currently existing within the Aboriginal community-controlled health sector. These are:

- Queensland Aboriginal and Islander Health Council, which is a State-based peak body with a Sector Development Unit
- Bila Muuji Health Services Incorporated, which began as a peer support network for CEOs and operates across western New South Wales
- Katherine West Health Board, which is a regionalised health service operating in the Northern Territory – this service has its corporate headquarters in Katherine and runs community health services in a number of remote communities west of Katherine
- Central Australian Aboriginal Congress, which auspices a number of remote health services in its surrounding area.
- Significant interest was expressed in the work of the Kimberley Aboriginal Medical Services Council (KAMSC); however, we were unable to include a case study of this model in this report. Further information about KAMSC can be found on the organisation's website (www.kamsc.org.au).

Queensland Aboriginal and Islander Health Council

The Queensland Aboriginal and Islander Health Council (QAIHC) was established in 1990 as the Queensland Aboriginal and Islander Health Forum. QAIHC has 26 member services and is governed by a Board elected from the membership to represent the different regions across Queensland.

In 2004 QAIHC established a Business Support Unit (now the Sector Development Unit) to provide corporate support to members. The unit provides direct support from three locations, manages consultant support, facilitates support from other QAIHC units, runs a help desk, facilitates State-wide training, facilitates specialist networks, organises information sharing (conferences) and has worked with the sector to develop Business Quality Centres.

Members of QAIHC pay an annual 'retainer fee' according to the services required and this is formalised in a written agreement. QAIHC has strategic and business plans and benchmarks the performance of the Sector Development Unit against these. Key performance indicators are around activity and feedback from services. A formal review of the unit is conducted every two to three years.

Bila Muuji Health Services
Bila Muuji (which means *river friends*) is a CEO network based in western New South Wales. It was established in 1995 by the CEOs of six rural and remote Aboriginal Medical Services in New South Wales. The network was set up so the CEOs could meet as a regional forum and share ideas and support each other. Currently ten CEOs of services participating in Bila Muuji meet on a bi-monthly basis.

Bila Muuji identifies and addresses issues of common concern and organises for likely changes in service systems. The CEOs work collaboratively on joint initiatives for service development, share skills and expertise, and provide one-on-one and joint peer support. Bila Muuji has recently been incorporated so the group will be able to hold joint funds for future collaborative work. Joint training is also carried out on occasion. Member organisations pay an annual fee, which is split into two tiers, one for smaller organisations and one for larger organisations with higher operating budgets.

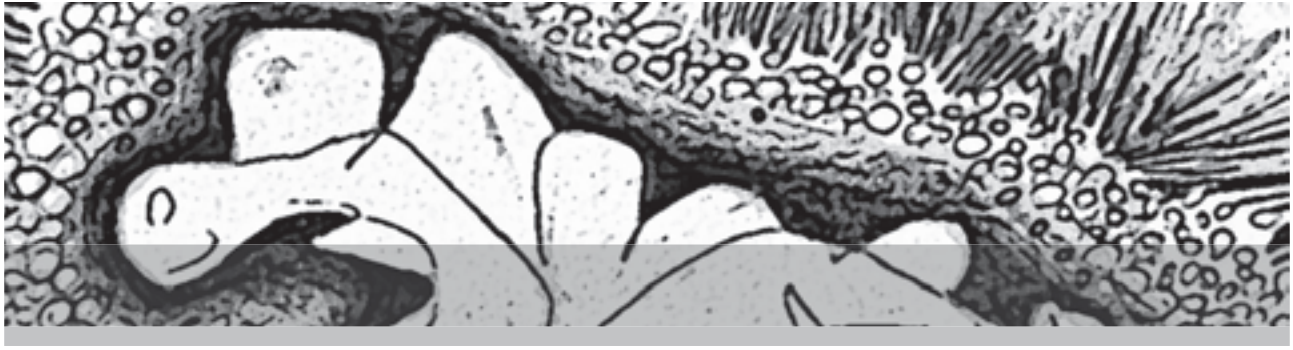
Katherine West Health Board
The Katherine West Health Board (KWHB) was initially established as part of a coordinated care trial in 1996. By 1998 it had become a purchasing body, and in 1999–2001 it transitioned to become a service provider. The corporate office, located in Katherine, provides corporate services to seven community health centres in remote communities. Representatives from the communities sit on the Board and also participate in subcommittees. Development of corporate support services is integrated into, and built alongside, health service development. The organisation takes a carefully planned and incremental approach and a has a strong commitment to communication and meaningful community engagement.

KWHB has a fairly flat structure to enhance communication between community health centres and those providing corporate functions. Key features of KWHB's model are the ongoing development of IT for communication, knowledge sharing, problem-solving and CQI. Many corporate functions are provided internally by employees. Consultants are only used when the right skills are not available locally, demand for support is limited or there is a skilled local provider who works as a consultant to a number of organisations. Capacity building is incorporated into the model through the employment and training of local staff. An administration fee is levied to fund corporate services, and evaluation and review is ongoing, with KWHB recently undertaking a process for restructuring.

Central Australian Aboriginal Congress
The Central Australian Aboriginal Congress (CAAC) was established in 1973 and first had an auspice role in 1977. The CAAC's charter embraces supporting the development of community-controlled services. CAAC currently auspices six services (in nine communities). Since its first arrangement, demand has grown rapidly.

CAAC has 10 branches, and the Remote Health Branch manages services under the auspices of CAAC. The Remote Health Branch provides direct support to services and facilitates corporate support from the CAAC Corporate Support Branch. Although the CAAC Board is responsible for auspice service contracts, services also have their own Boards, which the CAAC Board and CEO work with; however, the CAAC Board can override any decisions made by service Boards under its auspices.

Entering an auspice arrangement may be a funding body requirement – however, services often can choose the auspice body. A set administration fee is taken from the auspiced service's funding to finance the model.



Corporate support services: Themes and learnings

The case studies illustrate some of the significant thinking, work and effort invested in developing a range of models to support the corporate functions of ACCHSs over many years. This chapter draws together some of the key themes from across the case studies and our reflections on what some of the key learnings might be. The discussion at the second national roundtable also focused on organised models for provision of corporate support. Points made during the roundtable discussion are included here and a summary of the key elements of good models identified during the roundtable is provided in Appendix 3.

Terminology

There are many complex organisational, individual and community relationships involved in the area of corporate support, so it is not easy to develop terms that are easily definable. However, at the risk of over simplification and to make this discussion simpler to follow, we have adopted the following terms to indicate different stakeholders in the support provider – support accessor relationship. These are:

- 'supporter' or 'support provider', which are used to refer to the structure through which support is provided
- 'support stakeholder' or 'organisation/service accessing support', which are used to refer to those accessing services provided by the supporter or support provider.

An example of how this language can overlook complexity is in a peer support network, where those who provide support also access support, so it is not really appropriate to talk of participants as either support providers or accessors. However, for ease of discussion when their role is support provision they will be called 'supporters' or 'support providers' and when their role is accessing support they will be referred to as 'support accessors'.

We recognise that there are many additional informal or one-off mechanisms through which ACCHSs obtain corporate support. However, this document focuses on organised or more structured models through which a number of services or centres obtain support. We also recognise that we have not been able to include in this work all of the organised corporate support models that currently exist in Australia.

Why were support structures developed?

Each case study model grew out of identification by those working in the sector – either as direct service providers (Bila Muuji, KWHB, CAAC) or as a peak body (QAIHC) – of the need for a supportive structure that would enable ACCHSs to maximise their operations so that they could deliver the best possible primary health care to their communities. That is, the case study models grew from the ground up and did not necessarily begin with a primary focus on corporate support but were established as a means of supporting effective and sustainable clinical service delivery in environments where there continues to be significant challenges.

Models were developed or emerged for a range of reasons:

- a peak body responding to the needs of members for corporate support and organisational development (QAIHC)
- a group of CEOs identifying the need for peer support and for taking joint action on issues of common concern (Bila Muuji)

- individuals identifying opportunities for making improvements in their sector (for example, the opportunity to develop improved services under the coordinated care trials) and as a consequence developing improved structures for corporate support (KWHB)
- a commitment to support communities to establish and/or develop their own community-controlled services (QAIHC, Bila Muuji, CAAC)
- necessity, as in the case of auspices where small, remote services require the auspices of an agency for a range of reasons, including that the funder requires it, that it is part of implementation of structures like health zones, that a former auspice no longer exists or that the service is transitioning from being State-run to community controlled (CAAC)
- responding to the immediate needs of services experiencing difficulty (QAIHC, CAAC).

Implicit in each of these is that there will be a range of benefits to participants, including capacity development across the sector (further discussion of these benefits is provided at the end of this document).

Establishment phase: The importance of good process

There was acknowledgment among most of those engaged in this project that there was unlikely to be one existing model that would fit all community-controlled services in their different contexts. Rather, it was considered that the structures (and emerging models) for providing good corporate support needed to be developed in ways that would ensure they met the specific needs of services. Therefore, it appears that the process of engagement of all stakeholders (including potential support accessors) in the development of models is at least as, or possibly more, important than having a defined structure or model to apply. In the case studies, this engagement occurred in two main ways:

- support accessors were actively engaged in the process of developing the model from the beginning – this is ideal because decisions about the support structure can be based on participant support needs, as well as on the kinds of organisational relationships they wish to enter into; that is, form should follow function (KWHB, Bila Muuji, QAIHC)
- if the above is not possible (for example, a new support accessor seeks assistance from an existing supporter), then the support should be tailored to meet the needs of individual support accessors (QAIHC and, as far as possible, CAAC).

At the second national roundtable the first element of good support models was considered to be 'working out ownership issues' – which is basically about having a process to establish the parameters for working together. Some of the issues identified as needing to be addressed in this phase were working out how to ensure work was community driven and that local community governance was maintained, working out decision-making processes, balancing autonomy with working together, and setting boundaries around who was going to be involved and what would be included.

Building in a transition period and a transition process (as services moved towards operating differently with a support provider, or went through their own transitions, such as from being a small to a large organisation) was another aspect of ensuring good process that was highlighted at the second national roundtable.

The importance of principles

Consistent with the goal of corporate support to assist improvements in health service provision and improvements in health and wellbeing, the principles underpinning the support providers were generally set within this broader aspiration. Common to all were the principles of supporting self-determination and community control (and autonomy of communities) and strengthening the capacity of organisations so that they could deliver improved services to their own communities.

Other principles that were common to a number of models included:

- commitment to holistic understanding and approach to health and wellbeing
- elimination of health inequalities
- promoting and maintaining culture
- cultural respect, 'respect for ourselves and others', promoting respect and trust
- collaboration – including intersectoral collaboration, 'working as a team'
- demonstrating strong leadership
- integrity, commitment, 'doing the best we can'
- quality and excellence
- learning
- good and open communication
- moving forward carefully, 'one step at a time'
- transparency and accountability
- responsiveness – 'addressing need not want'.

The principles identified by the case study models were important because they set out a framework for the way participating organisations would work with each other and could be used to guide decision-making.

Involving support accessors in governance structures

Three of the four case study models were part of larger community-controlled organisations and were therefore governed by the Boards of those organisations, which included:

- a State-based peak body for the community-controlled health sector whose Board members were elected from the organisation's membership (QAIHC) – the corporate support unit reported directly to this Board through the CEO of the peak body; however, unless there were extenuating circumstances (such as an organisation being 'in crisis') details of the services obtaining support were not reported to the Board to maintain confidentiality
- a regional community-controlled health organisation whose Board was elected from the communities in which the organisation operated community health centres (KWHB)
- a large community-controlled health service governed by an elected Board that took an auspice role with respect to smaller, more remote community health services on a temporary basis; the Board of the large organisation (elected by the organisation's members) holds the funds (and associated responsibility for them) – within this model there were mechanisms for the Board of the large organisation to communicate with and be advised by the Boards of the agencies under its auspices (CAAC).

