

IMPROVING CULTURAL RESPONSIVENESS OF VICTORIAN HOSPITALS

FINAL REPORT

Acknowledgements

We acknowledge the traditional Aboriginal owners of country throughout Victoria and pay our respect to them, their culture and their Elders past, present and future. We acknowledge and are thankful to the many Aboriginal people who participated in this project and for the welcome they gave us as we visited their land and country.

To the Traditional Owners, Elders and community members in each community we visited, we hope we respected your land and country and that we walked lightly on it on the occasions we were there.

We would also like to thank the many staff at the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) who provided support, expertise and advice at critical points in the evaluation.

Disclaimer

The opinions, comments and/or analysis expressed in this document are those of the authors and do not necessarily represent the views of the Department of Health and Human Services.

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Abbreviations

ACCHO	Aboriginal Community Controlled Health Organisation
ACCO	Aboriginal Community Controlled Organisation
AEP	Aboriginal Employment Plan
AHLO	Aboriginal Hospital Liaison Officer
AMHLO	Aboriginal Mental Health Liaison Officer
BRHS	Bairnsdale Regional Health Service
CQI	Continuous Quality Improvement
DAMA	Discharge Against Medical Advice
DHS	Department of Human Services
DHSV	Dental Health Services Victoria
DNA	Did Not Attend
ED	Emergency Department
GEGAG	Gippsland and East Gippsland Aboriginal Cooperative
ICAP	Improving Care for Aboriginal and Torres Strait Islander Patients
IAHA	Indigenous Allied Health Australia
KMHLO	Koori Mental Health Liaison Officer
KMO	Koori Maternity Officer
KMS	Koori Maternity Service
KRA	Key Result Area

MDAS	Mallee Districts Aboriginal Services
MOU	Memorandum of Understanding
NAMHS	Northern Area Mental Health Service
NHAAC	Northern Health Aboriginal Advisory Committee
NSQHS	National Safety and Quality Health Service Standards
PECAC	Patient Experience Community Advisory Committee
QoC	Quality of Care
RAP	Reconciliation Action Plan
SOP	Statement of Priorities
SRHS	Sub-Regional Health Service
VACCHO	Victorian Aboriginal Community Controlled Health Organisation
VAED	Victorian Admitted Episodes Dataset
VAHS	Victorian Aboriginal Health Service
VEMD	Victorian Emergency Minimum Dataset
VHES	Victorian Healthcare Experience Survey
WIES	Weighted Inlier Equivalent Separation
WHCG	Wimmera Health Care Group
WPCP	Wimmera Primary Care Partnership

Preface

The hospital system is often very hard for Aboriginal people to understand. We live in a holistic environment and that is quite often not understood. Aboriginal culture is quite often not known by hospital staff and it is important when considering the journey of the patient in hospital and importantly the healing. Aboriginal people quite often face stereotypes, stigma and racism and this can put many barriers up from prior experience. There is a need to make sure the patient completely understands what is happening. Communication is quite often lacking. We need to understand all aspects to enable us to close the gap. As an Elder I am quite often asked for advice and assistance, I think every hospital should have Aboriginal advisors (Wurundjeri Elder, Aunty Di Kerr)

For many the reality is that hospitals, health centres, family and community services and other service ... are painful reminders of the marginalisation of Aboriginal people. This collective memory of past inappropriate or substandard treatment can be reinforced today by unintentional acts that are viewed as a continuation of the unwelcomed past (NT Government 2013)

In the process of undertaking this evaluation, more than 100 Aboriginal people (community members, consumers and staff) provided stories about their past and current experiences in Victorian hospitals. A consistent story that was retold many times over was that hospitals have been sites of trauma for many Victorian Aboriginal men, women and children. They have not been “*places of healing or where you got better*”. Many older women shared stories of not being allowed to give birth inside a hospital and how they had given birth on verandahs of hospitals or at ‘birthing trees’ within the grounds of the hospital. Stories were also shared of mothers who came to the hospital to give birth and left without their babies and, indeed, many who never saw their child again.

These experiences have reinforced for many people their sense of otherness and being in a strange and unsafe place. One Aboriginal woman was reminded that hospitals had been places where historically identity could be removed and currently it was “*best to leave it [identity] at the door*”.

This evaluation seeks to place the voice of Aboriginal people at the centre of its findings. The importance of hospitals being culturally responsive and culturally safe for Aboriginal people is best understood in terms of how Aboriginal people understand these terms. That is, Aboriginal people suggested hospitals need to be places that acknowledge local Aboriginal people and culture; recognise past trauma and are sensitive to its effects; do not (re) produce such trauma; and ensure – as far as possible – local Aboriginal people still feel they are on their own country when they enter the hospital. It is important too that Aboriginal people living off country feel recognised and accepted. While there are some complex policy responses at the state, regional and local level described in this report, Aboriginal people are hopeful for simpler initiatives and actions:

It takes a lot for me to walk into a hospital... even more to stay but seeing our flag and an acknowledgement of who we are makes a huge difference. Just a small thing like that. Every hospital can do that (Elder)

Executive Summary

This evaluation is part of a wider evaluation of the *Koolin Balit* Investment and was commissioned by the Department of Health and Human Services (the department) to examine Victorian hospital's efforts to improve the cultural responsiveness and cultural safety for Aboriginal people.

The five evaluation questions under examination are:

1. To what extent have Victorian hospitals improved their cultural responsiveness to Aboriginal people?
2. To what extent have people's healthcare experiences in Victorian hospitals (including cultural safety) changed?
3. What strategies have led to the most significant and sustainable improvements in cultural responsiveness and cultural safety of hospitals for Aboriginal people and staff? What are the critical contextual factors which enabled this success, and how could the successful strategies be replicated in other hospitals/settings? Have there been any unintended consequences of the successful strategies?
4. Are there strategies being employed which are relatively ineffective or unsustainable?
5. How can we improve measurement and monitoring of cultural responsiveness and cultural safety, both by individual hospitals and state-wide? How can we incorporate measuring the gaps between Aboriginal and non-Aboriginal people's access to quality care as a key impact?

The evaluation was conducted during January 2016-October 2016 and relied on a predominantly qualitative approach. There were four phases to the methodology. These were:

- › Consultations: Over forty consultations were held with key department staff (central and regional) and external stakeholders to the department including hospital Chief Executive Officers and in the Loddon Mallee region Board Chairs
- › Document and Data Review: A content analysis was undertaken of more than 200 documents which included Continuous Quality Improvement reports, Quality of Care reports, Statement of Priorities analysis, Aboriginal Employment Plans, Victorian Healthcare Experience Survey results, previous evaluations and academic research
- › Case Studies: Seven case studies were undertaken in the following Victorian hospitals - Barwon Health, Mildura Base Hospital, Wimmera Health Care Group, Bairnsdale Regional Health Service, Northern Health, Dental Health Services Victoria and Alfred Hospital. Interviews were undertaken with hospital staff, local Aboriginal Community Controlled health Organisations, patients and community members, and other key stakeholders
- › Aboriginal Hospital Liaison Officer (AHLO) Survey: An online survey was provided to all AHLOs / Koori Mental Health Liaison Officers (KMHLOs) exploring the findings from interviews with AHLOs / KMHLOs at case study sites. The survey was administered through the ICAP Network with the assistance of the Victorian Aboriginal Community Controlled health Organisation (VACCHO). There were 15 surveys returned with a response rate of 20 per cent.

This evaluation places the voices of Aboriginal people at the centre of the findings. Of the 173 interviews conducted for this evaluation, 144 were Aboriginal people. Of these 98 were patients and community members who provided stories about their experiences in Victorian hospitals. A consistent story that was retold many times over was that hospitals had been sites of trauma for many Victorian Aboriginal men, women and children. They had not been *“places of healing or where you got better”*.

There are a number of theories and definitions of cultural responsiveness and cultural safety explored in the report. The evaluation draws of the definitions used in Koolin Balit and the definitions as they emerged from community interviews.

	Cultural Responsiveness	Cultural Safety
Koolin Balit	Healthcare services are respectful of and relevant to the health beliefs, practices and cultural needs of the communities they service. This is more than cultural awareness. Organisations have processes and systems in place to achieve cultural change and to embed it in everyday behaviour.	People feel safe and secure in the hospital environment due to shared respect, meaning, knowledge and experience, ensuring dignity and truly listening. Cultural safety incorporates cultural sensitivity which refers to sensitivity to cultural factors, and taking them into account.
Community	Health services will listen to and understand our needs and demonstrate empathy. Staff will involve us in our own health care and the services themselves will know and respect our Elders, our land and our culture because they will trained in cultural safety training. They will know the importance of working alongside us and our people. It is about the way you do business with us to help us improve our health.	The feeling and the experience that means we feel like we are still connected to culture, community and country in the health service. Our [Aboriginal] flag will be flying outside of the service and the entrance will acknowledge our Traditional Owners. There will be no loss of identity or dignity and we will feel welcomed and at ease. Being Aboriginal will not lead to a feeling of otherness, outsider or feeling unwelcome - our Aboriginality is a normalised and accepted part of our identities.

Across the stakeholder consultations, the data and document review and seven case studies, a set of highly consistent themes emerged. The themes were as salient for hospital Board members, hospital Executives and non-Aboriginal health professionals as they were for Aboriginal Elders, Aboriginal health workers, Aboriginal community members and Aboriginal patients and their families. Effective and ineffective strategies for improving cultural responsiveness and cultural safety are contained within these six key themes. These are consistent with the literature theorising cultural responsiveness and cultural safety within health service settings.

