



Health



NSW Health Aboriginal Health

DASHBOARD TOOLKIT



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INTRODUCTION

The NSW Aboriginal Health Dashboards (the Dashboards) provide a measure of performance for Local Health Districts and Specialty Health Networks (LHDs/SHNs) across a range of health indicators in relation to Aboriginal health. They bring together 20 key indicators relating to access and equity of health care for Aboriginal people, to help inform efforts to improve health outcomes for Aboriginal people.

The Dashboard indicators are derived from a range of data sources and are grouped under four domains:

- Safety and Quality of Care
- Access to Care
- Health of Mothers, Babies and Children
- Workforce

The 2019 LHD Dashboard and data specifications are included as Appendices to this toolkit. Indicators have been selected based on availability, reliability and the ability to be influenced locally in the short to medium term. The NSW Ministry of Health produces the Dashboards annually, allowing progress to be tracked over time.

The NSW Ministry of Health has developed this toolkit to support LHDs/SHNs in the delivery of the best healthcare possible for Aboriginal people. This toolkit synthesises published evidence, expert opinion and information from health service consultations to produce a guide to improving Aboriginal health across the key indicators in the Dashboards.

This toolkit comprises:

Section 1: Fundamental approaches to improving Aboriginal health – an overview of broad strategies to improve the health care system for Aboriginal people.

Section 2: Dashboard Indicators – strategies to improve performance against indicator groupings in the Dashboard

Section 2 includes the following information for indicators, which have been grouped where common strategies for improving performance apply:

- Why the indicators are considered important for Aboriginal health outcomes
- Questions to guide a review of systems and services and direct improvement work
- How do we make things better, including:
 - Evidence-based strategies for improvement
 - Links to useful resources
 - Case studies and contact details for innovative programs that are underway in NSW

This document will be updated on an annual basis as further evidence becomes available. Throughout this toolkit the term Aboriginal is used to refer to Aboriginal and Torres Strait Islander people in acknowledgement that Aboriginal people are the first peoples of NSW.

SECTION 1:

FUNDAMENTAL APPROACHES TO IMPROVING ABORIGINAL HEALTH

There are some fundamental features of a health care system that are needed to ensure responsive and high quality care for Aboriginal people. These are described below.

Common challenges to improving performance are also summarised and, where possible, resources for addressing these challenges have been included.

IMPROVING THE HEALTH CARE SYSTEM FOR ABORIGINAL PEOPLE

The Australian Commission on Safety and Quality in Health Care's Guide to Improving Care for Aboriginal and Torres Strait Islander People provides a foundation on which to build an effective health system for Aboriginal people. It includes advice on building cultural competency, improving identification, establishing cultural safety of environments and effective communication.

The **Guide to Improving Care for Aboriginal and Torres Strait Islander People** can be accessed at the following link:

<https://www.safetyandquality.gov.au/our-work/assessment-to-the-nsqhs-standards/improving-care-for-aboriginal-and-torres-strait-islander-people/>

WORKING IN PARTNERSHIP

Effective partnerships with Aboriginal communities and organisations are essential to ensure safety and quality of care, and improved health outcomes for Aboriginal people. LHDs and SHNs are expected to establish sustainable partnerships with Aboriginal Community Controlled Health Services (ACCHSs) in their area and to ensure that these partnerships are implemented at all levels of the organisation, from the executive and strategic planning level, through to operational and program level.

Key tasks required to achieve mutually beneficial partnerships

- Identify Aboriginal communities within the organisation's catchment, and the relevant cultural protocols to guide building of partnerships
- Identify key contacts, elders and opinion leaders in the Aboriginal communities and health services and make contact with them
- Establish and implement mechanisms for forming and maintaining partnerships with Aboriginal communities and representative organisations
- Show an understanding of and respect for the cultural protocols of working with Aboriginal communities and organisations
- Prioritise Aboriginal self-determination, and enable Aboriginal people to determine their own health priorities and be involved in key decision-making stages

Characteristics of effective partnerships

- Partnership equality
- Regular contact between parties
- Multi-agency collaboration
- Signed formal agreements
- Active engagement of LHDs in ACCHS activities
- Strong leadership at the executive level from both parties

- Annual executive level meetings to review data and progress towards agreed objectives
- Consultation mechanisms with the ACCHS and other stakeholders as appropriate
- Joint planning and service delivery
- Resource sharing
- Maintenance of clear and up-to-date records and supporting evidence of all documentation or communications related to the partnership

For more information and suggested strategies for working in partnership with Aboriginal communities, see:

National Safety and Quality Health Service Standards - User Guide for Aboriginal and Torres Strait Islander Health: <https://www.safetyandquality.gov.au/wp-content/uploads/2017/12/National-Safety-and-Quality-Health-Service-Standards-User-Guide-for-Aboriginal-and-Torres-Strait-Islander-Health.pdf>

A summary of the User Guide is also included as an Appendix to this toolkit.

CASE STUDY

South Western Sydney LHD and Tharawal Aboriginal Medical Service Partnership Agreement 2016-2019

The Partnership Agreement between South Western Sydney LHD and Tharawal Aboriginal Medical Service aims to improve health outcomes and access to health services among Aboriginal communities. It sets out guiding principles for working together (including the use of collaborative approaches), details a range of initiatives to be implemented, and delineates the responsibilities of each organisation.

An objective of the Partnership is to establish culturally safe mainstream health services by leveraging the expertise and experiences of Tharawal Aboriginal Medical Service staff. The Partnership is implemented through regular meetings of both organisations and other consultative mechanisms. Engagement occurs at both the executive and operational levels.

The collaborative mental health model is a good example of a joint initiative of the Partnership. The model includes a mental health outreach service for Tharawal Aboriginal Medical Service clients and joint consumer review meetings. These meetings clarify the roles and responsibilities of each partner in delivering culturally safe and effective care, particularly for patients with complex needs.

The Partnership has improved pathways to healthcare for Aboriginal patients in the region. There is also a view that it has improved the cultural safety of South Western Sydney LHD services by establishing innovative outreach models, and through Tharawal Aboriginal Medical Service's input into how mainstream services are provided to Aboriginal clients and their families.

For further information contact Nathan Jones, Director of Aboriginal Health South Western Sydney LHD on Nathan.Jones3@health.nsw.gov.au.

RECORDING OF ABORIGINALITY

Accurate identification of Aboriginal patients is one of the essential first steps towards improving the health of the Aboriginal population. Accurate identification ensures the delivery of tailored, culturally safe, and clinically relevant care, and allows targeted services and programs to be put in place to support patients and address inequalities. Accurate data collection also enables effective monitoring and reporting of efforts to improve Aboriginal health.

For accurate identification to take place, patients must feel comfortable identifying as Aboriginal, staff must be confident in asking patients about their Aboriginality, and staff must have access to hospital systems that support the asking and recording of identification.

Increase patients' comfort in identifying as Aboriginal

An individual's comfort with identifying as an Aboriginal person is likely to reflect the cultural safety of the health care environment. Providing a welcoming environment demonstrates a health service's commitment to Aboriginal health. This includes Aboriginal people working in the service and the display of Aboriginal artwork, flags or statements of reconciliation – refer to the section on **Creating a Welcoming Environment** (Page 7) for more detail.

Discuss with the local ACCHS or other community groups about how the service can be more welcoming and comfortable for Aboriginal people.

Improve staff's ability to ask about Aboriginality

Identify which staff are responsible for asking patients about their Aboriginal status – this may occur at multiple points in the patient's journey. Ensure staff feel confident about how and why to ask the question and support this with training if required. Ensure that staff can answer patient questions around why it is important and address any misconceptions or concerns that staff may have. It is important to remember that the question should be asked at each presentation.

The Health Education and Training Institute (HETI) have developed an online module called Asking the Question: Improving the Identification of Aboriginal People. The module helps staff understand how and why identification is important, and includes advice on different patient scenarios and barriers.

Asking the Question: Improving the Identification of Aboriginal People:

<https://www.heti.nsw.gov.au/education-and-training/courses-and-programs/asking-the-question-improving-the-identification-of-aboriginal-people>

Review current information management systems

Work towards improving IT systems to record and display Aboriginal status. This may involve including identifiers in administrative and clinical data sets. Ensure that once Aboriginality is recorded it can be seen by all relevant staff, including clinicians.

National requirements and advice on implementation are outlined in the **NSW Health policy directive Aboriginal and Torres Strait Islander Origin - Recording of Information of Patients and Clients**: http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2012_042.pdf

CASE STUDY

Prioritising recording of Aboriginality in Hunter New England Local Health District

Recording of Aboriginality has been a priority for Hunter New England Local Health District for a number of years. The Aboriginal Health Unit and Information Technology teams worked together to develop a multi-component approach, including:

- Reviewing clinical data systems and applications used to record patient information across the LHD
- Prioritising clinical applications and identifying applications considered the 'true' source of information
- Working with vendors and the Information Technology team to change data recording processes in applications with the biggest impact on clinicians and patients.
- Including Aboriginal and Torres Strait Islander flags in the Clinical Applications Portal demographics banner when a patient is identified as Aboriginal and/or Torres Strait Islander to prompt appropriate care and health pathways
- Education and training of frontline staff responsible for accurate recording of Aboriginality status

- Continuous monitoring and feedback to staff on identification completion

Reporting of Aboriginality in admitted patients is 94.8% for Hunter New England Local Health District. The NSW average is 87.4% for 2017/18 in the 2019 Dashboards.

For further information contact Aimee Louise Smith, Senior Program Manager Aboriginal Health Unit on Aimee.Smith@hnehealth.nsw.gov.au

BUILDING A CULTURALLY COMPETENT AND INCLUSIVE WORKFORCE

Building a culturally competent workforce is fundamental to creating a culturally safe environment for Aboriginal patients. All members of the health workforce need to be accountable for the wellbeing of Aboriginal patients. Aboriginal patients are not the sole responsibility of Aboriginal healthcare staff.

Increase the Aboriginal workforce

The NSW Health Aboriginal Workforce Unit is dedicated to improving Aboriginal participation in the health workforce and has created a number of programs and resources to address barriers to entry into the workforce for Aboriginal people.

NSW Health Aboriginal Workforce Unit: <http://www.health.nsw.gov.au/workforce/aboriginal/Pages/default.aspx>

The Stepping Up resource is for applicants and managers who are hiring staff. Stepping Up aims to assist Aboriginal job applicants to apply for NSW Health roles by clarifying the recruitment process and support managers to more effectively structure recruitment to roles within NSW Health.

Stepping Up: www.steppingup.health.nsw.gov.au

The Good Health - Great Jobs Aboriginal Workforce Strategic Framework 2016 – 2020 is the overarching policy for all NSW Health Aboriginal workforce resources and includes practical suggestions for improving hiring practices and provides a service wide framework for implementation.

Good Health - Great Jobs Aboriginal Workforce Strategic Framework 2016 – 2020: http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2016_053.pdf

CASE STUDY

Increasing representation of Aboriginal people in workforce - Mid North Coast LHD

At July 2014 3% of employees of the Mid North Coast Local Health District (MNCLHD) identified as Aboriginal. This was significantly less than the proportion of Aboriginal people living in the district which was 5%. A number of strategies were implemented to increase employment of Aboriginal staff and reach the MNCLHD Aboriginal employment “stretch target” of 5%. These strategies included:

- Implementing the Mid North Coast Local Health District Good Health Great Jobs Aboriginal Workforce Action Plan 2011-2015, which was recently refreshed through the Mid North Coast Local Health District Aboriginal Workforce Plan 2017-2021
- Mandating regular reports on Aboriginal staff recruitment MNCLHD Close the Gap Board Sub-Committee
- Providing ongoing support for the intake of Aboriginal School Based Trainees
- Implementing the Mid North Coast Affirmative Action Strategy, which encourages Aboriginal applicants to apply for non-identified roles and provides opportunities to undertake professional development

- Holding the Mid North Coast Local Health District Careers in Health Expo to generate career aspirations among Aboriginal people and support community engagement

Retention strategies focused on creating a sense of belonging and community for Aboriginal staff and included; holding Aboriginal Workforce Forums; establishing networking opportunities for Aboriginal staff; and school-based, vocational and tertiary-level traineeships pathways and opportunities. MNCLHD also developed a mentoring program to foster leadership capacity among Aboriginal staff. Ensuring Aboriginal staff are represented on a range of planning and implementation Committees has significantly contributed to Aboriginal leadership capacity.

