

TAKING CARE OF BUSINESS:

Corporate Services for Indigenous Primary Health Care Services

CASE STUDIES



Kate Silburn, Alister Thorpe and Ian Anderson

with

Bila Muuji Health Services Incorporated

Central Australian Aboriginal Congress

Katherine West Health Board

Queensland Aboriginal and Islander Health Council



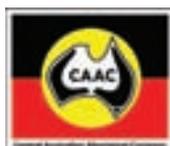
Onemda

VicHealth Koori Health Unit



Australia's National Institute
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Islander Health Research

*Incorporating the Cooperative Research Centre
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Bila Muuji Aboriginal Health
Services Incorporated



CAAC
Central Australian Aboriginal Congress



KATHERINE WEST
HEALTH BOARD



QAIHC
Queensland Aboriginal
and Islander
Health Council

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As we have noted in the companion 'Overview Report', those who successfully work on developing models for sharing corporate support are generally highly skilled, highly committed and have big workloads. We are therefore especially grateful to those from Bila Muuji Health Services Inc, Central Australian Aboriginal Congress, Katherine West Health Board and the Queensland Aboriginal and Islander Health Council for making the time to participate in the development of these case studies.

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 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.

ABBREVIATIONS

ABCD	Audit and Best Practice in Chronic Disease
ACCHS	Aboriginal Community Controlled Health Service
AH&MRC	Aboriginal Health and Medical Research Council of New South Wales
AHW	Aboriginal Health Worker
AMS	Aboriginal Medical Service
CAAC	Central Australian Aboriginal Congress
CCHS	Community Controlled Health Service
CRCAH	Cooperative Research Centre for Aboriginal Health
DHF	Department of Health and Families
GP	general practitioner
HR	human resources
HSDA	health service delivery area
KWHB	Katherine West Health Board
MOU	memorandum of understanding
OATSIH	Office of Aboriginal and Torres Strait Islander Health
PHCAP	Primary Health Care Access Program
QAIHC	Queensland Aboriginal and Islander Health Council
RN	registered nurse
SDRF	Service Development and Reporting Framework



INTRODUCTION

The Cooperative Research Centre for Aboriginal Health (CRAH), now operating as the Cooperative Research Centre for Aboriginal and Torres Strait Islander Health under the management of The Lowitja Institute, 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. This project was one of three priority projects of the CRAH. The other two projects focused on quality standards in Aboriginal and Torres Strait Islander health and funding and regulation of Aboriginal Community Controlled Health Service (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.

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?

This report focuses specifically on existing models for sharing corporate services and highlights the different ways those working in the sector have developed strategies for addressing their specific needs. Four case studies of organised support structures are documented. These are:

- Queensland Aboriginal and Islander Health Council
- Bila Muuji Health Services Incorporated
- Katherine West Health Board
- Central Australian Aboriginal Congress.

The case studies were developed by reviewing documentation about each site and conducting onsite interviews with those who were involved in the provision of corporate support and those who worked in organisations that accessed this support. The project findings are reported in *Taking Care of Business: Corporate Services for Indigenous Primary Health Care Services*, which comprises three documents: *Overview Report*, which provides full details of the project; *Case Studies* (this document); and *Summary Report*, which briefly presents the main points.



QUEENSLAND ABORIGINAL AND ISLANDER HEALTH COUNCIL: SECTOR DEVELOPMENT UNIT AND MEMBER SUPPORT SERVICES

Introduction

The Queensland Aboriginal and Islander Health Council (QAIHC) was incorporated in 1990 and is the peak body for the community-controlled health sector in that State (it was formerly the Queensland Aboriginal and Islander Health Forum, but was 'reconstituted' as QAIHC in 2004). In its early days, it consisted of a small team of people comprising a Chief Executive Officer (CEO), a Workforce Policy Officer, a Sexual Health Project Officer and administration support staff. At this time, it was largely influencing and facilitating engagement with government through key policy and partnership processes and providing dedicated health issue policy support to the sector.

QAIHC now has three business units, including the Sector Development Unit. The others are Policy, Research and Population Health, and Corporate Services (for QAIHC itself). QAIHC has also recently established offices in Cairns and Townsville, which enable services in the north of the State to obtain local access to QAIHC services.

QAIHC has 27 member services and is governed by a Board elected from the membership to represent the 10 QAIHC regions across Queensland. The Board also includes an honorary Chairperson.

The focus of this case study is on the Sector Development Unit and, in particular, the Member Support Services team within the Unit.

History of the Sector Development Unit

QAIHC established the Member Support Program in 2005 as a result of a deliberate strategy to provide direct organisational support to Aboriginal and Torres Strait Islander health services in Queensland. Although recognising that partnerships, policy and health issue-specific engagement were important, QAIHC considered that if it could not support health services to enhance its organisational capacity, it was not 'hitting the mark' as a peak industry agency in Queensland.

These deliberations occurred at a time when two health services in Queensland were identified as 'high risk' by the Office of Aboriginal and Torres Strait Islander Health (OATSIH). As such, the first member support strategies were implemented to support these organisations and comprised a number of QAIHC staff and an external business consultant providing one-on-one business administration assistance and support in negotiations with the funding agency.

As a result of this activity, the QAIHC Board of Directors established a dedicated program function to deliver member support services to health organisations in Queensland. Initially, there was one staff member, funded by QAIHC, and the focus was on services in difficulty. The main functions supported were governance and finances.

The demand for support grew and the Sector Development Unit (at that time called the Business Support Unit) made services available to all member organisations on a fee-for-service basis. The income from these fees, with some additional funds from QAIHC and a one-off grant of \$50,000 from government, enabled employment of two staff members whose focus was on corporate (or 'non-core') functions.

Following further growth in demand the then (two) staff of the Business Support Unit 'were running themselves ragged' and they realised they needed a different approach (key informant). The Unit was restructured so that

member support could be included in other roles and the support provided to services could be expanded to cover any aspect of the work of a community-controlled service, including clinical services – that is, the Unit wanted to reflect the holistic nature of the way its member services worked. These changes were reflected in a change of name, with the Business Development Unit becoming a broader Sector Development Unit in 2007.

[The Unit] has moved from [a] member support role of non-core functions to member support for whatever members need... we try to be a one stop shop... [what we] offer is more than straightforward member support (key informant).

Governance

As a QAIHC program area, the Sector Development Unit is governed by the QAIHC Board. Strategic issues relevant to the Sector Development Unit are referred to the QAIHC Board but information about the individual services the Unit is working with is not generally provided to the Board.

Principles

QAIHC's vision is for 'the elimination of disparities in health and wellbeing experienced by Aboriginal and Torres Strait Islander peoples in Queensland' (QAIHC n.d.a). Their mission is:

To advocate for and provide effective and efficient corporate and health service support to Community Controlled Health Services and communities in Queensland to facilitate access to comprehensive primary health care responsive to the needs of local communities and integrated into the health system in Queensland (QAIHC n.d.a).

QAIHC's key values include commitment to Aboriginal and Islander community control; cultural respect; intersectoral collaboration; leadership and integrity; quality and learning; capacity building; comprehensive primary health care; and a holistic approach.

Principles underpinning the Sector Development Unit's work are consistent with the values of QAIHC.

It's about self-determination – we're taking control of it – it's not always about what government is wanting – government has programs etc, but how they are delivered is up to organisations. Member Support and what it provides is very much an Aboriginal and Torres Strait Islander version of what support and organisations look like.

Structure

By 2009 the Sector Development Unit had 11 staff members working across six portfolios. The Director of the Unit reports to the CEO (QAIHC n.d.b). The portfolios are:

- Member Support Services
- Sexual Health and Blood Borne Viruses
- Bringing Them Home/Stolen Generations
- Medical Benefits Schedule and Quality Use of Medicines Maximised in Aboriginal and Torres Strait Islander Peoples (QUMAX)
- Queensland Indigenous Substance Misuse Council member support
- Service Planning (including regional planning and development)
- Regional Quality Accreditation Support Program.

The objectives of the Sector Development Unit are to assist Community Controlled Health Services (CCHSs) and, where relevant, Community Controlled Substance Misuse Services across Queensland to:

- develop and expand comprehensive primary health care and substance misuse services
- plan, develop and effectively manage and commission delivery of comprehensive primary health care services integrated into local and regional health systems

- effectively influence reform of mainstream health systems at both local and regional levels to improve access to a full range of health services for Aboriginal and Torres Strait Islander peoples
- guide investment of financial and human resources and information technology (IT)
- maximise income from the Medical Benefits Schedule
- develop and support implementation of a continuous quality improvement agenda
- deliver counselling and support services to members of the Stolen Generations
- develop and deliver comprehensive Sexual Health and Blood Borne Viruses services (QAIHC 2008:21).

Within the Sector Development Unit, the Member Support Services portfolio focuses on providing practical and technical support to services in areas of governance, organisational development and health service provision. Its objectives are to:

- assist the community-controlled health sector to develop and expand
- assist the community-controlled health sector to plan, design, manage and deliver primary health care services at local and regional levels
- enhance the organisational development capacity of the community-controlled health sector to provide high-quality primary health care
- enhance and enable quality improvement within the sector to guide investment in human resource management, IT and primary health care
- enhance the community-controlled health sector capacity to engage in health system reform at the local and regional level (QAIHC n.d.c).

The Service Planning portfolio supports the 'coordination, development and implementation of regional Aboriginal and Torres Strait Islander health planning and service development within community controlled health services throughout Queensland' (QAIHC n.d.d). This work includes:

- leading or assisting with development and implementation of service, local and regional-level planning processes (and with the activities that follow under these plans)
- supporting capacity development so that CCHSs can participate in regional-level planning¹
- supporting adoption of best practice in service delivery
- reviewing capital works/infrastructure needs of CCHSs and assisting with obtaining funds for these works.

Through this work the Sector Development Unit provides different levels of support. These include:

- local level (work with individual services)
- community level (working with communities to support new and emerging services and with local health forums as noted above)
- regional level (through facilitating and supporting Regional Health Forums)
- State and national levels (through policy and advocacy).

Although these levels are obviously interlinked, the following section focuses on the support for corporate functioning provided to individual services.

¹ In Queensland regional planning is undertaken by Regional Health Forums, which were established under the Queensland Aboriginal and Torres Strait Islander Regional Health Agreement. This Agreement is overseen by the Aboriginal and Torres Strait Islander Partnership, which includes QAIHC, OATSIH and Queensland Health. There are nine Regional Health Forums across Queensland, each supported by one of the three partners.

Support provided

The main topic areas where corporate support is provided to individual services is summarised in the Table 1.² The areas of highest demand are governance, finance, recruitment and human resources.

Table 1: Main areas in which QAIHC provides corporate support to individual services

Main area of support	Details of types of support provided
Budget and finance	<ul style="list-style-type: none"> • Annual budget preparation • Review of current chart of accounts, cost codes and posting procedures • Re-development/improvements to financial management information and reporting system for CEO and governing committee • Enhancements to finance and budgeting policies and procedures • Quality control via remote monitoring of accounts • Skill training for finance officer, accounts clerks • Coordinate topic-specific finance workshops • Advice on jobs policies and wages policies • Risk and financial management
Budget and finance	<ul style="list-style-type: none"> • Enhance corporate policies and procedures • Development of clinical practice guidelines • Development of staff code of conduct • Develop and install performance appraisal systems • Introduce standard position descriptions and contracts
Development and implementation of service delivery structure processes	<ul style="list-style-type: none"> • Clinical direction – recruitment and retention strategies • Identify and develop programs to enhance service delivery to clients • Staff training – training/development opportunities for existing staff • Staff and Board training
Program delivery	<ul style="list-style-type: none"> • Analyse and determine existing resources
Managing external relationships and governance	<ul style="list-style-type: none"> • Improved governance • Develop Service Development and Reporting Framework (SDRF) Strategic and Business Plans • Develop/enhance Code of Conduct for Governing Committee • Coordinate training for Governing Committee Members • Building relationships with other Aboriginal Medical Services (AMSs)
Review and development of memorandum of understandings (MOUs)	<ul style="list-style-type: none"> • Identify and develop working relationships • Manage external relationship management strategies
Facilitate access to new funding sources for improved outcomes	<ul style="list-style-type: none"> • Assistance from QAIHC to negotiate funding proposals to enable AMSs to sustain an effective and efficient health service
Community Engagement Strategy	<ul style="list-style-type: none"> • Organisation/governance structures • Service model • Community consultation • Community engagement

² Information provided by key informants and from QAIHC n.d.c.

The main areas where organisations obtain assistance within a basic agreement/retainer (see 'Funding' below) are strategic planning, business planning, governance planning, policies and procedures, and some human resources advice. Other services, such as assistance with developing performance appraisal systems and accreditation, are provided at additional cost.

QAIHC can also facilitate upgrades to the infrastructure of member services across the State. For example, it sought funding to upgrade servers and software. Doing this on a State-wide level facilitated improved consistency across the sector.

One member service also reported that the Sector Development Unit had assisted it to work out how to respond when it had negative (and untrue) publicity about funding for the service. Another reported that QAIHC had supported it in an ongoing process of transitioning to become a community-controlled primary health care service.

How corporate support to individual services is provided

While much of the work of Member Support Services is one-on-one peer support to organisations (see below), the Unit does a lot of work developing templates, or having these developed by relevant specialists for key areas of corporate functioning. This includes templates for strategic plans, business plans, various policies and procedures, Charter of Governance, Board roles and responsibilities, codes of conduct, risk management and position descriptions. These templates can be adapted to meet the specific requirements of each service. Having these templates not only saves time but provides organisations with access to, and support for, introducing up-to-date practices. A further advantage is facilitation of consistency across the sector 'around the foundational work'.

As well as peer support, direct support for corporate functions is also provided through having a help desk, through State-wide capacity building activities and through supporting planning at the regional level. Specific and tailored support is also provided for new and emerging services and for drug and alcohol services. QAIHC has also led a process of working towards the establishment of 'regional hub centres' for the provision of corporate support for members. Each of these types of support is described briefly below.

Peer support

The majority of the support provided to organisations is peer support, which can be provided by Member Support Services in a number of ways, including by:

- staff of the Member Support Services team providing the support directly – this includes through site visits and being in contact by telephone and email
- facilitating access to support from staff in any of the other Sector Development Unit portfolios or other QAIHC program areas (such as from the Population Health Hub or from the Centre for Clinical Excellence)
- identifying and engaging consultants for specific work. Sometimes consultants come from the sector; some have worked in other States or with organisations like the Kimberley Aboriginal Medical Services Council. Some of the criteria for selecting consultants includes their experience working in the sector (and their consequent reputation and feedback from organisations they have worked with) and their approach to working with organisations. QAIHC staff reported that generally the consultants they worked with were very passionate about the sector and engaged with it. If consultants do not provide adequate services they will not be engaged again.

Support can also be provided from the Townsville and Cairns offices, each of which has several staff members.

Through working in this way the Member Support Services team can facilitate access to support across all areas of health service activity. This is in line with the Unit's goal of providing services in a way that reflects the functions of a community-controlled health service at a very affordable price.

Some services accessing support identified that they had appreciated the scope and flexibility of the Member Support Services team to tailor their work to the needs of the individual service and to identify additional sources of assistance if required. One key informant said, 'they'll help us with anything.'

A couple of examples of the peer support provided include:

- facilitating recruitment of CEOs – from the development of position descriptions to advertising, sitting on panels, inductions and providing mentoring for the first three to six months; recently the CEO of QAIHC provided this kind of mentoring
- undertaking organisational reviews:

With one service... we are doing an organisational review – we are expecting a new model of service delivery to come out of this, with new governance structures... to do a job like this we put together a panel of experts that reflect how an AMS works... so we have management experts, general practitioners (GPs) etc. All of the consultants are paid under the cap so everything is still discounted.
- facilitating access to clinical staff for services – this includes negotiating with Queensland Health for specialists to operate services from AMSs
- assisting with negotiations with mining companies and other private sector organisations for funding
- negotiating with government departments regarding capital works projects.

Staff training

The Sector Development Unit can facilitate staff training for member services in areas such as use of Medicare items, various aspects of service delivery, medical receptionist training and accreditation. One service whose staff had received Medicare training commented on its quality:

It was really useful... not like Medicare... ringing Medicare is like a lottery... you might get someone useful or not.

State-wide support

Some member support is formally provided at a State-wide (rather than individual service) level. This includes:

- the Queensland Indigenous Health Finance Network, which was established in 2005/06 in response to identification of common needs for support around finances – QAIHC holds up to four Queensland Indigenous Health Finance Network workshops each year: the finance officers, CEOs and often Chairs of community-controlled services attend these workshops; examples of topics include relevant changes to legislation (for example, changes to the *Corporations Act 2001*), compliance, risk management, audits, salary issues (like salary packaging and fringe benefits tax), goods and services tax compliance, and changes to funding agreements
- leadership and governance workshops provided by contracted consultants³ – part of the agreement with these consultants is that they develop QAIHC staff so they can co-facilitate sessions and ultimately run the sessions themselves
- a yearly members' conference, the first of which was held in 2008 – at these conferences broad overviews of what is going on can be given to the sector, including information about best practice and available training: prior to these yearly conferences one-off conferences were held (for example, in 2007 a Governance and Business Improvement Conference was held⁴)
- disseminating information about State and national initiatives and pro-actively engaging member services in these (for example, the Council of Australian Governments processes).