Committed Leadership

Leadership and commitment within hospitals at the Board, CEO and Executive level is a necessary though not sufficient factor in enhancing culturally responsive care and cultural safety such that hospital staff and the Aboriginal community are enabled and experience change. Many hospital CEOs and leaders are looking for support to improve cultural responsiveness and cultural safety.

Relationships with Aboriginal Community Controlled Health Organisations (ACCHOs)

Relationships with ACCHOs are deemed a necessary though not sufficient factor to guaranteeing culturally responsive care and cultural safety for Aboriginal community members. They provide value in hospitals accessing local cultural knowledge, supporting the AHLO and building cultural competency / safety in the hospital.

AHLOs and a Stronger Aboriginal Health Workforce

The role of the AHLO is deemed critical to enhancing culturally responsive care and ensuring the cultural safety of patients. As critical roles within the hospital experience and as bearers of important knowledge and expertise, AHLOs mostly feel undervalued and neglected. AHLOs are the subject and object of community trauma and as such their roles are highly stressful and stress leave was common. Without sufficient support, legitimacy and acknowledgement of these roles, culturally responsive care and cultural safety become highly vulnerable for Aboriginal patients.

A Welcoming Environment

Aboriginal people place great importance on the display of flags outside the hospital and Acknowledgement of Traditional Owner plaques and local Aboriginal artwork inside hospitals. This has the effect of enabling people to feel they are still connected to land, community and culture. A welcoming environment plays a significant part in Aboriginal patients having a positive experience and feeling – in the first instance – culturally safe. However, these can feel tokenistic if the service system does not support them.

Cultural Safety Training

Hospitals generally view some form of cultural training as important. There are various mechanisms for developing and implementing programs. There is no evidence of particular standards that programs need to meet, though most hospitals have a preference for local providers. The results of such training are only anecdotal as there was no evidence available of systematic capturing of performance and / or outcomes. Hospitals are looking for more support with strategies / protocols for developing training, contracting providers, determining content and measuring the impact at the service and community levels.

Monitoring and Reporting

There is no rigorous monitoring or reporting at the hospital or statewide level of cultural responsiveness or cultural safety. The mechanisms for reporting that are in place are ad hoc, non-mandatory and provide an incomplete story at the sector level with regard to cultural responsiveness or cultural safety.

Further, there is no reliable data at the hospital or statewide level of Aboriginal patient experience. The Victorian Healthcare Experience Survey (VHES) data is problematic but suggests Aboriginal patient experience (inpatients and presentations to ED) is worse than for non-Aboriginal patients. The VHES data demonstrates higher levels of satisfaction of care for Aboriginal patients than the level expressed in community interviews.

The evaluation provides a set of indicators and measures that will assist hospitals to improve monitoring and reporting cultural responsiveness or cultural safety. This becomes more critical with the introduction of mandatory actions related to improved services for Aboriginal people in the 2015-16 Statement of Priorities and the new National Safety and Quality Health Service Standards being introduced in the next two years. The indicators and measures ensure progress can be monitored over time at the statewide and service level and learnings, successes and challenges can be shared.

Overall the evaluation finds that increasing the support and capacity of the AHLO/KMHLOs will have the biggest impact on cultural responsiveness and cultural safety.

1. Background

This evaluation was commissioned by the Department of Health and Human Services (the department) to examine Victorian hospitals' efforts to improve cultural responsiveness and cultural safety for Aboriginal people¹. The five evaluation questions under examination are:

1. To what extent have Victorian hospitals improved their cultural responsiveness to Aboriginal people?
2. To what extent have people's healthcare experiences in Victorian hospitals (including cultural safety) changed?
3. What strategies have led to the most significant and sustainable improvements in cultural responsiveness and cultural safety of hospitals for Aboriginal people and staff? What are the critical contextual factors which enabled this success, and how could the successful strategies be replicated in other hospitals/settings? Have there been any unintended consequences of the successful strategies?
4. Are there strategies being employed which are relatively ineffective or unsustainable?
5. How can we improve measurement and monitoring of cultural responsiveness and cultural safety, both by individual hospitals and statewide? How can we incorporate measuring the gaps between Aboriginal and non-Aboriginal people's access to quality care as a key impact?

1.1 Context

In 2003 and in the context of growing State Government concern about the health status of Aboriginal people in Victoria, the then Department of Human Services (DHS) commissioned the VicHealth Koori Health Research and Community Development Unit to produce the *Aboriginal and Torres Strait Islander Hospital Accreditation Report*. The report laid the groundwork for what is now the *Improving Care for Aboriginal Patients* (ICAP) program. The report focused on the policies, processes and procedures in health services which would lead to high quality, culturally responsive care, rather than on the role of a single Aboriginal worker, such as an AHLO.

In partnership with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO), DHS agreed on a new approach and from 2004 amalgamated previously separate funding for the Aboriginal Hospital Liaison Officer (AHLO) program and the Weighted Inlier Equivalent Separation (WIES) supplement. The aim was to provide a single coherent funding stream proportional to the health service's Aboriginal patient numbers and appropriate incentives to improve identification. Reflecting both this amalgamation and the injection of new funds, the WIES supplement was increased from 10 per cent to 30 per cent for Aboriginal patients.

¹ This document uses the term Aboriginal except where specific reference is required for the inclusion of Torres Strait Islander People. While Koori refers to Aboriginal people from South-Eastern Australia, the term Aboriginal rather than Koori is used, except when Koori is part of a title, to reflect the fact that not all Aboriginal people living in Victoria are Koori

This new funding regime aimed to increase the measures hospitals were taking to report the identification of Aboriginal and Torres Strait Islander patients – something that had been mandatory since 1993. That is, all Australian-born patients should be asked at every admission if they are of Aboriginal and/or Torres Strait Islander origin. The patient's self-identification should then be recorded by the hospital.

Since 2008 the Victorian Government committed \$119 million to support a wide range of initiatives to improve the health and wellbeing of Aboriginal people in Victoria. The aim was to achieve equality in health status and closing the gap in life expectancy between Aboriginal and non-Aboriginal people by 2030. The policy frameworks for achieving these aims have been *Closing the Health Gap*, and subsequently *Koolin Balit: Victorian Government strategic directions for Aboriginal health 2012–2022* ('*Koolin Balit*' hereafter).

Koolin Balit outlines the Victorian Government's policy directions for Aboriginal health from 2012 to 2022 to make a significant and measurable impact on improving the length and quality of the lives of Aboriginal Victorians.

The priorities set out in *Koolin Balit* (healthy start, healthy childhood, healthy transition to adulthood, caring for older people, addressing risk factors and managing illness better with effective health services) are those that Aboriginal communities identified as important during consultations. The three enablers that provide a foundation for results in these priorities are:

1. Improving data and evidence
2. Strong Aboriginal organisations
3. Cultural responsiveness.

The importance of this evaluation lies in the fact that *Koolin Balit* seeks to address the circumstance of Aboriginal Victorians continuing to experience poorer health and lower life expectancy than the general community. In the context of this evaluation, such health outcomes are compounded by the fact that Aboriginal people have been reluctant to present to hospitals as they have historically been places and spaces of trauma. Further, when Aboriginal people do present, they are more likely to have more acute and complex health issues.

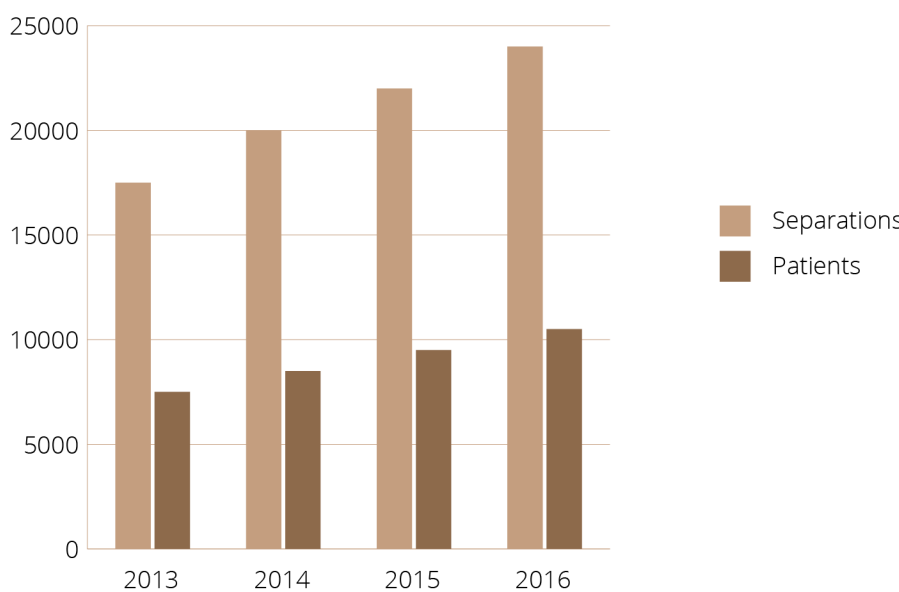
Importantly, since the introduction of the ICAP program and *Koolin Balit* – and post the *ICAP and KMHLO Developmental Review* – hospital admissions for Aboriginal and Torres Strait Islander patients have continued to rise. This could be due to increased identification or rising health needs. Either way, the imperative to build culturally responsive care and culturally safe environments for Aboriginal people is becoming more pressing each year.