In the peer support model (Bila Muuji), the CEOs of member organisations made up the Board. In this model funds for joint initiatives were currently held by the lead member organisation; however, Bila Muuji has become incorporated and will be able to hold funds for joint initiatives.

In two of the case study models organisations obtaining support (the support accessors) maintained complete organisational independence from the support provider (QAIHC, Bila Muuji). In the auspice model, auspiced organisations have their own Boards but the final decisions can be made by the auspicing agency. In the latter case, where auspicing effectively reduces community control at the local community level (because the Board of the auspicer has legal responsibility for the auspice), having an aupicer with a track record as a community-controlled organisation and which actively supports the principle of community control can result in the Board

of the auspiced organisation continuing to have an important role in the governance of its organisation even though it is not completely in control of it.

An additional model developed in the Kimberley (by KAMSC) as a regionalised structure to provide support (including 'centralised resources and collective advocacy') to community-controlled health services, has a Governing Council which includes a representative from each of the community controlled services that make up its membership. These members control their own independent health services (Kimberly Aboriginal Medical Services Council undated).

The key message about governance appears to be that no matter what the structure of the support provider, those obtaining support should be represented in the governance of the model. Consideration should also be given to mechanisms to maintain confidentiality about the internal business of support accessors.

Organising and managing corporate support models

The structure of each case study model was different. However, in establishing these models, each group had to deal with a number of issues in considering how to develop its structure. These issues are summarised below.

Location of corporate support functions in relation to core business functions of health service delivery

There appears to be a continuum of views about the location of corporate support functions compared to the core business functions of health service delivery. At one end is the view that the majority of corporate functions can be provided externally (that is, completely outsourced), while at the other is the view that corporate functions need to be highly integrated into the model for health service provision (especially in program development) and therefore as few functions as possible should be outsourced. Midway along this continuum is the hub model, in which groups of organisations create a shared service to provide corporate support functions – the model is owned by the group but is a separate entity to its member organisations and essentially provides support externally to group members who have joint control over what it does.

The potential advantages and disadvantages of each of these approaches might be different for different kinds of services. For example, small, remote services might simply not be of a size or location to have many in-house corporate functions. Larger organisations might have this capacity but might see advantages in sharing resources with others, while some will consider that the ability to integrate corporate support into program development outweighs potential advantages accruing from economies of scale, for example.

Where organisations sit on this continuum will influence the kinds of support structures they are prepared to enter into.

Supporting the core business functions of a health service and meeting the principles of self-determination and a holistic approach

Common to each case study is a commitment to Aboriginal community control, self-determination and a holistic approach to health. Consequently, in all models the corporate support function was linked with, or was able to facilitate access to, advice and support for non-corporate aspects of ACCHS work. This was achieved by the corporate support function being:

- integrated into health service program planning and implementation processes to ensure that corporate support capacity was considered in decision-making about health service program development – this meant that decisions about expanding and developing programs also included decisions about developing corporate support capacity
- located in a peak body that also did advocacy and policy development, along with providing clinical and health service program support functions (for example, in population health planning) – the Sector Development Unit, which provided corporate support, could facilitate support for support accessors from these other units within the peak body (QAIHC)

- one of a range of support services provided by a large community-controlled organisation acting as an auspice – within this organisation a specific branch, the Remote Health Branch, had been established to facilitate access to corporate support services, as well as provide non-corporate service support (for example, support in running specific programs such as drug and alcohol programs, allied health programs etc) (CAAC)
- one component of the work of a peer support network where members could contact each other directly to seek support and where issues (both related to corporate functions and non-corporate functions) of concern to all members were identified and collaborative action pursued (Bila Muuji).

Functions that might be sought externally (or outsourced) or done internally

In thinking about the kinds of support that might be obtained from external sources and the kinds of corporate functions that could be best undertaken internally, it appeared that corporate functions could be grouped into (at least) three main categories:

- corporate functions for the 'foundational' aspects of health service functioning – that is, the level of corporate functions required on a regular basis for the ongoing basic functioning of an organisation; this might include specific aspects of finance, human resources, data management etc
- corporate functions where expert skills or advice are required relatively infrequently but over a long period – these might include specific aspects of human resources management (for example, industrial relations advice, serious dispute resolution expertise and development of CEO job descriptions), aspects of accounting and auditing, and legal advice; in some cases those providing this expertise might also support workers internal to the organisation to build their skills (for example, an accountant might be available to provide support to a finance worker)
- corporate functions where there are one-off changes occurring – such change might either affect a whole sector (for example, changes to legislation such as the Corporations Act, where specific advice is required over a short period to introduce a given change) or individual organisations (for example, the development and implementation of a new IT system).

Generally, only large services will have the internal capacity to undertake most of these functions in-house, although they may choose not to do this. However, even large services will often employ external providers for the third category of support, although they may have in-house staff for ongoing maintenance and problem-solving related to maintaining the changes introduced.

There are different views about the extent to which aspects of the first and second categories of corporate functions can be contracted out to external providers, or provided through shared service models. As described above (in the section 'Location of corporate support functions in relation to the core business functions of health service delivery'), some informants considered that many of these functions could be provided externally or through a shared services model, while others considered that these functions should be integrated into the design and development of the whole health service – particularly to ensure that the consequences for these functions were not ignored as the service grew. The latter view could be more likely to be held by people working in organisations that have already achieved a size or scale that allows them to employ reasonably high-level staff internally (such as human resources personnel).

For some organisations one way to determine whether to obtain support externally or internally included questions such as:

- are people with the right skill sets available locally?
- is the demand for the support limited (and therefore employing someone internally would not be cost effective)?
- is there a skilled provider available who works with a number of services?
- if there was staff turnover in this role, would it create serious problems for the service?

Fitting corporate support roles into the business of an existing organisation
In two of the case studies (QAIHC, CAAC) providing corporate support to other organisations emerged as a role after the service had been established for another purpose – health service provision in the case of CAAC and advocacy and policy development in the case of QAIHC. Each of these organisations had considered how best to provide corporate support functions without overwhelming the existing role of the organisation.

QAIHC had established a defined structure within the existing organisation to manage the corporate support function. Having a business unit with this specific focus that was separate to, but could draw on and link with, other units within the organisation enabled the organisation to maintain its 'traditional' roles of advocacy, policy and program development and support etc without being overwhelmed by the increasing demand for corporate support. This model is moving into the next phase, which is to support the establishment of regional business quality centres ('hub' centres) where QAIHC will have a role in governance but will not be the direct support provider.

Similarly, CAAC had worked to manage its different roles by establishing a specific branch to focus on the needs of auspiced services.

Identifying support needs
One key step in accessing corporate support is for organisations to identify their support needs. Various ways of doing this were identified by support accessors, including:

- using the SDRF planning process to identify corporate support needs – some informants also reported that the OATSIH Risk Assessment Tool could be useful
- using other systems assessment tools – for example, the ABCD systems assessment tool was reported as being useful and one organisation was considering adapting it to review corporate support functions
- seeking the assistance of a support provider to help identify what was needed to improve a service and the associated support needs
- working through accreditation and CQI processes.
- Support providers identified that they could assist with this by:
- picking up issues in organisations while they were engaged in providing corporate support
- convening meetings or conferences or providing topic-related networks or templates to enable support accessors to find out about good practice – and therefore assist them to identify what they might need to change
- showcasing and promoting organisations that have done something really well so that others can learn from these organisations.

Consolidating the work so that the sector more broadly is supported to develop
Each case study model had a role in facilitating sector development more broadly than just for its members (or support accessors). These included, variously, the following levels:

- local level – this included direct corporate support to individual services
- community level – this included where the support provider worked with local communities to enable them to establish a new service or participate in an existing service
- regional level – this was where a support provider assisted or facilitated engagement of support accessors with regional processes or forums (where they existed) or organised regional level joint activity (such as training)
- State and national levels – this was where the support provider either mobilised the collective knowledge of its members or support accessors to act through advocacy and policy development or facilitated capacity building activities at a State-wide level.

Structuring communication and relationships

Good communication and relationship building was viewed as critical to the provision of good support. This meant that support structures needed mechanisms to promote and support effective communication and relationship building (and needed to factor in the time for staff to do this). In many ways the features of good working support structures were similar to those of effective partnerships – that is, there were good processes that supported strong relationships, mechanisms to promote transparency, formal agreements about working together and having a mechanism for review.

Relationships were important to both supporters and support accessors for a number of reasons:

- knowing and trusting the person who was providing support enabled support accessors to seek help and to discuss often sensitive issues openly
- having good relationships with support accessors enabled supporters to get a sense of when an organisation might 'be in trouble' (this could be particularly important if organisations did not have access to information that enabled them to work out what their issues were)
- good relationships enabled sometimes difficult and sensitive issues to be identified and addressed.

Good relationships often depended on having staff in the support provider who were highly skilled (that is, their support was valued), flexible (they could identify and work with the needs of different organisations and organise their work to prioritise the needs of others), highly committed (as the work often required long hours), prepared to visit services (which could include significant travel), approachable, able to listen and be non-judgmental, and able to maintain confidentiality.

The centrality of relationships means that models can be vulnerable to staff changes. In some cases the support structure was able to mitigate this to some extent by:

- planning for temporarily higher workloads among those staff with existing relationships with support accessors while new staff members built these relationships (for example, KWHB)
- reviewing the role when someone left to identify if it needed to be adjusted (particularly if the new incumbent was unlikely to have the breadth of skills of the previous staff member) and identifying whether other 'roles around that role' might also need to be adjusted (KWHB)
- having succession plans in place for when support staff left or changed roles (QAIHC).

Having mechanisms for good two-way communication between supporters and support accessors was critical to all aspects of model development, operation and ongoing review. Support accessors needed to be able to communicate with supporters when they needed support. Some of the main barriers to good support were when support accessors:

- did not know the person in the support provider to contact for different corporate functions
- had to go through too many intermediaries to obtain support
- had a complicated process to go through to get support or advice
- had to comply with processes that were more appropriate or relevant to the support provider than the support accessor
- had support needs prioritised by the support provider and therefore had difficulty getting the support they really needed.

Structures that had been put in place to support communication and relationship building by case study models included:

- having one person within the support provider as the first point of contact for support accessors

- having one person within the support structure clearly identified as being responsible for each corporate support function so that support accessors can directly access relevant expertise
- having one person or unit who is responsible for liaising between support accessors and the support provider
- the support provider having regular (and sometimes scheduled) meetings, email and/or telephone links with support accessors (either one on one or in group discussions)
- having support accessors on the Board of the support provider
- having open community meetings and advisory structures.

Providing support

The main way corporate support was provided in the case study models was through direct support from a staff member of the support provider (or a consultant engaged by it). The staff member of the support provider worked with staff from the support accessor to provide a corporate support function or to support the development of skills in the support accessor organisation so that the function could then be undertaken internally. This contact generally occurred through site visits, telephone or email contact.