3 This training is provided by Effective Governance, which is the trainer for the Australian Institute of Company Directors. The training is held in a central location and enables networking between CEOs and Board members.

4 This was held jointly with the Aboriginal Medical Services Alliance Northern Territory and Winnunga Nimmityjah Aboriginal Health Service. The event was held in Brisbane and QAIHC led the planning and facilitation of it. Sessions focused on current models of community control, research findings on governance, business modelling and best practice service delivery. Discussions about the concepts of regional hubs for corporate services were also discussed. More than 90 people attended (QAIHC 2008). For a report on this conference, see QAIHC n.d.e.

Regional hubs

Following the 2007 Governance and Business Improvement Conference, and to work out how to better address the common needs of member organisations, QAIHC invested in a study to look at the feasibility of developing regional support hubs for non-core services. This work included commissioning a literature review on shared services, conducting consultations with member services and developing a business case for such hubs.⁵

As a consequence two regional hubs are currently being trialled in central and south-east Queensland. QAIHC is working with the sector to set up governance structures for these hubs and is involved in the project management aspects of their further development.

There are a lot of issues to think about when developing this kind of model – you need all organisations to have buy in for it to be successful, but bigger organisations already have resources to buy in services so we can't see that they will access hub services – we are trying to get them to think more broadly about this... for example, they might have [a human resources] person, but can this person do all the things they need to do really well?

Each hub will be governed by a Board consisting of the CEO or Chairperson of each participating service and a QAIHC staff member. One key informant engaged in one of the pilot hubs was enthusiastic about the potential for sharing resources. They indicated that its hub would be incorporated as a separate entity and have a general manager and that the participating organisations will sign a MOU and have service-level agreements.

Regional planning

In 2005 QAIHC received government funding to support/facilitate coordination of four Regional Health Forums. This role was located in the Sector Development Unit and resulted in the employment of staff to facilitate regional planning. A range of support activities are performed in as part of the Regional Health Forum work. For example, in one region QAIHC, in this role, is working with a GP to develop shared services with three AMSs.

Help desk

QAIHC provides a help desk consultant to work with services to develop and write funding submissions. The help desk consultant works through the CEO of the member service to define the scope of work. The consultant can then draft the submission and send it back to the service for comment and confirmation. This service is provided at no cost to members and is largely funded by QAIHC without government assistance. However, in some specific areas QAIHC has received government funds to provide this support (for example, around mental health and wellbeing).

New and emerging services

The Member Support Services team also works with new and emerging services. This might include providing regional profiles, setting up meetings with other stakeholders and organisations, assisting in the development of partnerships, evaluating support needs, assistance in developing policies and procedures, organising training, assisting with advocacy and making sure services get access to the things they need.

Substance misuse services

QAIHC has received funding through OATSIH for an officer to support community-controlled substance misuse services to provide an increased range of services. Much of the work of this officer is around developing the capacity for corporate functions within these services (including for governance, planning, human resources, finance, and policies and procedures). This work has been done through one-on-one support and State-wide workshops (QAIHC 2008).

5 QAIHC 2008. The Business Case identified benefits (financial and non-financial) of hubs, proposed structures for shared services (including governance and service delivery model), a schedule of project activities in recommended trial locations and projected costs associated with trialling the model.

Capacity development

The Sector Development Unit has an implicit focus on capacity development. As one staff member noted:

Much of the capacity building work of the Unit is conscious but not formal. We don't go in and say 'we want to build your capacity in x'. Instead we go in and tell people about the process... this is what we use... you can do this for x, y and z... these are the things you should include.

Capacity building can be particularly important for organisations that are having difficulties, and part of the role of the Unit in these organisations is to up-skill staff so they no longer need this support:

Peer support is about the ongoing work... if you don't transfer knowledge and skills the same issues will reoccur.

Sometimes when the Unit assists an organisation the first issue will be to deal with an immediate need, but once that is addressed the Unit considers what supports are required to make the organisation sustainable. Part of this is identifying what the Unit can and cannot control:

Often we can't control the Board getting involved in operational stuff, but we can provide the framework for good governance. We can provide assistance and provide governance training and develop the Chairperson's role within the Board etc... but we can't control what they do or what happens in the community (staff member).

Where the same issues occur over and over the Unit might strengthen its advice about the consequences of the repeated behaviour; however, it has to be very sensitive about how this is done and it might need to be done over a long time period:

The reason some organisations come back to QAIHC is that they will have relationships and will have conversations about the issues.

As there is such a high turnover of staff across the sector, Member Support Services encourages organisations to do succession planning. It promotes the idea of organisations looking 'within their own ranks and building their own capacity'. They also do significant work to assist organisations to identify the skills required by CEOs, develop good practice in recruiting them, and in supporting the CEOs when they are appointed.⁶

As described above, the Unit aims to work in a way that enables organisations to sustain the work and the skills they have developed. A concrete example of this is that when OATSIH introduced the SDRF⁷ the Member Support Services team had to assist many organisations to complete their plans. Now they do workshops with staff and Boards about the SDRF and provide them with templates, and the organisations complete it themselves.

How do services know if they need support?

The support required by any service will depend on the size of the organisation, what it can do in-house and functions required that are additional to those done in-house.

The member services interviewed reported a number of ways of working out where they needed support. These included systems reviews (using tools like Audit and Best Practice in Chronic Disease (ABCD)); risk assessments; review of data collected about service activity; through the yearly SDRF process (which includes developing strategic and business plans and reporting against them); lacking staff to undertake particular functions; and seeking QAIHC's help to identify what was required.

6 The funding available from OATSIH for a CEO position is low (approximately \$70,000 per annum) compared to other types of health services, which can mean that new CEOs might not have the breadth of skills required, which in turn means they might need a lot of support.

7 The SDRF is a non-financial reporting framework in which services report to OATSIH against their yearly action plans and quality improvement initiatives.

The Member Support Services team assists services to identify areas where they might need support in a number of ways:

- sometimes the Member Support Services team is invited to assist organisations prepare for the OATSIH risk assessment process; that is, the Unit can assist organisations to work out where there are processes that might need to be improved and assist them to do this (one staff member noted: 'This is the preventive stuff')
- the Member Support Services staff might also pick up some issues in organisations during their peer support work 'through general observation' and through working with other officers in the Sector Development Unit who might see a potential need in a member organisation
- at member conferences the Unit gives presentations and promotes information about what it can do and what is good practice, and members will often identify some support in these areas that would be useful to them
- QAIHC promotes the services it provides, and their members will often approach them for support
It's through marketing and word of mouth... then it's up to the organisation if they want to buy support.
- when an organisation has done something really well, QAIHC will showcase and promote this to others, who may then want support to do something similar
- QAIHC gets an idea of how organisations are going through accreditation.

The Unit tends to do more work with smaller services and those experiencing difficulty:

We can help services with the least capacity. The really big organisations don't use much member support as they have enough cash to get support themselves. They also tend to attract more qualified people onto their boards and have ex-officio members on their boards. Bigger organisations also tend to have better access to government and they can often get dedicated employees to do stuff that QAIHC might otherwise pick up for smaller organisations.

Relationship of organisations with support providers

Participation in the support model is voluntary and generally services approach Member Support Services for assistance. The exception to this is when an organisation is in crisis and OATSIH has intervened; then the member service will have to develop a recovery plan and often it is a requirement of the funder that it works with QAIHC to do this.

The Member Support Services' relationship with a service is always through the CEO. It is then the CEO's responsibility to pass the information on to the Board or staff or ask the Unit to liaise directly with staff.

Generally, the Member Support Services team 'responds to need... we promote the service and then it's up to them [member services] if they'd like to buy [support services]'. Some of the member services interviewed identified that the relationship with their organisations was good and that QAIHC staff were accessible, would provide prompt advice (even when they were interstate or at national meetings) and could 'tell you what you can and can't do'.

Organisations of concern/organisations in crisis

There are a number of ways QAIHC knows or finds out about organisations 'in trouble'. These include through:

- having good relationships with the sector and being asked to provide assistance
- observing issues when visiting services
- being told by someone from the sector that there are issues in particular organisations
- being approached by OATSIH (usually with the permission of the organisation) to work with the service.

In the case that QAIHC is approached by OATSIH, QAIHC staff contact the service and look at the support it can provide – including what support is already being provided and what else needs to be bought in. Some QAIHC staff considered that:

OATSIH is getting better at identifying when services might be heading into trouble rather than getting to crisis. They might call and say [an] organisation is not responding, can you touch base and see how they're going.

Member Support Services staff often have to be very sensitive about how they engage with organisations of concern. For example, if the CEO of a service approaches QAIHC and indicates there are issues between the CEO and the Board, a member of the support team might go and meet with the Board and facilitate access to appropriate services such as governance training. If QAIHC has heard that there are issues in a particular service, a Member Support Services staff member might telephone all member services and ask how they are going. If the organisation is in crisis and OATSIH has been involved, the Member Support Services staff will meet with the Board and develop a recovery plan.

Funding

Member support is largely funded by member organisations, but in some cases is partially underwritten by QAIHC. Under retainer arrangements, QAIHC member organisations can sign up for an agreed type and amount of support depending on their needs. The fee depends on the support required, and for most organisations this results in paying between \$10,000 and \$15,000 annually. The agreement with each service is formalised in a contract (or 'retainer'). If organisations have not used member support before, QAIHC might provide a discount to encourage them to access the Unit.

Depending on the type of support required, consultants can be included. In most cases payment for these consultants is included in the retainer agreements if the relevant expertise is not available within QAIHC. Member Support Services identifies appropriate consultants, reviews the quality of their work, negotiates a fee cap of \$800 a day and project manages the process of engaging the consultants.

Some member services do not want to set up a retainer but will pay for member support on a fee-for-service arrangement for specific pieces of work (for example, governance training).

Member Support Services staff also do some pro bono work and some of the work they do is charged at reduced rates. This is because they are working in a competitive market place and sometimes they reduce rates to demonstrate what they can achieve.

QAIHC does not receive government funding for the Member Support Services work it does, but does get some funding to support some of the other functions of the Sector Development Unit. For example, in 2005 it was funded to provide support to four Regional Health Forums and it also has funding for Queensland Indigenous Substance Misuse Council member support. OATSIH also funds 'remedial' work with organisations of concern (but it currently does not fund developmental work).

Sometimes QAIHC also receives some funding from government to support a community group to establish a new organisation.

Accountability and reporting

The Sector Development Unit is accountable to its members through the Board of QAIHC and contractually to members through service agreements. It is also accountable to government for any government funding it does receive.

The Unit's reports to the QAIHC Board focus on strategic issues (which require Board decisions) and activity (for example, provision of member support to x number of services over a particular quarter). Details about the support provided to, or about, individual member organisations are not reported to the QAIHC Board. The exception to this is services of concern, in which case the Unit does report to the QAIHC Board. One reason for reporting in this case is that the intensity of the work required might limit the work the Unit is able to do with other organisations over a period.

When QAIHC has been provided with funds by government to support a new or emerging service the Unit reports to the QAIHC Board on contractual arrangements but does not go into detail about the new organisation's work and business.

Services know that the work they do with Member Support Services is confidential and this is important in development and maintenance of trust.

Review and evaluation of the model

The Member Support Program is continually reviewing its performance and getting feedback from services. It was formally reviewed in 2008. This review resulted in a shift in focus for the Unit from remedial work to developmental work and a realignment of the support services to better meet member need (hence the broadening of the scope of the Sector Development Unit and the strategy of bringing in resources from other QAIHC units). This kind of review is conducted informally on an annual basis and formally every two to three years.

The Unit also has a business plan and benchmarks staff performance plans against it. There are also performance indicators around levels of activity.

Indicators of success

Staff of the Unit commented that it was difficult to have outcome-based indicators for their work because outcomes were often beyond their control (and it is hard to identify if inputs have led to outcomes):

In some respects we can tell if members continue to provide good service to communities and don't get defunded, but we don't have full control over this... autonomy and independence is important... all we can do is develop support structures... we can't do the job.

Some indicators pointing to the success of the model could include:

- QAIHC provided comprehensive member support to 13 organisations in 2008–09 across the areas of corporate governance and management support, human resource management, strategic and business planning, and organisational and operational reviews
- member services participate in the events run by the Unit
- Member Support Services staff are invited by members to attend a lot of events and meetings (even though they often are not able to attend)
- approximately 90 per cent of submissions that had assistance from the help desk consultant have been successful
- some organisations that the Sector Development Unit has worked with now have more stable services.

In addition, indicators of the success of QAIHC overall in the past three years could include the following, to which the work of the Sector Development Unit has contributed:

- membership has increased from 16 to 27 members over three years – all AMSs in Queensland are now members of QAIHC
- the level of funding to QAIHC has increased and staff numbers have increased from between 10 and 15 to more than 60
- other stakeholders, such as government, are increasingly coming to QAIHC for advice.

Staff from the member services considered that the contribution of the Sector Development Unit to the overall gains made by QAIHC was through 'showing them that QAIHC was there for them... it bought them back in by providing support on the ground'.

Facilitators/enablers

Some facilitators and enablers of the model include:

- leadership of both the former and current CEOs of QAIHC who have a vision for providing member support and who have been entrepreneurial in their approach to this – the former CEO wanted the Unit to be able to be self-funding so that it was able to be independent
- QAIHC Member Support Services staff have good relationships with Boards and CEOs of services
- member services interviewed were generally confident of QAIHC being able to deliver
- having member service CEOs on the QAIHC Board means that QAIHC ‘does not lose touch’ with what is happening on the ground – the establishment of regional offices has assisted with ensuring QAIHC is seen as a State-wide (and not Brisbane-centric) organisation.

Benefits

There are many benefits of the model, including:

- community control and cultural respect is ‘always at the forefront’
- there is a recognition that different services will have different needs, and support can be tailored to meet the needs of different organisations – Member Support Services staff are willing to visit services
- the ability of QAIHC to have vision, identify what is ‘coming up’ for the sector and be strategic about positioning the sector well for the future
- member organisations get support at reduced rates (over commercial consultants) because of the capped rate and because QAIHC runs the service on a cost recovery basis or even at a loss
- the Unit brings a neutral, standardised, business perspective and understands what good practice looks like on the ground in community-controlled organisations

We don’t put our personal opinions in... we bring organisational and change management support without hanging anyone out... we align actions to the strategic direction of the organisation.

- organisations don’t have to rely on their own resources to do some of the corporate activities and can be supported in corporate activities through emails, site visits and telephone calls – this leaves them more time to focus on their health service delivery
 - quality control of external consultants
 - QAIHC has credibility with its members and works in a way that sustains this credibility
 - services get more money through assistance with submissions
 - QAIHC can assist organisations identify areas they can work in that they may not have thought about and then link them with funding opportunities related to these areas in a strategic (rather than ad hoc) way
- Often organisations will see a tender ad in the paper and see dollars... we try to get them to identify where they want to go first and then go for the dollars, not other way round.
- QAIHC can facilitate development of consistent policies and procedures across member services – one of the benefits of this is that staff can move more easily between organisations
 - QAIHC can assist member organisations to look for opportunities from other organisations, including (non-health) government departments, mining companies and philanthropic organisations.

- QAIHC can assist organisations to build relationships with each other by linking organisations in a region with others working in the same field or those that can assist an organisation in a particular area – examples of this include working with a new or emerging service to link with other services in the region, or linking member organisations with organisations outside the community-controlled sector, such as a local GP with an interest in Aboriginal health
- QAIHC can increase recognition of the good work occurring within services by nominating them for best practice awards – this can help to improve the image of AMSs
- as a State-wide organisation, QAIHC has access to information that many member organisations might not find easily, such as updates or changes to legislation – QAIHC can pass this information on and value-add to it by providing advice to members about what it means for them and how they can address any issues arising
- related to the above point, QAIHC has access to discussions about national reform (for example, Council of Australian Governments processes) and can lead the process of engaging the sector in national activity, including how initiatives should be shaped in Queensland for both the community-controlled sector and across primary health care more broadly
- some members who had received support indicated that without the assistance of QAIHC their services may not have survived or would not have been able to ‘turn around’ as quickly as they had

We were going to be shut down within six months. With QAIHC’s help we were able to improve in three months and survive.