Factors identified as underpinning the success of the MNCLHD rapid scale up of Aboriginal recruitment include: the early establishment of the ambitious Aboriginal employment KPIs and continuous messaging about the importance of recruiting and retaining Aboriginal staff.

At February 2019 the MNCLHD successfully met the stretch target of 5% Aboriginal workforce. The NSW Health average for Aboriginal employment in June 2018 was 2.6%.

For more information, please contact Helene Jones, Aboriginal Workforce Manager MNCLHD on Helene.Jones@health.nsw.gov.au

CASE STUDY

Aboriginal Oral Health Scholarships Program

Rural and remote Aboriginal people experience higher rates of oral disease associated with limited access to dental and oral health practitioners. The *Aboriginal Oral Health Scholarships Program* aims to increase the number of Aboriginal people trained in oral healthcare with the overarching goal of improving dental health in Aboriginal communities.

The Program offers financial assistance for Aboriginal people to study Certificate III and IV in Dental Assisting, and Certificate IV in Dental Radiography. Each scholarship also provides the following over the course of two years: one-to-one mentoring, online and face-to-face course fees, a laptop computer, prepaid internet access, weekly telephone and/or video support, and career and education planning.

Since commencement of the Program in 2014, 84 students have graduated, with a further 26 students enrolled in 2018. 21 of these students have also completed a Certificate IV qualification in Radiography. The program has a course completion rate of around 93%. Past students have gone on to complete additional qualifications such as a Diploma in Dental Technology and a Bachelor of Oral Health.

For further information contact the Poche Centre for Indigenous Health **02 9114 1149** or poche.admin@sydney.edu.au

Participation in Respecting the Difference: An Aboriginal Cultural Training Framework for NSW Health

All NSW Health staff are required to complete the e-Learning and face-to-face modules of Respecting the Difference training. The e-Learning module is a prerequisite to attending the face-to-face module.

If completion or attendance rates in Respecting the Difference training are low, consider discussing barriers to completing the training with unit managers. Issues that may be affecting uptake include availability of spaces on training programs, how staff absences are covered for during training, how the training is promoted and facilitated and how relevant staff feel the training is to their work.

The **Respecting the Difference Framework** gives guidance on the implementation of cultural awareness training across LHDs and is available at:

http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2011_069.pdf

CREATING A WELCOMING ENVIRONMENT

Consider both physical and social environment

This involves both considerations of the physical layout and environment, and the social environment within a health service.

The Australian Commission on Safety and Quality in Health Care's Guide to Improving Care for Aboriginal and Torres Strait Islander People suggests health service organisations can create a welcoming environment for Aboriginal and Torres Strait Islander consumers by:

- Collaborating with the local Aboriginal community to review the design, use and layout of public and clinical spaces
- Engaging local Aboriginal communities in the development of messages to explain how the health service organisation works
- Identifying spaces for Aboriginal people to hold family conferences and to consult with clinical staff and ensuring access to these facilities and outside spaces for family gatherings and consultations

Visual cues can be powerful demonstrations of a commitment to Aboriginal people and their health. Consider signs, symbols and displays including:

- The Aboriginal flag
- Statements of reconciliation and acknowledgement of traditional custodians
- Aboriginal artwork
- Local Aboriginal languages on signs

CASE STUDY

Hunter New England Local Health District Cultural Redesign Project

The Hunter New England LHD Cultural Redesign Project aims to increase the cultural competency of staff, deliver culturally respectful services, provide culturally safe work environments and increase Aboriginal participation in decision making processes.

Key components include:

- Establishing the Hunter New England LHD Closing the Gap intranet site, which provides a portal for key information, resources, strategies and reports
- Implementing the Facilities Audit Tool, which assesses the cultural safety of facilities against indicators relating to the physical environment, staff recruitment and retention, staff training and performance appraisal, Aboriginal patient identification, and reporting of Aboriginal health data
- Implementing the Service Planning and Monitoring Tool to monitor district operational plans and ensure relevant Closing the Gap strategies are included as routine business
- Delivering the Aboriginal Cultural Respect Education (ACRE) program, which is based on the NSW Health Respecting the Difference training

The Cultural Redesign Project has contributed to the following outcomes in Hunter New England LHD:

- Increase in the Aboriginal workforce from 4% in 2014 to 5% in 2017
- Estimated 95% accuracy of reporting of patients' Aboriginal status in hospital data, compared to 88% for NSW

- 93% of Aboriginal people admitted to a district hospital in 2014 rated their overall experience of care as either "Very good" or "Good"
- 30% of staff have completed the ACRE training, with a 5 year plan in place to increase the reach of ACRE training

For further information, contact Sharyn Tyter, Senior Program Manager Aboriginal Chronic Care, Hunter New England LHD on Sharyn.Tyter@hnehealth.nsw.gov.au.

COMMUNICATING EFFECTIVELY

Clear and effective verbal and written communication is essential when engaging with patients, delivering suitable health care and empowering patients to manage their own health care.

Some important considerations in communication include:

- When developing written resources, ensure that they are appropriate and will be understood by Aboriginal populations. This could be achieved by testing resources with local community, involving Aboriginal staff or collaborating with local community or ACCHSs to determine what information is required and how it should be delivered.
- Involve Aboriginal Health Workers and Aboriginal health care staff in consultations and discussions with patients as appropriate
- Be aware of the potential need for translators
- Use shared decision making models of care and involve family where possible
- Provide opportunities for input and feedback from community members. Aim for a constant cycle of feedback and improvement.
- Be conscious that concepts of acceptable levels of eye contact, silence, touching and the meaning of gestures or non-verbal communication is largely shaped by culture. These may differ between Aboriginal and non-Aboriginal people and between different Aboriginal peoples, and can lead to miscommunication.

For more information and guidance on appropriate word usage when working with Aboriginal people and communities, see:

Communicating positively - A guide to appropriate Aboriginal terminology:
<https://www.health.nsw.gov.au/aboriginal/Publications/pub-terminology.pdf>

COMMON CHALLENGES AND METHODS FOR OVERCOMING THEM

ENSURING MAINSTREAM IMPROVEMENT INITIATIVES ARE APPROPRIATE FOR ABORIGINAL PEOPLE

Many population-wide initiatives aim to improve the healthcare of everyone, Aboriginal and non-Aboriginal alike. It is important to consider the specific and unique needs of local Aboriginal populations in rolling out such initiatives to address any barriers to engaging Aboriginal people and ensuring that the anticipated benefits will be achieved for the Aboriginal population. If this is not considered then the gap between Aboriginal and non-Aboriginal health outcomes can widen. It is important that the needs of Aboriginal people are taken into account early in the development of initiatives, rather than trying to modify a program after implementation.

The Aboriginal Health Impact Statement (AHIS) is a tool that can help those planning programs or healthcare initiatives to work through the process of evaluating Aboriginal health needs step-by-step. It is NSW Health policy that an AHIS is completed for any new policy, program or other initiative. The Centre for Aboriginal Health is available to assist with completing the AHIS.

Aboriginal Health Impact Statement:

http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2017_034.pdf

DISTANCE TRAVELLED – TIME AND COST

The geography of NSW means that for many services people need to travel significant distances. This can be a barrier for many Aboriginal patients. The design of health programs should take into account barriers to participation including travel time, cost and isolation.

The Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) is designed to financially assist people, particularly in isolated or rural areas, who have to travel significant distances to access specialist treatment which is not available locally.

EnableNSW website has further information about IPTAAS:

<http://www.enable.health.nsw.gov.au/services/iptaas>

NSW Policy Directive for the IPTAAS Policy Framework:

http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2012_070.pdf

COLLABORATING WITH ABORIGINAL COMMUNITY CONTROLLED HEALTH SERVICES

Collaborating with ACCHSs is vital to ensure health services in the local area are integrated and responsive to the Aboriginal community's needs. This applies to both the development of new services and review of existing services. ACCHSs work for the community and have a wealth of experience and knowledge of both health and cultural issues and what works in the local area. Developing a robust partnership between LHD and local ACCHSs is essential to make certain the needs of Aboriginal people are being addressed – ensuring services are culturally safe, identifying community priorities and ensuring integrated service delivery.

Genuine collaboration involves shared decision making and negotiation. It should be thought about and initiated early, often at the point of issue identification and exploration rather than later on in the program design and delivery process. To ensure consultation with ACCHSs is a meaningful part of policy development consider the following:

- Collaboration processes should be Aboriginal community-driven, with ACCHSs able to decide “how” engagement takes place
- The number of issues or programs the ACCHS may be simultaneously providing input and advocacy on can be a substantial workload. Look for opportunities to consolidate meetings, arrange formal consultation avenues and minimise administration burden.
- Ensure staff from your organisation are culturally competent and have the right skill and authority mix to be able to make decisions and offer solutions
- Provide reasonable timeframes for input and feedback – remember that the ACCHS is often the contact point for the local Aboriginal community and additional time may be needed to allow for community engagement by the ACCHS
- Establishing relationships and long term processes of consultation, engagement and improvement is an important long term goal

For more in-depth discussion and guidance see:

Engaging with Indigenous Australia - exploring the conditions for effective relationships with Aboriginal and Torres Strait Islander Communities resource (Australian Institute of Health and Welfare): <https://www.aihw.gov.au/getmedia/7d54eac8-4c95-4de1-91bb-0d6b1cf348e2/ctgc-ip05.pdf.aspx?inline=true>

Working with Aboriginal People and Communities - A practice resource (NSW Department of Community Services): http://www.community.nsw.gov.au/_data/assets/pdf_file/0017/321308/working_with_aboriginal.pdf

CASE STUDY***Delivering programs with Aboriginal Community Controlled Health Services in Northern NSW LHD***

In Northern NSW, the Local Health District, Casino Aboriginal Medical Service, Primary Health Network and other community organisations work together to implement the One Deadly Step program. One Deadly Step aims to reduce the impact of chronic disease on Aboriginal people and involves health promotion, screening and early detection, timely referrals to specialist and follow up services and active chronic disease management. The One Deadly Step day led to 129 Aboriginal people receiving a screening assessment and every participant being referred to the Aboriginal Medical Service or General Practice within a few weeks for follow up. This program and partnership approach has led to increased awareness of chronic disease in the community, increased access to screening, more timely referrals and improved engagement with primary health care.

For further information, contact Anthony Franks, Aboriginal Chronic Care Officer Northern NSW LHD on Anthony.Franks@health.nsw.gov.au.

SECTION 2: DASHBOARD INDICATORS

The following section outlines strategies for improving the performance against Dashboard indicators.

These pages can be used individually to address areas requiring focus or together as a more general tool for improving Aboriginal health in your local area.

TAKING OWN LEAVE

Why is it important?

'Taking Own Leave' (TOL) includes Discharge Against Medical Advice (DAMA) and incomplete emergency department attendances. It is an indication of how appropriate and culturally safe hospital services are for the Aboriginal community they serve, and a reflection of Aboriginal peoples' satisfaction with their care. This is particularly true when there are large differences in DAMA rates between Aboriginal and non-Aboriginal people.