Koolin Balit outlined a policy challenge with regard to the care Aboriginal people are likely to experience when accessing health services. This challenge lies in the fact that the Victorian Aboriginal population is 0.65 per cent of the total Victorian population and therefore are thought to make up a small proportion of most health services patients. This results in Aboriginal health being marginalised in health services. However, the data suggests Aboriginal patients are in fact anything but a small proportion of patients. For most hospitals, the proportion of presentations and admissions is much higher than the 0.65 per cent of the overall population. Indeed, DDHS health service separations data (provided by the department September 2016) demonstrates that in 2015/16 the state average was 0.9 per cent.

In regional and rural areas, presentations of Aboriginal and Torres Strait Islander patients can be very high. For example, the same data provided by the department reveals that at Robinvale District Health in 2015/16 more than 12 per cent of hospital separations were Aboriginal and Torres Strait islander, while nearby at the Mildura Base Hospital almost 11 per cent of all hospital separations were Aboriginal and Torres Strait Islander. For health service providers to feel that being responsive to the needs of Aboriginal people is not relevant for them because Aboriginal patients are few, goes against the data. Further, knowing that not every Aboriginal patient is identified, this under-representation of Aboriginal patient admissions requires action.

Across Victoria the number of Aboriginal patients experiencing hospital separations continues to rise on an annual basis (see Diagram 1 below). One in four Aboriginal and Torres Strait Islander people living in Victoria will be admitted to hospital this year and are therefore 1.4 times more likely to have a hospital separation than non-Aboriginal people.

Diagram 1: Hospital Separations (Aboriginal and Torres Strait Islander People) 2013-16 for Victorian Public Hospitals²

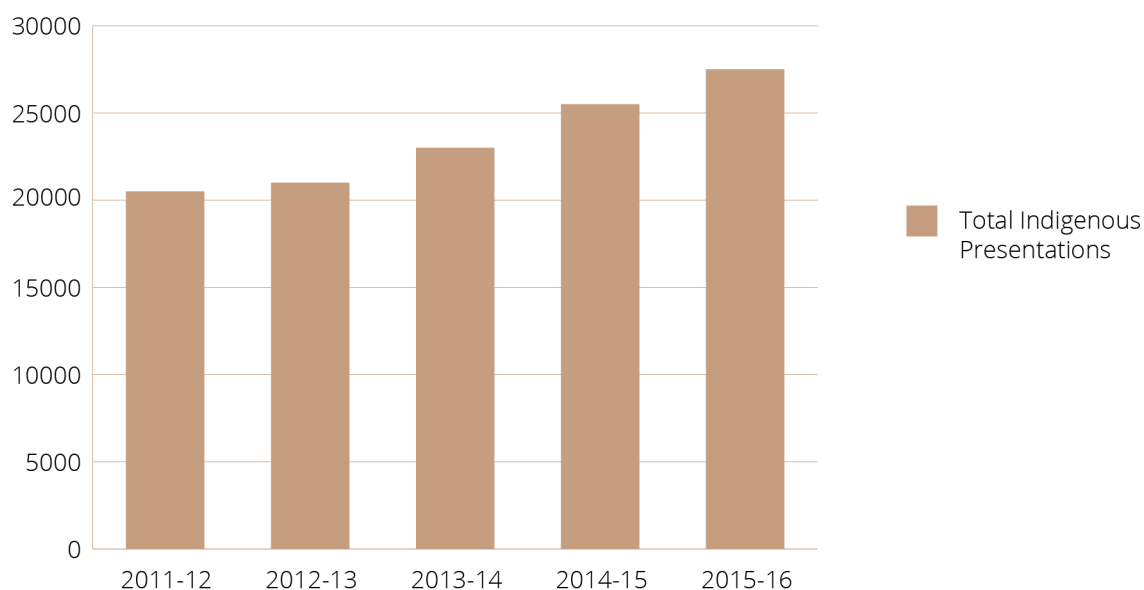


² Data provided by the department.

In 2015-16, there were more than 23,000 hospital separations for Aboriginal and Torres Strait Islander patients in Victorian public hospitals. This accounted for over 11,000 individual patients and marks a 33 per cent increase since 2013.

Across Victoria the number of Aboriginal patients visiting an Emergency Department (ED) also continues to rise on an annual basis (see Diagram 2 below). Aboriginal and Torres Strait Islander people living in Victoria are 1.4 times more likely to visit ED than non-Aboriginal people.

Diagram 2: Presentations to ED (Aboriginal and Torres Strait Islander People) 2013-16 for Victorian Public Hospitals³



In 2015-16 there were 28,180 Aboriginal and Torres Strait Islander people presentations at ED which is 1.7 per cent of all presentations. This represents a 37 per cent increase over five years.

While improved identification processes may in part explain the increase, it could equally be due to increased health challenges for Aboriginal people. At neither the site / service level nor statewide level has the reason for this increase been determined. The case studies in this evaluation suggests some hospitals have improved processes for identification but they also point to identification still being problematic for many people and within hospitals' processes for capturing cultural identity.

³ Data provided by the department.

The evidence demonstrates that a significant percentage of Aboriginal and Torres Strait Islander patients walk into the Victorian hospital environment each year and in increasing numbers. Further, it has already been noted that when they do, they present with more acute and complex health issues (*Koolin Balit* 2012). There is also evidence that when presenting to ED, Aboriginal and Torres Strait Islander patients are more likely to leave without treatment (LWT) than non-Aboriginal patients and when admitted are more likely to Discharge Against Medical Advice (Shaw 2016).

The data on the rates of Discharge Against Medical Advice (DAMA) in Victorian hospitals was not available at the time of writing this report. However, previous studies have demonstrated that Aboriginal people are over-represented in rates of DAMA – and especially in remote and rural contexts. This suggests acute care settings are not effectively addressing the concerns of Aboriginal patients in order to keep them engaged in care for the full duration of their treatment. The causal factors are complex and diverse and include institutionalised racism, a lack of cultural safety, a distrust of the health system, miscommunication, family and social obligations, and isolation and loneliness (Shaw 2016).

This evaluation examines the strategies hospitals are using to make that environment more welcoming and the degree to which patients feel culturally safe and receive culturally responsive care. The next section outlines the methodology.

2. Methodology

This section provides an overview of the methodology used for the evaluation. The evaluation was conducted during January 2016-October 2016 and relied on a predominantly qualitative approach.

2.1 Methodological Overview

In answering the five evaluation questions, a set of sub-questions were developed as a means to providing a deeper engagement with the evaluation questions.

Table 1: Evaluation Questions and Sub-Questions

Evaluation Question	Sub-questions
To what extent have Victorian hospitals improved their cultural responsiveness to Aboriginal people?	<ul style="list-style-type: none"> › Are hospitals achieving accurate identification of Aboriginal people? Where this is being done well, what is enabling them to do this and what are the challenges? › How are hospitals demonstrating respect for Aboriginal people? › How are the practices and cultural needs of Aboriginal people and communities respected / not respected? › What have been the changes in attitudes, understanding, and practices of hospital staff that demonstrate greater and more inclusive practices for Aboriginal people? › What are the changes in staff behaviour and organisational practices/ processes and what have been the enablers and drivers of such change? › Can levels of change since the ICAP Evaluation in 2011 be measured and reported?
To what extent have people's healthcare experiences in Victorian hospitals (including cultural safety) changed?	<ul style="list-style-type: none"> › In what ways are Aboriginal people feeling safe when entering and staying in hospitals? What creates a safe environment? › Do Aboriginal people report feeling respected, valued and included? › Are Aboriginal people being listened to in a way where knowledge is shared and understood? How is this demonstrated? › Is it possible to currently and / or in the future report gaps between the experiences of Aboriginal and non-Aboriginal?

Evaluation Question	Sub-questions
What strategies have led to the most significant and sustainable improvements in cultural responsiveness and cultural safety of hospitals for Aboriginal people and staff?	<ul style="list-style-type: none"> › What are the strategies that have been developed and implemented within the hospital setting? › How is success defined? Which strategies have been successful? › Why (how, and in what context for whom) were some strategies unsuccessful / ineffective? › What were the contextual enablers / barriers to success?
What has been ineffective / unsustainable?	<ul style="list-style-type: none"> › Are there partnerships in place with Aboriginal people, communities and organisations? What difference do these partnerships make and for whom in terms of improved cultural responsiveness for Aboriginal patients? › What are the organisational and workforce development strategies that have been used? How is success being measured?
How can measuring and monitoring of cultural responsiveness and cultural safety be improved?	<ul style="list-style-type: none"> › <i>This was to be developed as a key outcome of the evaluation</i>

In addressing these questions and sub-questions there were four phases to the evaluation.