Other ways in which support was provided to individual services included:

- the supporter identifying, negotiating with, managing and monitoring consultants to provide support to support accessors
- support providers facilitating training from external providers for support accessors (for example, Medicare billing)
- having a help desk that support accessors could access
- meeting bimonthly as a peer support network
- establishing ways to build capacity and facilitate consistency across a sector – for example, developing templates, policies and procedures (or having these developed by experts) that can be adapted by individual services to meet their needs (QAIHC, Bila Muuji) (these not only save time but provide services with information to introduce up-to-date practices)
- facilitating establishment of links between organisations so that they can develop local networks
- organising training on a regional or State-wide basis (for example, governance training, a yearly conference)
- supporting a network of practice (for example, a finance network)
- meeting monthly as a peer support network to identify issues for joint action and to share innovations between services ('if you're an organisation you think that normal is what is happening in your agency') (Bila Muuji)
- facilitating upgrades of infrastructure such as IT across a State or across a number of services
- facilitating the development of regional hubs (business quality centres) to take on the role of corporate support.

Accessibility of support providers and timely responsiveness to need

A number of support providers struggled to create structures that enabled support accessors to easily access the support they required and to do this in a timely fashion. This was particularly the case as demand grew and where there were a number of support accessors experiencing crises at the same time. Ways that support providers dealt with this included:

- developing a 'flatter' structure so that those needing support could get it 'fairly directly' (KWHB) or making support staff directly available to CEOs of organisations (QAIHC)
- increasing support staff (QAIHC, CAAC)
- managing consultants for services when expertise was not available within the support provider (QAIHC)
- having one individual who was the key liaison person between the support accessors and the support provider (CAAC)
- sharing tasks (and capitalising on the specific skills of different members) (Bila Muuji)
- trying to develop structures so that activity was less ad hoc (QAIHC, KWHB)
- developing or facilitating sector-wide capacity building activity (for example, governance training, finance networks) (QAIHC)
- increasing staff workloads.

Utilising available skills
The way skills are considered, utilised and developed were important features of support structures.

Staff whose main job was support provision needed to be highly competent, be responsive and be able to communicate well.

People working in peer support networks needed to be able to identify their skills and the skills of others in their network and utilise the different skills to create a functioning support structure. That is, they needed to be able to work out how to use everyone's skills to get the best (joint) advantage.

Although many organisations would consider that staff need to have specific competencies to undertake given roles, it is often the case in rural and remote Australia that staff with specific high-level expertise are either not available or the service is not large enough to employ such staff. There were a number of ways organisations providing support dealt with these scenarios. These included:

- outsourcing aspects of the role (for example, high-level industrial relations issues, technical accountancy issues)
- identifying and project managing consultants who were paid at a capped rate to work with those requiring support
- establishing entry-level training positions to build the skills of local people
- employing staff with some of the skills required and providing them with training, mentoring or support (either from an external provider or from a more senior person inside the organisation)
- doing the above and considering what else needs to happen within the support organisation to get particular aspects of the work done or support the person in the role while they gained the skills (for example, can an aspect of the role be done by someone else?)
- only employing staff with the requisite skills (some considered it was better to have a vacant position than to employ out of 'desperation').

The reverse of managing high staff turnover can occur when there are long-term staff in organisations that have not invested in training and support to update skills. This can result in staff not having up-to-date skills that match the requirements of modern business practices.

The importance of written agreements
Formal agreements were developed between support providers and support accessors in three of the four case studies (in the fourth, corporate support was a centralised function within a regionalised health service).

Capacity building

All case study models incorporated a capacity building approach. This was so that over time support accessors (organisations and/or individuals) gained skills and knowledge and therefore reduced their need for support in 'foundation' areas of health service operation. This was often on a number of levels, including:

- governance – this occurred through activities such as training for Boards, provision of templates for Board functions (such as Board codes of conduct), assistance with developing CEO job descriptions and recruiting CEOs, peer support for Board members through meeting with other Boards, or peer support for CEOs working with Boards.
- for CEOs and health service managers, which appeared to be particularly critical when individuals were new to an organisation or new to the role of CEO or health service manager – examples of ways capacity building occurred include through peer support (Bila Muuji) and through direct support from a support provider (QAIHC, CAAC, KWHB)
- building organisational capacity – this includes building organisational capacity through assistance to develop supportive structures such as IT systems and data management systems, and through the provision of templates for various aspects of health service functioning that can be adapted for use by different organisations
- building skills of those within organisations responsible for various corporate support functions – this includes having support networks (such as finance networks), one-on-one training or support, or having an external support provider (such as an accountant or industrial relations expert) work with relevant staff (for example, finance workers, human resources personnel).

Some of the case study sites had a commitment to developing the skills of local Aboriginal people to work in community-controlled services, although most noted that much more work could be done in this area.

Although the advantages of capacity building were acknowledged, it was also identified that capacity building could take significant time and resources, and in already stretched services there could be tension 'between building the capacity of people to provide the service or just providing the service'(key informant).

Capacity building was not always a formalised activity. For example, it could be achieved by working through a process with a service and discussing the elements required for a particular kind of corporate function, rather than through formal training.

Planning, monitoring, evaluation and sustainability – get it right or get it now?

Careful planning related to providing corporate support was undertaken in some of the models. This was generally highly participatory (including supporters and support accessors) and could be resource and time intensive. Planning occurred when:

- establishing the support structure – successful models appeared to be clear about assessing their context, having realistic goals and taking the time to build their structures slowly and carefully ('you have to walk before you can run')
- reviewing the support structure – this function could be ongoing and was important to ensure support models could respond effectively to (constant) changes and fix any problems arising. Changes included those in the policy and program environment, support accessor needs, changing practice in corporate rules and corporate practice, and changing needs of the organisation providing support.

One case study (KWHB) was explicit about the importance of careful rather than reactive planning. This organisation had a long history of, and understood the benefits of, prioritising community needs over externally imposed deadlines. This meant that it:

- created structures that enabled active engagement of communities in decision-making
- carefully planned service expansion rather than being reactive to funding opportunities

- integrated corporate functions into program development (which meant that those responsible for the corporate aspects of the service were engaged in all planning for service development)
- focused on developing the capacity of community people to undertake roles within the service
- had a number of strategies to support new staff who may yet need to develop some of the skills required in their role.

In another model (QAIHC) the corporate support provider function has evolved and grown over time in response to the needs of its support accessors. This has occurred in a planned way within QAIHC. This evolution is continuing into the development of regionalised corporate support structures.

Planning for corporate functions could be difficult in an environment where resources were scarce and workloads high and where much of the focus was on health service delivery. In one model where becoming a support provider was added to the role of an existing health service provider, there was recognition that more planning was required to ensure that support could be provided to support accessors effectively and efficiently in a way that did not put too much stress on the support provider's organisation.

In some models (where the relationships between support accessor and supporter were more interdependent – such as in an auspice arrangement or in a regionalised structure) some informants suggested that 'big picture' planning needed to occur to ensure that not only the needs of all support accessors were taken into account but that support resources were allocated equitably according to what was needed across a region/area/number of services.

Planning for the future was also important and was mentioned in most case studies. This was because support providers often needed to be able to identify what was 'coming up' for the sector and be strategic about positioning the sector/support accessors for this. Support providers could also assist support accessors to identify additional areas of work and associated funding opportunities (QAIHC).

Models – how static are they? Review and evaluation

In most of the case studies there was ongoing review of the corporate support work being done – this was either in an informal fashion by seeking feedback from support accessors about what was working well or how things could be improved, or in a more formal process. Two models had been formally (confidentially) reviewed within the past 12 months (QAIHC, CAAC)[11] and a third had gone through a process of restructure to improve service operation (KWHB). In the latter case part of the process for restructuring had been to map the non-primary health care functions and consult staff working in all sites (including supporters and support accessors) about their requirements (for example, what was not working very well, what was needed, when was it needed, who/what kind of person was required to do the task, where did they need to be located and who needed to be able to communicate directly with them?). The existing corporate support functions were also reviewed to make sure workloads were reasonable, systems were as efficient as possible, duplication was not occurring, decision-making was streamlined and communication improved. Through this work areas were identified where roles had to be changed or modified and others created.

What supported sustainability?

Sustainability is a critical issue for the sector and community-controlled services. This was addressed in a number of ways in the case study models. For example:

- in all models the corporate support work included an element of skills and knowledge transfer
- in some models some elements of corporate support activity were about establishing structures, processes and/or templates that, once established, would result in system or service-wide improvements

11 Due to the confidential nature of these reviews they were not made available to the project team.

- in some cases supporters were able to work with support accessors to meet immediate needs first; once this was done they were able to work with them to identify the supports required to make them more sustainable
- encouraging support accessors to do succession planning.

How corporate support models were funded

In each case study, the support provider had to support the establishment of its model through allocating funding from its own budget. Similarly, each of the support accessors contributed to, or directly paid for, the support they obtained (this might be in the form of fees or paying the salary and costs of staff to attend training). Once models were established they were funded using a variety of mechanisms, including the support provider:

- charging an administration fee (a percentage of support accessor income)
- having fee-for-service agreements with support accessors
- allocating a proportion of all incoming funding to corporate functions
- applying for funding to develop supportive systems, or participating in a sector-wide project to develop supportive systems (for example, IT)
- having a membership fee (this could be on a sliding scale to reflect the total budget of the participating organisations).

The extent to which participation in a support model is voluntary

The extent to which participation of support accessors was voluntary varied across the case studies. The types of participation varied between:

- entirely voluntary participation (Bila Muuji and most of those who are supported by QAIHC)
- participation required by funders of organisations experiencing difficulty (CAAC and some of those supported by QAIHC), although some supported services did have a choice of the provider they would work with (CAAC)
- participation as part of a regionalised health service delivery model where there was extensive consultation in establishing the regionalised service (KWHB).

In the two models where there was a support provider and independent support accessors (QAIHC, Bila Muuji), the relationship between the support provider and the support accessor was always negotiated through the CEO of the support accessor. In the model where there were auspice arrangements, the support provider liaised primarily with the managers of the remote health clinics.

Accountability and reporting

The three main mechanisms whereby support providers were accountable to support accessors were where:

- support accessors were members of the support provider and had elected representatives on the Board (QAIHC, KWHB, Bila Muuji) – in another model the support provider, in this case an auspicing organisation, was accountable through the Boards of the auspiced organisations (CAAC)
- written agreements or memorandums of understanding between the supporter and support accessors existed
- a range of processes, both formal and informal, existed for support accessors to discuss issues with supporters.

Support providers were also accountable to their funders in instances where they had obtained funds for specific corporate support activities.

Indicators for success

Although the provision of high-quality services to communities and the existence of viable and sustainable community-controlled health services might be the ultimate indicator of success of corporate support, it could be difficult to measure outcomes. However, various indicators were currently being used, or were being suggested – some of these indicators are mandatory reporting requirements for services funded by OATSIH, while others have been developed by support providers. The various indicators have been grouped as 'process indicators' (that is, they indicate the quality or extent/reach of an intervention) or as 'impact indicators' (that is, they indicate the changes that have occurred as a result of an intervention).