Barriers/issues/risks/weaknesses

The key barriers, issues, risks or weaknesses are summarised below. They include:

- provision of support for the corporate functions of member services is ‘extremely underfunded’ – this is the case whether funding is for external support (for example, through QAIHC) or whether it is to support member services to provide their own corporate functions

If they [government] don’t want to fund member support, they need to fund services properly so they can attract people with skills.
- not all member services want to have a retainer arrangement with QAIHC, but if all member services requested corporate support QAIHC may not have the current capacity to provide it
- private consultants can operate in the sector with little accountability or quality control – some have done very poor work or use out-of-date-templates and tools
- the model relies on having really good, competent people in the team and the relationships they have with the sector
- some issues with staff turnover
- the need for a pool of locums who can take up the work of CEOs while they are on leave (this gap was identified by a member service).



BILA MUUJI HEALTH SERVICES INCORPORATED

History and background

Bila Muuji, which means *river friends*, was established in 1995 and is one of a number of networks operating in New South Wales. It grew out of CEOs of some rural and remote AMSs in New South Wales wanting to meet as a regional forum and share ideas and support each other. The original network got together after a note was passed between CEOs at a New South Wales Aboriginal Health Research Council⁸ meeting asking, 'do you want to meet, and if so when?'⁹

There were originally six member organisations:

- Bourke Aboriginal Health Service
- Brewarrina Aboriginal Health Service
- Coomealla (Dareton) Aboriginal Health Corporation
- Dubbo (now Thubbo) Aboriginal Medical Co-Operative
- Walgett Aboriginal Medical Service Co-Operative Limited
- Wellington Aboriginal Corporation Health Service.

These six organisations have continued to be members, and a further four organisations have joined. These are:

- Balranald Aboriginal Health Service
- Coonamble Aboriginal Health Service
- Orana Haven Aboriginal Corporation
- Orange Aboriginal Medical Service (WAMS n.d.a).

To be a member of Bila Muuji, organisations must be Aboriginal community controlled¹⁰ and eligible for membership of the Aboriginal Health and Medical Research Council of New South Wales (AH&MRC). As community-controlled organisations, Bila Muuji members are independent from Area Health Services of the New South Wales Department of Health, but are eligible for partnership agreements with them.¹¹ Bila Muuji member organisations sit within three different AH&MRC regions.¹²

8 The Aboriginal Health Research Council was the peak body for ACCHSs in New South Wales at this time. The organisation has subsequently become the Aboriginal Health and Medical Research Council of New South Wales.

9 The three CEOs who met as a result of this and began the work of establishing Bila Muuji were Christine Corby (CEO, Walgett AMS), Judy Johnson (CEO, Bourke AMS) and a third CEO (we have not included her name as we have been unable to contact her to seek permission). Christine and Judy are still the CEOs of their organisations and members of Bila Muuji.

10 These include both ACCHSs and Aboriginal community-controlled health-related services (like drug and alcohol rehabilitation services).

11 In NSW State health services are organised into eight Area Health Services, which include both primary and acute health services. Four of these cover the rural and remote areas and four are in the metropolitan area (see NSW Government n.d.a for more information).

At the time Bila Muuji was established there was a larger number of Area Health Services and Bila Muuji member organisations sat within the boundaries of different Area Health Services, whereas in 2009 they all sit within the boundaries of the Greater Western Area Health Service. As independently incorporated health service organisations, each Bila Muuji member organisation is entitled to its own partnership agreement with the Area Health Service (and some are currently looking at developing such agreements).

12 For information about these regions, see the map provided on the AH&MRC website (www.ahmrc.org.au/MAPmemberregions.htm). The map provides links to the member organisations in any particular area.

Bila Muuji member organisations work with communities in western New South Wales (see Figure 1 for the location of services) and provide a range of comprehensive primary health care services.¹³ In 2008 Bila Muuji was a runner up in the Working Together to Make a Difference category at the New South Wales Aboriginal Health Awards (NSW Government n.d.b).

When Bila Muuji began, most participating services were quite small; however, all have grown considerably since 1995. For example, Bourke Aboriginal Health Service went from six to 37 staff (including 10 contract staff) with many visiting specialists. The service also had significant capital growth, with an injection of just under \$2 million for this purpose, which enabled establishment of a dental clinic and a social and emotional wellbeing site in Cobar.

Governance

The 10 CEOs of member organisations make up the Bila Muuji Board, which has a Chairperson, Deputy Chairperson and a seven member executive.¹⁴ The Board meets six times each year and has an annual general meeting (which is attended by Board members).

CEOs are responsible for referring/reporting relevant matters to their own Boards (including decisions about membership of Bila Muuji and payment of membership fees). Any decisions made by Bila Muuji or any decisions about the links between Bila Muuji and member organisations are tabled at the Board meetings of individual member organisations for their information, comment and endorsement (if applicable).

Once an organisation is a member of Bila Muuji, its CEO is invited to attend meetings. When new CEOs start at member organisations they are automatically invited to participate.

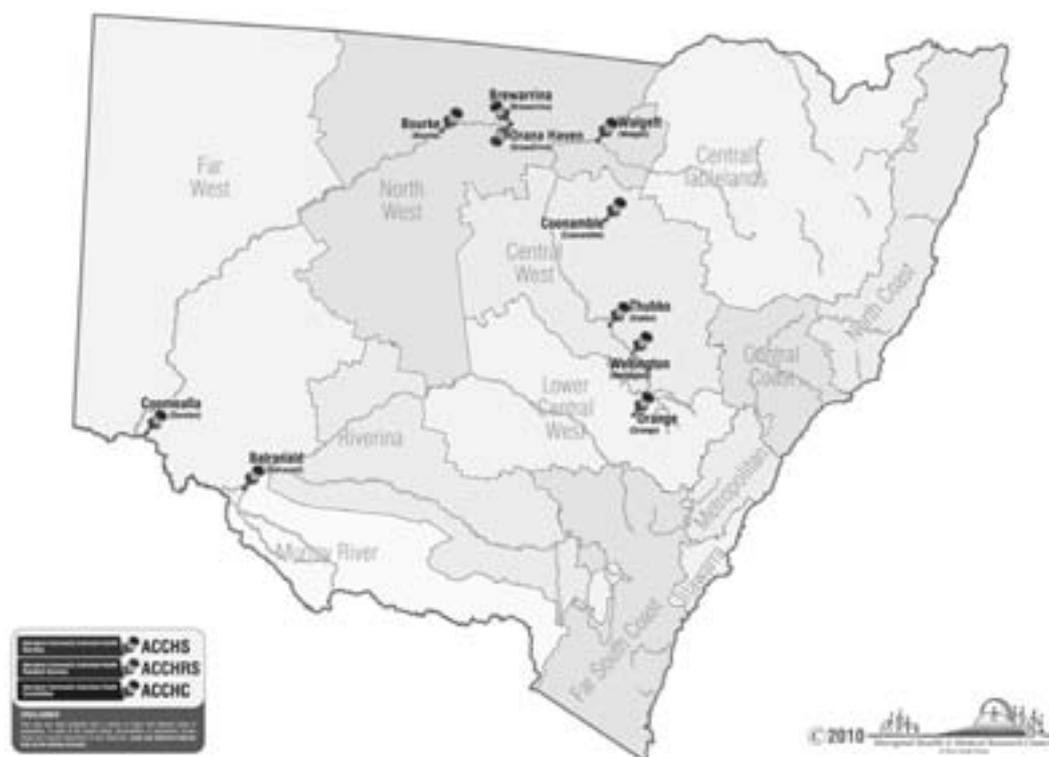


Figure 1: Region covered by Bila Muuji member organisations; Reproduced with permission from Bila Muuji Health Services Incorporated

¹³ Services operate in a holistic 'whole of life' perspective and services provided include health promotion, disease prevention, substance misuse, men's and women's health, child health, aged care services, mental health, clinical and disability services, dental services and work on the social determinants of health (such as amelioration of poverty) (WAMS n.d.b).

¹⁴ Only CEOs of member organisations can nominate to be on the Executive.

Principles

Bila Muuji's Charter sets out the following principles for its operation.

Bila Muuji Charter

C Community

ACCHSs are focused on providing services to our whole community

H Holistic

Total wellness

A Aboriginal control/management

Governed by Aboriginal community

R Respectful

Of clients, partners and stakeholders

T Transparent

Professional, responsible and accountable to one and all

E Excellence

Quality care and performance

R Responsive

Addressing 'need' not 'want'.

Structure

Bila Muuji began as a network of CEOs. Organisations were able to join if they were Aboriginal community controlled, based in a relevant geographical location (the western part of New South Wales), had the capacity to participate and were known to others within the network; there were no formal criteria for determining who could and could not join.

The initial role of the network was provision of peer support for CEOs, who have difficult and demanding roles. The focus was on operational issues. Over time members came to see Bila Muuji as an ideal mechanism for raising issues affecting all member organisations and their communities at regional, State and national levels. Consequently, Bila Muuji's function has grown to include identifying and addressing such issues.

The vision of Bila Muuji is now 'to support each service through the establishment of a broad network of AMSs in rural and remote NSW and to identify and address shared issues impacting on our communities' (WAMS n.d.b).

To create a structure that would more appropriately reflect this expanded role, Bila Muuji became incorporated in 2007 as Bila Muuji Health Services Incorporated. As an incorporated body, Bila Muuji would be able to hold funds for joint projects. However, this has not yet occurred because Bila Muuji does not have any funded staff, something that the group is working on addressing. Ideally, Bila Muuji would like to employ an Executive Officer, who would sit at the AH&MRC and could act as secretariat to the group, follow up on action items and manage jointly held funds.

Funds for joint projects are currently held by individual member organisations that auspice the project and have a service-level agreement with Bila Muuji, which is responsible for providing reports to the funding body. Decisions about which agency will auspice a project tends to be based on organisational capacity, perceptions about the organisation in which the program best fits, the best location for the project, and the relationships between the auspice organisation and others involved in the project (including the funder). In some cases sub-groups of the Bila Muuji membership will work together on projects. In this case participating organisations identify an auspice agency and have direct service-level agreements with the auspice agency. For example, the Wellington Aboriginal Corporation Health Service, Coonamble and Thubbo are currently considering a service-level agreement associated with a Healthy for Life outreach program.

Bila Muuji member organisations operate independently of Bila Muuji. Bila Muuji does not have any control over the operations of member organisations and contribution of information to discussion topics is voluntary (that is, member organisations would not be compelled to discuss specific issues about the operation of their services).

Bila Muuji also does not aim to be a representative organisation and sees the role of member representation as belonging to AH&MRC.¹⁵ However, it does work to address issues relevant to member organisations.

Bila Muuji holds bimonthly meetings over two days. The Bila Muuji Executive meets on the morning of the first day and these meetings have a standard agenda (items include business arising from minutes, financial reports, correspondence, working party reports, general business); written reports are provided against items on this agenda to ensure good communication. On the afternoon of the first day major stakeholders such as AH&MRC and OATSIH may attend. On the second day, staff of member organisations and guests (such as representatives from government) can attend. Initially, meetings were rotated between member organisations; however, more recently they have alternated between Dubbo and Sydney to reduce travel time for the majority of members and to enable guests to more easily meet with the group.¹⁶ As a consequence, two members have to do significantly more travelling than others and are subsidised by Bila Muuji in recognition of this. Bila Muuji members also reported that a lot of liaison takes place between them outside meetings. This is done by email or telephone.

Bila Muuji members are currently discussing the optimal size of the group, as more organisations would like to join. This includes how broad the membership should be, the geographical area that the group should cover and the potential for a role of a larger group to overlap or compete with that of the AH&MRC, especially as Bila Muuji takes on more of the functions of a regional body.¹⁷ Some Bila Muuji members suggested that it might be preferable to support the development of other groups or networks of AMSs in different regions, rather than expanding the size of Bila Muuji.

Support provided

Two main types of support are provided or enabled through Bila Muuji – support for CEOs in their roles, and joint action on issues of concern for member organisations and/or communities. These two roles are described in more detail in the following section.

Bila Muuji, itself, has sought support for its functions through engaging Indigenous Community Volunteers¹⁸ to develop a business plan and a website.

Support for CEOs and organisational development

Each CEO brings expertise and experience from previous roles and often has expertise in different areas. Bila Muuji enables CEOs to share skills and knowledge and to support each other in managing and developing their organisations. This knowledge and skills sharing can occur within meetings or between meetings. Individual members of Bila Muuji often seek the advice of other members on a one-to-one basis outside of meetings, particularly for advice about difficult and/or sensitive issues occurring within their services. In this way they can pool expertise and ‘grow from each other’. CEOs reported that they could have confidential discussions about difficult issues without ‘fear of retribution, or of the information being leaked’:

This is one of the few places where CEOs can speak freely with other people who understand... it helps overcome CEO isolation. As well as enabling CEOs to directly support each other, Bila Muuji also facilitates organisational development in a range of ways. These include:

15 The Chairperson of Bila Muuji is also the Chairperson of AH&MRC, which assists with providing clarity around the respective roles of the State-wide peak body and the regionally based Bila Muuji group. Some challenges in this include that the person in this role has to be very clear about which position he/she is representing in particular forums (including meetings of AH&MRC and Bila Muuji), ensuring that he/she declares any conflicts of interest (and that there is a process for dealing with this) and that he/she is not the only person invited when both groups should be represented.

16 This was partly driven by some funding bodies not wanting to visit remote locations due to the time required.

17 One of the drivers of this is an apparent push by governments towards regionalisation of health services.

18 For more information, see the Indigenous Community Volunteers website (www.icv.com.au).

- running training at central locations, including governance training for Board members of member organisations and training for staff on a range of common issues (for example, infection control, use of demographic data)
- sharing information, ideas, policies and procedures, strategic plans, work plans and advice about external service providers and consultants
- coordination of information provision from external organisations (such as governments and peak bodies) and responses to that information
- joint work on development of new policies and procedures, which can then be adapted for use by each organisation
- working together and sharing skills to develop funding applications
- informal benchmarking (for example, through discussion of doctors' pay and conditions)
- providing reassurance and support to each other when organisations are dealing with new processes, such as accreditation
- developing initiatives and projects to support organisational development, such as work on accreditation and IT (see below)
- some joint purchasing (this was done for contaminated waste disposal in the past but is not currently occurring)
- presentations to meetings from representatives offering regional corporate rates for insurances, vehicle fleet acquisitions and shared procurements for items such as medical and dental supplies, pharmaceutical supplies.

Organisations in crisis

If a member organisation is struggling or in crisis, Bila Muuji's role is not to 'go into' the organisation; rather, it is the role of the funding body (OATSIH or NSW Health) and the AH&MRC to do this. Bila Muuji is 'not a watchdog' and its role is to support the CEO (or if the CEO has resigned, others in management roles) to go through whatever processes are necessary (or required by the funding body) to get the organisation back on track. However, CEOs can seek advice from Bila Muuji or individual members at any time if they choose to do so.

Establishing new organisations

Some Bila Muuji member organisations have assisted in the establishment of new community-controlled organisations and have auspiced these emerging agencies. In these cases there has been direct agreement between the two organisations.

Advocacy and joint action on issues of concern

Bila Muuji undertakes a range of activities that could broadly be described as advocacy. These include:

- identification of issues of common concern and advocating for these to be addressed or getting funding to address them
- involvement in government policy development processes
- development of partnerships with non-member service providers and agencies.

This has resulted in action on issues that may not have otherwise been addressed:

We have worked with agencies and governments who were often reluctant to listen to problems confronting us as individual services (WAMS n.d.b).

An example of this was the group having a role in getting changes to the way the New South Wales Isolated Patients Travel and Accommodation Assistance Scheme operated so that the needs of Aboriginal people were recognised (WAMS n.d.b).

Identifying issues of common concern and advocating for these to be addressed or getting funding to address them

Issues of common concern worked on jointly by Bila Muuji include those relating to the corporate aspects of services (for example, IT, organising for accreditation) and on gaps in service delivery. Although the focus of the latter may be on a health service delivery issue (for example, social and emotional wellbeing), most of these projects include systems and workforce development activities and are therefore likely to build aspects of the corporate side of organisations, such as improving data collection processes or providing mechanisms for staff training and support.

These projects are based on a commitment to share and maximise the use of existing resources (within member organisations and within the region), as well as to build on them through seeking additional resources. These additional resources might include staff with specific expertise who support and develop existing staff (for example, employment of a qualified psychologist to provide supervision for mental health workers) or support the development of new systems and structures (such as IT infrastructure, common assessment, referral and data collection systems and processes, accreditation plans).

In some of these projects, sub-groups of the Bila Muuji membership elect to work together (for example, one grouping, the Bila Muuji 'Upper Sector',¹⁹ works on the social and emotional wellbeing initiative).

Examples of some of these joint projects are provided below.