The underlying causes of TOL can be broad and may begin outside the healthcare system. This can include factors related to the broader health institution, such as systemic racism, or the individual interactions within that healthcare system like communication breakdown between doctor and patient.

The Deeble Institute produced an issues brief¹ which catalogued some of the reasons behind the decision to DAMA, which included:

- Family, social and financial obligations
- Transport issues
- Isolation
- Loneliness

Evidence indicates that prolonged waiting times are the main reason for those who left emergency departments without being seen. A NSW based study² identified other reasons including:

- Resolution of the problem
- Too ill to stay
- Reassured following advice at triage
- Safety concerns in the waiting room
- Other commitments
- Staff rudeness

TOL is a clinical safety issue. Patients who discharge against medical advice have higher hospital readmissions rates, higher levels of multiple admissions and higher mortality rates than patients who do not discharge against medical advice. On a population level there is a significant cost to the health care system associated with TOL.

1 An evidence-based approach to reducing discharge against medical advice amongst Aboriginal and Torres Strait Islander patients: http://ahha.asn.au/system/files/docs/publications/deeble_institute_issues_brief_caitlin_shaw_2_1.pdf

2 They just don't like to wait! A comparative study of Aboriginal and non-Aboriginal people who do not wait for treatment or discharge themselves against medical advice from rural emergency departments: http://www.heti.nsw.gov.au/Global/Rural/RRCBP/Pre%202012%20RRCBP%20Intake/leanne_wright_report.pdf

5 Key questions to ask if Aboriginal patients are taking their own leave

1 Are Aboriginal people being identified early in their admission?

This allows considerations of any specific cultural needs and links with appropriate supports.

2 Are Aboriginal health care professionals, including Aboriginal Health Workers, part of the multidisciplinary team?

Are staffing levels for Aboriginal Health Workers adequate for timely involvement?

3 Do partnerships with ACCHSs need to be strengthened to support patients during their stay?

If the patient attends an ACCHS, are these services routinely notified early in admissions?

4 How can the environment be more welcoming?

(see Section 1 and appendix resource on the cultural safety of the environment)

How are the patient's family and visitors physically accommodated?

Can policy on visitors or gate leave be altered to be more accommodating?

5 Are there processes for Aboriginal patients and community members to provide feedback and input into how the hospital provides care to Aboriginal peoples?

How do we make things better?

Improving services

For a more in-depth exploration of potential causes and solutions to high rates of TOL among Aboriginal patients, see the Deeble Institute's issue brief:

An evidence-based approach to reducing discharge against medical advice amongst Aboriginal and Torres Strait Islander patients:

http://ahha.asn.au/system/files/docs/publications/deeble_institute_issues_brief_caitlin_shaw_2_1.pdf

Integrating health services and Aboriginal focussed medical services

Consider the role of ACCHSs. Links should be established to notify ACCHSs of admission and facilitate support of patients during the hospital stay, develop more flexible community-based care models, such as hospital in the home, and ensure post-discharge follow up with primary health service providers.

Providing culturally safe services

Aboriginal people are more likely to use health services that are culturally safe. Culturally safe health care refers to tailored care that effectively responds to Aboriginal peoples' unique needs

and cultural backgrounds. Many factors contribute to how culturally safe a service is, such as its physical environment, flexibility of service provision, linkages to community, and organisational commitment to provide culturally safe supports. Whilst health organisations can put these factors in place, ultimately only the Aboriginal person can determine whether or not their health care experience was culturally safe.

Acknowledging that the current health system, which predominantly operates within a Western model of care focussed on illness rather than wellness and well-being, implicitly and systemically advantages non-Aboriginal people is an important step in improving cultural safety. Overcoming this inherent disadvantage which contributes to current health inequities requires individuals to undertake an ongoing process of self-reflection on how their personal culture and unconscious bias impacts on the care they provide and their engagement with Aboriginal people and issues at an organisational level.

Making the physical and policy environment more welcoming

See **“Creating a welcoming environment”** in Section 1

Formal cultural respect frameworks can ensure a more welcoming and comfortable environment and support processes to address cultural concerns of Aboriginal patients early in their admission.

The **National Cultural Respect Framework** gives advice on implementing change:
<http://www.coaghealthcouncil.gov.au/Portals/0/National%20Cultural%20Respect%20Framework%20for%20Aboriginal%20and%20Torres%20Strait%20Islander%20Health%202016%202026%202.pdf>

Reviewing and auditing local services

Local audits and consumer focus groups will increase understanding of specific local barriers to remaining in hospital and help guide improvements.

Reasons for TOL can be complex. As well as the causes discussed above it will also be important to consider mental health and drug and alcohol issue screening and management, cultural appropriateness of information and patient resources. Practical solutions even if not specifically health related, such as taxi vouchers, may be the most cost effective way to reduce TOL rates.

UNPLANNED READMISSIONS AND EMERGENCY DEPARTMENT REPRESENTATIONS

Why is it important?

This section of the toolkit covers representations to the emergency department within 48 hours or readmissions within 28 days of discharge from the same hospital, which indicate the quality and continuity of care provided to patients while in hospital and following discharge. Some of these representations or readmissions will be unavoidable; they could be the result of complex healthcare needs or evolving clinical presentations, and appropriate medical advice to return if unwell. However research from Australia and around the world has identified large variations in rates and a number of potentially preventable causes³. A difference between Aboriginal and non-Aboriginal rates suggests that improvement is needed.

5 key questions to ask if readmissions and representations are high for Aboriginal people

1 Are Aboriginal Liaison Officers and other Aboriginal healthcare professionals part of the multidisciplinary care team?

This may support increased consideration of discharge needs as well as patient understanding of their treatment plan.

2 What processes are in place to link discharged patients with their primary/community care provider?

Can hospitals, departments or clinics strengthen linkages with local ACCHSs and other primary health care providers?

3 What supports are available on discharge?

Is there scope to improve community based care for Aboriginal people through partnerships with other organisations or further community based services?

4 Have patient resources and information been reviewed for cultural appropriateness?

5 Are there processes and resources to overcome physical barriers to accessing primary care post discharge e.g. Home visits?

How do we make things better?

Implementing initiatives to improve readmission rates requires careful consideration of cause and risk factors. In general, programs that are targeted to address specific risk factors such as lack of social supports at home show more success than generalised readmission prevention programs. A local audit to look at common elements in Aboriginal readmissions can guide the development of these specific interventions.

³ Factors associated with 28-day hospital readmission after stroke in Australia; Kilkenny M, Longworth M, Pollack M, Levi C, Cadilhac D; (2013) Stroke, <https://www.ncbi.nlm.nih.gov/pubmed/23800558>

Conducting an audit: Focus areas

Local audits should consider both the most common preventable causes and also the local risk profile.

Preventable causes of readmissions include:

- Discharge before clinically well enough
- Discharge late in the day when services, supports and medications are difficult to organise
- Inadequate information provided to patients throughout admission and on discharge
- Discharge planning that doesn't take into account the full range of supports required by the patient
- Poor integration with primary and community health care services
- Medication issues – patients unable to fill prescriptions (no prescription given on discharge, patient unable to afford or arrange filling of prescription), medication errors (wrong dose, wrong drug, or duplicate doses)
- Complications during the initial admission

Preventable causes of representations to Emergency Departments include:

- Incorrect diagnosis, treatment and management plan
- Poor integration with primary and community care services
- No follow up appointment – either with outpatient specialist or a primary care provider
- Miscommunication with patients and their family about the treatment plan

Risk factors for readmissions and representations to Emergency Departments:

- High dependency prior to admission
- Multiple co-morbidities or chronic diseases
- Discharging against medical advice
- Low health literacy
- Limited social supports

Some initiatives that work to address the above issues include:

- Employment of discharge co-ordinators within the hospital and the emergency department
- Follow up phone calls with discharged patients to ensure their medications are up-to-date, and their referrals and ongoing care management is in place
- Implementing an integrated care program linking primary care services and hospital services to better support patients in the community
- Development of more flexible community-based care models and links with primary care providers – reducing unnecessary admissions through alternative pathways to care such as Hospital in the Home
- Collaborative multi-disciplinary teams within hospitals, including Aboriginal Health Workers and other Aboriginal healthcare staff

A key enabler to the success of initiatives is good information sharing and exchange between hospital services and community services. It is important to make sure ACCHSs are part of this information sharing.

MENTAL HEALTH CARE

Why is it important?

Numerous studies throughout NSW and Australia have shown a high burden of mental illness in Aboriginal communities with higher rates of psychological distress, hospitalisation for self-harm and suicide. It is estimated that mental illness accounts for 10% of the life expectancy gap between Aboriginal and non-Aboriginal people (see **Living Well Report** on Page 17).

Performance in mental health care is measured with two indicators in the Dashboards – 'Unplanned acute mental health readmission within 28 days' and 'Mental health patients followed up within 7 days of acute discharge'.

It is important to note that there are significant differences in how mental health is conceptualised between Aboriginal and non-Aboriginal cultures. This must be considered at every stage of management and delivery, and necessitates robust consultation processes. A responsive mental health service with care that links well into the community is essential for addressing the inequality in mental health outcomes for Aboriginal people.

5 key questions if Mental Health Services are under performing for Aboriginal people

1 Are Aboriginal concepts of mental health accounted for at every level of local policy, planning and delivery of services?

2 How do Aboriginal people access mental health services?

Community health referrals, emergency presentations, referral from other government services?
Does this differ from the rest of the population, and are their different pathways that need to be taken into account?

3 What community mental health services are available for Aboriginal people?

4 Are mainstream community services culturally safe and appropriate?

Have staff attended cultural training and does this specifically cover the subject of mental health and the different issues associated with it?

5 Do inpatient services link and integrate well with Aboriginal community mental health services?

Is there room to improve this collaboration?

How do we make things better?

Considering different cultural approaches to mental health and wellbeing

Aboriginal concepts of mental health involve a holistic view of complete social and emotional wellbeing that is tied to connections to country, community and family. Building culturally appropriate mental health services can allow a greater recognition of, and response to, the cultural, social and other protective factors and influencers of the social and emotional wellbeing of clients.

CASE STUDY

Working with Aboriginal People: Enhancing Clinical Practice in Mental Health Care

The Mental Health Branch has developed a video and discussion guide to assist services that work with Aboriginal people to better support their mental health and wellbeing. These resources were created with assistance from a state-wide advisory committee made up of approximately 20 Aboriginal and non-Aboriginal professionals, local Elders, cultural ambassadors, youth and Aboriginal services. The resources provide a strong visual presentation combined with a structured approach to guide staff in considering the value of cultural identity in emotional and social wellbeing, as well as providing practical tips to improve engagement with Aboriginal people.

The resources complement the Respecting the Difference training and provides a further opportunity for services and staff to review and improve the quality of service delivery, reflect on clinical practices, and increase knowledge and skills in working with Aboriginal people and their families. The resources will also be relevant to many government and non-government services who work with Aboriginal people.

The Mental Health Branch is currently organising an official launch in collaboration with the Centre for Aboriginal Health.

The video and discussion guide can be accessed here:

<https://www.health.nsw.gov.au/mentalhealth/professionals/Pages/aboriginal-people.aspx>

Approaches to reviewing services

Formal engagement with the local Aboriginal community and ACCHSs to identify ways to improve the cultural appropriateness of services is an important first step.