Process indicators included:

- the number of organisations to which support is provided and the type of support provided
- the number of organisations that participate in events/training run by the support provider
- the number of invitations to support staff to attend support accessor events and meetings
- the proportion of support provider-assisted submissions that are successful
- the proportion of supported services that now have more stable organisations
- increased membership of the support provider (for membership-based organisations)
- the proportion of support accessors who express confidence that the support provider can deliver appropriate and timely support
- indicators about completion of various task, such as development of plans, development or review of policies, reconciliation of assets or equipment, having service agreements in place, completion of audits, scheduled meetings held, proper management of budgets etc
- specific indicators about aspects of service function; for example:
    - number of hours where the (IT) network was down per month in each locality
    - time taken to respond to problems with IT (and other maintenance tasks)
    - proportion of staff trained in using IT
    - proportion of staff actively using IT
    - percentage of recruitment panels with a Board member involved
    - number of health centre positions occupied x employment status (permanent/contract/relief) x location x month
    - number and proportion of positions with no incumbent for more than two weeks x location x month
    - number of performance reviews undertaken as a proportion of reviews due/overdue
    - proportion of staff using professional development subsidy during reporting period x position type
    - amount of overtime expenditure as a percentage of overall salary expenditure x location
    - proportion of remote staff employed for longer than 12 months x position x location
    - incumbency as a proportion of establishment x position type x Indigenous status x locality x month
    - (Board) meetings held and quorum achieved
    - list of community meetings x type x location

- reports on unplanned staff turnover (where possible by occupation) over each 12-month period
- reports on recruits (excluding locums) completing an orientation and induction program, including cultural awareness
- reports on overtime workload
- reports on quality improvement systems, including the use of best practice guidelines
- reports on service activities (position papers, collaborative meetings and services, published papers, policy submissions, participative research)
- reports 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
- evidence of appropriate reporting to the community on progress against core performance indicators (including clinical indicators not listed here).

Impact indicators included:

- the number of services in crisis that have become more stable (or that have not been shut down) as a result of accessing corporate support
- increased length of tenure of CEOs in support accessor organisations
- indicators relating to support accessors being able to enhance service delivery.

Some key factors for success

In addition to the factors discussed in the previous section (such as good planning, good communication structures etc), there appeared to be some further cross-cutting themes linked to the success of models. These include leadership, professionalism of the support provider, recognition of diversity and changing needs of support accessors, taking a capacity building approach and accruing benefits from participating in a support structure.

Leadership

High-quality leadership was critical to the development of support structures (QAIHC, KWHB, Bila Muuji, CAAC). This included two types of leadership:

- leadership at an executive level where strategic, high-level decisions about development of, and engagement in, support structures were made
- leadership at an operational level where the work of maintaining and continuing to develop the support structure occurs.

With respect to executive leadership, leaders had to be able to value the corporate (behind the scenes) aspects of a service, hold a vision for what was possible for services and for the sector, engage and collaborate with communities and/or services in developing the structures to work towards that vision, and negotiate within a complex funding and regulatory environment in which the pressures of Western administrative practice often did not align with good practice for development in Aboriginal communities.

This kind of leadership was also important because:

- entering support structures often required changes in the way Boards and services thought about the integrity/locus of control of their service (and consequent changes to the operation of the service once the structure came into place); for example, some organisations will be more prepared than others to share services or obtain aspects of a corporate function from an external provider

- entering a support structure (such as auspicing) where the service could potentially lose control of decision-making required leadership (from the auspicer) that included a track record in maintaining a community-controlled service, a commitment to community control (and therefore to ensuring the Board of the auspiced organisation had a significant role) and capacity to develop effective relationships with the auspiced organisation
- without good leadership, providing support can (often inadvertently and slowly over time) undermine the capacity of the support provider if it has an existing role other than providing support (for example, is a community-controlled service, is a peak advocacy and policy body)
- sometimes establishing support structures is a step-wise process and may require a long-term vision/strategy; for example, the first step might be to establish a centralised member support service that can tailor support to individual needs and then work towards establishing a regional 'hub' or more diffuse 'network' support structures within regions
- developing support structures could involve taking 'calculated risks' and being prepared to lead organisations through processes in which they could make mistakes and be 'a bit burnt'; however, some informants considered that unless these risks are taken and mistakes are made and learned from, it is less likely that robust systems will be developed.

Often there had been very committed and stable executive leadership over long periods of time while support structures were developed.

At the operational leadership level managers within support providers and support accessor organisations had to work hard to maintain the operation of the support structure (for example, to maintain communication structures, maintain provision of expert advice etc) and ensure the model was monitored, reviewed and adapted so that it was able to effectively meet the needs of all participants.

Being able to establish effective partnerships
Establishing support structures to some extent is similar to working in partnerships. There are stages that the development and implementation of partnerships go through – developing the partnership and organising the relationships (including mechanisms for clear communication), goal setting, implementing joint activity and reviewing partnership activity. Each stage is demonstrated in the case studies.

Infrastructure
All case studies recognised the importance of having the necessary infrastructure (such as effective IT and communication systems) to enable provision of effective and timely support. Availability of infrastructure was often very challenging, particularly in remote areas, and had either an enabling or limiting effect on both support provider and support accessors' capacity to engage in corporate support arrangements.

Some organisations had invested heavily in IT (often with the support of a peak body) to try to overcome some of the issues of communication and consistency between organisations.

Similarly, those in remote locations reported a range of issues associated with things like having enough accommodation for visiting professionals (whether they be clinicians or support providers) and large distances between services (which means that vehicles or aeroplanes are required and there are significant travel times, thereby reducing the available working time to use that expertise).

Professionalism of the support provider
The capacity of the support provider to bring a neutral, standardised, business perspective, as well as an understanding of best practice and what this looks like 'on the ground' for a community-controlled service was considered a significant contributor to effectiveness in several case studies. Similarly, capacity to maintain confidentiality when required was also critical to building the kinds of relationships required for support providers to operate effectively.

Recognition of the diversity of support accessors and the changing nature of support needs
Recognition that different services will have different needs and the capacity of the support provider to tailor support to those specific needs was recognised as a key success factor in several models (QAIHC, CAAC). Similarly, an identified strength of another model was that it had let the model evolve based on the needs of members (Bila Muuji).

Accruing benefits
Accruing benefits was critical to the success of support models. Many benefits were identified, some of which are outlined below.

Financial and resource benefits
The range of identifiable savings accrued by support accessors included:

- being able to access consultants at reduced rates (over commercial consultants) for corporate support (QAIHC)
- securing additional funds through accessing support for submission writing (QAIHC) or working collaboratively with others to develop submissions (Bila Muuji)
- being able to do 'informal benchmarking' to identify a common position on payment and conditions for medical practitioners – potentially saving organisations from paying above reasonable rates (Bila Muuji)
- being able to share resources and skills and participate in joint training, which saves resources through economies of scale (Bila Muuji).
- There were also efficiencies that may not have been considered direct financial benefits but resulted in improved service provision. Examples included:
- being able to introduce new programs without the same levels of stress among corporate support staff as had previously been the case (KWHB)
- being able to deal with unexpected and additional burdens more readily than had previously been the case (KWHB)
- streamlining work flows and improved processes for undertaking critical tasks like getting medical equipment repaired (KWHB)
- improved staff retention (KWHB)
- increased length of incumbency for CEOs (Bila Muuji).

The opportunity cost for small services of having to dedicate staff time and financial resources to many different corporate functions can also be high. Therefore, obtaining this support from a support provider can free up resources for use in service delivery.

Providing reassurance to CEOs
In several case studies an important role for the support provider was to provide support and reassurance to CEOs, particularly if they were new to the sector, new to a senior management role, when their organisation was going through change or when new processes, such as accreditation, were being introduced to the sector.

Consistency of practice
As mentioned previously, support providers can assist support accessors across a sector or region to develop consistent 'good practice' policies and procedures (QAIHC, KWHB, Bila Muuji). This means that staff can move more easily between organisations (and there is potentially less likelihood of avoidable errors).

Building the image of the sector
Support providers can identify support accessors with good practices and nominate them for awards, which builds the image of the sector (QAIHC, Bila Muuji).

Providing access to information not readily available to individual services
Support providers operating at a State-wide (QAIHC) or regional level (Bila Muuji, KWHB) often have access to information that individual services may either not have access to or may not be able to find easily. This information can then be passed on in a meaningful way by support providers to their support accessors – for example, information about changes to legislation can be forwarded to support accessors with value added by a support provider who can include information about the consequences of the changes and how to address issues arising.

A further advantage of information sharing in this way is that support providers can coordinate provision of information from external organisations (such as governments and peak bodies), as well as sector responses to that information. Related to this is that a group of organisations that can coordinate joint action might be more likely to influence action than organisations operating alone.

Don't expect it to be easy!
Working in support structures is basically about collaboration and partnerships. The Aboriginal community-controlled sector has been working in this way for many years and has a lot of experience in this area. However, there are still many difficulties faced when embarking on collaborative arrangements.

Factors associated with risk

The environment in which ACCHSs work is characterised by change. In some ways what services are trying to do by working together in support structures could be seen as mitigating some of this risk through collaboration. Collaboration can provide organisations with some degree of flexibility and can facilitate capacity to maximise value. Some of the risks for support structures are discussed in more detail below.

Continuous change and transitions
Community-controlled health services are often in a process of continuous change. This is due to a number of factors including the changing policy environment,[12] roll out of new programs and 'interventions', community need and staff turnover. Services can experience periods of rapid growth, particularly in health service provision, and this can leave them vulnerable if they are not able to obtain or develop associated corporate functions. Development of associated corporate functions might not be limited to increased numbers of staff who can provide higher-level skills but might also include redesign of systems and processes to support expanded service delivery in a sustainable way.

Organisations might need to enter into short-term corporate support arrangements during periods of transition, or corporate support providers might need to ensure they are able to provide different levels of support to organisations (possibly for limited periods) while they are going through transitions. Models that are able to provide flexible services that are responsive to the needs of individual organisations are potentially more able to respond to services in transition, although the risk for the supporters is that staff workloads can become too high if additional resources are not available at these times.

Similarly, some support structures are established as temporary arrangements, often to support small organisations undergoing difficulties or transitions – an auspice arrangement is an example of this. Therefore, the model of support and the model of service provision are both in flux (and in the case of the auspice arrangement in this case study, this will remain the case until stated policies are effectively operationalised – a process that is taking much longer than expected). There are two main dangers because of the temporary nature of such arrangements, particularly if the number of organisations getting support from one supporter grows quickly. The first is that the supporter might not plan the support service effectively (as it is not meant

12 One such policy change in the Northern Territory and Queensland includes the transition of government-run services to community-controlled services, which creates a number of corporate function challenges depending on the arrangements for the transition. A second example (sometimes occurring at the same time as the transition described above) involves moves towards regionalising the provision of health services.

to be permanent, it may occur in an ad hoc way, it may grow quickly or it may become a large support service without having been intended to be so). The second is that there might not be an exit strategy and the support accessors might feel they are 'stuck in the larger organisation' (this is particularly the case when services are waiting to see how a policy, such as regionalisation, will be implemented).

Funding and resources (also associated with transition)
Limited funding to perform corporate functions, let alone the provision of corporate support, was common to all case studies. Generally, community-controlled services reported that they did not get enough funding for their corporate support functions because funding was often tied to service delivery (particularly in the case of project-based funding).

Funding to support service development (as opposed to the performance of corporate support functions) was largely not available unless it was part of a (generally) Commonwealth-funded program. Examples of programs where there has been some capacity for planning (although not always the consequent development) include the Primary Health Care Access Program, the Enhanced Service Innovation and Delivery Program in the Northern Territory, and funding for establishment of Regional Health Forums in Queensland.

Changing purpose of support provider
It appears that a risk for support models is the potential for the purpose of the model to change (possibly slowly over time, or in response to changes occurring more broadly in the sector) without associated review of model governance and structure. Example of this might be where:

- a model that is working well might evolve to take on the role of a regional organisation without a review of whether its governance and membership is appropriate to a regional body
- a structure established to provide support becomes the provider of some kinds of health services and therefore may encroach on the core business of those it is providing support to.