- **A project to develop resources to meet community need.**
Responding to concern about consumption of methylated spirits in one community, Bila Muuji advocated for the development of resources about the health effects of this activity. This resulted in the Centre for Education and Information on Drugs and Alcohol developing a culturally sensitive training package on this issue (WAMS n.d.b).
- **Organising for predicted changes within the health system and health services.**
Bila Muuji identified that governments were starting to require that organisations be accredited as part of their funding requirements and acted early to ensure that member organisations would be ready if this was to occur for AMSs. Bila Muuji held meetings to discuss what it should do, looked at what was being done in other States, met with accreditation bodies, made a decision about which accreditation program would work best for members, developed a proposal to seek funds for a consultant to develop policies, procedures and organisational plans for accreditation, and organised for member organisations to present the proposal when a senior officer from OATSIH was visiting. The proposal was successful and Bila Muuji members then agreed on the best way for the consultant to work so that all organisations had access to them. Bila Muuji also negotiated for incremental accreditation, which means services can be reviewed in an ongoing structured process against a few standards each year rather than being reviewed against all of the standards once every five years. At least half of the member organisations have achieved or are in the process of achieving Quality Improvement Council (through Quality Management Services) or Australian General Practice Accreditation Limited accreditation. Bourke Aboriginal Health Service and Walgett AMS have also achieved GP Registrar Training Accreditation.
- **Developing systems to support service provision.**
The Bila Muuji Information Technology Project worked on IT and computerised data collection. (Note that in 2000 Bila Muuji members made a decision that they would all use the same Patient Information Reminder and Recall System.)

¹⁹ The 'Upper Sector' includes Bourke Aboriginal Health Service, Orana Haven Aboriginal Corporation, Walgett AMS and Brewarrina Aboriginal Health Service (Perino 2007)

- **Development of collaborative regional approaches to health service delivery and workforce training and development**, such as:
 - The Bila Muuji Social and Emotional Wellbeing Initiative focuses on developing a regional level, culturally sensitive, integrated and coordinated approach to the provision of mental health and wellbeing services across the Bila Muuji 'Upper Sector'. This includes community consultation; reviewing current service provision and identification of gaps; development of a plan; networking social and emotional wellbeing workers²⁰ in four different organisations into a regional team with some common policies and procedures; providing training, support and structured professional supervision to these workers; funding a part-time Regional Counsellor and Regional Psychologist who travel to provide services and support; standardising procedures, processes, systems and documentation (including those related to intake, assessment and referral); and development of links/partnerships with other Aboriginal and non-Aboriginal service providers (including those outside the health sector, such as schools). Some of the predicted outcomes of this work include improved culturally appropriate service provision (including establishing an effective case management structure and improving continuity of care) and improved workforce retention and service planning.²¹
 - The Bila Muuji Indigenous Tobacco Smoking Cessation Project, which aims to develop and implement comprehensive regional evidence-based tobacco control initiative for Aboriginal people.
 - The Bila Muuji Regional Oral Health Approach, which focuses on culturally appropriate prevention and oral health promotion. This includes working with and training both dental and non-dental staff; developing a regional oral health promotion plan; developing protocols for prevention for schools and preschools; and employing an oral health promotion coordinator.²²

Involvement in development of government policy

Bila Muuji provides an important forum for exchange of information with government officers and politicians. This can include briefings from Bila Muuji on issues affecting members or the impact of policies on their communities or briefings from visiting people about new policies. As described above, this also means that Bila Muuji members can discuss policies, form positions, analyse the way government policy is impacting on their communities and advocate for any changes required.

Links with non-member service providers and agencies – including partnership agreements

Bila Muuji has established partnerships and links with a range of non-member service providers and agencies. This includes with the Greater Western Area Health Service, divisions of general practice, universities and other Aboriginal health services. Partnership agreements include:

- the Greater Western Area Health Service (the Greater Western Bila Muuji Aboriginal Health Partnership): this agreement focuses on improvement of Aboriginal health outcomes through a range of agreed actions to be conducted in partnership – these actions relate to consultation, information provision, health policy, planning, services, equity in the allocation of resources, and integration of Aboriginal health into NSW Health policies and their implementation;²³ this partnership meets quarterly and as a network Bila Muuji is able to 'have more clout' by having multiple representatives at the table (one from each of the three AH&MRC regions)
- an MOU with Charles Stuart University for a Student Clinical Placement Program for dental and oral health therapy students
- a grant with the University of Sydney on falls prevention and injury prevention (Upper Sector).

²⁰ These include those working in sexual health, alcohol and other drugs, mental health and in 'Bringing them Home' positions and other workers working alone, such as a medical doctor and a health worker (Perino 2007).

²¹ For more information see Perino 2007.

²² *Bila Muuji Regional Oral Health Approach*, PowerPoint presentation (source and date unknown).

²³ This agreement was signed on Thursday 12 March 2009. For more information see WAMS 2009a. The Agreement was resigned on 18 August 2009 and meetings are held quarterly (see NSW Department of Health 2009 and WAMS 2009b).

Funding and accountability

Member organisations pay an annual fee to Bila Muuji. Organisations with an annual operating budget of under \$1 million pay \$3,000, while those with a budget greater than this pay \$4,000. In addition, all except two organisations bear the full cost of participating in meetings. The two organisations that have to travel significantly further than the others are paid a travel subsidy. As well as this subsidy, fees are used for a range of 'greater good' activities; for example, providing a subsidy for travel for a small number of invited 'special' guests and funding two oral health scholarships with Charles Stuart University.

This means we can do things we wouldn't be able to afford to do as individual organisations.

Where possible Bila Muuji will 'piggy back' on other meetings that members might be attending, such as AH&MRC meetings.

Bila Muuji is primarily accountable to its individual members (that is, to each other) and to the funders of joint projects. There is also accountability through each CEO to the Board of each member organisation, and to the AH&MRC (through the Chair of Bila Muuji, and through AH&MRC attendance at Bila Muuji meetings).

Review of the model

The Bila Muuji model is reviewed indirectly at meetings.

Strengths and advantages of Bila Muuji

The strengths and advantages of Bila Muuji identified by members included:

- that the group was built on good relationships (and this has continued) – there are high levels of trust and respect between members, as well as high levels of professionalism and expertise
- there is a shared understanding of the concept and why it would work and the members have let the model evolve based on the needs of members
- realistic goals and a planned approach to doing things – initially, this meant having short-term goals ('you have to walk before you can run')
- it builds on, and effectively utilises, everyone's skills (for example, in preparing submissions, providing advice and support to each other, working out how to get the best financial advantage)
- there has been a very committed and stable core group that has provided leadership – this includes two of the three women who initiated the establishment of Bila Muuji who are still participating in the group: there is now a structure in place that would facilitate the group continuing if key members left
- it allows sharing of innovations and enables CEOs to see what other services are doing and how they are doing it ('If you're in an organisation you think that normal is what's happening in your agency')
- working together as a group of 10 organisations means that a range of organisations, including government, seek to attend meetings to either brief members or discuss issues – having joint briefings facilitates member organisations receiving information from government and other stakeholders in a timely way and enables discussion of relevant issues among Bila Muuji members and often the development of joint positions on the issue. Having this number of organisations contributing to this work enables Bila Muuji to be seen as an 'equal player' and carry significant weight, something that individual services might not be able to achieve on their own. Through this, Bila Muuji has:
 - gained respect as a regional Aboriginal voice, which has enabled it to be more involved and influential in regional work (such as with the Greater Western Area Health Service)
 - been able to influence government policy and legislation
 - been able to influence procedures of funding bodies (including getting streamlined funding agreements and reporting arrangements)

- that it is cost and time effective – money and time are saved through sharing resources and skills, and joint training and additional resources have been attracted to the region through developing joint projects
- the provision of a single forum for key players to have a face-to-face meeting with services covering a huge geographical area – similarly, it provides a forum for discussion between members about government policies and how they impact on rural and remote communities: as a consequence members consider that they are better than they would otherwise be
- that it demonstrates that the Aboriginal community-controlled model can be successful, and it promotes this
- that it appears to extend the length of tenure of CEOs in member organisations – in the past three years, two CEOs have resigned: CEOs reported a number of instances when they may have resigned if not for the support of other Bila Muuji members

When I started at [this service] I wanted to quit most weeks... but I could talk to someone [another Bila Muuji member] and hear about their [similar] experiences and get moral support and advice.

- services get some protection through sharing information; for example, discussions about salaries of GPs enables organisations to determine what they will pay and protects organisations from ‘rouge’ providers.

Members considered that the value of Bila Muuji was demonstrated by the fact that most members attend most of the meetings, that ‘members have stayed with it’, and that there are a number of organisations that know about Bila Muuji and would like to join.

Challenges/issues/risks

Some of the challenges, issues or risks for Bila Muuji include:

- bimonthly meetings and members with high workloads, means that it can be difficult for Bila Muuji to:
 - o respond as quickly as it would like to information/requests (to the extent possible this is managed through teleconferencing)
 - o follow up on business
 - o maximise its potential for creating change/improvement
- making decisions about membership, including maintaining the model at a workable size, and identifying criteria for who can and can’t join
- increasingly, both State and federal governments want to engage with Bila Muuji or other regional groupings rather than individual organisations – although this provides opportunities for closer engagement with government bodies for member organisations, it also means that there could be less direct engagement with individual agencies and agencies that aren’t involved in regional groupings could be excluded from discussions; However, attending a Bila Muuji meeting might be seen as a ‘quick fix’ for those wanting to consult with the sector
- the move towards governments wanting to engage with regional organisations, combined with the respect Bila Muuji has achieved, might mean that the group could be asked to undertake more and more activities in line with being a regional body – this is likely to require review of the model, its governance, membership and operation, particularly if regional work (1) overlaps with the core business of member organisations, or (2) becomes the location for decision-making that will have an effect on non-member organisations (for example, decisions that affect a whole region).

In summary, Bila Muuji has made significant achievements in both supporting CEOs in their roles of managing the operations of community-controlled health services and in addressing issues common to a number of services. The local knowledge of the CEOs assists in the planning of services for the region, while at the same time providing local contacts to ensure programs delivered in their communities meet the actual need of the clients and their families.



KATHERINE WEST HEALTH BOARD

History and background

The Katherine West Health Board (KWHB) is an Aboriginal Community Controlled Health Service that provides clinical, preventative and public health services to approximately 3300 people living in a region covering 162,000 square kilometres west of Katherine in the Northern Territory. Within this region there are nine major Aboriginal communities; Lajamanu, Kalkaringi, Daguragu, Yarralin, Timber Creek, Bulla, Nijburru, Lingara and Mialuni, as well as a number of outstations (Cox et al. 2009; KWHB 2008; see map below). KWHB also provides services to a significant number of non-Aboriginal people, mostly living on remote cattle stations.

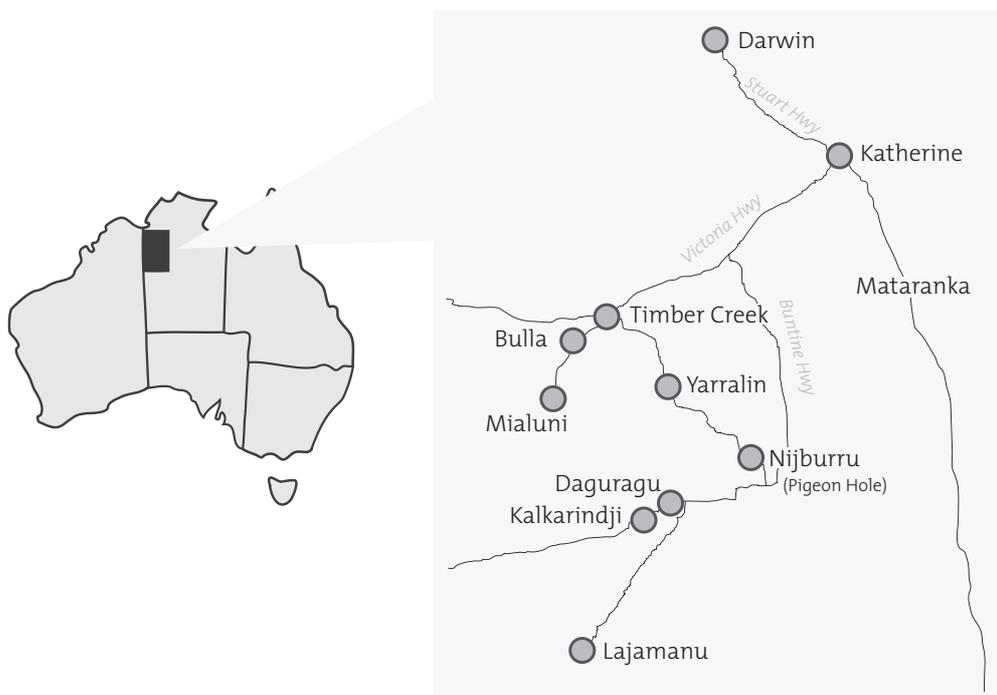


Figure 2: Location of Katherine West Health Board community health centres; Reproduced with permission from Katherine West Health Board

Establishment of the KWHB was proposed and funded in 1996–96 as part of the Katherine West Coordinated Care Trial. An Interim Board was established in 1996 and over the following two years oversaw community consultation, further proposal/model development and health service planning. Governance training was also provided. In 1998 the KWHB was incorporated as a purchasing body and in 1999–2001 it underwent a transition to being the provider, rather than the purchaser, of services.²⁴

Some of the main challenges for provision of corporate functions in organisations like KWHB, which deliver services in different communities in remote locations, include the diversity of communities and their needs, maintaining good communication (and issues with communications technology), differences in management systems between clinics and inconsistent access to decision support tools like organisational policies and procedures (KWHB 2008:30).

²⁴ For further information about the development of the KWHB, see KWHB 2003.

Governance

The organisation is governed by a Board made up of 18 Directors chosen by their communities to represent their interests.²⁵ The Board meets quarterly and there is a Board Executive that also meets regularly. Board meetings go for several days to enable time for proper discussion of issues and decision-making. Board members have governance training and 'money story' training provided by external consultants.²⁶

The Board also has two permanent sub-committees, the Ngumpin Reference Group Sub-Committee and the Non-Indigenous Sub-Committee, and can appoint other sub-committees including non-members when required. The Ngumpin Reference Group includes Directors, the CEO, the Community Development Manager and Senior Aboriginal Health Workers (AHWs). New Board members who have no health experience or background also attend to learn about the general health service delivery context. Its role is to provide specialist guidance on community cultural systems and processes, health programs, staffing issues, service delivery and cultural appropriateness,²⁷ thereby facilitating 'the merging of evidence-based health information with cultural beliefs' (KWHB 2008:16). The Non-Indigenous Sub-Committee represents the interests of the non-Aboriginal people living in the region.²⁸

To support community control of its service, the KWHB also holds annual open meetings in each community to hear about health issues.²⁹ Every third year community members are elected to the KWHB at these meetings.³⁰ As well as communities, these meetings are attended by senior staff of the KWHB (including the CEO) and Board members.

Board members often partner the CEO at meetings to ensure cultural safety. They also attend significant meetings and conferences outside the service; for example, those about aspects of Aboriginal health, health service delivery, health policy and evaluation. This enables Board members to participate in strategic development of initiatives, as well as to develop knowledge about broader issues in the health system.

KWHB is a member of the Aboriginal Medical Services Alliance of the Northern Territory (AMSANT).³¹

Prior to the restructure of local government in the Northern Territory,³² KWHB had a memorandum of understanding (MOU) with the Community Governance Council in each community which covered issues like information sharing, service provision, negotiating arrangements, participation in policy development and service delivery (KWHB 2008). At the time of writing this case study, arrangements for establishing agreements with the larger shires was not yet established. However, inaugural meetings have been facilitated with the Victoria River Daly Shire and the Central Desert Shire and their Chairpersons, CEOs and Senior Management.

25 To become a Director in this way, individuals have to be members of KWHB and the Board must have a majority Aboriginal membership. These Directors can also appoint one male and one female senior Elder advisor, who can come from any of these communities, as well as two specialist non-member Directors (KWHB 2009a). The number of Board members from each community or group of outstations is specified in the KWHB 2009a.

26 More information about this 'training' and its importance is provided in KWHB 2003:66–8, 115, 124–5.

27 This Sub-Committee was established in 2008, is chaired by a Director, and Senior AHW members are appointed by Directors (KWHB 2009a). Membership includes younger and older people, men and women. One of the roles of this sub-committee is to develop an overall cultural safety framework to guide all KWHB operations.

28 The Directors decide the responsibilities and powers of this sub-committee and it is chaired by a Director. Up to four members of this sub-committee can attend Director's meetings when aspects of service delivery relevant to non-Indigenous people are being discussed but they do not have voting rights (KWHB 2009a).

29 These meetings were originally held more than once a year for a single day, but communities requested that they be held annually and go over several days so that there was more time to discuss issues in depth.

30 If possible members are chosen by consensus, but if this is not possible an open election is held in front of community members. All nominations must then be ratified by members at the organisation's Annual General Meeting.

31 AMSANT is the peak body in the Northern Territory for Aboriginal Community Controlled Health Organisations.

32 In this restructure, small community-level local governments (or councils) are being amalgamated into larger 'super shires'. This requires changes to governance arrangements because, rather than having their own councils, communities will now be represented by a small number of individuals on the Shire Boards. These reforms also impact on service delivery because negotiations about who will provide some types of services previously provided by councils, as well as arrangements for use of council infrastructure (such as housing or space for health services), are still occurring.