Diagram 3: Methodological Overview

Consultations	
Over forty consultations were held with key department staff (central and regional) and external stakeholders to the department including hospital CEOs and in the Loddon Mallee region Board Chairs.	These interviews provided important background and information with regard to key initiatives within the Koolin Balit investment at central and regional levels. They also informed the Document and Data Review
Document and Data Review	
A content analysis was undertaken of more than 200 documents. Almost 50 per cent of these documents were Continuous Quality Improvement reports from 2013 and 2014.	Quality of Care, Statement of Priorities, Aboriginal Employment Plans, VHES survey results, previous evaluations and academic research were all part of the review and an Evidence Report was the output of the review.
Case Studies	
Seven case studies were undertaken in the following Victorian hospitals - Barwon Health, Mildura Base Hospital, Wimmera Health Care Group, Bairnsdale Regional Health Service, Northern Health, DHSV, Alfred Hospital	Interviews were undertaken with hospital staff, local ACCHOs, patients and community members, and other key stakeholders. The Evidence Report - as an output of the previous methodological stage - informed the development of the Interview Guides.
AHLO Survey	
An online survey was provided to all AHLOs / KMHLOs exploring the findings from interviews with AHLOs / KMHLOs at case study sites	The survey was administered through the ICAP Network with the assistance of VACCHO. There were 15 surveys returned with a response rate of 20 per cent.

2.2 Data and Document Review

The document review identified what is reported and documented at a department and service level. The aim being to inform and begin the process of answering the evaluation questions. Specifically, the document review considered the following questions:

- › How are key concepts (primarily cultural responsiveness and cultural safety) being defined at the department, sector, health service (hospital) and community levels?
- › What are the current reporting (mandatory, compliance or voluntary) mechanisms in place at a health service level and what are the common and divergent features of such reporting?
- › What enablers and barriers can be identified to providing cultural responsive care and ensuring cultural safety?
- › What evidence is there of Victorian hospitals improving cultural responsiveness to Aboriginal people and how is improvement being measured?
- › What data sets exist that could provide baseline data from which current and / or future progress can be measured?
- › How are Aboriginal people's healthcare experiences in Victorian hospitals (including cultural safety) being measured and are there reportable changes over time?
- › What is the efficacy of the Victorian Healthcare Experience Survey (VHES) in relation to measuring Aboriginal people's healthcare experiences in Victorian hospitals?
- › What are the reportable strategies hospitals have developed to improve cultural responsiveness and cultural safety and how are they being reported as being effective?
- › To what degree does measurement and monitoring of cultural responsiveness and cultural safety, provide meaningful information about differences and similarities in the quality of care between Aboriginal and non-Aboriginal people?

The purpose of the document analysis was to identify existing evidence of strategies, measures and improvements Victorian hospitals use and measure with regard to cultural responsiveness and cultural safety. This analysis, occurring alongside the consultations, provided context for the case studies undertaken across seven sites and identified significant gaps in measurement and reporting.

2.3 Case Studies

Seven in-depth studies in hospital / health settings were undertaken⁴. Site Selection Parameters were developed and guided the selection of case study sites:

- › There is a high Aboriginal population in the area
- › A low proportion of Aboriginal versus non-Aboriginal admissions but a high proportion of Aboriginal versus non-Aboriginal community members
- › The site has a mental health service
- › The site has a maternity service
- › A statewide service is included as a case study
- › Aboriginal Employment Plans are in place at all sites
- › The case studies are a mix of rural and metropolitan sites
- › Large and small services are included based upon the number of staff in the organisation
- › Some case study sites are close to, or have close links to, an ACCHO
- › Some case study sites are selected that are not close, or do not have links with, a nearby ACCHO
- › Some sites have received funding for clinical engagement projects
- › There is an AHLO/KMHLO and/or Aboriginal workforce
- › Certain sites are selected that are thought to be in the early stages of developing approaches to cultural responsiveness and cultural safety
- › Consideration is given in selection to the presence of other Koolin Balit evaluations and minimising evaluation burden.

In giving consideration to each of the Site Selection Parameters, Table 2 provides details of the seven case study sites and the parameters they met.

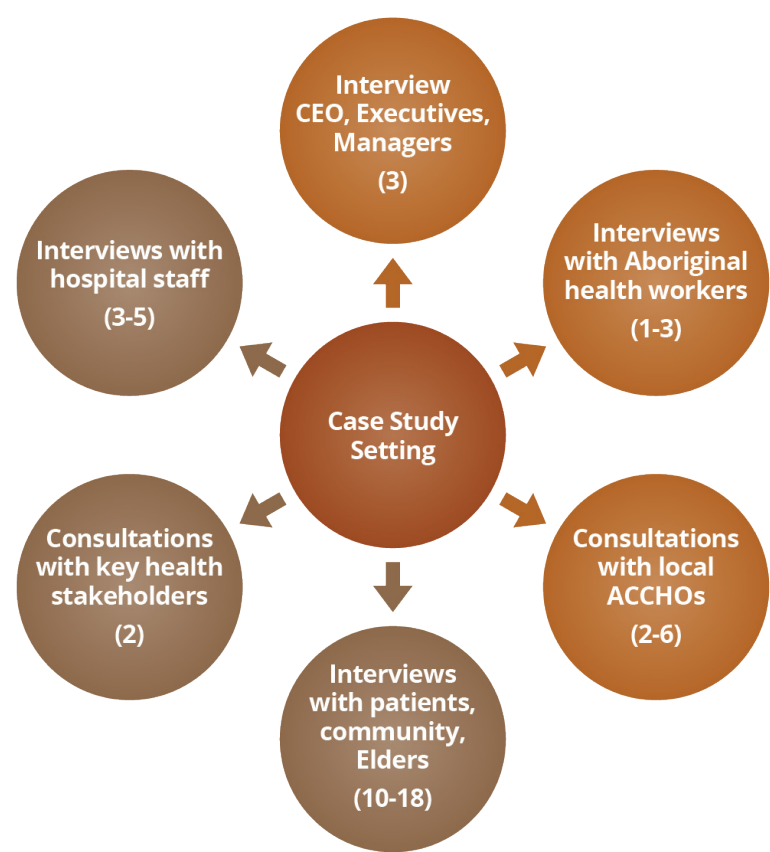
⁴ There were eight cases study sites selected. One site declined due to the fact that the service had been involved in a recent evaluation and there was concern about evaluation burden on the community and their own staff.

Table 2: Overview of Case Study Sites

Division	Hospital	Parameters included
North	Mildura Base Hospital (Ramsay Health)	Large, rural, inclusive of mental health, large ACCHO in the region, Aboriginal staff, large Aboriginal population, minimal <i>Koolin Balit</i> evaluation load. Has an ED Clinical Engagement Project and inclusive of an Aboriginal Employment Plan.
West	Barwon Health	Inclusive of maternity, mental health and clinical engagement, has an ACCHO in the region, AHLO employed, and thought to have an interesting HR/recruitment approach inclusive of an Aboriginal Employment Plan.
West	Wimmera Health Care Group	This is an emerging / less well developed site that has a link to an ACCHO and an Aboriginal Employment Plan.
South	Bairnsdale Regional Health Service	There is a large Aboriginal population, has an ACCHO in the region, is very rural and has a cardiac care link to St Vincent. There is CEO leadership, an integrated health service, large Aboriginal staff and an Aboriginal Employment Plan.
Statewide	Dental Health Services Victoria	This is a statewide health service and has outreach models. Inclusive of oral health and has a large Aboriginal population of users of service. Provides a very different model from other sites and has a unique funding model. It will allow for an examination of the impact of oral health for improving health and wellbeing of children, adults and families. The service has an Aboriginal Employment Plan.
North	Northern Hospital	Inclusive of mental health, clinical engagement and maternity and has an AHLO. The hospital provides services within a catchment for a growing population in outer suburbs and has an Aboriginal Employment Plan.
South	Alfred Hospital	Inclusive of mental health, clinical engagement and has an AHLO. The hospital is still early in the journey and has an Aboriginal Employment Plan.

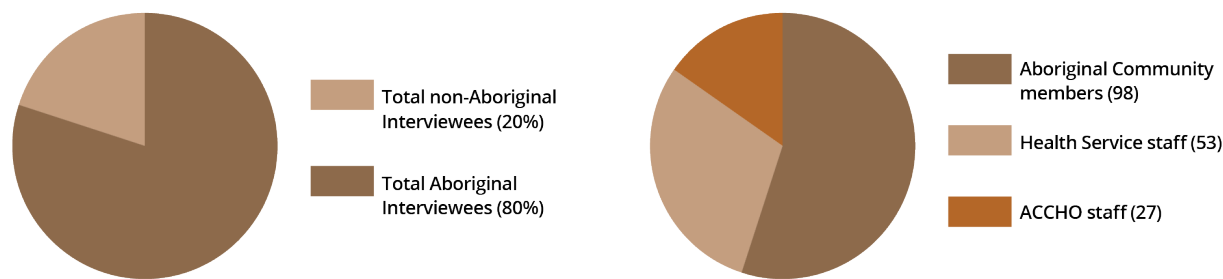
In terms of engagement with each hospital / setting, Diagram 4 below outlines the key components for completing the in-depth studies and data collection points including the number of interviews per case study site.

Diagram 4: Key Informants of In-depth Hospital Case Studies



The structure of the interviews and data collection at each site aims to ensure there is a continuous cycle where information flows into and out of both the hospital and community. Diagram 5 below gives a summary of the total number of consultations across the seven case study settings.

Diagram 5: Summary of Interviews across Case Study Sites



2.4 Governance

The evaluation received ethics approval from the St Vincent's Human Research Ethics Committee. The Department established a Project Reference Group that provided input into the evaluation from commencement to completion. Further, VACCHO was consulted throughout the evaluation and a number of workshops were held to explore the emerging themes and the findings.