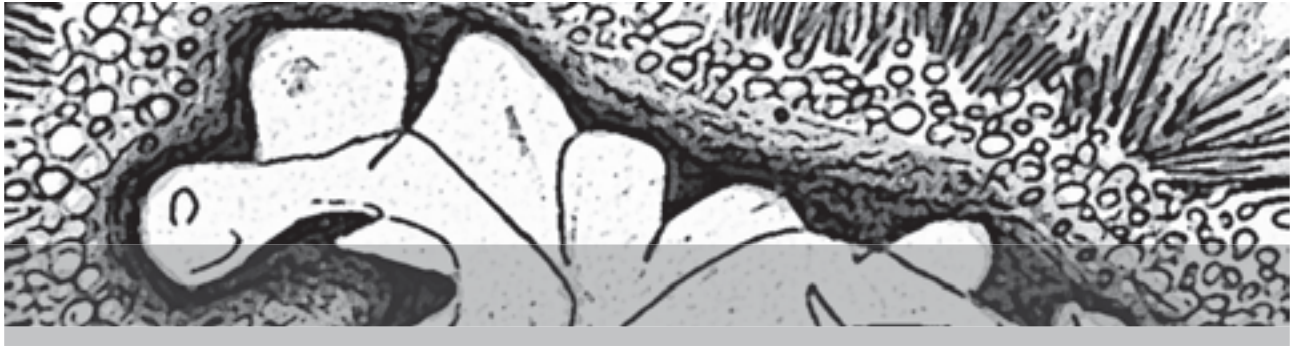
In both cases the changed purpose might be legitimate; however, the model needs to be reviewed in collaboration with its support accessors or members and other organisations (which the change may affect) to ensure the change in purpose is endorsed and the appropriate mechanisms are put into place to reflect the revised purpose.

A different risk is where the charter or purpose of the support provider is primarily something other than providing support. Examples of this are where a peak body or a large community-controlled service becomes a supporter. Unless the mechanism for developing the additional function of support provider is carefully planned, reviewed and resourced, the provision of support has the potential to undermine the operation of the supporting organisation – particularly if the role of support provider grows quickly. There are at least three risks in this, as staff try to juggle the competing priorities. These risks include:

- that the focus of the staff of the supporter shifts to providing support and there is less focus on the original work of the organisation
- that the staff of the supporter continue to focus primarily on the work of the supporter; consequently, support accessors can feel that their needs are of low priority and that they have to adapt to the structures and policies of a large organisation – this might be particularly difficult if the supporter is working in a different context (for example, a supporter that has a focus on an urban population and a support accessor that works in a small, remote environment)
- as the demands on the support accessor grow, the administrative processes can grow in an unplanned way, resulting in sometimes complex and slow mechanisms for provision of support and confusion among support accessors about how to access support.

Workloads
Developing good systems is difficult when most people who are either working in corporate functions within an organisation or in support providers are already busy with high workloads. High reporting loads were identified as placing particular demands on those staff responsible for this area.

High levels of demand
In each of the case study models, demand was often higher than could be met within existing resources. Two of the models in particular (QAIHC, CAAC) experienced high and increasing levels of demand for support within relatively short periods. This meant that those working for support providers could have extremely high workloads and/or might not be able to respond as quickly as is ideal to support accessors.



Key issues for further work

The second national roundtable was used as a forum to discuss the project findings. At this roundtable, participants identified elements of good corporate service models (these are provided in Appendix 3) and factors that agencies seeking corporate services might need to consider (see Appendix 4). They also identified issues for further work, as outlined below.

1. Define core corporate functions

Having a defined core set of corporate functions might be useful to ACCHSs.[13] This might include modelling corporate services requirements for different-sized organisations, highlighting areas organisations might need to pay particular attention to as they go through phases of development. Following from this, a set of standards or benchmarks for these functions could be drawn together,[14] so that services could monitor their own functions (on a regular basis) and identify their strengths and areas for further development. It is important that any definitions allow for local factors and preferences to be 'mixed in' to the criteria.

2. Develop monitoring and accountability mechanisms for support providers

The performance of organisations or individuals who provide corporate services needs to be monitored by primary health care providers. There may be a role for NACCHO affiliates and other peak bodies in assisting health services to ensure the quality of corporate services. For example, standards of timeliness, accuracy and effectiveness of corporate service providers, including competence in working across cultures, could be developed by peak bodies, with advice from corporate service industry bodies and existing standard setters.

3. Improve processes for supporting organisations experiencing difficulty

Roundtable participants identified that organisations in the sector who might be able to assist services experiencing difficulty were often not aware of problems until there was a crisis. Roundtable participants considered that the sector and government funders could develop an approach that would enable early identification and mobilisation of assistance when a primary health care provider shows signs of difficulty in order to prevent a crisis from developing. Careful consideration and discussion would be needed to design a method that respects the autonomy of organisations and confidentiality, but also enables early assistance – and doesn't involve intrusive actions by funders.

4. Review government data to identify lessons

OATSIH has funded and monitored ACCHSs since 1996 so it has considerable knowledge and data about services in difficulty. Reviewing these data (while maintaining relevant confidentiality requirements) to identify key lessons about what leads to difficulty and what the risk points/early indicators of such a scenario are would provide valuable information to the sector.

13 It was considered that developing an agreed set of corporate functions, similar to the way core primary health care services have been defined, might be useful. However, it was also noted that there may be dangers in this because each service and service system is different and will be influenced by local factors and preferences.

14 It was noted that there is already a range of standards and benchmarks for these activities that could be drawn together rather than developing new ones (this is related to point 9). Having said this, there might be some areas where additional standards are required (for example, in relation to governance and kinship relationships – see point 10). Some participants suggested that an ABCD-like tool to enable organisations to assess CQI progress in administration, management and governance might be a useful way of bringing such knowledge together.

5. Streamline government processes and requirements on ACCHSs to reduce administrative load

The complexity of funding processes for ACCHSs was highlighted as a significant administrative load for services. This is consistent with the findings of *The Overburden Report* (Dwyer et al. 2009). Therefore, it was considered that reviewing and streamlining government funding and reporting requirements was likely to reduce some of the administrative burden on services (see Dwyer et al. 2009 for further recommendations in this area).

6. Ensure ACCHSs are appropriately funded to undertake corporate functions

Rapid growth in the delivery of clinical services can occur without appropriate development of the corporate services needed, which can leave organisations vulnerable to inefficiency and, in the worst case, in crisis. Being located in communities where there are high levels of need and limited resources can exacerbate this, as can competitive project-based funding processes, which focus on direct service delivery and do not explicitly include the costs of corporate services. Therefore, it was recommended that governments develop funding processes that ensure ACCHSs are appropriately resourced for their corporate services functions.

7. Maintain the role of State/Territory peak bodies as providers of support to their sector, rather than as regulators of it

There were some concerns that governments might be expecting the national and State/Territory peak bodies to become regulators of services rather than being advocates and working for the development and strengthening of the sector. This was not considered to be consistent with the role of these organisations.

8. Develop a 'tool bank' to improve access to existing tools and materials for business improvement

Given that a range of tools is available to assist organisations with business development, it was considered that establishing a 'tool bank' through which services could access these materials would provide a useful resource for the sector. Tools might include audit tools, CQI tools, and checklists and templates for commonly utilised protocols (like memorandum of understandings, contracts or service agreements). Such a mechanism might also provide a means of disseminating information about good practice models and processes for corporate support. To be useful, a tool bank would need to be maintained and updated on a regular basis.

Healthy business tool

As a result of the knowledge gained from this project a decision-making tool has been developed to help ACCHSs decide their best strategy or model for getting support for their corporate functions. This tool is scheduled to be uploaded on to the Lowitja Institute website in August 2011 (www.lowitja.org.au).

9. Progress work on governance to address complexities of community control

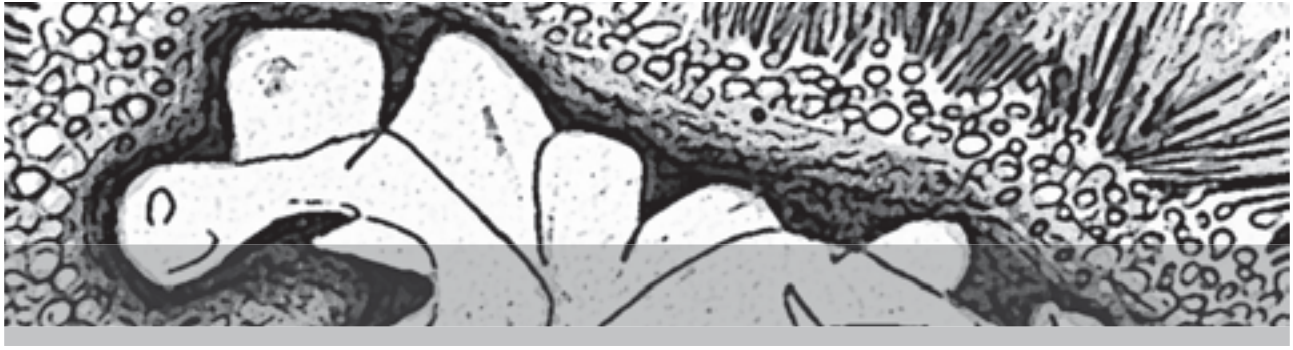
There was significant discussion at the roundtable about governance. Existing governance tools and training cover the generic skills required of those on Boards (like delineation of roles, financial accountability, dealing with conflict of interest) but do not always address some of the complexities associated with community control, such as managing kinship relationships for Board members. Consequently, it was suggested that further work could be done to support governance in ACCHSs.

10. Ensure any development of shared corporate support models is appropriately resourced, that participation is voluntary and that benefits accrue to organisations involved

Development of shared corporate support structures takes significant resources, time and skill and the process of establishing them is important. Shared corporate support structures need to be regularly reviewed to ensure they are meeting the changing needs of their member organisations and that their governance and organisation is appropriate to any change in role. It is critical to the success of shared corporate service structures that the organisations that purchase and use the services are the ones that have the authority to require and assess good performance. Thus, participation in any formalised shared corporate support structure must be voluntary, and benefits (such as savings) must accrue to the organisations.

11. Develop national, State/Territory and/or regional processes for sharing and further developing sector knowledge about corporate support functions

During the course of the project it was noted by some people working in the sector that they have limited opportunities to discuss, learn from each other and further develop knowledge about strengthening corporate support functions. This could be a role for NACCHO and affiliates.