Creating mental health services that cater to Aboriginal clients will need careful review and consultation. Particular areas that may need to be addressed include:

- Visitor and family policies, including family rooms and facilities
- Improving understanding among healthcare professionals of Aboriginal culture and history
- Development or enhancement of feedback mechanisms for Aboriginal clients
- Improving timely access to Aboriginal Health Workers – this includes access in all appropriate services but also consideration of staffing levels

Information resources

The 2014 Living Well Report into Mental Health in NSW includes discussion of Aboriginal mental health, both the historical factors that impact on current health, as well as outlining future steps.

Living Well - Putting people at the centre of mental health reform in NSW: A report:

<https://nswmentalhealthcommission.com.au/living-well-report-downloads>

CASE STUDY***Promoting mental health literacy and community led suicide prevention with Aboriginal people***

NSW Health is funding the delivery of Mental Health First Aid across NSW to improve mental health literacy and equip people with the skills they need to provide appropriate support to people experiencing mental health problems. NSW Health has funded Aboriginal Controlled Community Health Services in Orange, Condobolin and Forbes to increase the number of Aboriginal Mental Health First Aid instructors and improve access to psychological support for Aboriginal people. This course teaches members of the public how to assist an Aboriginal or Torres Strait Islander adult who is developing a mental health problem or in a mental health crisis.

Funded through NSW Health's Suicide Prevention Fund, the Kumpa Kiira Suicide Prevention Project integrates suicide prevention within a whole-of-community perspective, targeting young people and Elders in Balranald and Wentworth Shires of NSW. The project also provides training and support to local GPs. Activities include community-based health promotion, community development, engagement of Elders and support for Aboriginal people to access culturally appropriate mental health services.

For further information, contact Patricia O'Riordan, Director of HSSG MHB Director Clinical Services on Patricia.ORiordan@health.nsw.gov.au

ORAL HEALTH

Why is it important?

Aboriginal populations are both more likely to fit eligibility criteria for access to public dental care and have a higher burden of oral disease. This means that Aboriginal peoples' access to dental care should be well above the proportion of Aboriginal people in the population. Poor oral health can have significant impacts on a person's ability to eat and talk, as well as causing significant pain and chronic disease. Ensuring adequate access is an important part of an equitable healthcare system.

5 key questions to ask if access to oral health services is low for Aboriginal people

1 How are oral health services delivered within your LHD?

In what locations and with what models?

What partnerships exist to ensure access to culturally appropriate and sustainable oral health services?

2 How are these services delivered to Aboriginal people?

Are there links with local ACCHSs and outreach models of delivering care?

How are Aboriginal people referred to public dental services in your LHD? Are Aboriginal people aware of the services available and how to access these?

3 Are there barriers or weaknesses in the services that disproportionately affect Aboriginal clients?

For example: distances to services in remote areas

4 How is cultural competency training delivered to public oral health services in your LHD?

How could cultural competency of staff be improved?

5 How do Aboriginal health professionals work within oral health services in your LHD?

Is there scope to expand their participation or role?

How do we make things better?

Conducting a local audit: Focus areas

A local review of services and service delivery data to Aboriginal people can help inform future directions. The following issues have been identified in the literature as affecting access to dental services and should be assessed as part of any audit:

- Out of pocket costs –“gap payments”
- A focus on emergency dental care rather than preventive care in the public sector
- Distance to services
- Scheduling and time costs
- Patients unsure how to access services
- Other healthcare providers unsure how to refer
- Dental health not considered important/necessary
- Lack of case management and help for patients to co-ordinate care
- Fear of dentists

While the above issues can affect Aboriginal and non-Aboriginal patients it is important that any solution takes into account the situation and cultural needs of local Aboriginal populations to avoid exacerbating any inequalities in access.

Further information on Aboriginal Oral Health

The Aboriginal Oral Health Plan provides a framework for improving oral health that includes both primary prevention and strengthening oral health services.

NSW Aboriginal Oral Health Plan 2014 - 2020 : <http://www.health.nsw.gov.au/oralhealth/Publications/aboriginal-oral-health-plan.PDF>

For a more in-depth exploration of access issues in Aboriginal oral health care, see:

Review of Indigenous oral health. Williams S, Jamieson L, MacRae A, Gray C (2011):
http://healthbulletin.org.au/wp-content/uploads/2011/05/oral_health_review_2011.pdf

CASE STUDY

Building Brighter Grins on the Mid North Coast

The Mid North Coast Local Health District recognised that Aboriginal children in the area were presenting with acute oral health issues and not receiving preventive care. The *Building Brighter Grins Oral Health Program* aims to improve access to oral health services for Aboriginal children, improve awareness of good oral health practices and reduce the prevalence of oral disease.

This program is a school based dental program for primary school aged children in schools which have a high Aboriginal population. The program involves oral health education delivered by an Aboriginal Health Worker, a tooth brushing program, dental assessments and treatment provided in the Mid North Coast Local Health District dental van which is located on the school grounds during program delivery. Referrals are also provided to Mid North Coast Oral Health for these treatments unable to be delivered on the van in the school setting.

This program is coming into its sixth year and has expanded to include three schools, in predominantly rural settings, to increase access to oral health education and clinical care.

For further information please contact Claire O'Rourke, District Oral Health Programs Coordinator on **02 6588 2674** or Claire.ORourke@health.nsw.gov.au or Carmel Ireland, District Manager Oral Health on **02 6561 2891** or Carmel.Ireland@health.nsw.gov.au.

CASE STUDY

Awabakal Medical Service - Hunter New England LHD

Since January 2015, Awabakal Medical Service has partnered with Hunter New England LHD to provide oral health services to the local Aboriginal community in the Greater Newcastle region. As per a Memorandum of Understanding (MOU), the partnership covers three functions:

1. The coordination of two oral health teams employed by Hunter New England LHD to work from the Awabakal Dental Service for the purpose of providing dental treatment to publically eligible and non-eligible patients who would normally access dental treatment at the Awabakal Dental Service
2. Provision of clear structures for activity performance reporting requirements for both parties
3. Collaborative development and delivery of oral health preventive or promotional strategies for Aboriginal people.

Awabakal reimburses Hunter New England LHD for all dental activity provided to non-eligible patients (approx. 35% of patients) and this activity is attributed to Awabakal. Hunter New England LHD provides and funds services for eligible patients (approx. 65% of patients) and receives the activity for this treatment.

Through this partnership arrangement dental activity has increased approximately four-fold since January 2015 and the dental waitlist has been substantially reduced. In 2017/18 Awabakal reported 4,862 clients, of whom 94% are Aboriginal and exceeded its DWAU target by 32%. In doing so, it reached an impressive \$480 funding per DWAU achieved.

Strengths of the partnership include strong executive leadership and collaboration. As per the MOU, bi-annual meetings are held between the two parties to discuss program status, review strategies, activity performance measures and service delivery including clinical pathways, prevention and health promotion activities.

The partnership also allows each party to benefit from the other's strengths. For example, Awabakal is able to use the clinical expertise of Hunter New England LHD to meet the local community's dental needs while Hunter New England LHD is able to expand its chair capacity and build off Awabakal's level of community trust to expand service provision, meeting their objectives to provide culturally safe dental care for Aboriginal people.

For further information, please contact Debbie Massie, Health Planning & Performance Manager on dmassie@awabakal.org.

BREAST CANCER SCREENING

Why is it important?

Breast cancer is the most common cancer in Aboriginal women in NSW. Aboriginal women are more likely to have higher mortality rates from cancer compared to non-Aboriginal women, and have more breast cancers diagnosed at a later stage. The causes for this are likely multifactorial, however a key strategy to improving mortality is ensuring Aboriginal women are participating in the Breast Screen NSW screening program. Breast screening (mammography) can be a sensitive area so requires careful consideration of culture, privacy and access.

5 key questions if breast cancer screening is low among Aboriginal women

1 Do eligible women (40 - 74 years) know about the importance of regular breast cancer screening?

How has information about breast cancer and breast screening been promoted to Aboriginal communities within your LHD?

Is screening supported by the Aboriginal community and championed by organisations such as ACCHSs?

Is screening delivered in partnership with BreastScreen NSW, optimising cultural appropriateness and reach?

2 How do Aboriginal women access BreastScreen NSW?

Are women aware that BreastScreen NSW is a free service and that a doctor's referral is not required?

3 What community outreach services are available?

Are they well utilised by Aboriginal women?

Is community transport and/or the BreastScreen NSW mobile van available to address distance barriers to breast cancer screening?

4 What processes are in place to link Aboriginal women in to screening?

Has a connection been made with local BreastScreen NSW health promotion staff and resources?

5 Have local ACCHSs been consulted on how to improve access?

How do we make things better?

Approaches to improve regular screening participation

Strategies that are currently used across NSW and Australia and might be useful for your area include:

Staff training about BreastScreen NSW key messages

- 1 in 8 women in NSW will develop breast cancer
- BreastScreen NSW is a free service for women aged 40 – 74 years
- Early detection of breast cancer improves survival – mammograms every two years are recommended for women over 50
- Most women who develop breast cancer do not have a family history of breast cancer
- The appointment only takes 20 mins
- All Radiographers are female
- Group bookings led by Aboriginal health workers are welcomed
- Call 13 20 50 to make an appointment

Community and partner collaboration

- Requesting BreastScreen NSW mobile van to visit an ACCHS
- “Block booking” - having blocks of time set aside for Aboriginal participants, allowing a more flexible, culturally appropriate approach.
- Ensuring Aboriginal women are informed and encouraged to take a support person(s) with them to screening and assessment appointments
- Links between ACCHS healthcare staff and BreastScreen NSW. Women are much more likely to have a mammogram if it is recommended by their doctor or health care worker.
- Promotional materials and approaches developed by Aboriginal communities that encourage eligible women to call their local BreastScreen NSW Screening and Assessment service on 13 20 50 to talk with a health promotion officer.

BreastScreen NSW resources for Aboriginal women

BreastScreen NSW aims to increase the participation of Aboriginal women in biennial breast screening by working with Aboriginal communities and organisations to develop a coordinated approach to engagement.

The BreastScreen NSW Framework for engaging Aboriginal women in breast screening was developed and implemented by nine Screening and Assessment services across NSW in 2018. The Framework aims to guide a coordinated, best practice and measurable approach to marketing and engagement activity across NSW, to meet the needs of Aboriginal women and engage them in regular breast screening.

BreastScreen NSW has developed information for increasing community awareness specifically for Aboriginal women:

Information for Aboriginal Women:

<https://www.breastscreen.nsw.gov.au/about-screening-mammograms/information-for-aboriginal-women>

BreastScreen NSW Robin's Story - Video:

<https://www.breastscreen.nsw.gov.au/stories/robins-story/>

Further information on breast cancer in Aboriginal women

Breast cancer in Australia: an overview provides comprehensive national statistics on breast cancer in females:

<https://www.aihw.gov.au/reports/cancer/breast-cancer-in-australia-an-overview/contents/summary>

Breast cancer risk factors at a glance (Cancer Australia):

https://canceraustralia.gov.au/system/tdf/publications/breast-cancer-risk-factors-glance/pdf/breast_cancer_risk_factors_at_a_glance_0.pdf?file=1&type=node&id=6426

CASE STUDY

BreastScreen on the NSW North Coast

The BreastScreen Services of the Mid North Coast Local Health District work with local ACCHSs and the Primary Health Network to identify and implement strategies to increase the number of Aboriginal women aged 50 - 74 years to access the screening program.