Principles

The work of KWHB is underpinned by a set of guiding principles outlined in the Rule Book developed by the Board.³³

KWHB Guiding Principles

- That health and wellbeing includes the physical, mental, emotional and spiritual wellbeing of the person and community
- Work as a team – Aboriginal and non-Aboriginal together
- Commitment to our work and doing the best we can
- Promote respect and trust
- Respect for ourselves and others
- Respect for the autonomy of our communities
- Promote and maintain culture
- Good and open communications, talking and listening
- Moving forward carefully, one step at a time
- Look after the head, heart, body and soul of our corporation and members
- We will demonstrate strong leadership (KWHB 2009a).

In relation to the corporate support functions within the service, these principles are reflected in attempts to:

- ensure all activity, including corporate functions, clinical service provision and population health programs are integrated to create a holistic organisation
- achieve quality improvement through implementing a collaborative model³⁴
- carefully plan service expansion, rather than just being reactive to funding opportunities – this planning includes associated development of the corporate functions of the service so that greater integration with service delivery is achieved
- recognise the real skills of staff, including not assuming that staff can stand in for other staff without appropriate training
- develop a structured approach to developing Aboriginal leadership, capacity and employment
- achieve full staffing rather than cutting costs through understaffing
- re-organise the service to have a less hierarchical structure so that those needing support (particularly those working in community health centres) can get it *fairly* directly
- build extensive consultation, participation and communication into ongoing service development structures
- develop structures and systems so that activity is less ad hoc and potentially the support provided and received could be less reliant on individual personalities.

³³ The Rule Book was developed to comply with the *Corporations (Aboriginal and Torres Strait Islander) Act 2006*.

³⁴ A collaborative model refers to a specific method for quality improvement in which participants share information about issues and ideas for addressing them, as well as make a plan of action. Results from the plan of action are reported back and the cycle repeated. For further information, see APCC 2010.

Structure underpinning the model

Integration and incremental, planned development

KWHB works to grow slowly and to consolidate in an incremental way. This means that the organisation does not submit proposals to funding rounds unless it has had the time to consider the implications of, and the best way to implement, new programs.³⁵ When applications are made for additional funding for service provision, the corporate support functions required to support the additional services are also planned. The organisation has refused or returned funds when it has not been able to undertake the relevant planning associated with utilising funds effectively.

KWHB underwent a restructure in 2007–08 and the corporate support functions are now organised around a focus on remote health service delivery.³⁶ Overall, the restructure aimed to increase integration between all aspects of KWHB's functions, including clinical functions (largely provided through seven remote community health centres³⁷ and a mobile team of two nurses), population health programs led from Katherine, and Katherine-based senior staff (including those providing corporate functions such as general management and human resources management). Essentially, the restructure resulted in a less hierarchical organisation with better communication processes and more 'supportive collaborative management and administration systems' (KWHB 2008:30).³⁸

An example of integration is that when changes to population health programs and/or health service provision are developed, consideration is given to the consequences of these for corporate functions (such as administration and management) and infrastructure (for example, accommodation, vehicles). This is done by ensuring those providing key corporate support services are involved in planning any expansion of, or changes to, health programs and health care.

Communication

Central to the way KWHB works (and consequently to the way the corporate functions operate and integrate with the rest of the service's functions) is a commitment to communication and engagement, both between the service and communities and within the service. Investment in communication is considered critical to facilitate service provision and development in an environment where the players have very different world views and knowledge bases; where there has been a lot of change over the past few years; where people speak many different languages; where communities have different needs; and where service provision is multidisciplinary and occurs in multiple locations covering a large geographical area.

A lot of resources have been invested in creating the structure and infrastructure to enable communication and a lot of time is committed to it. When new staff are oriented to the service they are informed about appropriate communication styles and about expectations for *punyu jarrakap* (good talking). This extends to an organisational ethic around joint decision-making; staff understand that they are not to make decisions about the service on their own but must do this in consultation with others.

You don't just go and do something because you know how to do it... you make sure that it's ok and that people understand what is going to happen... it's about getting the mindset that it's not about the bottom line, the dollars, the profit... it's about the development of people as well as getting the work done.

Some of the consequences of this commitment to communication are that:

It's a collaborative talking system... issues get talked around... sometimes for a long time. We don't just have people sitting in an office making decisions based on what they think is right.

35 An example of the consequence of such considerations is that when developing its Healthy for Life Program, KWHB was originally going to employ two nutritionists, but they identified that critical to the success of the program was support for AHWs. As a consequence they employed one nutritionist and one position to support AHWs.

36 The restructure was informed by obtaining funding to participate in Healthy for Life, a program focused around improving service provision and outcomes for Aboriginal and/or Torres Strait Islander people in the areas of chronic disease and child and maternal health (recently men's health has also been included). This program includes systems assessment tools (based on the ABCD project) and provided the service with some of the tools and resources for developing a more integrated approach. For more information, see the Healthy for Life website (www.health.gov.au/healthyforlife).

37 The largest is in a community with approximately 1500 permanent residents; the smallest in a community of 40 (KWHB n.d.).

38 A diagram of the new organisational structure can be found in KWHB 2009b p8.

if there is a problem for a community health service that needs to be resolved quickly it is dealt with immediately and 'not left to fester', even if this means that people from Katherine need to fly into the community at short notice

difficult and 'high-level' information is broken down to 'grass roots level' so that community people can understand and discuss it.

This commitment to communication is built into the structure of the organisation. Formalised mechanisms for communication include:

- quarterly Board meetings (see 'Governance' above) and encouraging Board members to spend time in the service
- yearly open community meetings (see 'Governance' above) – at these meetings the KWHB seeks feedback from communities about what they are doing well, what the challenges are, what isn't working, what needs to be improved: senior management spends a few more days in the community at the same time to make themselves available to community members about any issues that may be concerning them about their health service
- the Ngumpin (Aboriginal) Reference Group, which has an active function in program development and testing of resources – this group was initially established to support the Community Development Manager: workers can bring things to the Reference Group for advice; if the Ngumpin Reference Group does not understand something about a program then it cannot be rolled out
- the Leadership Group, which meets monthly and has representatives from each of the key areas within the organisation (including corporate support), which means that decisions are not based on the input of people from only one discipline; for example, when decisions are being made about increasing service delivery, the corporate support representative will be thinking about how to bring on more accommodation, office space or vehicles

One person might be excited about something because of their expert area, but they will also need to think about it from the perspectives of others.

- weekly 'collaborative' meetings involving population health staff and clinical staff and using web-based technology.

These avenues for communication mean that, generally, issues are identified early and are often dealt with before they become crises.

Quality improvement across the organisation

KWHB applies the lessons it has learned from improving its clinical services to improving its administrative and supportive systems. The service participates in the National Primary Health Care Collaboratives Program,³⁹ which is a program to facilitate quality improvement through a process of issue identification, learning from others, action planning, implementation of small steps to create change and measurement of achievements. By using IT and communications technology, KWHB now runs its own internal collaboratives in which the managers and other staff in each of the community health centres and the Katherine West office can web-conference regularly. These collaboratives link the whole region and all the clinical people together. In addition to having coordinators coming in (to Katherine) once every three months, they now all talk together. every Friday everyone is linked up by webex [the internet] and talking. The corporate staff are very involved and integrated into this system work'.

Use of information technology

KWHB has researched and invested in using IT to help alleviate some of the issues associated with remoteness. Each clinic now has two sources of internet connection; a fast speed cable and a satellite. This means that all community health centres should always have access to the internet.

KWHB participated in AMSANT's intranet pilot project (called AMSNET), which resulted in improved satellite services, including installation of a connectivity monitoring box in each of the clinics that can be accessed from

³⁹ For more information on this initiative see the Australian Primary Care Collaboratives website (www.apcc.org.au). The primary focus of these collaboratives was improving service provision for people with chronic conditions.

Sydney. This means that clinic staff do not have to spend time trying to sort out internet issues. Participating in the AMSNET project also resulted in KWHB improving its intranet architecture⁴⁰ and identifying the need for a professional Information and Communication Officer (a position then created as part of the 2008–09 restructure). KWHB now has an intranet accessible to all staff, including those in remote locations, which includes the most up-to-date version of each policy, procedure, forms etc. This means there are not multiple versions of forms ‘floating around’. The intranet also provides a ‘newsfeed’:

every few days there is a new photo; staff coming and going, who got engaged, whose son did well in the footy, updates on work practices. This helps link everyone in the region.

It also means that everyone within the service has access to the same information. The intranet also has orientation resources, a staff calendar, regional maps and information, information on each community, SDRF plans and annual reports.

An example of how the lessons from developing clinical services have been applied to developing corporate systems is that successful implementation of an electronic patient information and recall system has led to work on developing ways to use IT more effectively for other kinds of organisational systems such as human resources management, assets management and finance systems. Again, the principle of integration has been important and, where advantageous, electronic systems have been developed so that there are interfaces between them; for example, between human resources management systems and finance systems.

Generally, when introducing electronic systems KWHB has a transitional period in which paper-based forms are still used and staff are encouraged to start using the electronic system.

Capacity building

KWHB builds capacity in a number of ways, three of which are particularly pertinent to corporate functioning. These include Aboriginal employment, staff support and training, and capacity for change.

KWHB has a commitment to supporting Aboriginal employment, including in the corporate support functions of its service. Strategies for this include:

- having entry-level positions where people are mentored on the job (for example, receptionist positions)
- building training and mentoring into the role of those providing corporate support (whether they are employees of the service or contractors) – this includes functions such as human resources, general manager and finance
- planning ways of enabling people working in communities to develop broader skills; for example, by bringing community-based administrative staff into the Katherine office for short periods.

Capacity building also occurs across the organisation for all staff. For example, the General Manager has access to an industrial relations consultant for advice but also to enable them to develop skills in this area. In the Leadership Group the organisation’s finances are gone through so that all members develop an understanding of how the finances work and can take more responsibility in this area. Similarly, an in-house Finance Officer works with an external Consultant Accountant. One staff member indicated the importance of the roles of external consultants with specific expertise:

it’s like a nurse telling you how to do some stuff, but you still wouldn’t be able to practice as a nurse.

Similarly, there is support for new corporate support staff coming from outside Katherine and who haven’t worked in community-controlled primary health care services before and have a big learning curve. Staff at KWHB considered:

that it can take up to two years before you ‘get’ stuff... develop a bit of an understanding about what is going on here... the view of the world is very different.

⁴⁰ Prior to 2008/09 the intranet was only available to staff in the Katherine office.

New staff members have extensive orientation and also opportunities to participate in meetings and activities in communities; sometimes this will include roles like note-taking at Systems Assessment Tool workshops, so they are drawn into community health centres.

Often when new systems are introduced there might only be partial uptake or only use of certain functions. When this occurs the responsible manager will work out what is stopping people from using it and what work practices need to be changed to enable people to use it as part of their everyday activity.

Challenges for capacity building include difficulties around recruiting and retaining skilled staff and the subsequent demands on whoever is employed at the time to pick up the work:

Multi-tasking isn't a good way to go because all jobs have become more specialised, so people can't just cover for others. This is unfair and doesn't pay due respect to the skill area. This means that to do proper internal capacity building you might need more staff positions. Katherine West has been good at grouping people so that they can gain skills. However, many organisations have to have people doing multiple tasks as they just can't employ people. It can also be difficult to retain corporate support staff in a central office location if they come from communities.

Ongoing review

There is ongoing review of the corporate support systems to work out what is not working and why and addressing problems. Every time a position becomes vacant there is a 'mini review' of the role to identify if it needs to be adjusted (and whether other roles 'around it' also need to be adjusted). Sometimes it is not possible to recruit people who have all the skills required (or that the previous incumbent had) and in this case there is consideration as to how the corporate support team might adapt to ensure all aspects of the role are covered as well as to support the new team member. In the case of senior roles, the General Manager might need to work with the team for a considerable time while it re-adjusts to the new arrangements.

Process for developing supportive systems

Prior to 2008–09 corporate support was provided by a corporate support unit with a manager and a number of staff. There were a number of issues that needed to be addressed. These included:

- the original unit had been established in the early days of the service and as a result many of the systems had been in place for about 10 years and weren't necessarily meeting contemporary needs; for example, much information was kept in paper files and was difficult to access
 - There was still the old thinking of people having custody of information, an old paper based thing, where individuals had to protect it and keep it private.
- the service did not have some of the skill sets now required – this highlighted the need for continual training and updating of skills: in summary the systems and skills did not adequately match the requirements
- reporting requirements demanded by funding bodies had increased and there was a need to develop better systems to enable collection of the evidence required (as well as the need to have people to 'drive' the systems)
- the Corporate Support Unit (as well as other parts of the service) had become 'silo-ed' and there was often poor communication between different areas of the service
- the support provided tended to be prioritised and determined by the Corporate Support Unit and sometimes people working in remote clinics would have difficulty getting the support they needed.

The process for informing the restructure of corporate functions included:

- mapping all of KWHB's non-primary health Care functions and consulting staff in both the town and remote locations about their requirements (for example, what wasn't working very well, what was needed, when it was needed, who/what kind of person was required to do the task, where they needed to be located and who needed to be able to communicate directly with them)

- investigating innovations in information and communications technology
- reviewing the corporate support functions of the organisation to make sure workloads were reasonable, systems were as efficient as possible, duplication was not occurring, decision-making was streamlined and communication was improved.

Through this work it was identified that there were areas where specialisation was required and that some positions would need to be modified while others would need to be created. In particular, improved capacity in human resources, assets management, compliance and reporting and administrative support was required. This included needing to spread access to these functions evenly throughout the service (KWHB 2008).

Support provided

Support provided internally

Post-restructure, the permanent corporate support positions include Business Operations Manager, Finance Officer, Policy Planning Coordinator, Information and Communication Officer, Human Resources Manager, Health Centre Staffing Coordinator (and a human resources administration support officer from August 2009 onwards), administrative staff (for example, Personal Assistant to the CEO, reception staff, Health Programs Administration Support Officer), Health Operations Administrator (who deals with logistics such as moving people in and out of remote locations, coordinating accommodation and travel, and coordinating visiting specialists), Assets Administration Officer, Driver/Storeperson/Handyperson, and a Community Development Manager (who is also responsible for cultural safety).⁴¹

During the restructure it was identified that those working in remote health services wanted to be able to directly contact the person in the Katherine office who would deal with their request, and a system to enable this has been developed. There are now two pathways for people working in community health centres to access support internally; either to directly contact the person in the Katherine office responsible for the relevant area, or to go to their community health centre manager, who will identify the appropriate course of action (and possibly then go directly to the relevant person in the Katherine office).

There are no (apparent) organisational barriers to remote staff having direct contact with the relevant officer in the Katherine office. However, sometimes direct contact does not occur when corporate office staff members are new and have not yet developed relationships with those working remotely, or when remote staff do not know who to contact in Katherine (both of these issues are exacerbated by high levels of staff turnover). In these cases, remote workers will often contact other workers in the Katherine office who may be able to assist (even though it is not their role to do so) but this can result in them becoming overburdened. The appointment of a Health Operations Administrator was designed to provide a one-stop-shop for all remote staff so that they do not have to go around a circuit of different staff members for different issues. This has had varying success, depending on the skills and experience of the person in the Health Operations Administrator role.

There are also now mechanisms in place for those working remotely or as a consultant to the service to remotely access the relevant organisational systems (for example, the consultant accountant and the payroll consultant can dial into the accounting and payroll information systems) (KWHB 2009b).

Another key aspect of the work of corporate support at KWHB is to meet professional standards with cultural appropriateness. So while corporate support might be ‘the backbone... [and] very rigid’ with respect to providing the services that allow the organisation to function effectively, many of these services are provided in a way that is acceptable to communities. For example, although KWHB has to have police checks done for employees, the process for introducing these to potential staff members from communities can be ‘done differently’ to how it might be done in a mainstream organisation.

Corporate support staff considered that their role was:

supporting and enabling people who need to be providing the care with all the tools. 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.

⁴¹ From Staff List by Month, July to December 2008.

At the end of the day the people delivering the service on the ground... their passion is delivering it... the more seamlessly you can deliver the back end the more effectively they can deliver the service.

When people in the corporate support area take leave, they identify what aspects of the roles needs to be addressed while they are away and then identify who is needed to do that work. KWHB has also hired a relief CEO for a period to enable the CEO to go on leave. The relief CEO came into the organisation two weeks prior to the CEO going on leave and also stayed for a few days after the CEO returned for a short hand-over.

External support

While interviewees considered that it would be ideal to have all corporate support functions provided by an employee of KWHB (because he/she would understand the culture, principles and operation of the service), external support was sought in areas where specialist skills were required and:

- people with the right skill sets are not available locally, or
- the demand for the support is limited (and therefore employing someone internally would not be cost-effective), or
- there is a skilled provider in the town who works with a number of services, or
- where staff turnover (or the risk of it) would create significant problems for the service.