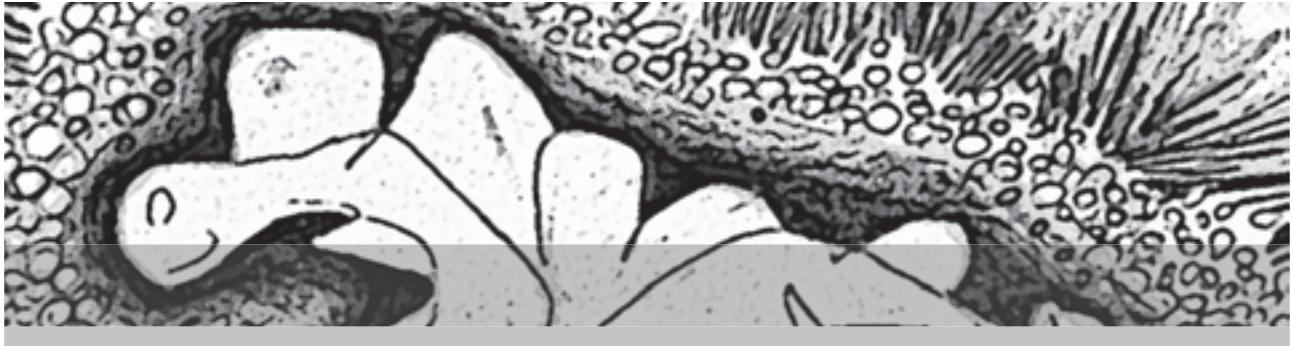


Conclusion

There has been significant effort invested by the ACCHS sector to develop ways of strengthening the corporate function capacity of services – a particularly difficult task given that many organisations are small, have access to a limited workforce, operate in communities where there are very high levels of need and very limited resources, and exist in a changing and complicated funding and regulatory environment. Despite this, innovative approaches to improve corporate services have been developed in ways that ensure the autonomy of individual services. This has required the leadership, strategic vision and commitment of those working at different levels within the sector and of community members. In this work, particularly when corporate services are to be shared, it has been important for participating ACCHSs and their communities to be engaged in a process of decision-making about new ways of doing things. This is so that models can be tailored to suit the needs, requirements and circumstances of those services. Therefore, we suggest that the process for developing models appears to be more important than having a specific model or structure to apply at the outset. This means that the initial costs of developing shared approaches to delivery of corporate services is likely to be significant (particularly when both the consultation and infrastructure development needs are considered).

Corporate support systems also need to have capacity for ongoing monitoring, review and evaluation so that they can evolve over time. Without this, there are significant risks that such structures will be unable to meet the changing needs of a sector in continual transition and/or take on new roles and functions without developing the appropriate governance and operational mechanisms for supporting these roles.

The work outlined in this report highlights the capacity of the ACCHS sector to develop innovative solutions to difficult issues while working in a quickly changing environment. Additional resourcing to facilitate ongoing action by the sector in developing appropriate models to support corporate services is likely to enable further innovation in this area. Such work should contribute to stronger and more viable health services for Aboriginal communities.



Appendix 1: Study methods

Scope

This Project focused on corporate support for Aboriginal Community Controlled Health Services (ACCHSs). Initially there was discussion about including State/Territory-run Aboriginal health services; however, it was considered that as these services had access to a substantial infrastructure for provision of corporate supports, the issues for them might be quite different to independently run ACCHSs.

The intent of the project was to examine the corporate support needs of ACCHSs, the issues associated with obtaining appropriate corporate support and existing support structures used by these services. Clearly, there will be differences between corporate support needs and corporate support available depending on a range of factors (such as organisational size and capacity and the context in which the service operates) and we aimed to take a range of these factors into account throughout the project.

In summary, the key research questions were:

- what is the nature (scope and characteristics) of the support needs of ACCHSs as corporate entities, taking into account differential organisational capacity and contexts?
- how do ACCHSs, as corporate entities, access the different kinds of support they require in each area (taking into account the diversity of services, differential organisational capacity and the contexts in which they operate)?
- what frameworks (organised support structures) are required for the provision of adequate corporate support for organisations with different organisational capacity operating in different contexts, and what are the barriers to implementing and accessing such frameworks?

The project was conducted in two parts. Part 1 focused on support needs to obtain a broad overview of the range of ways services get support. Part 2 focused in detail on four existing support structures. Working in this way meant that findings from the first part of the project could be used to inform the work of the second phase.

Ethics

Approval for each part of the project was obtained from the Population Health Human Ethics Advisory Group at The University of Melbourne.

Advisory group

We established an advisory group, which met face to face early in the project, and members of this group subsequently provided advice as required. Members of the advisory group were representatives from:

- Aboriginal Medical Services Alliance Northern Territory (AMSANT)
- Queensland Aboriginal and Islander Health Council (QAIHC)
- Aboriginal Health and Medical Research Council of New South Wales
- Victorian Aboriginal Community Controlled Health Organisation
- Office of Aboriginal and Torres Strait Islander Health (OATSIH)
- PlanHealth

- Cooperative Research Centre for Aboriginal Health (CRCAH)
- Flinders University
- Australian Institute of Aboriginal and Torres Strait Islander Studies.

Part 1 of the project: Support needs

A brief literature review was conducted to identify knowledge about a range of aspects of corporate support in Aboriginal community-controlled organisations. Additional literature, generally produced by organisations or individuals working within the sector, was identified by members of the advisory group.

A brief search of the internet, focusing on the types of information and resources available to ACCHSs in Australia, was also conducted.

Semi-structured interviews with a small number of key informants from across Australia were conducted (face to face or by telephone) to find out about support needs, factors influencing support needs and the kinds of support that services have access to. Participants included staff from five State/Territory Aboriginal community-controlled peak health organisations, CEOs and/or corporate support staff of six ACCHSs, government officers from OATSIH and one State health authority, a researcher and a quality improvement professional. Notes were taken during these interviews and analysed by theme.

The questions asked in interviews are included in this appendix (see 'Interview questions for Part 1'). All informants were provided with written and verbal information about the project and asked to sign a consent form prior to participating.

Findings from Part 1 were collated and developed into a discussion paper

A national roundtable was held in Melbourne in November 2008. There were 19 participants including people from five State/Territory-based Aboriginal community-controlled health organisation peak bodies, four ACCHSs, OATSIH, two research organisations, the CRCAH and the project team. The discussion paper was sent to participants prior to the roundtable and formed the basis for the discussion at the roundtable. The aims of the roundtable were (1) to refine our knowledge of the support needs of ACCHSs as corporate entities and discuss/check/build on the findings to date; and (2) to seek advice about the second phase of the project, including identifying potential sites and the kinds of questions participants were interested in for the case studies.

Notes were taken at the roundtable, and were collated and distributed to all participants. The agenda for the roundtable is included this appendix (see 'Agenda for first national roundtable').

Part 2 of the project: Existing models for provision of support

Based on the information provided at the first national roundtable, a list of potential case study sites was generated. Web-based research identified key features of these sites, how they were governed, their organisational structure, the nature of their relationships with organisations getting support, the main areas where support was provided, the jurisdiction in which they operated and the types of services obtaining support. This information was circulated to the advisory group, which, in collaboration with the project team, identified five potential case study sites that would provide information about a range of approaches.[15] Interview questions were also generated based on advice from the roundtable and are included at the end of this appendix (see 'Interview questions for Part 2'). For a range of reasons (including relevance and time constraints) not all questions were able to be asked of all case study sites.

15 One potential case study site did not participate, resulting in 4 case studies being conducted.

Each potential site was contacted by telephone and letter. Once agreement to participate was obtained, further documentation was obtained and reviewed, site visits were organised, and interviews were conducted both with those engaged in the provision of support services and those obtaining support. Interviews were recorded and notes taken (recordings were used to check the accuracy of notes but were not transcribed). These data were then used to develop case studies, which were sent back to each site for review and approval. The case studies, along with an analysis of cross-cutting themes and issues, were included in a second discussion paper.

A second national roundtable was held in Melbourne over two days in June 2010. Thirty-six people attended this meeting, including representatives from five of the State/Territory peak ACCHOs, ten ACCHSs, one State/Territory government, OATSIH, one university, one independent consultant and the project team. The discussion paper was distributed prior to the meeting and used as the basis for the roundtable discussion. Notes were taken during the roundtable, collated and sent to all participants. The roundtable agenda is included at the end of this appendix (see 'Agenda for second national roundtable').

Focus of literature reviewed for Part 1

Published literature and grey literature in the English language on corporate management support for Indigenous organisations from the past 10 years (since 1998) were used to inform the literature review. The literature was located from a non-systematic review of electronic databases, the internet, Google Scholar and reference lists of retrieved works. The search terms included governance, management support, human resource management, workforce capacity development, training, information system management, evaluation, financial management, quality improvement, Indigenous organisations, corporate support, Aboriginal, Indigenous, Maori and Inuit.

The management literature provides little material on best practice in Australian Indigenous organisations (Finlayson 2004). Therefore, the literature review also made use of the international development literature and learnings from Indigenous projects overseas, such as the Harvard Project on Indian Economic Development in the United States.

The literature review (unpublished) gathered evidence and expert opinions on key corporate functions in an Indigenous or international development context and successful and less successful strategies.

Focus of literature reviewed for Part 2

Published literature focusing on shared models for corporate support was located from a non-systematic review of electronic databases, the internet and Google Scholar, as well as from organisations participating in the advisory group. The search terms included economies of scale, service and models, governance, service and capacity, service and community control, governance support, shared service, organisational support, financial management, services and capacity combined with Aboriginal or Indigenous.

Interview questions for Part 1

There were two sets of questions for key informants in Part 1 of the study. The first set was for peak bodies and others with relevant expertise who were not working within an ACCHS. The second set was for those working in ACCHSs. Information about the project was provided prior to and at the beginning of the interview.

Questions for peak bodies and key informants other than those working in ACCHSs

1. What factors do you think will influence the support needs of ACCHSs in your jurisdiction?
2. In which areas do you think ACCHSs in your jurisdiction are likely to require support?
3. Which of these functions could be provided by an external organisation/person? Which need to be done internally (and could be assisted by building capacity within the organisation)?

4. Is any of this support currently provided? If yes, what is provided, who provides it and how is it organised?
5. How would you prefer this support to be provided?
6. Could you tell me who I else to talk to, to find out more about this support?
7. Is there anything else you would like to tell us?

Questions for ACCHSs

1. What kinds of support or assistance would be useful to your service in your corporate or business areas?
2. Do you currently get any support or assistance from outside your service in relation to these areas of business needs? If yes, what areas do you get support in?
3. Can you describe how you get this support?
4. How effective do you think this support is?
5. How do you identify the areas in your service where you need support?
6. What are the unique features of your organisation that need to be taken into account by anyone who is interested in providing organisational support to you?
7. Is there anything else you would like to tell us?

Agenda for first national roundtable

The first national roundtable was held in Melbourne in November 2008.

Morning session

The aim of the morning session is to refine our knowledge of support needs of ACCHSs as corporate entities. This will include reporting back on our findings to date and asking for your views on these findings.

9.30 – 9.40	Welcome and introductions
9.40 – 10.10	Introduction to the project and project context *Discussion: Does this reflect what is 'happening in your world'?*
10.10 – 10.40	Corporate support – key areas for support *Discussion: Are there other key areas where corporate support might be required?*
10.40 – 11.00	Factors influencing the support required *Discussion: Are there any other factors that will influence external support required by different ACCHSs?*
11.00 – 11.15	MORNING TEA
11.15 – 11.30	Issues associated with getting support Some features of good support
11.30 – 12.00	External support and/or internal capacity building? *Discussion: How would you work out the areas in which services might need external support and which areas might be better addressed by internal capacity building? Are there some principles that might underpin a framework for working this out?*
12.00 – 12.30	How do services currently get support? *Discussion: Are there any other types of support models?What are the advantages & disadvantages of each?* *What examples of each do you know of?*
12.30 – 1.15	LUNCH Review posters

Afternoon session 1.15 – 4.00: Going forward – developing support structures

The aim of the afternoon session is to focus on support structures and to get advice about the next phase of the project.