2.5 Methodological Limitations

Despite the rigorous and consultative process of developing the methodology, there were a number of limitations that impacted on the ability of the evaluation to fully address the evaluation questions. Limitations included the following:

- › A paucity of valid and consistent measures of hospital efforts to improve cultural responsiveness and cultural safety meant there were challenges reporting change over time. Further, no baseline data reporting Aboriginal people's experience of hospital services with regard to cultural responsiveness and cultural safety from which change over time could be measured
- › There was a general lack of data that could inform the evaluation questions and, with no evaluation frameworks in place, the analysis of hospital efforts to improve cultural responsiveness and cultural safety in an integrated way was limited
- › While the case studies are a representative mix across the parameters developed as a tool for selecting sites – and noting the findings were consistent across each case study site – care should be taken in generalising the findings across all Victorian public hospitals
- › While some hospital Board members were engaged, they could not be accessed at all sites and therefore the evaluation was not able to fully explore the relationship between the Board and the Executive with regard to cultural responsiveness and cultural safety. The importance of this relationship emerged during the field work and more interviews and analysis would have added considerable value to the evaluation
- › It was challenging to maintain a consistent approach to interviewing patients and community members across sites. At some sites a yarning circle was held while at others there were focus groups and / or one-on-one interviews. At one site there was a mix of face-to-face interviews and online responses to the interview guide. While all mechanisms used the same interview guide, it is known people act and behave differently in different environments / situations. While a limitation, it should be noted there was nonetheless highly consistent data across the interviews
- › AHLOs / KMHLOs were significant informants in developing the case studies. However, due to low capacity, stress leave and/or general absence, accessing these key staff members proved challenging and slowed the data collection process

- As noted in the Alfred Health case study, the investigation and engagement in this particular health service was limited by two crucial barriers. First, the limitations on the AHLO's time to be able to coordinate community members to be part of the consultations. Second, the Community Health Service programs being concerned about the burden of research which may have been placed on community. These barriers led to a low engagement rate with community.

The following sections answer the evaluation questions as the findings emerged from the methodology and analysis of the data.

3. Answering the Evaluation Questions

This section presents the findings of the evaluation. The presentation of the findings are structured against the evaluation questions. Structuring the report this way allows for the common and divergent themes of each of the case studies to be incorporated and integrated into the findings from the data and document review and the consultations that were outside of those undertaken as part of the case studies.

3.1 'Cultural Responsiveness' and 'Cultural Safety': What Do They Mean?

Key Findings

For Aboriginal community members, cultural responsiveness means health services will listen to and understand their needs and demonstrate empathy. Staff will know and respect community Elders, their land and their culture and they will know the importance of working alongside Aboriginal people.

For Aboriginal community members, cultural safety means feeling like they are still connected to culture, community and country in the hospital. The Aboriginal flag will be flying outside of the service and the entrance will acknowledge Traditional Owners. There will be no loss of identity or dignity; and being Aboriginal will not lead to a feeling of otherness, outsider or being unwelcome.

3.1.1 Definitions from the Literature

A key output of the evaluation is to better define and measure cultural responsiveness and cultural safety. This requires an examination of definitions and current measures. While subsequent sections will examine more closely current means for measuring cultural responsiveness, this section considers definitions that have informed the department's monitoring and reporting prior to and as part of *Koolin Balit*.

In 2009 the Department of Health's *Cultural Responsiveness Framework: Guidelines for Victorian Health Services* defined cultural responsiveness as the capacity to respond to the healthcare issues of diverse communities. The framework does not have a particular focus on Aboriginal diversity; though in its broadest definition 'capacity to respond' to Aboriginal patient needs marks a good starting point.

According to Indigenous Allied Health Australia (IAHA 2015), culturally responsive care can be defined as an extension of patient centered-care that includes paying particular attention to social and cultural factors in managing therapeutic encounters with patients from different cultural and social backgrounds. IAHA views it as a cyclical and ongoing process, requiring health professionals to continuously self-reflect and proactively respond to the person, family or community with whom it interact. IAHA notes three layers of responsibility to ensure that Aboriginal and Torres Strait Islander people receive culturally responsive healthcare:

1. It is the responsibility of health education providers to ensure their graduates attain the necessary skills, knowledge and attitudes that will enable them to deliver culturally responsive care. This includes providing clinical experiences that expose them to the unique needs of Aboriginal and Torres Strait Islander populations
2. It is the responsibility of the health service provider to demonstrate culturally responsive leadership and build governance structures and environments that ensure health professionals are encouraged, expected and able to respond to the needs of Aboriginal and Torres Strait Islander people effectively. The processes and supportive structures around health service delivery are equally as important as the actual health outcome measures when determining the overall effectiveness of health service delivery
3. It is the responsibility of the health professional to deliver culturally responsive healthcare. Being culturally responsive places the onus back on to the health professional to appropriately respond to the unique attributes of the person, family or community they are working with. Self-reflection and reducing power differences are central to being culturally responsive. Therefore making assumptions based on generalisations about a person's ethnic, cultural or social group is unacceptable. Part of the challenge of becoming a culturally responsive health professionals is learning to reach beyond personal comfort zones and being able to comfortably interact and work with people, families and communities who are both similar and markedly different to one self (IAHA 2013).

This third layer ties closely with current theorising on the concept of cultural safety which has evolved as Aboriginal people and organisations have adopted the term to define new approaches to healthcare and community healing. In particular, the concept has been used to express an approach to healthcare that recognises the contemporary conditions of Aboriginal people which result from their post-contact history. The process of colonisation has led to historical and contemporary trauma and the loss of cultural cohesion. The resultant power structure has undermined, and continues to undermine, the role of Aboriginal people as partners with healthcare workers in their own treatment (Brascoupe and Waters 2009: pp.6-7).

In this context, culturally unsafe practices are defined as *“any actions that diminish, demean or disempower the cultural identity and well-being of an individual”* and, therefore, cultural safety represents a potent tool in the development and delivery of policies and services relating to Aboriginal people – not just in the health field but other areas of social policy (Nursing Council of New Zealand 2002).

The literature makes considerable reference to the concept and practice of cultural competence. This appears to represent the high point of cultural understanding demonstrated by health care professionals and is taught and measured as a function of knowledge and understanding of Aboriginal culture by practitioners. Cultural safety in practice is often made in reference to cultural competency, as an extension of and improvement to competence (Brascoupe and Waters 2009).

Elsewhere in the literature, Ball (2007 cited in Brascoupe and Waters 2009) suggests this understanding of cultural safety represents more of a paradigm shift than a movement along a continuum. According to Ball, this concept of cultural safety represents “*a more radical, politicised understanding of cultural consideration*”, effectively rejecting the more limited culturally competent approach for one not based on knowledge but rather on power. Ball (2007 cited in Brascoupe and Waters 2009) states that:

(U)nlike the concepts of cultural sensitivity or cultural competence, which may contribute to a service recipient's experience, cultural safety is an outcome. Regardless of how culturally sensitive, attuned or informed we think we have been as a service provider, the concept of cultural safety asks: How safe did the service recipient experience a service encounter in terms of being respected and assisted in having their cultural location, values and preferences taken into account in the service encounter?

The 2011 *ICAP and KMHLO Developmental Review* used the following definitions of cultural competence (the closest the review got to providing a definition for cultural responsiveness) and cultural safety:

- *Cultural Competence*: is being mindful of cultural difference and modifying the way services are delivered to better meet the needs and cultural beliefs of people from different cultures. A culturally competent practitioner will provide care in ways that are responsive to the different values, beliefs, or behaviours of their patient/client
- *Cultural Safety*: is reached when a recipient of care deems the care to be meeting their cultural needs. The person providing the care is mindful of the impact their own cultural identity can have on the care they provide. Providing culturally secure care to Aboriginal people requires a commitment to the cultural rights and values of Aboriginal people with the best that health and community service providers and practitioners have to offer (*ICAP and KMHLO Developmental Review 2011*).

These definitions have been operationalised and the *ICAP and KMHLO Developmental Review* examined how existing Key Result Areas (KRAs) could assist health services to become more culturally responsive and safe for Aboriginal people. This included:

- Health services establishing and maintaining relationships with their local Aboriginal community
- The provision and coordination of cross-cultural training for hospital staff
- Effective discharge planning
- Referral arrangements that support effective primary care referral.

The Review reported that most health services were at low levels on the performance spectrum and, as a result of the findings, changes were made to the KRAs with cultural responsiveness and cultural safety in health services deemed to be best secured through the following:

- › *Engagement and partnerships* with Aboriginal organisations, Elders and Aboriginal communities
- › *Organisational development* that acknowledges, respects and is responsive to Aboriginality and includes increased cultural knowledge at the CEO, Board and operational staff levels as well as including culturally responsive planning, monitoring and evaluation for the organisation
- › *Workforce development* where training, development and support is provided and appropriately targeted to Aboriginal and non-Aboriginal staff at all levels of the organisation
- › *Systems of care* where culturally competent healthcare and a holistic approach to health are provided to Aboriginal patients with regard for the place of family.

Koolin Balit outlined the following definitions for cultural responsiveness and cultural safety:

- › *Cultural responsiveness*: means healthcare services are respectful of and relevant to the health beliefs, practices and cultural needs of the communities they service. This is more than cultural awareness. Organisations have processes and systems in place to achieve cultural change and to embed it in everyday behaviour
- › *Cultural safety*: means people feel safe and secure in the hospital environment due to shared respect, meaning, knowledge and experience, ensuring dignity and truly listening. Cultural safety incorporates cultural sensitivity which refers to sensitivity to cultural factors, and taking them into account.