The areas where external support is sought include industrial relations issues, legal advice, IT and accounting. In most cases there is one person within KWHB who is the primary contact/liason person with each consultant. However, in relation to IT, where it is integrated into all systems in the organisation, a number of people will interact with the support provider.

Some of the systems that have now been developed include coordination of visiting specialists by staff with this dedicated function; previously this was done by the coordinator in each community health centre.

Community health centres in crisis

Although KWHB has seven remote health centres, supporting them is different from other organisations (such as Central Australian Aboriginal Congress) that may auspice a similar number of independent or semi-independent services. When a crisis occurs in KWHB remote services, KWHB staff can respond quickly. This can include senior staff members from other parts of the service being flown in within a day, or resources from other community health centres being provided on a short-term basis (this might include experienced staff or assets such as vehicles).

Funding and accountability

The model is funded through a 20 per cent administration fee being included in all budgets. This includes the organisation's core funding from OATSIH.

Planning, review and evaluation

OATSIH-funded services have to report twice yearly against a SDRF. They also have to provide Service Activity Reports once a year. The process for completing the SDRF includes developing an organisational action plan each year, then reporting progress against the plan twice a year. KWHB has chosen to integrate the plans and reports for a number of different funding programs into one combined organisational plan. KWHB uses this as its operational plan, but also as a quality improvement tool/planning process.

Through participating in Healthy for Life, KWHB has also introduced the use of a Systems Assessment Tool, which includes looking at how all the different aspects of each of the community health centres are working or integrating.⁴² This assessment has a key set of questions that are worked through in a day and this information is then used to identify where systems are not working. The tool has been found to:

⁴² These indicators are generally process indicators – for example, indicators of whether something has been done, or how many of them have been done. There are some indicators of effect/ impact – for example, those pertaining to staff retention.

be a useful tool in getting an idea of how things are functioning and it tends to highlight issues you can generalise throughout the health centres.

When common issues are identified across different sites, addressing them can be included in the yearly strategic planning process.

Through having these types of processes, along with the mechanisms for communication, most problems are identified before they become major issues.

Through the SDRF, KWHB reports on a number of mandatory indicators, as well as a number of self-nominated ones twice yearly.⁴³ Domains in which indicators exist include:

- health services with indicator topics relating to both clinical services and health promotion and prevention programs
- management with indicator topics related to organisational leadership and governance, business and finance, assets and infrastructure, community development and cultural safety, human resources, information and communications, quality improvement
- linkages and coordination which is the indicator topic
- community involvement (including feedback and accountability), which is the indicator topic.

Some of the indicators are about various tasks being completed, 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 etc. There are also quantitative indicators relating to corporate functioning; for example:⁴⁴

- number of hours where (IT) network is down by month by locality
- percentage of recruitment panels with a Board member involved
- number and proportion of permanent Ngumpin (Aboriginal) employees x full time equivalent
- number of AHWs supported in formal study to advance to next level
- 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 utilising KWHB professional development subsidy during reporting period x position type
- amount of overtime expenditure as a percentage of overall salary expenditure x location
- number of exit interviews conducted as a proportion of permanent staff leaving service
- proportion of remote staff employed by KWHB 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
- frequency of collaboratives x program area x topic
- (Board) meetings held and achieve quorum

⁴³ The adapted assessment tool includes incorporation of Aboriginal language.

⁴⁴ All of these indicators except one have been developed by KWHB. The indicator pertaining to overtime expenditure as a percentage of overall salary expenditure x location is a mandatory indicator to be reported to OATSIH.

- list of community meetings x type x location
- plain language minutes produced and circulated to community members.

These indicators are reported to funders and to the Board and staff twice yearly. They are also used to look for trends and gaps.

KWHB also does the OATSIH Risk Assessment once every two years. This was considered a useful tool, particularly in helping the organisation work out what critical information and decision support tools it needs to collect.

Feedback from the community, via community meetings, the Board, AHWs and the Ngumpin Reference Group are also part of the way the service reviews its function.

The organisation has gone from working blindly to going through a period of time where we have worked hard at getting systems in place and we are now at the stage where we can analyse data and compare our work with others.

Community health centre staff reported finding out about how well they were doing through feedback from community consultation, Board members in the community, surveys and audits. A further indicator for some managers was that their staff did not have to raise the same issues multiple times.

Strengths and advantages

Strengths and advantages of the model were identified by informants. These included:

- more streamlined workflows through having integrated information management systems
- increased efficiency in getting critical tasks done (for example, repair of medical equipment now occurs much more quickly than before)
- more directly accessible and up-to-date information
- improved communication and relationships between different parts of the organisation (including between the ‘town and the bush’)
- more consistency across sites (and therefore more likelihood of getting visiting professionals to integrate with the KWHB system)
- less frustration among staff, particularly about getting small tasks done.

Some informants considered that having good corporate support systems in place meant that new programs could be bought on without the level of stress among corporate staff as has previously been the case.

If the systems hadn’t started changing there would be more crisis and stress on corporate support.

Some staff at KWHB thought that the capacity of the organisation to cope with unexpected and additional ‘burdens’ placed on the service was an indicator of the strength of the model (‘the system gives better crisis endurance’). An example of this was that when the Commonwealth Government’s Northern Territory ‘Intervention’ was implemented ‘suddenly and without careful planning’ (KWHB 2008:19), significant stress was put on existing organisations because there were large numbers of visiting health professionals implementing child health checks (in the first phase) and following up these checks (in the second phase). Consequences of this included that work was being done in communities without integration with the local health services, there were varying levels of cultural competencies among those professionals coming into communities, and significant strain was put on existing infrastructure (for example, accommodation, vehicles, medical equipment), management and administration (particularly as the short-term nature of the first phase of the intervention meant that additional administrative staff could not be employed). Those responsible for human resources experienced high workloads due to the numbers of visiting professionals. In addition to being able to cope with this added workload, the service was able to negotiate for some of the work in the second (follow-up) phase to be integrated into its existing service provision model.

We were able to deal with the intervention... dealt with it and got over it quite quickly... whereas other services are still reeling from the impact.

Since the 2008–09 restructure, corporate services personnel have reported that staff seem to be happier and more satisfied and there is now 'a really positive, happy work environment'. It was noted that people had a better understanding of the different roles and respect for the expertise required for each. There has also been a measurable effect on staff retention, both in the Katherine office and in the community health centres. Data collected against the workforce indicators outlined above indicate that from the December 2007 to June 2008 reporting periods staff incumbency (averaged over the reporting period and encompassing all positions) rose from 58 per cent to 87 per cent. In the June 2009 reporting period this level had been almost maintained and was 85 per cent. Twenty-eight per cent of permanent positions in both periods were held by Indigenous people.

It's positive in that things are working better and it is effective... it is a change that has moved the systems into something that is closer to an Aboriginal world view and by doing this it has made it better. For example, communication and relationships are very important and the system is enabling us to do this better and to value-add at the same time... it's not just token.

Community health centre staff also considered that support was better than it was two years previously and that things were being done differently and in a more structured and systematic way. There was also a 'change in mindset' and 'a genuine desire to be moving forward and improving systems'.

When asked about whether the model had led to efficiencies, staff suggested that although they were 'not sure if it equates to savings we are definitely doing things better'. They also considered that doing things better might have an influence on clinical outcomes, particularly in the case of quick repair of medical equipment and improved patient information reminder and recall systems. In relation to the latter, good processes for data collection and use has meant that the service can now report on process and clinical indicators and compare its performance over different reporting periods and with other services.

Overall, corporate support staff were proud of their model. They considered that because there were enough people in the organisation who understood how it worked and supported it, the systems were somewhat protected from new people coming in and changing them for arbitrary reasons.

Challenges/issues/risks

Various challenges were identified by KWHB staff, including that staff need to be flexible and do what has to be done and that it can be difficult to focus on developing good systems when everyone in the organisation is already extremely busy carrying out their 'day-to-day business'. Related to this was the high staff turnover (which can create high workloads for corporate support staff) and the reporting burden:

there is a bit of tension between the things we are obliged to do for outside parties such as getting audits done or producing x, y or z report... this takes time away from continually working on the systems and in doing things like reporting back to communities... when the focus is on producing reports in complex bureaucratic language we don't always have time to put it in simple language for communities.

Similarly, there is a tension between:

building the capacity of people to provide the service versus just providing service... there needs to be a balance... don't want to tip it too much one way or the other.

The community health centres operate (or are on call) at all times, and the Katherine office is open in business hours. This can cause difficulties for remote staff and also makes it difficult for remote staff to 'come to town for team bonding' because there needs to be people on the ground throughout the region at all times.

KWHB would like to have more administrative functions in each community health centre. Generally, the only administrative staff in these centres are the reception staff, with most other administrative functions being provided by clinical staff or the team in Katherine. This means that clinical staff 'might do more admin and cleaning than they expect when they arrive'. The service is trialling a full-time, non-on-call health centre coordinator in one of its larger communities. The organisation also wants to limit the number of non-local staff

living in communities. The level of new infrastructure required to support these functions means that many of them have to be provided from Katherine.

Funding was an ongoing issue, with one staff member noting that ‘there is no way [running a full service] could be done on current budgets’.

KWHB staff emphasised the importance of relationship building, and even when good systems are developed they often do not function effectively in the absence of such relationships. This was illustrated by the following comments:

The glue is the relationships. This is the key. If you don't have relationships things don't work.

You can create a new position – and even when you explain it to employees out bush – they won't know the person so they won't go to that person – they'll go to other people they know and those people will become overburdened.

No matter how much you think about a process, work out a role and get people in to do it, the relationship stuff is still important... I'm not meant to say this because people are meant to be professional.

Another thing is that we're meant to have constructive models, but we really do have to construct them around the skills of the people we have... to say this is also seen as unprofessional. We're about to lose [a very skilled manager] and it is unlikely we will be able to get another manager that does the breadth of things that [she/he] does, so we need to look at our model and say, how are we going to do here? This might mean splitting the role [and locating part of it with someone else].

There was concern about some proposals to centralise corporate support for the three community-controlled services based in Katherine because it was considered important for each service to be able to ‘stylise [their support] to what best supports them’. Given the importance of relationships, it was also considered important that the human resources manager was well known in the service so that people were comfortable to contact him/her directly to address issues early.

Succession planning (for Board members and senior staff) is difficult. For Board members, the organisation is trying to do this through having the Ngumpin Reference Group.

For clinics there are still a range of issues related to working in remote locations, such as dealing with visiting staff, infrastructure etc.

Although the service is developing ways to streamline orientation (including through the development of ‘self-serve’ orientation resources on the staff intranet), there can be orientation ‘burnout’ for both staff and communities who have to continually orient new staff.

In relation to corporate support functions, there are some ongoing issues for community health centres with communication, decision-making and exchange between, and understanding of, the local and ‘global’ levels. Some of these concern issues of employment of (short-term) agency staff, numbers of clinical staff visiting at the same time, delegations for some purchases, clinic budgets and that the systems development is not yet fully embedded so there is still quite a lot of dependence on the individuals in particular jobs.

Sometimes we just get the momentum and someone leaves.

Enablers/lessons

Various enablers were identified by informants. These included:

- leadership and the quality of the leaders – in particular, it was considered that the leaders have been people who would listen to other people and ‘thinkers about what was happening and why’: they had also valued the corporate (behind the scenes) aspects of the service and were committed to community control, which meant they understood that sometimes things need to be done differently to a mainstream service:

[They] have to be constantly talking... if you didn't have the right leadership as a community controlled organisation you could easily turn into a Department of Health and Families (DHF) style of service provision because in some ways it is easier and most people have worked in government services, and the outside world works like that so it takes energy to buck against this.

- the history of the service has shown people that it was possible to develop good services, 'get them strong' and then build on them:

At the beginning Marion⁴⁵ and the Board members wouldn't rush through things, they got the building blocks in place before they'd move forward... they had a lot of pressure to do things more quickly. This legacy of planning everything, not taking on things you can't manage, making sure the community knows about everything... knowing the history makes you more committed to working like that.

- that the organisation does not take on 'random projects' to increase service delivery and only accepts money for things it knows it can 'support and nurture'
- ensuring there is a good mix of people and skills and that everyone is heading in the same direction
- recognition that all roles are important:
 - corporate support, or finance, or reception is not second class and is just as important to the whole service as everyone else.
- the networks that staff have with others, which assists the service to learn from others
- constant review of support functions and addressing the problems.

Key lessons included:

- recruitment can be difficult and take a long time but that it is important to go through a thorough process and get the right people in the right roles and not to make decisions out of desperation – good support for new employees, as well as good orientation to the organisation, is also critical
- TALK!
- make the time and listen to communities and make time to adjust to new ways of thinking:
 - community sits at the top... sometimes people find this hard to adjust to... as a professional you're [used to being] central.
- don't expect it to be easy
- there are no tick boxes
- shape the model to meet the needs of the service:
 - Maybe your model might not look like theirs [another service's model]... look at the support that you need and shape the model to fit that.
- be realistic about the capacity of an organisation
- take calculated risks based on focusing on the outcome that the risk will achieve – being calculating about risk means assessing the risk and involving many people in making the decision so that the risk is shared:
 - We have taken a risk and been a bit burnt but on reflection have solved problems along the way so have a much more robust system... if we hadn't taken the risks along the way we wouldn't be where we are.
- spend time thinking about what might be coming up next.

⁴⁵ Marion Scrimgeour was the first CEO of the KWBH. More information about the history of establishing the organisation, including Marion's role in this, can be found in KWHB 2003.



CENTRAL AUSTRALIAN ABORIGINAL CONGRESS: AUSPICING REMOTE ABORIGINAL PRIMARY HEALTH CARE SERVICES IN CENTRAL AUSTRALIA

Introduction

The Central Australian Aboriginal Congress (CAAC or Congress) was established in 1973.⁴⁶ Congress provides a wide range of primary health care services including a medical clinic and onsite pharmacy, a range of community health programs, a women's health, pregnancy care and well birthing service (Congress Alukura), a male health service (Ingkintja), a social and emotional wellbeing service including youth outreach, an alcohol treatment program and family support service, and a childcare centre, as well as public health and political advocacy, health promotion and an AHW training program (CAAC n.d.b). By 2010 CAAC was providing 71,694 episodes of care to 8800 clients a year (this included approximately 2200 'visiting' clients) (CAAC 2008).

The main goals or aspirations as described by CAAC are:

1. To be the leading Primary Health Care provider for Aboriginal people in Australia.
2. To improve the health of our community.
3. To provide the highest quality services to our community.
4. To assist communities that wish to establish their own community controlled health service.
5. To remain a community controlled organisation.
6. To provide opportunities for Aboriginal people to train in all areas relevant to Congress.
7. To maintain self-determination.
8. To secure the financial resources to continue Cabinet's Dreaming.
9. To expand the services offered by Congress consistent with community needs (CAAC n.d.c).

The history of auspicings other services

Part of the CAAC Charter from its beginning was to play a role in assisting communities to develop their own community-controlled services, and in 1977 Congress had an auspicings arrangement with Utopia Angarappa Health Service while it was being established, and Papunya Community approached Congress about running its hospital and medical service (CAAC n.d.d). About six years ago the role of CAAC in auspicings smaller services was intensified and in 2009 six services covering nine communities within a five hundred kilometre radius from Alice Springs were in auspicings arrangements (three of these arrangements commenced in 2009).

⁴⁶ For more information about the history of Congress, see CAAC n.d.a.

The context in which this has occurred is one in which the Northern Territory is moving towards establishing regionalised ACCHSs⁴⁷ and where formerly government-run clinics are being transitioned to community-controlled services.⁴⁸ Reform of local government, with movement from local community-based councils to larger shires, has also recently been occurring,⁴⁹ as has the Commonwealth Government's Northern Territory 'Intervention'.⁵⁰ In some of the communities around Alice Springs there are both government and community-controlled services operating as dual providers and this has created added complexity.

Further contextual issues are associated with the circumstances of each community, the history of services in that community, and the history of the relationship between existing services, the community and CAAC. Some services in remote communities have experienced difficulties or been in administration prior to entering auspicing arrangements.⁵¹

Governance

Congress is an ACCHS. It has a Cabinet (Board) consisting of 11 members elected from local communities and two additional members who are native title holders nominated by Lhere Artepe, the Alice Springs native title holders' body corporate.

Auspiced organisations have their own Boards elected from their local communities and are incorporated organisations in their own right. However, none of these organisations currently hold their own funds and Congress does this on their behalf, as well as providing their services. Those services covering more than one community generally have representatives from the different communities on their Boards. The role of Congress can be defined as being the fund-holder and service provider.