Education is provided to relevant staff working with ACCHSs and PHNs on the importance of regular screening. This gives eligible Aboriginal women access to timely accurate information about the program to support them to make an informed decision about screening. The strategies to support improved participation in the program include:

- Sending invitation letters to women who are in the BreastScreen target age range
- Sending reminder invitation letters to women who are due to have a subsequent two-yearly mammogram
- Providing transport to attend the screening appointment
- Providing refreshments to improve the client experience with the program
- Taking the BreastScreen mobile unit to the Aboriginal Medical Centre to improve access
- Providing a number of back to back appointments to facilitate a number of Aboriginal women attending the program as a group. This means the women can support and counsel each other as they attend their appointment. These appointments are made available on the mobile unit and at the permanent BreastScreen sites at Coffs Harbour and at Port Macquarie.

Participation rates for Mid North Coast LHD in 2017/2018 for Aboriginal women aged 50 - 74 years were 46.8%. The NSW rate for Aboriginal women within the same period was 42.3%. Between 2014 and 2018, the gap in participation between Aboriginal and non-Aboriginal women has reduced.

For further information about this program, please contact Jane Walsh, Director BreastScreen Northern NSW & Mid North Coast Local Health District on **02 6621 1207** or Jane.Walsh@health.nsw.gov.au.

HEALTH OF MOTHERS AND BABIES

Why is it important?

High quality maternity care for Aboriginal women requires evidence-based practice that is coordinated according to the woman's clinical needs and preferences, based on collaborative multidisciplinary approaches, and woman-centred, culturally appropriate and accessible⁴. The maternity Dashboard indicators reflect how well services are providing high quality care to Aboriginal women. This section of the toolkit includes information on the first antenatal care, mothers smoking in pregnancy, low birth weight babies and breastfeeding on discharge indicators.

5 key questions to ask if there are differences in maternal health indicators for Aboriginal families

1 Are all Aboriginal women who wish to access LHD maternity services being provided with a timely appointment?

What is the average wait time between contact and first appointment?

Are all women who wish to access culturally appropriate maternity services offered and able to access these services?

2 Are Aboriginal health professionals, including Aboriginal Health Workers, part of the multidisciplinary team?

Are there adequate staffing levels?

Are there processes for outreach and continuity of care through local ACCHSs?

Have all maternity care staff completed cultural training? Does this address key issues in this area e.g. women's business?

3 What services and supports are offered to Aboriginal women in your LHD?

What services and resources are available for those smoking during pregnancy?

How well are these utilised by Aboriginal women and their families?

4 Can policies be adapted to allow more flexibility in service delivery?

Consider appointment time flexibility and visitors policy

Are there processes and respect for shared decision making (involving family) approaches to care?

5 Are there processes for Aboriginal healthcare staff and community members to provide input into the design and delivery of maternity care?

How do we make things better?

The following provide some practical guidance on improving overall health and care for pregnant Aboriginal women:

Reviewing services for cultural safety

This checklist from NSW Health gives detailed advice on assessing how culturally inclusive maternity services are with practical suggestions on how to improve.

Aboriginal Cultural Inclusion Checklist for Maternity Services:

<http://www.health.nsw.gov.au/kidsfamilies/MCFhealth/Documents/Ab-cultural-inclusion-checklist.docx>

Smoking cessation

Smoking cessation is being embedded into routine clinical care. Data system upgrades will allow health professionals to ask and record relevant questions about smoking habits and prompt the user to offer cessation support.

Quit for New Life is an online training module on HETI for practitioners to support pregnant women to quit:

<https://www.heti.nsw.gov.au/education-and-training/courses-and-programs/quit-for-new-life>

The **Tackling Indigenous Smoking Initiative Information Hub** is an evidence based resource for planning smoking cessation programs, including a section specific for women:

<https://tacklingsmoking.org.au/>

These are programs specifically for smoking cessation in pregnancy:

Aboriginal Quitline is a free and confidential telephone service that provides information and support to quit smoking. Clients can choose to speak with an Aboriginal advisor by calling 13 78 48: <https://www.icanquit.com.au/media/14616/aboriginal-quitline-leaflet.pdf>

Quit for you – Quit for two program is a national service with a number of mobile apps and online resources:

<http://www.quitnow.gov.au/internet/quitnow/publishing.nsf/content/quit-now-apps>

Breastfeeding support

The **Aboriginal Maternal and Infant Health Services (AMIHS)** provides education and support for breastfeeding, starting antenatally and up to eight weeks postnatally:

<http://www.health.nsw.gov.au/kidsfamilies/MCFhealth/priority/Pages/amihs.aspx>

Building Strong Foundations for Aboriginal Children, Families and Communities is an early childhood health service that includes support for breastfeeding:

<http://www.health.nsw.gov.au/kidsfamilies/MCFhealth/priority/Pages/bsf.aspx>

Other resources can be found at:

Australian Breastfeeding Association: <https://www.breastfeeding.asn.au/>

Raising Children Network: <http://raisingchildren.net.au/>

For further information and contacts at the Ministry of Health:

NSW Health: Aboriginal mothers and babies:

<http://www.health.nsw.gov.au/kidsfamilies/MCFhealth/priority/Pages/amihs.aspx>

CASE STUDY

Aboriginal Maternal and Infant Health Service (AMIHS)

The AMIHS is a NSW Health funded maternity service for Aboriginal families that aims to improve health outcomes for mothers and babies. AMIHS Aboriginal Health Workers and midwives work together and with other services to provide continuous, high quality antenatal and postnatal care. Care starts as early as possible in pregnancy and continues through pregnancy and up to eight weeks postpartum.

Key components of the AMIHS include:

- Being accessible, flexible and mobile
- Working with other services to provide integrated care for women and families
- Being involved in community development and health promotion activities
- Supporting women and families to transition from AMIHS to child and family health services

The AMIHS has contributed to the following outcomes:

- Proportion of Aboriginal mothers who commenced antenatal care at less than 14 weeks gestation increased from 51% in 2012 to 68% in 2017.
- Between 2012 and 2015, the rate of low birth weight in Aboriginal babies has been 11% or greater, and was 11% in 2017.

For further information contact Elizabeth Best, Manager Aboriginal Maternal Child and Family Health on Elizabeth.Best@health.nsw.gov.au.

IMMUNISATION

Why is it important?

Performance indicators for childhood immunisation assess the extent of timely immunisation in Aboriginal communities at both one and five years old and influenza immunisation coverage for under-fives. The National Immunisation Program Schedule has been developed to provide protection from diseases at the age when the child is most at risk, so correct timing is crucial for population health.

Historically Aboriginal children have had lower rates of immunisation than non-Aboriginal children and this continues to be the case in a number of areas within NSW. Ensuring high rates of immunisation coverage for Aboriginal children can significantly reduce childhood morbidity and mortality.

5 key questions to ask if immunisation rates are low among Aboriginal children

1 Are Aboriginal Immunisation Healthcare workers employed in your LHD?

What role do they play in supporting Aboriginal families to immunise their children?
Is there room for expansion or refocussing?

2 Are patient resources and information culturally appropriate?

This includes both immunisation information and also more broad child and maternal information specific to the local area

3 What are the barriers to immunisation for Aboriginal children and families within your LHD?

What processes are in place for collecting information on these barriers? From the community? From the Aboriginal Immunisation Healthcare Workers?

4 How has immunisation been promoted to Aboriginal populations within your LHD?

If rates are lower at 1 year of age, has the importance of timeliness been promoted?

5 Are there processes and resources to overcome physical barriers?

e.g. Lack of transport and home visits

How do we make things better?

Following a successful pilot program Aboriginal Immunisation Healthcare Workers are now permanently funded in all LHDs. Each LHD has developed a different model of care, with different roles for Aboriginal Immunisation Healthcare Workers within it, to help support Aboriginal families to immunise their children.

Activities implemented by Aboriginal Immunisation Healthcare Workers

- Pre-immunisation phone calls – making contact with parents prior to immunisations being due to act as both a reminder and to discuss the rationale for immunisations
- Identifying and following up children who are overdue for their immunisations – this can be an opportunity to promote immunisation, trouble shoot any access issues and facilitate engagement with the healthcare system
- Collaboration with Aboriginal Maternal and Infant Health Services to develop systems to proactively engage new mothers with on-time infant immunisation
- Collaboration with ACCHSs, community health centres and other services to integrate immunisation into routine health delivery
- Working in partnership with Aboriginal child care centres to promote timely immunisation
- Attending local community events to promote immunisation including Close the Gap events, NAIDOC Week and the Aboriginal Rugby League Knockout
- Collaboration with Building Strong Foundations for Aboriginal Children, Families and Communities and LHDs' Child and Family Health Services

For further information and resources on Aboriginal Immunisation, see:

<http://www.health.nsw.gov.au/immunisation/Pages/Aboriginal-Immunisation.aspx>

CASE STUDY

Improving immunisation among Aboriginal children in Western Sydney Local Health District

Immunisation coverage among Aboriginal children, in particular those in out-of-home care and other vulnerable children, was identified as a priority by Western Sydney Local Health District. The Immunisation Aboriginal Health Worker established organisational partnerships and networks with Aboriginal health workers in key stakeholders including the Community Health Service, Family and Community Services, the local Baabayn Aboriginal Women Elders and local Aboriginal childcare centres. These networks led to:

- The delivery of resources promoting immunisation through various services including information bags, flyers, education sessions for parents and training for services providers
- The development of a system with Family Community Services and the Public Health Unit to identify those children in vulnerable circumstances requiring immunisation and catch up schedules
- Utilising a purpose built database to compile a weekly report download for children overdue for vaccinations and generate SMS, email and letter reminders to parents.

Between 2013 and 2018 immunisation rates for Aboriginal children increased from 86.9% to 94.2% at 1 year of age, and from 91.6% to 97.8% at 5 years of age.

For further information contact the Western Sydney Public Health Unit Immunisation Team on **02 9840 3603**.

APPENDIX

Period		Aboriginal Health Dashboard – 2019 (Example data)									
		LHD				NSW					
2017	Aboriginal population (% of total population)	3.2%				3.0%					
		Aboriginal		Non-Aboriginal		Aboriginal		Non-Aboriginal			
2014	Patient reported 'good' or 'very good' care in hospital (BHI report)	90.0%		96.0%		89.0%		93.0%			
SAFETY AND QUALITY OF CARE											
	Measure	LHD *				NSW *				Aboriginal people in LHD	
2017/18	1. Reporting of Aboriginality in admitted patients	85.9% ↑2.6				87.4% ↑2.4				●	
		Aboriginal *	Non-Aboriginal *	Aboriginal *	Non-Aboriginal *	Aboriginal *	Non-Aboriginal *	Aboriginal *	Non-Aboriginal *	Progress	Gap
2017/18	2. Discharge against medical advice	2.4%	↓3.2	0.8%	↔0.0	2.3%	↓0.3	0.9%	↓0.1	●	●
2017/18	3. Unplanned/unexpected hospital readmission within 28 days	8.7%	↑0.7	8.2%	↓0.1	6.0%	↓0.4	6.0%	↓0.4	●	●
	4. Unplanned acute mental health readmission within 28 days	15.7%	↓6.7	12.5%	↓1.0	18.2%	↑0.9	14.4%	↑0.4	●	●
	5. Mental health patients followed up within 7 days of acute discharge	70.5%	↓2.7	79.7%	↓3.5	70.2%	↑3.5	75.8%	↑2.1	●	●
	6. Incomplete emergency department attendances ('Did not wait' or 'left at own risk')	4.9%	↔0.0	2.9%	↓0.1	7.5%	↑0.5	5.3%	↑0.4	●	●
	7. Unplanned emergency department representations within 48 hours to same ED	8.1%	↑0.3	4.4%	↓2.5	6.2%	↓0.2	4.7%	↓0.1	●	●
ACCESS TO CARE											
2017/18	8. % of all public dental activity provided to Aboriginal patients	7.5%	↑0.7			6.7%	↑0.7			●	
	Note: Aboriginal people are overrepresented in the population eligible for public dental services and have a higher burden of disease and should comprise a higher proportion of dental activity.										
2018	9. Biennial BreastScreen participation rate for women 50-74 years old	36.2%	↓4.1	51.3%	↑3.0	42.3%	↑0.7	52.9%	↓0.1	●	●
HEALTH OF MOTHERS BABIES AND CHILDREN											
2017	10. First ante-natal care < 14 weeks	43.4%	↑14.6	60.3%	↑10.0	68.1%	↑3.5	73.3%	↑5.5	●	●
	11. Smoking cessation recorded in the second half of pregnancy	25.0%	↑10.3	24.7%	↑3.2	16.0%	↓1.1	29.0%	↓1.1	●	●
	12. Low birth weight babies	9.5%	↑0.5	6.3%	↔0.0	11.1%	↑0.3	6.5%	↑0.2	●	●
2018	13. Full breastfeeding on discharge from hospital	74.4%	↓0.1	82.8%	↓1.3	61.7%	↓1.1	74.4%	↓1.0	●	●
	14. Fully immunised at 1 year	97.6%	↑2.1	95.7%	↑0.4	94.3%	↔0.0	93.9%	↑0.1	●	●
	15. Fully immunised at 5 years	97.5%	↓1.3	95.7%	↑1.4	97.3%	↑0.3	94.4%	↑0.6	●	●
	16. Influenza vaccination under 5 years of age	23.4%	↑0.9	28.9%	↑0.5	26.0%	↑20.0	24.3%	↑22.3	●	●
WORKFORCE											
2017/18	17. Aboriginal workforce	2.7% ↑0.2				2.6% ↑0.1				●	
At 30 June 2018	18. Respecting the Difference compliance face-to-face	78.2% ↑16.9				57.4% ↑13.5				●	