Cultural responsiveness and cultural safety – as practice and experience respectively – implies:

- › A commitment to Aboriginal people receiving care that acknowledges their identity and is respectful of it
- › When in hospitals, Aboriginal people will be less likely to experience racism which is known to have an adverse impact on the health of Aboriginal people and significantly hinders their access to effective healthcare
- › Improved cultural sensitivity and responsiveness among staff will improve access to healthcare.

The KRAs were deemed to be a guide for hospitals to achieve such outcomes as outlined in the definitions.

3.1.2 Community Meanings

All 144 interviewees were asked how they would define cultural responsiveness and cultural safety. That is, what do these two ‘concepts’ actually mean for Aboriginal people?

While many of the definitions and approaches described above resonated with Aboriginal patients, families and communities, the themes emerging from the data were less complex and technical:

- › Aboriginal people define cultural responsiveness primarily around three words; there is understanding, respect and empathy – from practitioner to client
- › Being culturally safe means feeling comfortable and having a sense of still being ‘on country’ or ‘at home’ – identity is maintained and certainly not diminished or demeaned
- › Aboriginal people feel like they have (some) control over their health-care needs through acknowledgement and understanding – there is a shift in power from the health practitioner to the consumer / client.

Table 3 provides a summary of the key words / terms that were most often identified in the data with regard to cultural responsiveness and cultural safety. Those in bold are the five most mentioned words. These inform the indicators and measures outlined later in this section of the report.

Table 3: Community Meaning for Cultural Responsiveness and Cultural Safety

	Listening	Understanding	Empathy	Respect
Cultural Responsiveness	Love	Equality	No racism	Consideration
	Cultural knowledge	Involved	Acknowledged	Trained staff
	Responsive	Caring	Genuine	
	Comfortable	Friendly	Artwork	Control
Cultural Safety	At ease	AHLOs / Aboriginal staff	Still on my country	Culture acknowledged
	Family friendly	Flags	Engaged	At home
	Not different	Not the same	Welcome	

Aboriginal patients and community members suggested the following as suggestions for providing cultural responsive care:

We need people that are truly listening to our needs and acknowledging we are all different and some of us have barriers (Patient – DHSV)

They need to understand our needs and think differently. Having empathy that's all... there is no magic list (Patient – Northern Health)

We need to be involved and not told but listened to. More asking than telling (Aboriginal Health Worker)

When they consider my cultural needs as well as other clinical and wellbeing... respecting that we might need other considerations and understanding why we might react the way we do (Community Member – Wimmera Health Care Group)

Aboriginal patients and community members suggested the following for ensuring their cultural safety:

I feel safe, respected and acknowledged and I am aware that there is an Aboriginal Liaison Officer that can help me. I have seen the poster in the hospital to encourage me to identify as an Aboriginal patient and, when I do, I feel safe (Patient – Wimmera health Care Group)

Displaying the Aboriginal flag, being given the option of support from the Koori Health Liaison Officer, displaying Aboriginal art throughout the hospital (Patient – Wimmera Health Care Group)

They just make you feel welcome and have trained Aboriginal staff (Patient – Bairnsdale Regional Health Service)

Friendly staff that are non-judgmental... Acknowledgement of Traditional Owner's plaque, artwork, saying 'hello' and making the patient and family feel important (Aboriginal Health Worker)

The word respect gets thrown around too much. Respect is an outcome and empathy is the action that makes me feel safe (Patient – Northern Health)

Definitions for cultural responsiveness and cultural safety as they emerge from the voices of Aboriginal patients might be described as follows:

- *Cultural Responsiveness*: health services will listen to and understand our needs and demonstrate empathy. Staff will involve us in our own health care and the services themselves will know and respect our Elders, our land and our culture because they have received cultural safety training. They will know the importance of working alongside us and our people. It is about the way you do business with us to help us improve our health.
- *Cultural Safety*: the feeling and the experience that means we feel like we are still connected to culture, community and country in the health service. Our [Aboriginal] flag will be flying outside of the service and the entrance will acknowledge our Traditional Owners. There will be no loss of identity or dignity and we will feel welcomed and at ease. We will still feel and be proud to be Aboriginal; as our Aboriginality is a normalised and accepted component of our identities. Being Aboriginal will not lead to a feeling of otherness, outsider or being unwelcome.

The data suggests Aboriginal people need to trust those who are providing services and have confidence that service providers understand their needs and culture. They want to feel comfortable and confident to ask questions and to seek the services and help to which they believe they are entitled. They want to feel like they are still on their own country. Cultural barriers for Aboriginal patients focus heavily on social relationships and issues of respect and trust. For Aboriginal patients, changes to physical environments are important but can be seen as token gestures if the service system does not reinforce such changes.

3.2 Cultural Responsiveness and Cultural Safety: What Works and What Does Not Work?

In considering the efforts hospitals make to improve cultural responsiveness and cultural safety, three of the evaluation questions can be examined. These are:

- To what extent have Victorian hospitals improved their cultural responsiveness to Aboriginal people over time?
- What strategies have led to the most significant and sustainable improvements in cultural responsiveness and cultural safety of hospitals for Aboriginal people and staff?
- What has been ineffective / unsustainable?

3.2.1 Improvements over Time: What the Data Says

Key Finding

There has not been a systematic monitoring and measuring of cultural responsiveness and cultural safety that allows for valid and reliable conclusions to be made with regard to improvements over time.

Analysis of CQI reports suggest some progress is being made with regard to three Key Result Areas (Organisational Development, Workforce Development and Systems of Care).

Such progress appears to demonstrate improvements when CQI findings are approximated with the findings of the *ICAP and KMHLO Developmental Review* in 2011 – the last major analysis of health services efforts.

The first evaluation question suggests the evaluation will be able to examine and measure change in Victorian hospitals efforts to improve cultural responsiveness and cultural safety over time. To undertake such analysis – at least at the statewide level – a set of identified baseline data against consistent measures would have been required.

Unfortunately, no such data exists and the closest to measuring previous performance of health services with regard to Aboriginal patient care is the analysis and findings in the *ICAP and KMHLO Developmental Review*. As previously noted, the KRAs at the time of the review differ from those that currently exist and that hospitals have been using to report against over the last three years (specifically in the Continuous Quality Improvement Reports (CQI) and / or Quality of Care Reports).

Essentially in 2011 health services' relationships with ACCHOs were at a low level with few Memorandums of Understanding (MOU) signed and partnerships few and far between. Cultural awareness⁵ training was under-developed and existed only marginally within services as part of orientation rather than as strategic and compulsory component of a learning / training pathway embedded within and across the service. Discharge summaries were provided to patients but there was little evidence of efforts being made to link patients to primary care services and few effective measures were in place to support referrals.

The key achievements for the previous five years of ICAP (2006-2011) reported in the Review were:

- › Increased identification of Aboriginal patients
- › Continued expansion in the number of AHLO roles supporting Aboriginal patients
- › Care coordinator roles emerging in EDs linking Aboriginal patients with community based services to reduce inappropriate hospital admissions
- › Creation of KMHLO positions to support Aboriginal people using area mental health services in rural areas
- › Facilities becoming more welcoming through the display of Aboriginal art work, flags, acknowledgement plaques, and cultural celebrations
- › Staff becoming more culturally aware of Aboriginal patient/client needs as a result of training programs.

In terms of measuring improvements at a statewide level over the next five years, an analysis of CQI reports provided the best picture of hospitals effects.

The aim of the CQI Tool – as a key part of the ICAP program – is to provide a process for health services to reflect on their progress and achievements in providing culturally responsive healthcare. It allows hospitals to identify gaps in organisational and clinical practice and identify priorities for actions to improve the delivery and outcomes of culturally responsive healthcare for Aboriginal people. The CQI tool aims to ensure greater systemic effort and accountability for an organisation-wide approach to continuous quality improvement in culturally responsive healthcare for Aboriginal people.

As noted, the current KRAs within the CQI tool do not align well with those that preceded them since they were changed post the *ICAP and KMHLO Developmental Review*. Each of the four KRAs listed in the CQI Tool has a number of contributing success factors. These are outlined in Diagram 6.

5 Cultural competency, cultural safety, cultural respect, cultural awareness and cultural sensitivity are all terms that have been used (often interchangeably) to describe the training and/or attributes required by health professionals to effectively engage with Aboriginal and Torres Strait Islander people. These terms, however, are not interchangeable and have distinct meanings. This report uses cultural training generically to cover the various terms – noting the preference is for cultural safety training as a key element of enhancing cultural responsiveness.