CAAC holds the contract for the funds for each auspiced service and is therefore liable against these. CAAC works with the Board of each auspiced service to ensure that the Board has a significant role in governing its community's health service. However, there are potential tensions in this relationship because as the legally liable entity Congress has occasionally over-ridden a community Board where the administrative practices are not consistent with legal obligations. These situations are challenging and require the need to ensure that health Boards are consulted and listened to, on the one hand, and, on the other hand, are fully aware of their legal obligations in making decisions and the limits these obligations place on some decisions.

CAAC is a founding member of the AMSANT.⁵²

47 One of the drivers of the development of regionalised services is recognition that small services in remote communities may not be able to have sufficient economies of scale to be able to deliver all of the core services as well as the necessary support services. In order to achieve this reform, appropriate health service delivery areas (HSDAs), formerly known as health zones under the Primary Health Care Access Program (PHCAP), have been identified (currently the thinking is that these HSDAs should include approximately 3000 people), communities will need to negotiate about which other communities they want to work with and structures will need to be put in place for creating regionalised services to work across HSDAs with pooled funds. There is also a debate about where both clinical and support services should fit within the new structures – for example, should some services be provided from major centres for a number of HSDAs, what support services need to be located within regionalised services and what needs to be located in communities? Progress towards regionalisation has been much slower than expected. (Source: case study interviewee.)

48 Both regionalisation and the transition of government services to community-controlled services are being led through the Northern Territory Aboriginal Health Forum, a partnership between the Northern Territory Government, AMSANT and OATSIH.

49 One of the consequences of this is that councils, which did not always have health expertise, are no longer responsible for managing health services. However, this has also meant that in some cases much of the infrastructure (such as buildings) previously allocated to health services is now being allocated by shires to other uses.

50 One of the consequences of the Intervention has been changes to leasing arrangements, which has increased the difficulty associated with obtaining housing infrastructure. (Source: case study interviewee.)

51 Two of the services had been under administration prior to entering into an auspicing arrangement with CAAC.

52 AMSANT has done significant work investigating corporate support needs and potential models for provision of support for its members. It also provides some corporate support services.

Principles

The main principle behind auspicing remote health services in communities in Central Australia is to support the establishment, development and/or maintenance of community-controlled services.

Structure

Congress has grown rapidly over the past five years from having 129 to 300 staff members. The budget for the organisation has also grown significantly.

CAAC is organised into 10 Branches.⁵³ These are:

- Directorate (which includes the Director and Deputy Director, and key officers for public health, sexual health, health policy and systems, systems enhancement, data integrity, quality enhancement, and research)
- Services (general services)
- Corporate Services
- Headspace
- Ingkintja (Male Health)
- Alukura (Women's Health and Birthing Services)
- Social and Emotional Wellbeing
- Remote Health
- Childcare
- Education and training.

The Branches most relevant to provision of corporate support to auspiced services are the Directorate, Remote Health and Corporate Services. (Please note that in this case study, 'Remote Health Branch' is used to refer to the Branch whose headquarters are located in Alice Springs, and 'remote health services' is used to refer to the services located in remote communities that are auspiced by CAAC and that are part of the Remote Health Branch.)

The Directorate has overall responsibility for the management of CAAC. All Branch Managers report to the Deputy Director except for the Remote Health Services Branch Manager, who reports to the Director, who is located in the Directorate. Sign off for most major requests, such as human resources or purchases over a certain value, must be signed off by the Directorate.

Auspiced services are part of the Remote Health Branch. This Branch has a Manager and a small number of staff based in Alice Springs. These staff members include an Operations Manager, an Administration Officer, a Receptionist and two Regional Program Coordinators (for eye health and allied health), as well as a diabetes educator, a nutritionist, a podiatrist, and two alcohol and other drugs workers. It has recently been funded to employ two Quality Enhancement Nurses to assist all the auspiced remote health services and other existing ACCHSs. The Branch engages short-term positions for specific tasks (such as nurses with expertise in continuous quality improvement) to assist with accreditation across services. The six auspiced services and their staff also form part of this Branch. They include Utju, Amoonguna, Ltyentye Apurte, WYN (Willowra, Yuendumu, Nyrripi), Mutitjulu and WAHAC (Western Aranda Health Aboriginal Corporation). Each auspiced service has a service manager and a number of other staff members. In total the Remote Health Branch has approximately 90 staff members, which is about a third of the CAAC staff.

⁵³ CAAC Organisational Chart (provided by CAAC in September 2009).

The Corporate Services Branch provides support to both CAAC and to auspiced services. Twenty-six staff members provide services in the areas of finance, human resources, assets management, IT, records management, corporate communications and general administration (for more details see Table 2 at the end of this case study) (CAAC n.d.f). Corporate Services also provides training across the organisation in aspects of corporate functioning (for example, privacy, records management systems etc). Due to the increase in the number of services being auspiced, this Branch has employed an additional four staff members in the areas of IT, human resources and assets management. While most of the staff in the Corporate Services Branch work across the organisation (including with auspiced services), there is one IT position dedicated to working with remote health services. The Corporate Services Branch also employs consultants in some instances – for example, to conduct work on the patient information recall and reminder system (Communicare). It also employs experts for high-level advice when needed – for example, legal advice for complex matters.

There are six-weekly Branch Manager meetings and a three-weekly Health Services Executive, which comprises Health Service Delivery Branches (Services, Alukura, Ingkintja, and Social and Emotional Wellbeing), the Director, Deputy Director and Public Health Medical Officer. There are also bimonthly general staff meetings.

When CAAC takes on the auspice for a remote health service, the Corporate Support Branch works with the manager to ‘identify what needs to be done’ (in many cases, the manager and some of the staff will have left the remote health service and a new one needs to be appointed).

Support provided

While many of the remote health services are not large enough to have their own specialist corporate services staff, they do undertake some aspects of corporate functions themselves. This is particularly the case for the remote health service managers. This might include aspects of budgeting, ordering and human resources management. Remote health services can develop their own policies, although these then have to be approved by CAAC. Sometimes services use templates provided by other organisations (for example, AMSANT) to do this.

The Remote Health Branch has three main (inter-related) roles in relation to supporting the corporate functions of auspice services.

- 1. To deal with certain aspects of corporate functioning related to remote health services.**
CAAC operates under the *Northern Territory of Australia Associations Act 2005*, while remote health services generally report to the Office of the Registrar of Indigenous Corporations under the *Corporations (Aboriginal and Torres Strait Islander) Act 2006* (CATSI Act). Corporate Services ‘look after Congress as a legal entity’, while the Remote Health Branch Manager does this for remote health services.
- 2. To provide direct support to managers of remote health services.**
The Remote Health Branch can provide some types of support directly to remote health services. For example, the Remote Health Branch Manager can provide direct one-on-one support to remote health service managers, particularly when they are new in the service. To be effective, it is important that the Remote Health Manager can respond to issues quickly. The Remote Health Branch’s Operational Manager has overall responsibility for remote health service budgets, so might also work quite closely with remote health service managers on these. The Remote Health Branch also has a role in advocating for the support needs of remote health services and identifying ‘innovative ways of funding’ these needs.
- 3. To be the interface between CAAC and remote health services and facilitate support from CAAC (particularly the Corporate Services Branch) to remote health services.**
Most of the support provided to remote health services has a ‘degree of tripartite-ness’ – that is, it involves the remote health services and Remote Health Branch, the Directorate/Public Health Branch, and the Corporate Services Branch – and each will have a different role depending on the issue. Generally, the Remote Health Branch Manager is the ‘nexus between the needs of the remote health services and corporate services and directorate and public health’. Staff of the Corporate Services Branch (aside from the IT professional employed to work directly with remote health services) generally do not have direct contact with staff from remote health services, unless this is facilitated through the Remote Health Branch Manager.

The Remote Health Branch Manager advocates for remote health services when policies and procedures are not working well for the remote services or in the development of new (corporate function-related) policies and procedures (for example, the recent Enterprise Bargaining Agreement).

Put most simply, generally the process for getting corporate support is as follows.

- The remote health service identifies what it needs. There are at least three kinds of need – one is for the regular corporate functions (such as assistance with human resources management, IT or finance issues); one is if there is a need for additional resources (such as a new staff member or an asset like a vehicle); and one is for assistance with the planning and evaluation of current services and continuous quality improvement.
 - o For support for the regular corporate functions, the process is that the remote service manager contacts the Remote Health Branch Manager or Operations Manager and these staff then liaise with Corporate Services to get the support required.
 - o For requests for additional resources, the Remote Health Branch asks the remote service to identify the reasons they need the additional resources (or the gaps the resources will address) and then considers whether the request is appropriate in the context of the broader needs of all the remote health services. If the request is appropriate, the Remote Health Branch will either approve the expenditure (which it can do for small amounts) or work on developing the case for obtaining the additional resources, and then submits this to the Corporate Services Branch. Then, again depending on the size of the request, this can be either signed off by Corporate Services or, if necessary, sent to the Directorate for sign off. Then the documentation is returned to Corporate Services to action in collaboration with the Remote Health Services Branch.
 - o There is a three-weekly Remote Health Services management meeting between the Director, the Deputy Director, the Public Health Medical Officer and the Remote Services Manager, which enables the development of programs and services to be discussed along with other issues that the Manager wants advice and support on. The focus of these meetings is on quality improvement and health policy issues.

Figure 3 provides an overview of the process for obtaining support for many functions.

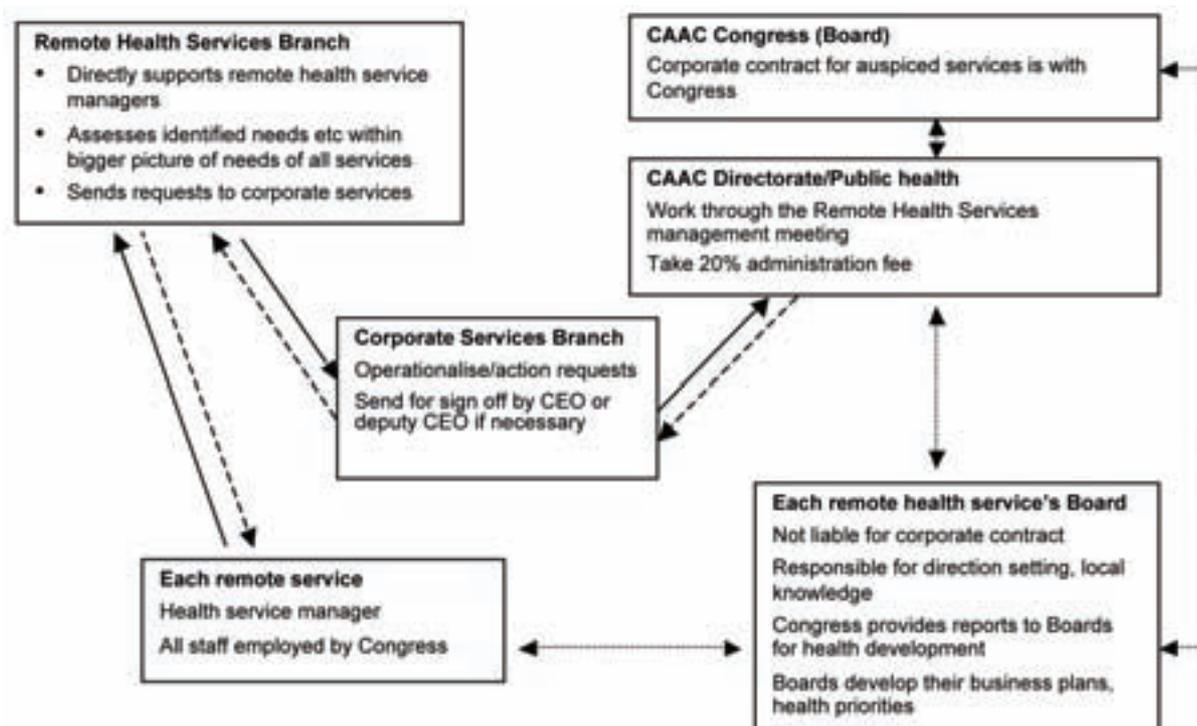


Figure 3: The structure of the CAAC corporate support model for auspiced services

Due to the 'tripartite' nature of support provision and the multiple steps in processing many types of requests, there can be significant delays. There is also room for confusion, particularly for remote health service managers about who does what and who they should contact for what purpose. Some interviewees noted the need to have more standardised processes across services (within the constraints of having some flexibility to allow for differences between communities and organisations) – something that was being addressed by the Remote Health Branch.

In addition to support being provided in the above ways, there are bimonthly two-day meetings in Alice Springs for remote health service managers. On one day they can discuss their experiences and issues, and one day is for training (for example, on topics like Medicare and Communicare). Part of the purpose of this is to try to reduce the isolation managers can experience, to enable them to identify problems and work out how to address them, and to facilitate development of common processes across clinics. In addition, some managers have been to a School of Remote Health Management Course.

Capacity development

Capacity development is an important part of the model; however, some Congress staff noted that lack of funding can limit the extent to which they can be proactive in addressing needs for capacity and service development in both town and remote health services and communities.

Having Congress Cabinet (Board) members attending remote service Board meetings and vice versa enables some capacity building in governance and facilitates Board members getting support from others. Congress staff identified that they could better build the capacity of Boards by developing a governance plan specifically for the purpose of such capacity building.

Each person holding the position of Manager of the Remote Health Branch has prioritised different aspects of capacity building – this may be a function of development of the role over time and/or the approach of those in this role. For example, one focused on providing direct support to remote health service managers (including a lot of face-to-face meetings, and email and telephone contact), while another focused on developing standardised protocols and systems across services.

Capacity building for remote service managers is a critical aspect of the model. Often when people are recruited to manage small remote health services they might not have all the skills required for what is a very demanding role in an often difficult environment. For example, some will have a background in managing a clinical service but not necessarily in broader health service management. Others may be recruited from government health services and will be used to having a lot of their support provided centrally from within their government organisations and so may not be familiar with the range of tasks they need to undertake to manage a community-controlled service. Some may have managed services in less remote areas of Australia and have little relevant cultural knowledge. For many of these managers, support is important to assist them in developing the full range of skills required. Without this support some managers identified that they would have been less likely to remain in the position – this can particularly be the case if the services they are managing have also experienced recent difficulties and so have an added layer of complexity.

The extent of the training required by new managers, even though they may be extremely experienced remote health service providers, can be significant:

I didn't realise how much training I required... I needed training in budgets, report writing, grant applications, [occupational health and safety], accreditation... if I can't get training in these areas I need someone accessible to me that can do these things for me. I have a Masters degree in [a subject tangentially related to management] so managing staff has been easier than it might have been for others without this training.

One interviewee noted the importance of capacity development – both for non-Aboriginal staff going into remote settings and for local Aboriginal people so that they can take over as managers of services:

I would like to have an Aboriginal person working with me, as a trainee manager. I would also like to see local people working in parallel with the people in the shire office etc... not with a view to keeping them

as health workers, assistant teachers and so on, but with becoming managers. Train them in money management, including how the Reserve Bank works... as they're smart people and its patronising not to do this. English should be taught as a second language in the school. Otherwise people will always be set up to fail and then condemned for failing.

However, this interviewee also noted the difficulties in achieving this. Others argued that there is also a limit to what vocational training can achieve and this may depend on the prior educational level of the individual. One interviewee suggested:

it can also be patronising to suggest that someone from a community can be a trainee manager when they do not have the necessary pre-existing educational attainment. There is a limit to what on the job type training can achieve.

How are support needs identified?

Many factors influence the support required by different remote health services. For example, each community will be different in terms of its health needs, population groups, language groups, cultural practices, population size, and relationships with and ownership of their health service. Similarly, each service is different and the managers of each service will need to meet different requirements depending on the size of the service, the qualifications and experience of the staff, the service function and the community needs. There are also workforce issues including difficulties in recruiting and retaining staff. Therefore, some aspects of the corporate support provided to each auspiced service will be different depending on the combination of need created by the above sets of factors. There are also many common factors between services in light of the fact that all services deliver the same set of core primary health care services and programs, which means there is a lot to be gained by a support service system that enables services to share the knowledge and experience they have gained by implementing core services in their local context.

Support needs are identified by remote health services making requests, or by the Remote Health Branch staff being able to identify needs based on having good working relationships with services and by noticing when meeting routine requirements (such as reporting etc) are falling behind.

Relationship of organisations with support providers

There were a number of paths to organisations entering auspice arrangements with Congress. These included:

- the funding body requiring an auspice when a remote service came out of administration or experienced difficulty (that is, was a services of concern) – in some cases local communities were able to have some say in choosing the auspicer (either as part of a tendering process or as part of a Primary Health Care Access Program (PHCAP) planning process)
- as part of the implementation of PHCAP, Aboriginal communities in designated health zones had to choose who they wanted to auspice the new Commonwealth funds coming into their area – in Central Australia the WYN and Western Aranda health zones chose Congress to auspice their funds and therefore have dual providers as a pathway to achieving full community control and a single provider: other health zones (such as the Eastern Arnernte, Anmetjere and Pintubi Luritja zones) chose the Department of Health and Families to auspice their funds on their behalf (however, there have been no health boards established in these later three zones and their auspiced funds have simply been internalised within the DHF system and the positions that were funded for these zones are not necessarily there on the ground)
- needing an auspice to support organisations as they transitioned from the auspice arrangement they had with the former local government Aboriginal community-council structure to community control – this became necessary because the newly formed shire councils were not allowed to take on the responsibility of providing primary health care services because they did not have sufficient expertise: thus the communities of Ltyentye Apurte (Santa Teresa) and Amoonguna approached Congress to auspice their services as part of this transition.