Key: * Percentage point change from the previous period

Progress (improvement since previous period for Aboriginal people excluding indicator #8, #14 and #15): ● = Performance has improved by =>2% or performance for Aboriginal people is better than for non-Aboriginal people and the NSW average, ● = Performance has worsened by =>2%, ● = No substantial change (less than 2% difference)

Gap (between Aboriginal and non-Aboriginal people in the LHD excluding indicator #8, #14 and #15): ● = Gap Closing, ● = Gap Widening, ● = No substantial change (less than 2% difference)

Progress and Gap for indicator #8: ● = Performance has improved by =>2% or performance =>2.2 times higher than Aboriginal population in LHD ● = Performance < 2.2 times higher than Aboriginal population in LHD

Progress and Gap for indicator #14 and #15: ● = Performance > 94%, ● = Performance < 94% and => 2% decrease since previous period, ● = Performance < 94% and < 2% decrease since previous period

DASHBOARD DATA SPECIFICATIONS

ABORIGINAL POPULATION	
Description	Proportion of the population that is Aboriginal at 30 June each year
Measure Type	Percentage
Numerator	The number of Aboriginal people living within the LHD at 30 June
Denominator	The total number of people living within the LHD at 30 June
Notes:	Based on population estimates developed by Prometheus Information Pty Ltd (SAPHaRI) from the 2011 Census data. Centre for Epidemiology and Evidence, NSW Ministry of Health
	NSW Ministry of Health
Data Source	HealthStats NSW http://www.healthstats.nsw.gov.au/Indicator/dem_pop_atSI/dem_pop_atSI_lhnmap

PATIENT REPORTED 'GOOD' OR 'VERY GOOD' CARE IN HOSPITAL (BHI REPORT)	
Description	Patient reported experience of care while in hospital
Measure Type	Percentage
Numerator	Number of people who answered good or very good
Denominator	Total number of people who answered the question "Overall, how would you rate the care you received while in hospital?"
Notes:	These data come from the Adult Admitted Patient Survey. In 2014 Aboriginal people were oversampled to ensure the sample size was sufficient to report by Aboriginality and by LHD.
Data Source	http://www.bhi.nsw.gov.au/BHI_reports/patient_perspectives/hospital_care_for_aboriginal_people/nocache

REPORTING OF ABORIGINALITY IN ADMITTED PATIENTS	
Description	Quality of reporting of Aboriginality in hospital data
Measure Type	Percentage
Numerator	Observed count of records reported for Aboriginal people in admitted patients
Denominator	Expected counts of records based on Enhanced Reporting of Aboriginality (ERA) variable
Notes:	<p>The level of reporting of Aboriginal people in each dataset is calculated by comparing the observed counts of records reported for Aboriginal people in the Admitted Patient Data Collection with the expected counts of records in the same data collection based on the ERA variable and presenting the result as a percentage.</p> <p>Enhanced Reporting of Aboriginality (ERA) is a method that improves reporting of Aboriginal people on administrative data collections using record linkage. Enhanced reporting relies on having independent sources of information on whether a person is Aboriginal. Each independent report is counted as a “unit of information” that contributes to the weight of evidence as to whether a person was reported as Aboriginal. The following approach was used:</p> <ol style="list-style-type: none"> 1. if the person has 3 or more units of information, at least 2 units indicating that the person is Aboriginal are required to report the person as Aboriginal; or 2. if the person has 1 or 2 units of information, 1 is sufficient to report the person as Aboriginal. This approach results in the creation of an ERA variable, which indicates whether the person is reported as Aboriginal based on the above weight of evidence. 3. if a person is listed as Aboriginal on their death certificate they are always reported as Aboriginal, regardless of the weight of other information. <p>The following data sets were used to create the ERA variable:</p> <ul style="list-style-type: none"> - NSW Admitted Patient Data Collection - NSW Emergency Department Data Collection - Australian Coordinating Registry Cause of Death Unit Record File - NSW Perinatal Data Collection - NSW Registry of Births, Deaths and Marriages birth registration records <p>See NSW Health Policy Directive <i>Aboriginal and Torres Strait Islander Origin - Recording of Information of Patients</i> for information on how Aboriginal and Torres Strait Islander status of clients accessing NSW public health services is collected and recorded: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2012_042.pdf</p>
Data Source	HealthStats NSW http://www.healthstats.nsw.gov.au/Indicator/dqi_era_apd/dqi_era_apd_lhn

DISCHARGE AGAINST MEDICAL ADVICE	
Description	Proportion of hospitalisations of patients ending in discharge against medical advice during the reporting period
Measure Type	Percentage
Numerator	Number of episodes of admitted patient care where the mode of separation is recorded as “left against medical advice / discharge at own risk” during the reporting period, by Aboriginality
Denominator	The total number of episodes of admitted patient care people during the reporting period, by Aboriginality
Exclusions	None
Data Source	NSW Admitted Patient Data Collection Hospital PAS Systems. HIE / EDWARD. NSW Admitted Patient Data Collection (SAPHaRI)

UNPLANNED/UNEXPECTED HOSPITAL READMISSION WITHIN 28 DAYS	
Description	The percentage of admissions that are an unplanned readmission to the same facility within 28 days following discharge for any purpose
Measure Type	Percentage
Numerator	The total number of unplanned admissions (counted as stays not episodes) with admission date within reporting period and patient discharged from same facility in previous 28 days for any purpose
Denominator	Total number of admissions (counted as stays not episodes) with admission dates within the reporting period
Exclusions	Additional episodes created through a change of care type; Transfers from other hospital (i.e. source of referral = 4 or 5); ED only admitted episodes (i.e. ED Status = 1 or 4)
Notes:	<p>Defining admissions – stays refer to entire period in hospital. Additional episodes of care can be created through a change of care type or transfers from other hospital (i.e. source of referral = 4 or 5).</p> <p>Unplanned is defined as Urgency of Admission (emergency_status) = 1.</p> <p>A readmission is defined as an admission with an admission_date within 28 days of the discharge_date of a previous stay for the same patient at the same facility (identified by MRN and facility_identifier).</p> <p>The definition of readmission has changed between 2014/15 and 2015/16. The 2015/16 definition includes ALL readmissions whereas 2014/15 definition excludes mental health/dialysis/chemotherapy</p>
Data Source	NSW Admitted Patient Data Collection

UNPLANNED ACUTE MENTAL HEALTH READMISSION WITHIN 28 DAYS	
Description	The percentage of overnight admissions that follow a previous overnight admission to any NSW acute mental health unit within 28 days
Measure Type	Percentage
Numerator	Overnight separations from a NSW mental health acute psychiatric inpatient unit(s) occurring within the reporting period, that are followed by an overnight readmission to the same or another acute psychiatric inpatient unit within 28 days
Denominator	Number of overnight separations from a NSW acute psychiatric inpatient unit(s) occurring within the reporting period
Exclusions	<p>Excludes separations where “mode of separation” = death, discharge at own risk, transfer, or type change</p> <p>Excludes same day separations. This exclusion applies to each separation in the denominator and any subsequent readmission.</p> <p>Excludes separations where the purpose of admission was for maintenance ECT and length of stay is one night only. This exclusion applies to each separation in the denominator and any subsequent readmission</p>
Notes:	<p>Separations are selected from NSW HIE Inpatient tables, where Ward Identifier = designated MH units and Unit Type=MH bed types, from Mental Health Service Entity Register (MH-SER) ward tables</p> <p>Readmission between facilities detected by</p> <ol style="list-style-type: none"> 1. SUPI where available or 2. Local identifier (combination of facility identifier and person identifier) where SUPI not available. <p>Primary point of collection: Administrative and clinical staff at designated facilities (including stand-alone psychiatric hospitals) with mental health units/beds</p>
Data Source	NSW Admitted Patient Data Collection

MENTAL HEALTH PATIENTS FOLLOWED UP WITHIN 7 DAYS OF ACUTE DISCHARGE	
Description	Percentage of mental health patients who received community follow up within 7 days of discharge, by Aboriginality
Measure Type	Percentage
Numerator	Overnight separations from NSW Acute Mental Health inpatient units occurring within the reference period which were followed by a recorded public sector Community Mental Health contact, in which the consumer participated, within the seven days immediately following that separation
Denominator	Number of in-scope overnight separations from a NSW acute psychiatric inpatient unit(s) occurring within the reference period.
Exclusions	Excludes same-day separations and separations where the mode of separation is death (6,7); discharge own risk (2); transfer to another acute or psychiatric inpatient hospital (4,5); type change (9). Post-discharge contacts do not include: Inpatient events in a mental health inpatient unit by inpatient staff, community contacts on the day of separation, community residential events in a community residential facility by community residential staff, non client-related events, travel time or contacts by non mental health program or NGO service providers.
Notes:	Includes follow-up in any LHD regardless of hospital of separation. Follow-up by AMSs, GPs, NGOs or private practitioners (eg psychologists, psychiatrists) is not included because activity from these providers is not captured in the Mental Health Ambulatory collection. Target = 70%
Data Source	NSW Health Information Exchange (HIE). Admitted Patient Data Collection linked to Mental Health Ambulatory collection using State Unique Patient Identifier.