1.15 – 1.30	Developing corporate support structures – advantages, potential risks & issues Some issues discussed in reviewing options for support structures
1.30 – 2.00	*Discussion: What are the key lessons you have learnt from your work on developing systems for and/or obtaining corporate support?*
2.00 – 2.10	The proposed second phase of the support systems project
2.10 – 2.30	*Discussion: What would be the most useful focus for the second stage of the project?*
2.30 – 3.00	*Depending on the outcome of the above discussion:* • *What do you think are the key questions we need to ask in the second phase – or, what would you like to know from the second phase?* • *If we need to select sites to do case studies, what criteria do you think we should use to select these sites so that case studies reflect the range of needs for different services?*
3.00 – 3.15	AFTERNOON TEA
3.15 – 3.40	*Discussion: We have also undertaken to develop some kind of resource from this project – what do you think would be most useful to ACCHSs?*
3.40 – 3.50	Project next steps
3.50 – 4.00	Brief update on the work of the CRCAH
4.00	Roundtable close

Interview questions for Part 2

There were two sets of questions for key informants in Part 2 of the study. The first set was for support providers. The second set was for services seeking or receiving support.

For support providers

1. What is the history behind the model and its development?
2. How would you describe the model?
3. What are the main principles behind the model?
4. How is it governed?
5. What is the organisational structure and how is this managed?
6. What is the nature of the relationship with organisations getting support?
7. What are the main areas where support is provided?
8. How is the support provided?
9. How is the model funded?
10. Who is the support provider accountable to?
11. Do you undertake some functions for services and/or build capacity within services (and if so, what do you provide directly and what capacity building do you do)?
12. Is participation voluntary?
13. How is reporting done?
14. How do you work out when services are doing well or not? Are there 'diagnostic tools'?
15. Can the model provide different types/levels of support to different kinds of organisations? How do you determine the support required in different circumstances?
16. How are organisations 'in strife' supported? At what point(s) does intervention occur?
17. How are well-functioning organisations supported to do their work better?
18. Can the model provide different types/levels of support to different kinds of organisations? How do you determine the support required in different circumstances?
19. Is the support provided as a permanent, temporary or transitional arrangement?
20. How does the model support community control?
21. Does the model have a process for changing and developing (that is, can it adapt and change and is it regularly reviewed)?
22. How do you know if you're doing a good job? Prompt: Do you have benchmarks? If so, in what areas and what are these?
23. What is the relationship between what the support provider does and improved services?
24. How are organisations receiving support involved in deciding what the key indicators are?
25. What are the main effects of having your model for services?
26. Has your model been evaluated? If so, what were the main findings?

For services seeking or receiving support

1. What do you see as your organisation's core business?
2. How do you work out whether your service is doing well or not, or the areas where you might need support? Are there 'diagnostic tools'?
3. Are there aspects of your corporate functions that must be undertaken within the organisation (ie cannot be outsourced)? If so, what are these?
4. How are decisions about whether your service should enter into outsourcing arrangements made? How are decisions made about who to enter into these agreements with? Who asks these questions and what questions do they ask?
5. In what areas does your organisation get external support? How do you get this support?
6. In what areas does your organisation get support to build its internal capacity? How do you get this support?
7. How do you work out which areas where you need to get support to build internal capacity and areas where you can get external support?
8. How does your organisation maintain essential control over whatever is done externally over time?
9. How is the relationship between your organisation and the support provider organised?
10. How does your organisation overcome busy work to engage in change?
11. What do you think are the strengths of the support services you work with?
12. What do you think are the weaknesses of the support services you work with?
13. What are the main advantages to your service of getting this support?
14. Does the support enable your service to improve the quality of service delivery? If so, how? Do you have any evidence or data that would support your views?

Agenda for second national roundtable

Goals of the roundtable

The aim of the roundtable is to engage a range of key stakeholders, including those who currently participate in or access support services, in contributing to:

- formulating the main messages from the project findings
- shaping the recommendations for action from the project
- suggesting strategies with potential to support stakeholder adoption and adaption of recommendations and research products.

Roundtable process

To do this we will work through a process to:

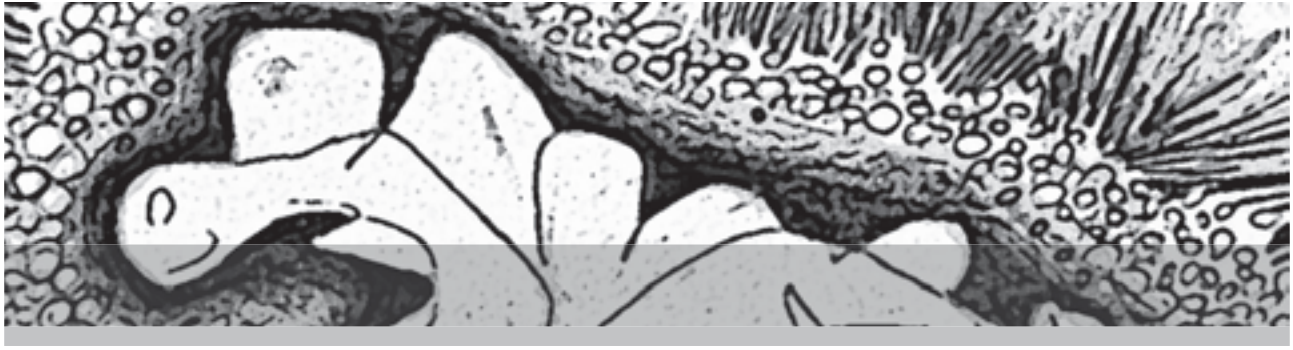
- consolidate our joint knowledge about the learnings form this project relevant to strengthening corporate support
- identify what products or tools are needed and can be created from this knowledge and start to develop these
- identify potential strategies for action
- discuss what might be needed to implement such strategies.

Day 1

Time	Task	Format/who
10 – 10.15am	**Welcome, introductions** **Overview of the roundtable**	Alwin Chong Alister/Kate
10.15 – 12.00	**Overview of current support models – collective knowledge** **Case studies – what have we learnt?** Presentations • Kimberly Aboriginal Medical Services Council • Developments in WA Panel Discussion with: Bila Muuji, Katherine West, Congress, QAIHC, KAMSC	Alister/Kate David Atkinson Fred Stacey Bila Muuji, KWHB, CAAC, KAMSC
12.00 – 1.00	**Consolidating joint knowledge** **What are the key lessons we've learnt about good practice in corporate support?** For example, • What might be the main elements of good models? • What might be some of the features of these elements?	Group discussions
1.00 – 1.45	Lunch	
1.45 – 2.15	Report back from key lessons discussion Where does this work fit within a national context?	Groups Ian Anderson
2.15 – 5.00 with break for afternoon tea	**Products or tools needed or that can be created** **What might services seeking support/wanting to work within a support structure need to consider?** The aim of this session is to try to develop a 'tool' which might help services (or support providers) work through a process by asking a set of questions when considering getting corporate support. Part 1: What are the key steps organisations need to go through? We suggest these might include: • Identifying the purpose • Identifying potential opportunities, identifying potential limitations/risks • Developing a model • Managing a model • Evaluating and reviewing the model • There might also be some cross cutting themes – like building in capacity development Part 2: What are the key issues/questions that services (or support providers) have to ask and answer at each of these steps to make decisions about the kinds of support they might need or structures they might enter into? *This might be different for different types of services.* Part 3: What might the results of the above discussion mean – eg for work force development, the way partnerships are developed, what is being done internally/externally Part 4: How might you prioritise what has to happen first? Part 5: What resources might services use/need at each step to help them make decisions?	Groups

Day 2

Time	Task	Format/who
9.00 – 9.15	**Welcome & Overview of Day 1**	Ian Anderson
9.15 – 9.35	**Establishing Business Quality Centres in Queensland**	Selwyn Button, QAIHC
9.00 – 10.30	**Products or tools needed/that can be created** **What tools might be helpful to services or the sector? What are the key things we could start to shape today that could assist people?** Some ideas include: • How do we know how 'expert' private providers are: questions to ask to help you find out and to limit the risks? • What are the key features of a good partnership with a support provider? • Managing transitions: What are some of the support needs of services in transition? What are the features of support in this context (eg it might be a temporary requirement)? • How can capacity building be incorporated into support structures?	Groups to work on different things depending on interest
10.30 – 11.00	Morning tea	
11.00 – 1.00	**What are some potential strategies for action?**	Group discussions
1.00 – 1.45	Lunch	
1.45 – 3.00	**What might be required for these strategies to be implemented?** **Who are the potential players and what might be required for/or from them?** **What are the current opportunities for taking this work forward & how can these be best taken up?** Some topics might include: • What is the long-term goal? • What needs to be done at different levels to support development and implementation of support structures (and who should be responsible for what)? • What are the things that we don't want/we should try and avoid? • What are some of the challenges ahead? • Report back *At the end of this process we may be able to construct a map of suggested strategies for corporate support*	Whole group
3.00 – 3.15	Afternoon tea	
3.15 – 4.15	**Review day 2 and finalise suggestions for action**	Groups or whole group
4.15	**Next steps, thanks and roundtable close**	Ian Anderson



Appendix 2: Accreditation domains related to corporate functioning of ACCHSs

Significant work is being done across the ACCHS sector on accreditation. There are significant administrative requirements associated with accreditation, as well as domains related to business functions. This appendix shows the domains of activity contained in accreditation programs relevant to corporate functioning of ACCHSs. The items in this list were described in the *Aboriginal and Torres Strait Islander Health Sector Accreditation and Quality Standards Project* (CRCAH 2008).

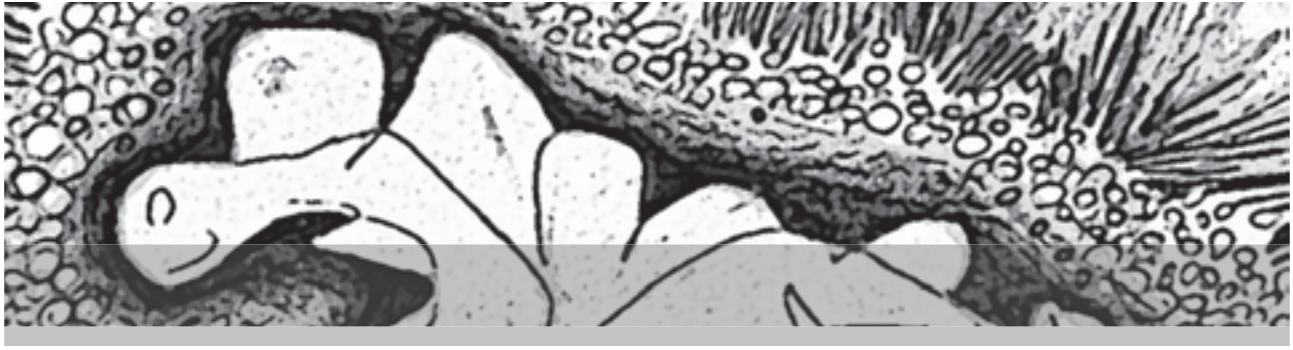
Domain	Function	Activity
Business services	Board	Annual general meeting Meetings Orientation and training Roles and responsibilities Code of conduct Legal – incorporation Board/staff separation of duties Policy and planning Reports from management Feedback to management
Business services	Community participation	Community participation
Business services	Governance	Complaints handling
Business services	General administration	Management Office management support Staff meetings
Business services	Legal	Legal Incorporation Legislation
Business services	Finances	Financial management Financial reports to the Board Insurances Audits Service agreements Risk management Adequate funding

Accreditation domains related to corporate functioning of ACCHSs continued

Business services	Human resources	Recruitment Contracts Industrial relations Duty statements Job descriptions Code of conduct Staff qualifications/credentials Staff registration Staff appraisals
	Staff education and training	Orientation Continuing professional development (clinical and non-clinical) Management development Team development
	Cultural awareness	Language and training
	Service development and planning	Business plan/SDRF planning Data collection Analysis Dissemination CQI Evaluation Errors (opportunities improvement)
	Research	Process, ethics, documentation
	Information Communication Management/IT	Purchasing and maintenance • *Hardware* • *Software*
		Security, access

Accreditation domains related to corporate functioning of ACCHOs continued

Business services	Infrastructure	Infrastructure Accessibility to buildings Reception Waiting area Male/female areas Signage Storage areas Lighting, heating, cooling Staff housing
	Vehicles	Purchasing and maintenance Communications
	Asset management	Asset management Equipment
	Occupational health and safety	Occupational health and safety Emergency equipment Safety delegate Conflict resolution Supportive work environment
Advocacy	Advocacy	
	Personal advocacy	External Liaison/committees Community development and engagement
	Systems advocacy	Political leadership Regional planning forum Health system development National policy development



Appendix 3: Elements of good support models

The second national roundtable was held in Melbourne over two days in June 2010. The key points/elements discussed by participants at the roundtable are shown in this appendix.