Each remote health service has a MOU with Congress. These are guidelines rather than legally binding agreements.

Remote health services staff described the core business of their organisation as providing comprehensive primary health care, including prevention and health promotion, as well as disease management and treatment services. For some, the idea of having corporate functions provided efficiently by another organisation was an ideal scenario, although it was also noted that this generally sounded easier to achieve than it actually was. Some also indicated that some decisions (and the processes for implementing them), such as employment of local staff, should be made locally rather than by an auspicing agency.

However, some noted that there were some difficulties in the auspicing relationship, including that sometimes the processes took a long time, that it could be difficult to know who to contact about specific issues and that some processes that were developed for town-based services were not appropriate in remote health services.

Organisations of concern/organisations in crisis

Some of the organisations that have entered auspicing arrangements with Congress have experienced some difficulties. For these services the focus of their work with the support services within CAAC is initially on establishing themselves as well-functioning services rather than on developing independent services.

The Remote Health Branch can provide additional support when organisations are 'in strife'. For example, if a service is without a manager, someone from CAAC might go out to the service for part of each week until a manager is employed. Or it might be that a service has operated well and then been without a manager for a period of time in which the operations have deteriorated and a new manager coming in might need additional support to re-establish processes and relationships.

How the support is funded

The auspicing role of CAAC is not directly funded by government and CAAC charges auspiced services a 20 per cent administration fee. Initially, CAAC funded the Remote Health Manager position; however, this position is now funded through the administration fee.

Accountability and reporting

CAAC is accountable to remote communities through the Boards of their services and to funders through the CAAC Cabinet (Board). The CAAC Board tries to meet with community Boards at least once each year by either going to the community Board meeting or inviting Boards to a CAAC Cabinet (Board) meeting. The CAAC Director attends at least two Board meetings in each community per year. She also tries to play a role in these communities and build relationships with community members.

Review and evaluation of the model

CAAC develops a business plan based on the core services template and the SDRF and reviews its work against this plan every six months.

The Remote Health Branch has a range of informal ways to identify whether it is operating effectively. These include the 'normal good management and governance structures' of looking at each function (for example, human resources, assets) and monitoring progress. Some of the potential indicators include:

- whether budgets are being managed properly
- delivery of reports to funding bodies
- having successful recruitment
- feedback from remote service managers through meetings
- supply and functioning of IT hardware and software

- the time taken to respond to problems with IT
- that all staff are able to use IT and have had relevant training
- making sure that assets management is in place and that requests for vehicles, maintenance and capital works occur within a reasonable timeframe
- ensuring appropriate levels of communications between the different levels of the service.

A confidential review of auspicings arrangements was undertaken in 2009.

There are also 19 key performance indicators set down by the Northern Territory Aboriginal Health Forum that all Aboriginal health services should report on and these align to agreed core services. These include indicators associated with service activity, as well as organisational indicators. The latter are reported in CAAC's annual report (CAAC 2008:15) and include:

1. Management and Support Services:
 - report on unplanned staff turnover (where possible by occupation) over each 12 month period
 - report on recruits (excluding locums) completing an orientation and induction program, including cultural awareness
 - report on overtime workload
 - report on quality improvement systems including the use of best practice guidelines
2. Linkages, policy and advocacy:
 - report on service activities (position papers, collaborative meetings and services, published papers, policy submissions, participative research)
3. Community involvement:
 - report on community involvement in determining health priorities and strategic directions through any of the following: health Boards, steering committees, advisory committees, community councils, health councils
 - show evidence of appropriate reporting to community on progress against core performance indicators.

Benefits and strengths

One of the main benefits to auspiced organisations was that CAAC supported and advocated for community-controlled health services and that the organisation was focused on the needs of Aboriginal people and supported community control. There is also much greater transparency and accountability to the auspiced communities for the auspiced funds and the services that are meant to be provided compared with the situation when the DHF is the auspicings agency.

[CAAC has] clout and expert advocacy skills... they are strategic and sophisticated and can lobby for positions and services.

Other benefits included:

- that auspicings:
 - provides a safety net that's really needed in Central Australia... when things fall apart as they often do in the little bush services particularly when staff leave at short notice... having Congress being able to step in is very useful. In some communities, services have become very poorly managed ... when a new manager comes into these kinds of services it can be very difficult for them as an individual to address issues... having a large organisation like Congress to support them in their roles can make a big difference.

Having worked [in another organisation] supporting bush services taught me how fragile they were... many services were dysfunctional... auspicing seems to protect against this... none of the auspiced services have fallen over completely.

- that auspicing can take a lot of stress off services and if done well it allows them to concentrate on service delivery rather than 'focusing on the bigger picture' or having to do all their own 'back-of-house' operations – it also means that services can develop slowly over time:

Once a service can deliver its primary service, it can then focus on slowly picking up the other bits.

- that for managers of remote health services:

it can be useful to have outside pressure to do things right... which takes away some of the community pressure.

- that remote health services could get support from the Remote Health Branch and that many of the corporate functions they needed could be provided from a central location, although often the process for this was slow
- while there were some difficulties with the model, it still allowed for flexibility to respond to local needs
- that there are generally good relationships between CAAC and the Boards of remote health services, with Congress respecting the role of the service Boards – this was the case even when initially Boards had been opposed to having such arrangements:

Boards want to see themselves and their communities improving their community's health ... not doing the corporate stuff.

- that while some of the policies, procedures and business rules of an organisation like (CAAC which is large and town based) may not necessarily fit well with smaller remote health services, having the Remote Health Branch staff in Alice Springs to mediate the needs of the two different types of organisations, as well as to negotiate with busy corporate support staff, could be very useful
- having someone who was good at relationship development, problem-solving, advocacy and the provision of one-on-one support in the role of Remote Health Branch Manager, which was appreciated by remote health service managers:

Being the clinic manager in a remote service... you can feel quite isolated... its different to being in [a town service] where you can just walk down the corridor... here there is just you and your staff... you need to be able to have a really empathetic person on the end of the phone who you can just ring [for advice and support].

- that some of the services provided by the Corporate Services Branch were highly valued:

Congress IT Department is one of the best things around. It has fantastic people working there but there is not enough of them and they work very hard.

- that, over time, it was considered that having support provided from a central location could facilitate the development of systems and consistency in services operating in the region – in relation to support, this could enable streamlining of processes and should enable time saving as each clinic could use similar processes and not have to develop their own
- the leadership and corporate knowledge of the leaders (who have been in the organisation for a long time) were able to:

extend thinking to accommodate highly unusual and different needs without breaking the law... need to be able to innovate.

Barriers/issues/risks/weaknesses/challenges

There were many challenges, issues and risks for both Congress and the auspiced organisations. Many of these were associated with the fact that there was rapid change in Central Australia and there had not been enough time or resources to properly plan for such large-scale support. As one interviewee put it:

Auspicing is tough because you are dealing with a lot of individuals that make a whole – Congress plus community Boards... a lot of work and explanation goes into negotiation about auspicing.

There is a vacuum of communities having a choice about wanting to have greater control over their own services but a gap with capacity to effectively deliver, facilitate and support this. Through auspicing CAAC is trying to support capacity development. No one else is doing [this] with the number, extent and range of services and it is not that well funded. There are over 4000 people using auspiced services. Having to do this in an environment where communities are already overstretched, where there is no infrastructure, and where some communities are dysfunctional is very difficult.

The challenges, risks and issues are summarised below.

Governance

- There are limits to the community control of auspiced services because although CAAC works to promote community control and to work through the Boards of auspiced services as much as possible, there have been (a few) times when the Congress Board has not been able to take up the recommendations of the remote service Board. As the Congress Board is accountable against the contracts of the auspiced organisation, the remote service Board does not have the final authority.
- More governance training was required for remote service Boards. Ideally, this should be provided locally so that employed Board members do not lose wages in order to attend training.

Planning

- Congress's role as an auspicing agency has tended to occur out of necessity rather than being a planned function of the organisation. Consequently, at the same time as CAAC has been expanding quickly, so has the increase in the number of services being auspiced. This has meant that the structure to support auspicing has been added onto the existing organisation (as the Remote Health Branch) to meet urgent needs. This may not necessarily have resulted in the most strategic means of supporting auspiced organisations. A further consequence of this is that the Corporate Services Branch has had to expand the services it is providing to auspiced agencies as well as CAAC and may not always have the resources to meet all demands quickly. This has placed some stress on this Branch. There has been some discussion within the organisation as to whether additional positions for corporate support should sit within the Corporate Services Branch or whether these positions should be located in the Remote Health Branch. Some staff considered that it might be useful to look at the whole of CAAC's charter and how the functions of the different branches come together to create the whole (or the gaps in this).

It's about looking at the organisational model from a Google Earth perspective.

- On a business level, some interviewees suggested that more planning could be done about what is needed in different clinics because at the moment it is dependent on the managers to 'go cap in hand' with requests. Some were uncertain about how the decisions were made about what would and would not be funded and thought there should be a more rigorous process for identifying priority needs across services. This could include developing standards about what was required to deliver what services in what environments. Related to this was that some interviewees considered it important that CAAC engage with remote health services in planning corporate support so that the needs of the different types of services (for example, town-based services and remote health services) could be taken into account.

Funding

- The enormity of the role of the auspicing organisation was not recognised by government, which has not directly funded this work.
- Allocation of resources to corporate support in an environment where service provision is often inadequately funded can cause debates. Add to this considerations of equitable provision of corporate support across a large town-based organisation and six small, remote health services (each of which pays a percentage of its overall income to the auspicing agency), and there is room for many issues to arise – such as debates about what can be provided for this amount and whether remote health services get the support they need for the money they contribute.
- While the Corporate Services Branch has increased its staff in key areas, the resources available are still limited compared to need for corporate services. Related to the above point, some staff considered that the limited expansion in corporate services staff did not reflect the increase in the administration fee paid.
- Originally, CAAC wanted to have health service development workers/community development workers in each of the auspiced services to work on building the capacity of Boards and communities; however, it was unable to get funding for these positions. The current funding allows for basic organisational support but limited resources for service and community development. One staff member noted that service development could often only be addressed when there was a Commonwealth Government program that allowed this. An example was PHCAP, which enabled planning – but once new funding for this program was discontinued in the 2003/04 budget there was no further funding for service development until the Enhanced Service Delivery Initiative was introduced in 2008. Some Congress staff suggested that it would be useful to have a resource that identified the costs associated with auspicing. This might include identifying the kinds of resources required for auspicing services with different levels of risk/need. Some considered that ‘the organisation might be trying to do too much with too little’.

Workforce and infrastructure

- There are two significant and related issues with staffing. The first is that it can be difficult to attract and retain experienced staff and the second is that the workloads can be high and the positions stressful (both lead to high staff turnover). This means it can be ‘difficult in terms of work health’. A further consequence is that sometimes people are taken on for roles they are not fully trained for and a lot of time and resources are committed to training people who may then move on after a very short time. In addition, there are relatively few staff in the community-controlled sector (compared to government organisations), so these staff need to have vast expertise and it is unlikely that one person will have all the expertise. This can often lead to burnout as people try to gain new skills at the same time as undertaking difficult roles.
- In addition to the above, a lot of the work is underpinned by the personalities of different people and the relationships between them – which can mean that things can fall over when an individual leaves.
- Some of the auspiced services have had periods of great difficulty prior to entering auspicing arrangements, and often they may have had one or more changes in manager in a short period. This can mean that when a new manager comes into the service, as well as developing relationships with the community they have a lot of issues to sort out in the service; they also need to learn about CAAC and the way support services are provided and identify what aspects of the service they have responsibility for managing. Without clear systems in place this can be daunting for a new manager, especially if his/her experience is in provision of clinical services or not in remote Australia.
- Infrastructure issues, such as limitations to IT and accommodation in remote communities, can provide challenges for provision of corporate support. One issue is that remote service staff do not have access to the Congress intranet, which means they are unable to access a range of policies and procedures.

Transitions and exit strategies

- CAAC intends auspicing to be a temporary arrangement while services gain the skills and resources to become independent community-controlled services. However, the move towards regionalisation means that there is uncertainty about what the service structure within Central Australia will look like and in this context it is difficult to develop an exit strategy. There were some concerns that without a defined 'plan for handing back' the service to full community control, the auspiced service:

can get stuck in the bigger organisation for a long time... [and] the little guy can feel like they are being taken over. Having a timeline would give them something to work towards.
- Another issue for exiting is 'how to disband the current arrangements without breaking all the eggs'.

Competing priorities and needs – town and remote health services

- There can be competing priorities between the needs of CAAC and the needs of remote health services. As corporate services staff are employed by Congress, they sometimes prioritise Congress business. The workloads in the Corporate Services Branch can also become very high. For some remote service managers, awareness of the workloads of Corporate Services staff meant that they could be reticent to seek help.
- Some informants considered that CAAC had been established largely to work as a town-based service and was still largely focused on providing such a service. They thought it would be useful if remote area services could have their own identified support services staff, rather than requiring those with already full workloads to be providing services to both CAAC and remote health services.

Structure and delays

- The delays caused by the multiple steps in the process for getting corporate support can result in services missing opportunities. For example, the employment process can mean that potential employees have been recruited by other agencies before they can be offered a job.

Consultation, communication and participation

- Many of the remote health services cannot access the information available to CAAC staff on the intranet. This included documents like policies and procedures that are available through the intranet but not available in hard copy. These can result in development in the remote health services lagging behind those of town services (particularly in relation to electronic health records etc).
- Some managers considered that they should be more involved in the development of the processes for corporate functions.

Credibility

- The issue of credibility is important in both directions in the auspicing model. The auspicing agency must have credibility with the communities and their services entering auspicing arrangements. Similarly, the actions of organisations that are auspiced can reflect on the credibility of the auspicing organisation (which is liable for them) and therefore they need to try to ensure their operations do not negatively impact on this.

Support for the support providers

- Those providing support to remote health services often also require support, particularly if they are supporting a number of organisations at once and are required to undertake significant travel.

Table 2: Corporate Services provided centrally at CAAC

Area	Functions
Financial	<ul style="list-style-type: none"> • Accounting and financial management services including budgets, audited financial statements, and debtor and creditor services • Internal payroll service • Administration of the staff fringe benefit scheme • Preparation and management of funding applications to external agencies • Preparation and control of various agreements/contracts/MOU
Human Resources	<ul style="list-style-type: none"> • Recruitment and staff selection • Training and development • Administration of the workers' compensation scheme • Development and administration of human resources policy • Administering discipline/complaints/mediation/dismissals/dispute resolution • Developing and negotiating Congress's Enterprise Bargaining Agreement and management of all industrial relations issues • Development of occupational health and safety policy/procedure and convening occupational health and safety committee
Assets	<ul style="list-style-type: none"> • Management of all buildings and property, including repair and maintenance and capital works projects • Management of office accommodation requirements and minor new works • Cleaning and sanitation contracts • Security contracts • Occupational health and safety issues affecting property/buildings • Management of vehicle fleet • Responsible for disaster evacuation plan • Act as Chief Warden in event of security breach/disaster
Information Technology	<ul style="list-style-type: none"> • IT services and IT help desk • Development and control of website • Purchase hardware and software • Development of an annual IT strategic operations plan for future needs • Development of IT upgrades • Maintain Communicare medical records system
Records Management	<ul style="list-style-type: none"> • Provision and maintenance of a comprehensive records management system • Development of a file storage, retrieval, disposal and archives system • Development of appropriate records policies and procedures • Establishment of appropriate training for records handling staff • Compliance with statutory records management practices and IT licensing
Corporate Communications	<ul style="list-style-type: none"> • Provision of a centralised public relations and media focus • Preparation of annual report • Development of corporate image and communications policy • Planning and implementation of significant 'showcase' events; for example, NAIDOC, Expo.

<p>General Administration</p>	<ul style="list-style-type: none"> • Corporate insurance needs • Administration of the annual general meeting • Development of sound corporate governance protocols within Cabinet • Preparation of statutory returns to ensure compliance with various agencies • Complaints Commission return • Corporate Affairs Commission re Cabinet • Service activity reports • Insurance reports • Business planning submissions • Strategic management planning • Control of complaints procedure for clients/patients accessing services • Chairing Communicare Working Group • Maintain various registers for contracts, MOUs and agreements • Control and administer all legal representations on Congress's behalf • Act as Public Officer under Corporations Act and as Privacy Officer under Commonwealth privacy legislation • Development and control of corporate policy and procedures
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