**Diagram 6: KRAs and Success Factors for
Improving Cultural Responsiveness and Cultural Safety**

Engagement and Partnerships	<ul style="list-style-type: none"> • Collaborative and inclusive with local ACCHOs, Elders and community • Aboriginal people are informed in a culturally appropriate manner • Culturally appropriate mechanisms are in place for engagement and feedback.
Organisational Development	<ul style="list-style-type: none"> • Aboriginal health is a stated priority reflected in organisational development and strategy • Senior executives 'walk the talk' regarding cultural responsiveness • Board outlined expectations to CEO regarding cultural responsiveness • Hospital/Area mental health service provides culturally safe and welcoming environment • Data collection systems are in place to evaluate protocols / systems relevant to cultural responsiveness.
Workforce Development	<ul style="list-style-type: none"> • Aboriginal workforce is supported within the organisation • Comprehensive cross-cultural training strategy is in place, allowing staff to develop competency • Cultural awareness and respect is a requirement in recruitment of new staff.
Systems of Care	<ul style="list-style-type: none"> • Culturally appropriate strategy for ID data collection • Data systems are robust and used to strengthen Aboriginal patient care • Culturally responsive, age appropriate, gender specific strategies are in place • People are informed about preventative care/early intervention • Culturally responsive patient centered pathways are embedded in the service • Acute, sub-acute primary services are consistent with clinical guidelines • Cultural and individual factors are accounted for in patient notes • Comprehensive discharge plans exist for all Aboriginal patients.

The CQI Tool states the contributing success factors are “*aspirational statements outlining some aspects of the KRAs*”. Health services are asked to self-rate the degree to which they are meeting each KRA using the following criteria:

1. = no progress on the KRA (the journey has not commenced)
2. = starting to achieve the KRA (the journey has begun)
3. = progressing towards fully achieving the KRA (advancing on the journey)
4. = achieving the KRA (at the destination and other journeys identified)
- 4+ = excelling in achieving the KRA (ongoing journey to new destinations).

Health services are encouraged to complete the CQI Tool through a process led by senior managers with responsibility for Aboriginal health, and with input from the health service's 'quality' unit, the AHLO, area mental health service manager, KMHLO and relevant clinical and administrative staff. Involving the local ACCHO and/or Aboriginal health advisory committee is highly recommended. The completed tool should be endorsed by the health service's Chief Executive Officer and / or an executive sponsor for Aboriginal health and provided to the Aboriginal Health Branch in the department – though this is not mandatory nor is completing a CQI report for health services.

An analysis of CQI reports considered how hospitals rated their progress against each KRA in 2013 and 2014. These ratings have been aggregated across all hospitals that provided reports in either or both years and then averaged to provide a statewide rating against the ranking / scoring criteria. The analysis is summarised in Table 4 below.

Table 4: Progress against ICAP KRAs (2013-2014)

Category	Number	
Total number of health services that have submitted one or more CQI Reports	32	
Total number of CQI Reports for 2013 and 2014	55	
Total number of CQI Reports for 2013	24	
Total Number of CQI Reports for 2014	31	
Total number of health services providing a 2013 and 2014 CQI Report	23	

Key Result Area	Rating	CQI Rating Descriptor
Average rating in 2013 for KRA1 – Engagement and Partnerships	3.25	Beyond progressing - moving to achieving
Average rating in 2014 for KRA1 – Engagement and Partnerships	3.19	Beyond progressing - moving to achieving
Average rating in 2013 for KRA 2 – Organisational Development	2.96	Started and progressing well
Average rating in 2014 for KRA 2 – Organisational Development	3.26	Beyond progressing - moving to achieving
Average rating in 2013 for KRA3 – Workforce Development	2.63	Started and progressing well
Average rating in 2014 for KRA3 – Workforce Development	2.94	Started and progressing well
Average rating in 2013 for KRA4 – Systems of Care	2.79	Started and progressing well
Average rating in 2014 for KRA4 – Systems of Care	2.95	Started and progressing well

Positive progress is reported across three KRAs – organisational development, workforce development and systems of care. Engagement and partnerships appears to have regressed across the comparative years (marginally from 3.25 to 3.19). Relationships are organic and dynamic and generally do not progress along a continuum. A number of case study sites found that, as relationships ‘progressed’, they in fact got harder. As staff in each organisation came and went, relationships strengthened and weakened and, at the point in time of CQI reflection, there may have been emerging challenges:

We are working really hard on our relationship [with local ACCHO] but it's not easy. We thought we were going well and then the CEO changed and that changed everything. Then the CEO changed again and it got better. We need to work harder and make the relationships stronger and sustainable but they are pretty good... for now (Hospital Executive)

Further, some hospitals initiated relationships and communication and, having done so, recognised that first positive reflections (say ranked as progressing towards fully achieving the KRA) were premature and demanded more time and resources (therefore in the following year ranked the KRA as starting to achieve success).

As a non-mandatory reporting process, there are many hospitals that have not provided any CQI reports. Others have submitted one in 2013 but not in 2014 and vice versa. As a self-reflection tool, it is impossible to compare hospitals with each other since the case studies demonstrated that the process of reflection varies and the value placed on particular initiatives is not applied consistently. For example, one hospital rates informal conversations with their local ACCHO as *progressing towards fully achieving the KRA (advancing on the journey)* while another rates the formalisation of the relationships with their ACCHO through a MOU as *starting to achieve the KRA (the journey has begun)*.

Further analysis of the CQI reports sought to identify the key achievements hospitals identified in 2014 as key signifiers of progress. The five most identified achievements for each KRA are outlined in Diagram 7 below.

Diagram 7: Hospitals Key Achievements 2014

Engagement and Partnerships

- ACCHO relationships are strong or improving
- There are Aboriginal committees supporting strategies
- Memorandums of Understanding are in place with a local ACCHO
- NAIDOC celebrations take place in consultation with local Aboriginal groups
- Welcome to Country procedures have been developed in partnership with a local ACCHO

Organisational Development

- Cultural (awareness / competency / safety) training is being developed
- Acknowledgement of Country procedures are being / have been developed
- Flags are flying outside the hospital
- Aboriginal artwork and acknowledgement plaques installed in foyer.

Workforce Development

- Culturally specific training/education is being established
- Traineeships are being developed or have been identified
- Aboriginal Employment Plans established
- Identified Aboriginal roles have been developed and increased.

Systems of Care

- Improved patient identification measures
- Improved models of care
- Community input into improved pathways and referrals
- Improved data systems
- Culturally specific project work.

Comparisons between 2013 CQI reports and subsequent years suggest there is an increased familiarity with the reporting of actions, but not specifically a trend in improved outcomes. Many health services reported activities that were commencing or going to be commenced in their 2013 reports – for example, the implementation of MOUs with ACCHOs or the development of Aboriginal Advisory Committees. In subsequent years the same services rarely show reporting of the resulting outcomes. Notably, one of the case study hospitals had seen several leadership changes (causing significant disruption to the service delivery and cultural responsiveness overall), but did not reflect this in their CQI report. The case studies presented in this report often tell a different story to the one told in the hospitals CQI reports.

There are a number of potential problems with CQI reports being used as a measure of progress and continuous quality improvement process. From an analysis and / or evaluation perspective there is no validation of self-reported achievements against specific criteria or standards – something that characterises reporting and monitoring with regard to cultural responsiveness and cultural safety. Further, evidence of outputs and impacts is rarely reported.

The CQI reports suggest that in 2014 key strategies to improving cultural responsiveness in service delivery were building and sustaining relationships and partnerships with ACCHOs, cultural awareness training, mainstream training and employment and patient identification. These are similar to 2013 and measuring degree of progress and / or change is problematic.

While comparative analysis against the findings of the 2011 *ICAP and KMHLO Developmental Review* is also problematic (due to non-comparable KRAs), the list of achievements (from 2006-2011) outlined on page 29 of this report are similar to the achievements outlined in the 2014 CQI reports and might indicate little progress. This highlights the challenge of measuring progress over time when indicators and measures (qualitative and quantitative) have not been developed and rigorously monitored with mandatory reporting requirements.

That said, CQI reports do suggest hospitals' relationships with local ACCHOs have expanded beyond the AHLO having the sole relationships with the ACCHO and cultural awareness training is currently being delivered more intentionally than it was in 2011. The case studies presented later in this report demonstrate that measuring progress is best gained through the perspective and views of Aboriginal community members and Aboriginal patients. For example, the Bairnsdale Regional Health Service (BRHS) case study, demonstrates considerable and ongoing success in its Aboriginal health programs and overall community engagement. This success is attributed to a strong combination of committed leadership and the presence of a highly committed, community connected and capable AHLO. The change is not easily measured within the CQI reports but is demonstrated through the voice of the community and ACCHO staff:

The town has come a long way. Staff community involvement has come a long way (Community Member)

[The CEO] came at just the right time. Big change. She's got a really great style. She's open, and allows experts to advise and inform programs (ACCHO Staff)

Our rapport with the hospital is becoming really, really solid. In the last couple of years, there's been a lot of work done. It has enhanced the community's relationship between the hospital and ACCHO (ACCHO Staff)

Community are hearing about the change then seeing it when they come in (Community Member)

Hospital attitudes have changed. It used to be redneck and horrible. There is a noticeable improvement in communication with the community (AHLO)

The hospital has changed in the last 15 years. We've seen a lot of progression here. More cultural stuff happening (Community Member)

3.2.2 What Strategies Work Best and Why

Key Findings

Across the stakeholder consultations, the data and document review and seven case studies, a set of highly consistent themes emerged. The themes were as salient for hospital Board Members, hospital Executives and non-Aboriginal health professionals as they were for Aboriginal Elders, Aboriginal health workers, Aboriginal community members and Aboriginal patients and their families. Effective and ineffective strategies for improving cultural responsiveness and cultural safety are contained within these six key themes (see Diagram 8).