1. Working out ownership issues:
    - being community driven, maintaining local community governance (community control)
    - working out decision-making processes
    - balancing autonomy
    - setting boundaries.
2. Leadership and vision.
3. Careful planning – for services and support providers. This should include:
    - assessing the context
    - taking the time to get it right
    - using good processes which will enable the right model to emerge
    - active community engagement on support needs and extensive consultation with all stakeholders
    - setting the ground work for support
    - succession planning.
4. Ensuring good management and governance of support services.
5. Development of partnerships between support providers and those seeking support. This includes:
    - having good processes that support good relationships
    - transparency/honesty/trust
    - having and promoting a charter of membership
    - having a mechanism for 'self correction'
    - having a transitional process (as services move towards operating differently with a support provider or go through their own transitions – for example, from being a small to a large organisation).
6. Technical aspects of organising support. This includes:
    - establishing clear contracts and service agreements
    - having support providers who understand the funding agreements and key performance indicators of the services
    - having support providers who understand the context of Aboriginal community-controlled comprehensive primary health care
    - having a strong financial reputation
    - developing an investment strategy
    - having interview skills and strategies

- having tools to assist services identify issues
- using best practice supports where they are available (this would result in promoting consistency across the sector and provide for a national focus for some aspects of support)
- developing best practice supports where they are not available and where this is possible
- developing an expert staff pool to cover for unexpected absences
- linking with (and acknowledging) other sources of support (for example, training run or provided by the State or by universities)
- being able to manage change (and support the sector to manage change).

7. Support provider capacity – the support provider needs to have organisational capacity/a model that:

    - is able to support good governance (and work with CEOs and Boards)
    - supports training, mentoring and working with organisations in a way that 'leaves them with the capacity to do things the right way'
    - supports cross-fertilisation between members (for example, through staff placements)
    - supports continuous service improvement (for example, accreditation support)
    - provides culturally secure support
    - is proactive around problems (for example, organisations in crisis)
    - has the strategies and resources to take action
    - is appropriately resourced (funding, skills, workforce)
    - can be flexible and provide support that is appropriate to meeting local needs
    - enables both equity of support provision and equity of distribution of resources.

8. Evaluation.

9. Communication strategy:

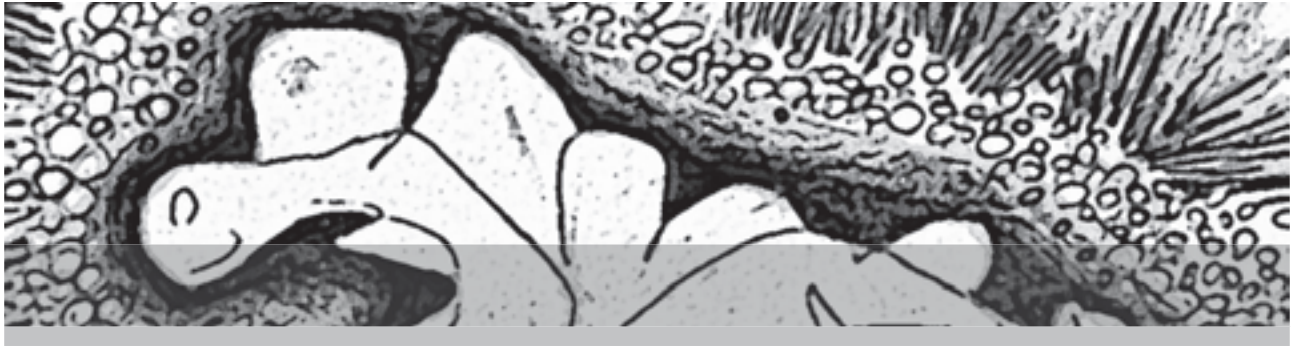
    - promote good practice
    - promote what is possible.

10. Other:

    - avoid competitive models
    - support systems should operate in a way that enhances the credibility of the sector
    - need to deal with inadequate funding for administration
    - need resourcing that grows incrementally over time
    - overall the role of the support provider is to support the maintenance of high-quality health services delivery
    - need to sort out Commonwealth/State responsibilities as funders of Aboriginal primary health care
    - there needs to be a strong commitment to offering support to services in difficulty and the processes for doing this need to be formalised
    - modelling needs to be undertaken on organisational sizes (for example, what internal capacity is required for organisations of a particular size, what do services need to establish as they grow in size etc).

Difficult issues for further consideration

1. Who supports organisations in crisis?
2. How might this support be organised?
3. How to deliver/develop cumulative capacity over time as organisations grow.
4. How to adapt 'historical' ways of doing things to meet new challenges.
5. How not to be a victim of success.



Appendix 4: What might services seeking support need to consider?

Roundtable participants considered issues that services seeking support or wanting to work with a support structure might need to consider. The key points from the discussion were grouped, summarised and presented to participants at the beginning of the second day of the second national roundtable.

Prior to entering/developing a structure

About the organisation:

- When do we access information – oops too late!
- Is our organisational structure appropriate to meet service needs of target population?
- What do we need to do internally to progress areas of need? What could be outsourced?
- Is there an audit tool we can use to find out if we need/areas where we need support? Is there a tool we can routinely use to assess this?
- Do we have a clear idea of the existing executive/senior management structures in the service and clear role statements and the supports for that structure (managing expansion/CEOs may also auspice external services)?
- Does the organisation service have a clear idea of its future growth and development?
- As organisational growth occurs (threshold levels) has organisation developed its necessary internal support structures (human resources, industrial relations, finance, occupational health and safety) (concept of 'internal sponsor' role)?
- What are the actual costs of program (core primary health care services) delivery comprising: a) 'front-line' costs; b) supervision; c) program administration?
- Know yourself: be aware of any historical patterns (cycles) of effectiveness within the organisation.
- What are the needs/expectations of funding bodies?

About corporate support:

- Principles.
- What does corporate support mean to individual ACCHSs (staff input)?
- What support services do we already have access to (affiliate supports, regional supports)?
- Are there support alternatives?
- Can the funding body help?
- How do we tap into pro bono support? What kinds of things can we use pro bono support for? What functions wouldn't you use pro bono support for?
- How much do we want to own the process and what outcomes do we want?
- What are the risks and how do we assess them?

Developing a structure

What kind of model:

- Should we have a national model?
- What support structures already exist and what can we learn from them?
- How do we define core corporate services?
- What is our ideal model of service delivery in primary health care? Then:
- What are the core business capabilities required for ACCHOs for functionality/ sustainability; and then:
- What is the most appropriate corporate support structure (include cost, access, responsiveness, cultural appropriateness); then:
- What will be the key functions of the support service (have a clear idea of this)
- How will these functions be performed/managed?
- Are there clear expectations?
- Can the funding body help?
- Is there a baseline of trust?
- Under which Act do we establish ourselves?
- What does the constitution look like?
- Who do we go to for help with Act and constitution?
- What are our obligations?
- What role do governance arrangements play within the corporate support structure?
- How can we support risk management in services?
- How much do we want to own the process and what outcomes do we want?
- Who's making the decisions?
- How do we engage services and keep them engaged?
- How do we create a safe environment for people/organisations to discuss sensitive issues?
- What is value for money in corporate support? How will we know this?
- Do we have benchmarks for quality and value-for-money corporate services?
- How do we make sure services have access to accurate information in a timely way?
- What professional development should be provided?
- How can we prioritise support needs to enable/meet realistic goals/outcomes?
- How do we plan for and manage growth? How do we identify what is required for growing organisations?
- Will we manage if the pattern of support changes as the organisation grows?
- Do we have an agreement and what should be in it?
- How much does it cost?

- How can we minimise competition between organisations?
- How do we respond to the different needs of members?
- What are realistic outcomes?
- What mechanisms do we need to put in place to ensure the model is self-sustaining?
- What reporting will be required and to whom will we report?

Managing models

- Performance management.
- Make sure we are increasing the service delivery capacity to respond to member service needs.
- Make sure we are cost efficient and saving time.
- Positive publicity and marketing.
- Do we have a clear idea of the cost of delivery of support (compared to what people will pay for us to provide it)?
- Can we use the benefits of accreditation and a CQI process for managing support?
- Good performance management and development for team.

Reviewing and evaluating models

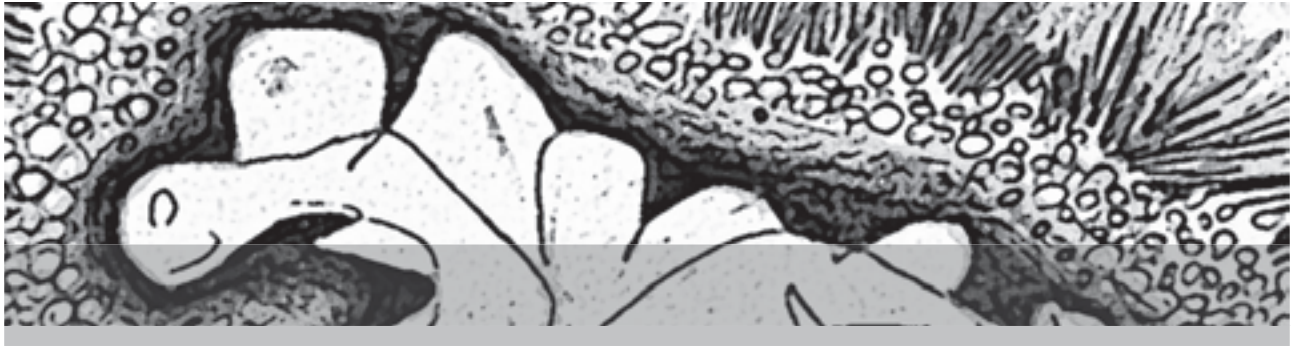
- How will we monitor progress or evaluate process?
- Is the information consistent?
- time to time
- place to place.
- Do the parties trust each other?
- How involved is the CEO?
- Do we meet all funding obligations, reporting requirements, audits etc?
- Is it good value? How do I know? Is it good value on other criteria?
- Are we making best use of our specialist support expertise?

Sustaining a model

- Advocacy for systems changes to make corporate functions easier – for example, OATSIH manual, streamlined key performance indicators between State and Commonwealth.
- Advocacy for maintenance of good support structures – for example, Indigenous community volunteers.

Key questions

- What are some of the key differences in organisations and jurisdictions that will influence support structures (needed, able to be developed)?
- What do we need to keep in mind about this when we are having the kinds of discussions we're having now?



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