INCOMPLETE EMERGENCY DEPARTMENT ATTENDANCES ('DID NOT WAIT' OR 'LEFT AT OWN RISK')	
Description	Proportion of persons who leaves before treatment is commenced or who leaves after treatment has commenced, against advice.
Measure Type	Percentage
Numerator	The number of presentations with departure date/time within the reporting period, where the mode of separation is '6' for 'did not wait' or '7' for 'left at own risk'
Denominator	All emergency department attendances in NSW, by Aboriginality
Exclusions	<ul style="list-style-type: none"> - Duplicate with same facility, MRN, arrival date, arrival time and birth date - ED visit type '12', '13' - Records where Mode of Separation is null or = '99'.
Notes:	
Data Source	Emergency Department Data Collection HIE (ED_Visit_mrn)

UNPLANNED EMERGENCY DEPARTMENT REPRESENTATIONS WITHIN 48 HOURS TO SAME ED	
Description	The percentage of emergency presentations to an Emergency Department where the patient returns to their place of usual residence following treatment and then re-presents at the same facility within 48 hours of departure from the Emergency Department
Measure Type	Percentage
Numerator	<p>The number of emergency presentations with departure date/ time within the reporting period where the previous emergency presentation of the same patient to the same facility was in the 48 hours and resulted in the patient returning to their place of usual residence following treatment where:</p> <ul style="list-style-type: none"> - Departure time is measured using ED departure date/time from the Emergency Department record - The time difference is measured from departure date/time of the first record to arrival date/ time of the subsequent record. <p>The subsequent record has:</p> <ul style="list-style-type: none"> - Visit type in ('1','3;') i.e. Emergency presentation or Unplanned return visit for continuing condition - Any separation mode <p>The immediately previous record has:</p> <ul style="list-style-type: none"> - The same MRN and facility_id - Is within 48 hours of the following presentation - Mode of Separation is ('2','4') i.e. Admitted and discharged as an inpatient in ED or Departed treatment completed - Visit type is ('1','3','11')
Denominator	<p>The number of emergency presentations with departure date/time within the reporting period, where the patient returns to their usual place of residence following treatment</p> <ul style="list-style-type: none"> - Visit type is ('1','3','11') i.e. Emergency presentation, Unplanned return visit for continuing condition or Disaster - Separation mode is ('2','4') i.e. Admitted and discharged as an inpatient in ED or Departed treatment completed <p>All persons includes all ED presentations Aboriginal includes ED presentations with indigenous status in ('1','2','3') only</p>
Exclusions	<p>Records where total time in ED is missing.</p> <ul style="list-style-type: none"> - Records where total time in ED is less than zero or greater than 99,998 minutes. - Overlapping records i.e. where the arrival date/time of the second record is before the departure date/time of the first record. In such circumstances, the second record is not included in the calculation of the indicator with respect to the ED visit preceding it. - Records where the separation mode on the initial presentation was not '2' or '4' - Duplicate with same facility, MRN, arrival date, arrival time and birth date - Records where Mode of Separation is null or = '99'.
Data Source	NSW Emergency Dept Data Collection, HIE (ED_Visit_mrn)

PUBLIC DENTAL ACTIVITY	
Description	The percentage of Dental Weighted Activity Units (DWAU) by Aboriginality
Measure Type	Percentage
Numerator	DWAU for Aboriginal patients
Denominator	Total DWAU for the LHD
Exclusions	
Notes:	A Dental Weighted Activity Unit (DWAU) is a Commonwealth measure based on the relative value of treatment provided in dental appointments. 1 DWAU is the equivalent of 11 dental examination items (ADA item number 011). The Commonwealth have a code set of allowable ADA treatment items with relative weighting against the index value of the 011, which is supplemented by NSW-based weighting for certain service items.
Data Source	Centre for Oral Health Strategy

BIENNIAL BREASTSCREEN PARTICIPATION RATE FOR ABORIGINAL WOMEN 50-74 YEARS OLD	
Description	Percentage of Aboriginal women in the target age group who were screened by BreastScreen NSW during the 24-month reporting period
Measure Type	Percentage
Numerator	Number of individual women residing in the Service catchment areas (LHD) in NSW aged 50-69 and 70-74 years who had one or more breast screening episode with any Service in the Program during the 24-month reporting period, by Aboriginality
Denominator	The population is the most recent Australian Bureau of Statistics (ABS) Aboriginal Estimate Residential Population (ERP) population forecast.
Exclusions	Interstate women are excluded Men Women for whom Indigenous status is not stated or missing are excluded from the numerator
Target	≥70% of women aged 50-74 years participate in screening in the most recent 24-month period
Notes:	
Data Source	BreastScreen NSW data

FIRST ANTENATAL VISIT BEFORE 14 WEEKS BY LOCAL HEALTH DISTRICT AMONG ABORIGINAL MOTHERS IN NSW	
Description	Percentage of women who gave birth where an antenatal visit was reported in the first trimester (up to and including 13 completed weeks) by mother's Aboriginality
Birth Type	Stillbirth or live birth
Measure Type	Percentage
Numerator	Number of women who gave birth where an antenatal visit was reported in the first trimester, by mother's Aboriginality
Denominator	Number of women who gave birth, by mother's Aboriginality
Exclusions	Women giving birth outside NSW, who normally reside in NSW
Notes:	Data includes all mothers who gave birth (stillbirth or live birth) in NSW regardless of place of permanent residence Stillbirth is defined as the complete expulsion or extraction from its mother of a product of conception of at least 20 weeks gestation or 400 grams birth weight who did not, at any time after birth, breathe or show any evidence of life such as a heartbeat.
Data Source	NSW Perinatal Data Collection (SAPHaRI)

SMOKING CESSATION RECORDED IN THE SECOND HALF OF PREGNANCY	
Description	Percentage of women recorded as not smoking in the second half of pregnancy, of all women recorded as smoking in the first half of pregnancy
Birth Type	Stillbirth or live birth
Measure Type	Percentage
Numerator	Number of women who smoked during the first half of pregnancy, and did not smoke at all in the second half of pregnancy, by mother's Aboriginality
Denominator	Number of women who smoked during the first half of pregnancy, by mother's Aboriginality
Exclusions	Aboriginal or non-Aboriginal women giving birth outside NSW, who normally reside in NSW, or who gave birth in a private hospital or an independent midwife
Notes:	As Aboriginal mothers are under-reported on the Perinatal Data Collection, it is likely that the true numbers of Aboriginal mothers are substantially higher than shown. Data include all mothers who gave birth (stillbirth or live birth) in a public hospital in NSW regardless of place of permanent residence. Data are reported on the basis of the Local Health District of the hospital of birth.
Data Source	NSW Perinatal Data Collection (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health

LOW BIRTH WEIGHT BABIES	
Description	Percentage of babies who are born with a low birth weight
Birth Type	Stillbirth or live birth
Measure Type	Percentage
Numerator	Number of newborn infants weighing less than 2500grams, by Aboriginality
Denominator	All births (stillbirths and live births) in NSW, by mother's Aboriginality
Exclusions	None
Notes:	<p>Birth weight is the newborn infant's first bare weight in grams. Low birth weight is birth weight less than 2,500 grams.</p> <p>As Aboriginal mothers are under-reported on the Perinatal Data Collection, it is likely that the true numbers of Aboriginal mothers are substantially higher than shown. Refer to the Related indicators tab for more information.</p> <p>Data for some LHDs may not be included individually due to low numbers. All LHDs includes these LHDs where numbers are low, and records where the LHD was missing or not stated. Albury Local Government Area (LGA) is included in All LHDs.</p> <p>Data include all births (stillbirths and live births) in NSW regardless of mother's permanent place of residence.</p>
Data Source	<p>NSW Perinatal Data Collection (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health</p> <p>Available on health stats: http://www.healthstats.nsw.gov.au/Indicator/mab_lb/mab_lbw_atsi_lhn</p>

FULL BREASTFEEDING ON DISCHARGE FROM HOSPITAL	
Description	Women who reported breastfeeding on hospital discharge, by Aboriginality
Birth Type	Live births only
Measure Type	Percentage
Numerator	Number of babies who are fully breastfed on discharge from hospital, by mother's Aboriginality
Denominator	Total live births, by mother's Aboriginality
Exclusions	Births occurring outside NSW to mother's that normally reside in NSW
Notes:	<p>Full breastfeeding on discharge includes babies who were breastfed or received expressed milk, any breastfeeding includes babies who received breastmilk and infant formula</p> <p>This measure looks at Aboriginal mothers who breast feed. Information on Aboriginal fathers is not reported on the Perinatal Data Collection, as such this indicator is not the same as percentage of Aboriginal babies that are breastfed. In addition Aboriginal mothers are under-reported on the Perinatal Data Collection so it is likely that the true numbers of Aboriginal babies are substantially higher than shown</p> <p>Data include live births in NSW regardless of mother's permanent place of residence.</p>
Data Source	<p>NSW Perinatal Data Collection (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health</p> <p>Available on Health Stats: http://www.healthstats.nsw.gov.au/Indicator/mab_feed_cat/mab_feed_cat_atsi_lhd_snap</p>

FULLY IMMUNISED AT 1 YEAR	
Description	The percentage of children aged 12 to 15 months who are registered with Medicare and have received all age appropriate vaccinations as prescribed by the Australian Immunisation Register, by Aboriginality
Measure Type	Percentage
Numerator	Number of Aboriginal children aged 12 to 15 months who have received all age appropriate vaccinations as prescribed by the Australian Immunisation Register
Denominator	Aboriginal children registered with Medicare Australia in 12 to 15 months age group
Exclusions	Children aged <12 months or > 15 months Vaccinations which are not prescribed by Australian Immunisation Register
Notes:	
Data Source	Australian Immunisation Register, Medicare Australia

FULLY IMMUNISED AT 5 YEARS	
Description	The percentage of children aged 60 to 63 months who are registered with Medicare and have received all age appropriate vaccinations as prescribed by the Australian Immunisation Register, by Aboriginality
Measure Type	Percentage
Numerator	Number of Aboriginal children aged 60 to 63 months who have received all age appropriate vaccinations as prescribed by the Australian Immunisation Register
Denominator	Aboriginal children registered with Medicare Australia in 60 to 63 months age group
Exclusions	Children aged < 60 months or > 63 months Vaccinations which are not prescribed by Australian Immunisation Register
Notes:	This indicator measures uptake of the vaccines due at 4 years of age by the time the child turns 5 years and 3 months
Data Source	Australian Immunisation Register, Medicare Australia

INFLUENZA VACCINATION COVERAGE UNDER 5 YEARS	
Description	The percentage of Aboriginal children between 6 months and under the age of 5 who have been vaccinated against influenza in the calendar year
Measure Type	Percentage
Numerator	Number of Aboriginal children aged 6 to 59 months recorded on the Australian Immunisation Register as receiving an influenza vaccine in the calendar year
Denominator	Number of Aboriginal children aged 6 to 59 months registered with Medicare Australia as of June 30.
Exclusions	Children aged < 6 months or > 59 months
Notes:	This indicator measures uptake of the funded annual influenza vaccination for Aboriginal children aged 6 months to 4 years of age. The denominator is an approximation of the number of children eligible throughout the year. The vaccination is most likely to be given between April and June, but can be administered at any time.
Data Source	Australian Immunisation Register, Medicare Australia

ABORIGINAL WORKFORCE	
Description	The percentage of staff employed in the health workforce who identify as Aboriginal
Measure Type	Percentage
Numerator	Total number of staff employed that indicate they are Aboriginal
Denominator	Total number of staff employed in health workforce
Exclusions	None
Target	2.6% representation of Aboriginal staff in the NSW Health workforce
Notes:	Note that Aboriginal people include people who identify as Aboriginal and/or Torres Strait Islander. This information shows the number of employed staff who responded to the Equal Employment Opportunity (EEO) question regarding Aboriginality. Not all staff employed respond to this section of the EEO form. Department of Premiers and Cabinet applies a weighting to the base staff employed figures to derive an estimate of the representation of the number of Staff employed that are Aboriginal to account for non-respondents.
Data Source:	Public Service Commission Workforce Profile via the State Management Reporting Service (SMRS)

RESPECTING THE DIFFERENCE COMPLIANCE FACE-TO-FACE	
Description	Percentage of staff employed in the health service who have completed face-to-face Respecting the Difference training
Measure Type	Percentage
Numerator	Number of staff currently employed who have completed face-to-face Respecting the Difference training
Denominator	Number of staff currently employed
Notes:	Respecting the Difference compliance data by online and face-to-face by LHD. Online Respecting the Difference training is a pre-requisite for undertaking the face-to-face training.
Data Source	Workforce Planning and Development

OVERVIEW OF THE AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE'S RESOURCE - USER GUIDE FOR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH¹

Summary of the National Safety and Quality Health Service Standards - User Guide for Aboriginal and Torres Strait Islander Health

Overview

The introduction of the National Safety and Quality Health Service Standards (second edition) requires health service organisations to address six actions that specifically to meet the needs Aboriginal people and re-orientate the health system.

The User Guide provides practical:

- Strategies for what to consider and how to bring the six actions to life in any health service organisation, and
- Examples from across Australia that demonstrate that these actions can be, and are being, implemented in health service organisations.

The guide outlines each of the six actions by what they mean for the organisation, the benefit of taking action, key tasks, examples of supporting evidence and details of additional resources.

Table 1: The six actions in the National Safety and Quality Health Service Standards that focus specifically on meeting the needs of Aboriginal people

Standard	Action	
Partnering with Consumers Standard	2.13	The health service organisation works <i>in partnership with Aboriginal communities</i> to meet their healthcare needs
Clinical Governance Standard	1.2	The governing body ensures that the organisation's <i>safety and quality priorities</i> address the specific health needs of Aboriginal people
	1.4	The health service organisation <i>implements and monitors strategies</i> to meet the organisation's safety and quality priorities for Aboriginal people
	1.21	The health service organisation has strategies to improve the <i>cultural awareness and cultural competency</i> of the workforce to meet the needs of its Aboriginal patients
	1.33	The health service organisation demonstrates a <i>welcoming environment</i> that recognises the importance of cultural beliefs and practices of Aboriginal people
Comprehensive Care Standard	5.8	The health service organisation has processes to routinely ask patients if they identify as being of <i>Aboriginal and/or Torres Strait Islander origin</i> , and to <i>record</i> this information in administrative and clinical information systems.

¹ National Safety and Quality Health Service Standards: User Guide for Aboriginal and Torres Strait Islander Health. <https://www.safetyandquality.gov.au/wp-content/uploads/2017/12/National-Safety-and-Quality-Health-Service-Standards-User-Guide-for-Aboriginal-and-Torres-Strait-Islander-Health.pdf>

Health service organisations can achieve the greatest impact when they:

- Strengthen relationships and partnerships
- Ensure equity in access and quality of care, according to need
- Recognise racist attitudes impact health outcomes
- Provide culturally safe care
- Demonstrate an understanding of, and respect for, the cultural identity of clients/families
- Consider the individual as a whole
- Include family in all patient planning and decision-making
- Taking a comprehensive approach to addressing health concerns at the point of service
- Strengthen links between primary care and acute sector
- Strengthen the Aboriginal workforce
- Engage with Aboriginal community organisations, services and individuals in ways that are relevant to their circumstances, concerns and priorities.

Steps to progress the six specific actions

1. Develop partnerships with Aboriginal communities and relevant Aboriginal community controlled health services, and mechanisms to ensure that these partnerships are sustainable and of mutual benefit (Action 2.13)
2. Ensure that the safety and quality care needs of Aboriginal people are addressed in the health service organisation's priorities (Action 1.2)
3. Undertake a gap analysis to help inform strategies and understand the specific needs of Aboriginal people in the health service organisation's catchment (Action 1.4)
4. Using the identified priorities, develop and implement strategies, in partnership with Aboriginal people, and establish associated monitoring and evaluation systems (Action 1.4)
5. Develop strategies to address the remaining actions (Actions 1.21, 1.33 and 5.8).

Table 2: Approach to addressing the six actions that specifically meet the needs of Aboriginal people



Actions	Key tasks	Examples of supporting evidence
<p>Action 2.13: Working in partnership</p>	<ul style="list-style-type: none"> Identify Aboriginal communities within the organisation's catchment, and the relevant cultural protocols to guide building of partnerships Identify key contacts, elders and opinion leaders in the Aboriginal communities and health services and make contact with them Establish and implement mechanisms for forming and maintaining partnerships with Aboriginal communities and representative organisations. 	<ul style="list-style-type: none"> Reports or summary descriptions of the Aboriginal patient population and communities Documentation from consultation processes, committees and meetings relating to the engagement of the Aboriginal community Documentation on consultation with Aboriginal communities Evidence-based clinical guidelines and decision support tools which have been co-designed in partnership with Aboriginal people Membership of Aboriginal people on the organisation's governing body, clinical governance committee or consumer advisory committee Memorandum of understanding or other documentation of formal partnerships with local Aboriginal health service providers and community groups Safety and quality action plans that incorporate Aboriginal communities' strengths-based approach and key principles of the <i>United Nations Declaration on the Rights of Indigenous Peoples</i>.
<p>Action 1.2: Addressing health needs of Aboriginal people</p>	<ul style="list-style-type: none"> In collaboration with Aboriginal communities, determine the priorities for the organisation to meet the needs of Aboriginal people in the organisation's catchment. 	<ul style="list-style-type: none"> Minutes of meetings, plans or strategies relating to development, endorsement or implementation of Aboriginal priorities overseen by the governing body, which deal with specific needs of the local community Documented targets and performance indicators for Aboriginal health outcomes of the health service organisation that are endorsed by, and reported to, the governing body Policies, procedures, protocols or project plans endorsed by the governing body that deal with the specific needs of Aboriginal people Records of consultations with Aboriginal communities relating to the development of priorities, targets and performance indicators Membership and terms of reference for the governing body or relevant advisory and consultative committees that include Aboriginal community representatives.
<p>Action 1.4: Implementing and monitoring targeted strategies</p>	<ul style="list-style-type: none"> Collaborate with managers and clinicians, together with Aboriginal clinicians and community representatives, to design and implement improvement strategies in priority areas Routinely monitor, report and evaluate processes, targets and measures of success against the priorities set by the governing body. 	<ul style="list-style-type: none"> Policies, procedures or protocols that incorporate the safety and quality priorities for Aboriginal people Templates of Aboriginal health impact statements, or examples of these impact statements being used to develop or revise policies or major projects Reports of performance against indicators for Aboriginal health outcomes and employment targets provided to the executive, governing body, and Aboriginal community Documents from committees and other meetings in which the safety and quality priorities and strategies for Aboriginal people are discussed Documentation of strategies implemented to meet the needs of Aboriginal people – for example, annual reports, newspaper articles, publications and newsletters.

Actions	Key tasks	Examples of supporting evidence
<p>Action 1.21: Improving cultural competency</p>	<ul style="list-style-type: none"> • Use the national <i>Cultural Respect Framework 2016–2026 for Aboriginal and Torres Strait Islander Health</i> to develop, implement and evaluate cultural awareness and cultural competency strategies • Implement an ongoing professional development program of cultural awareness and cultural competency that is tailored to the needs of the local Aboriginal community • Evaluate the effectiveness of the cultural awareness and cultural competency strategies • Develop and maintain mechanisms to partner with Aboriginal communities to gain feedback on, and improve, cultural competency • Develop and implement an Aboriginal employment strategy that incorporates: <ul style="list-style-type: none"> - training and ongoing professional development processes - workforce support, including systems to retain employees and provide appropriate employee assistance programs - recruitment of Aboriginal people to positions at all levels of the organisation - increasing employment opportunities for Aboriginal leaders by establishing leadership development programs and pathways • Use continuous quality improvement processes to improve the cultural safety of the health service organisation • Incorporate into the professional development program opportunities to discuss and develop the workforce's cultural awareness and cultural competency • Report on the effectiveness of the cultural awareness and cultural competency training to the governing body, the workforce, and the Aboriginal community. 	<ul style="list-style-type: none"> • Documentation from cultural competency training and assessments • Schedule of cultural awareness and cultural competency training • Data and reports on evaluation of the cultural competency of the health service organisation • Policies, procedures or protocols that cover cultural competency • Patient experience surveys and feedback • Hospital treatment and performance outcomes such as discharge against medical advice, and employment of Aboriginal clinicians • Documentation from meetings at which the cultural needs of Aboriginal employees are discussed, or strategies to meet their needs are identified, monitored or evaluated • Position descriptions, duty statements and employment contracts that detail the roles and responsibilities of the Aboriginal workforce • An Aboriginal employment strategy • Evaluation reports or routine updates provided to the governing body on strategies to improve cultural awareness and cultural competency • Established and monitored workforce targets; these include proportions of Aboriginal employees in the overall organisation workforce, and in clinical and non-clinical areas of the organisation.

Actions	Key tasks	Examples of supporting evidence
<p>Action 1.33: Creating a welcoming environment</p>	<ul style="list-style-type: none"> • Work in partnership with local Aboriginal people to identify strategies to create and maintain a welcoming environment • Implement and monitor the effectiveness of the strategies • Involve local Aboriginal people in evaluation of the environment • Consider the impact on Aboriginal people as part of planning for capital works programs and prioritise projects that have significant benefits for Aboriginal people. 	<ul style="list-style-type: none"> • Documentation of community consultation relating to creation of a welcoming environment • Policies, procedures or protocols on cultural diversity that cover the needs of Aboriginal patients and their families • Signs and plaques acknowledging traditional custodians • Statement of recognition, such as a plaque; printed words on glass doors and pavement; or artwork telling the story of place, traditional ownership, individuals or significant events • Flying of the Aboriginal flags, and a policy on half-mast days, including the death of a community member • Evidence of celebrating important events in the Aboriginal cultural calendar • Information brochures that outline what to expect when visiting the organisation, and the services available to support Aboriginal patients and families • Documentation of services that are tailored to meet the needs of Aboriginal people • Use of Aboriginal names (developed in partnership) for wards and meeting rooms • Survey results and reports on consumer satisfaction with the organisation's actions to meet the needs of Aboriginal communities • Availability of Aboriginal liaison officer(s) or health worker(s), including in emergency departments • Evidence that Aboriginal people are involved in the development and implementation of the strategies and that their views are sought routinely, particularly when the effectiveness of welcoming strategies are evaluated.

Actions	Key tasks	Examples of supporting evidence
<p>Action 5.8: Identifying people of Aboriginal and/or Torres Strait Islander origin</p>	<ul style="list-style-type: none"> • Develop and implement policy, procedures and protocols on Aboriginal identification • Raise awareness with Aboriginal community members of the importance and benefits of recording Aboriginal status • Promote self-identification by creating environments in health service organisations that are welcoming and friendly for Aboriginal people, including: <ul style="list-style-type: none"> - displaying Aboriginal or Torres Strait Islander arts in the service facilities - making promotional materials such as posters and pamphlets readily available • Train and support the workforce to collect identification information in a culturally appropriate way • Implement monitoring and evaluation systems to monitor and measure improvements in accuracy and consistency of identification rates, practices and data quality • Develop or adapt user-friendly data collection systems that transmit data between administrative and clinical data systems. 	<ul style="list-style-type: none"> • Policies, procedures and protocols outlining processes for identification of Aboriginal patients, and recording of this information in administrative and clinical information systems • Observation of the admission system to demonstrate that the identification question is mandatory • Prompts in the admission and patient information systems to complete identification fields • A continuous quality improvement protocol to monitor and review processes to improve the rate of Aboriginal identification and recording • Results of audits of completed admission records • Communication materials to inform Aboriginal and/or Torres Strait Islander people and encourage them to self-identify • Orientation manuals and education resources on requesting Aboriginal status and records of attendance at training by the workforce • Orientation manuals, memos, newsletters or other communication material provided to the workforce on the importance of identifying Aboriginal patients • Evidence that information is shared between administrative and clinical information systems.