The themes that emerged within the evaluation are not new or radical in form, description or implementation. They are common to the literature that considers culturally responsive care and cultural safety for Aboriginal people and they resonate with findings from previous reviews, policy frameworks and reporting mechanisms. For example, Renhard et al (2014), in developing the *Aboriginal and Torres Strait Islander Quality Improvement Framework and Toolkit for Hospital Staff*⁶ suggested the following as critical elements to changing organisational culture in hospitals for Aboriginal patients:

- › Strong partnerships with Aboriginal communities
- › Enabling State and Federal policy environments
- › Leadership by hospital Boards, CEO/General Manager and key clinical staff
- › Strategic policies within the hospital
- › Structural and resource supports
- › Commitment to supporting the Aboriginal and Torres Strait Islander workforce including the role of the AHLO

Further, the Hume Region's, *Closing the Health Gap-Aboriginal Health Cultural Competence Framework* identifies five focus areas with associated standards:

1. *Organisational Effectiveness*: where a whole-of-organisation approach to Aboriginal cultural competence is demonstrated and leadership within the organisation actively promotes a workplace culture that embraces Aboriginal cultural competence
2. *Engagement and Partnerships*: where feedback from Aboriginal service users, their families and the wider Aboriginal community are actively sought and the organisation is continually developing and expanding relationships/partnerships with ACCHOs (or other Aboriginal organisations if no ACCHO is present) and Traditional Owners
3. *Culturally Competent Services*: the organisation oversees the provision of care to ensure that the specific rights and needs of Aboriginal services users are addressed through their health care journey

6 See <http://www.svhm.org.au/aboutus/community/ICHPToolkit/Pages/toolkit.aspx>

4. *Workforce Development*: where the organisation is committed to the development of a culturally competent workforce for Aboriginal people, including the employment of Aboriginal staff
5. *Public Image and Communications*: where the organisation has a culturally safe, welcoming environment for Aboriginal people and communication processes empower Aboriginal people by building their understanding of availability of services and their expectations as users of services.

Renhard et al (2014) note that the first phase in developing a more culturally responsive practice is to gain and understand Aboriginal people's experience of hospital care. The emphasis within this report is the voice of nearly 100 Aboriginal patients and community members. These voices have enabled this evaluation to better understand the themes, as they have emerged, are not discrete but are interconnected and any one theme can have influence on or over another. Aboriginal people are suggesting that, when there is a balanced effort across the six themes, cultural responsiveness and cultural safety are both enhanced.

Diagram 8 outlines each of the six themes and how these themes can impact on the cultural safety of patients and how culturally responsive care is enhanced or diminished according to the activity within each of the six themes. While each theme is important to the other, the evaluation finds that the role of the AHLO and Aboriginal health staff generally has highest impact (noting the emphasis is demonstrated in the diagram).

Diagram 8: Key Themes Emerging from the Case Study Data



High Level Commitment and Capacity

Key Findings

Leadership and commitment within hospitals at the Board, CEO and Executive level is necessary though not sufficient on its own in enhancing culturally responsive care and cultural safety such that hospital staff and the Aboriginal community are enabled and experience change.

Many hospital CEOs and leaders are looking for support, assistance and information to improve cultural responsiveness and cultural safety. However, many Board members, CEOs and Executives simply do not know what to do.

[The CEO] is a lovely person! Makes us feel very welcome. Always says hello. Before, it wasn't like that. Never (Community member)

[The CEO] is excellent... and brought great change (ACCHO staff)

There is no question from the case study data that when the Board, CEO and the Executive, at any given hospital, have a significant commitment to improving care for Aboriginal patients more is achieved in terms of the provision of culturally responsive care and cultural safety. As the interface between the Board and the Executive, and the key leader within the organisation, the CEO can determine good practice across the organisation. The commitment of the CEO to enhancing, monitoring and reporting cultural responsiveness and cultural safety in policy and practice enhances the experience of Aboriginal patients.

The evaluation found three levels of engagement and capacity at the CEO / Executive / Board level. These are represented in Diagram 9 below.

Diagram 9: Levels of Understanding and Type of Response to Aboriginal Patient Needs



Across the case study sites there are two hospitals at each level of leadership commitment and capacity. One site has recently appointed a new CEO. It is yet to be determined at what level this CEO will operate and, therefore, whether the hospital will progress with the journey it has undertaken or whether progress will be stalled as other priorities take over.

It is important to note that over the course of developing the case studies, one hospital had a relatively new CEO (less than one year), one had a changeover from an Acting CEO to the permanent appointment of a CEO (different individuals) during the evaluation, one had an interim CEO and four had long standing CEOs (over two years). Changes at the Executive level were also commonplace.

The case studies demonstrate a need for the department to facilitate more opportunities to share learnings and challenges. In every interview from Executive through to Board members and Board Chairs, there was an overwhelming desire to know more about best practice and what other hospitals had successfully implemented or had been challenged implementing.

The case studies not only demonstrated varying degrees of commitment, understanding and capacity, they also demonstrated a diversity of leadership styles. For those CEOs that demonstrated a strong commitment to improved Aboriginal health outcomes, the driver came in different forms. For one CEO, engaging with and improving Aboriginal patient experience “*is a no brainer given the population we have here*”. For another it was the absence of Aboriginal patients that drove the hospital to do more. For another still, it was personal experience from previous roles or experiences with Aboriginal people and communities that were the drivers for change. In other case studies, a push from the Board and / or the Executive enabled change as CEOs were held accountable by one or both for change.

The common theme amongst those CEOs or Executive leaders / champions deemed committed to change, was a personal experience that had them place Aboriginal health in a personal context of responsibility. For example, two of the more committed CEOs had a background in local government, which had allowed them to gain grassroots community development skills and perspectives. At two other case study sites that were at an earlier stage of the journey, executive sponsors in each location that were committed to improved outcomes for Aboriginal people placed the genesis of such commitment into personal experiences

I saw a fellow student from school who was Aboriginal and all those years later he was not doing very well and here I was a professional. Then I heard later he had taken his own life and you know there is something unacceptable about the difference in those two outcomes. I just think we have to do better... (Executive Manager)

I came to Australia and heard about the difference in life expectancy for Aboriginal people. I could not believe it in a country like this with all our wealth and resources. So working in health I committed to doing whatever I could to contribute to that change and I have pushed this stuff really hard... so hard I am not sure people could keep up (Former CEO)

The CEO from BRHS who was driving change in the service had experience in community development. This experience, with personal values and ethics and a particular approach to leadership that combines all three, has meant the health service is an excellent example of a hospital providing culturally responsive care and where patients feel culturally safe. Within this service past and present trauma is identified, understood and acknowledged. Staff know they can contribute to healing journeys beyond the provision of medical care:

We know this place has been a place and source of upset for people. How we provide medical care can reach into healing of past trauma and build trust that will make a difference to one patient and then to their family so future generations won't carry the fear of the past generation... confident we won't treat people that way again (Executive Manager)

The CEO at BRHS describes her leadership style as being “essentially based on the Greenleaf Servant-Leadership style”, and one which is there to “serve first and foremost” and not necessarily be “the boss”. This style of leadership, which encourages experts and champions within the organisation to be central to decision-making, and also accepts the Aboriginal community as being intertwined with the organisation rather than simply a recipient of service, is achieving positive results based on its alignment with Aboriginal cultural values – holistic, community-centred, collaborative and focussed on positive long-term (sustainable / intergenerational) outcomes.

While high level commitment drives strategy and aspirational change, hospitals have commenced their journeys at different stages. For some hospitals the appointment of an already committed CEO (due to previous work that incorporated Aboriginal engagement) was the genesis for change and for others it was compliance with existing policies. For others it is a recognition of the community population. This is an important finding since the department's policy levers (WIES funding, *Koolin Balit* funding, *Karreeta Yirramboi*, CQI Reporting, Quality of Care Reports, Statement of Priorities, Networks and Forums) are being identified as enablers for building strategies to improve cultural responsiveness and cultural safety by some CEO and Executives, while for others these levers have enhanced already existing work – “*Koolin Balit won't give you the commitment and culture but it has been an enabler*”.

As noted, when the case study data was being collected, a number of hospitals had changes or had recently had changes at the CEO level. The case studies highlight how quickly positive change can be made or how quickly the strategies and efforts hospitals have undertaken to strengthen cultural responsiveness and cultural safety can suffer from atrophy:

The new CEO has different priorities and things are starting to go backwards. What we had which was not great but developing is in real danger of being lost (AHLO)

Further, during consultations with metropolitan, regional and rural CEOs, and the Board Chairs and CEOs from the Loddon Mallee region, it became clear that many Board Chairs and CEOs did not know what strategies could be developed that would enhance cultural responsiveness and cultural safety in their services. This highlights the real need to build knowledge, information and capacity to implement policies and practices that support culturally responsive care and enhanced cultural safety.

Indeed, the WHCG case study highlights the positive effect ‘champions’ can have with a previous Executive Manager, who has moved from WHCG to Echuca Regional Health, continuing to provide guidance to WHCG to great effect. This included a visit coordinated by the Wimmera Primary Care Partnership (WPCP) of staff from the hospital, ACCHO, Community Health, the department and WPCP to Echuca. The aim of the trip was to meet with peers and contemporaries and gain knowledge, understanding and ideas of how to improve cultural safety for Aboriginal patients. This included time spent at the hospital and the local ACCHO with peers. Such ‘mentoring’, leadership, and opportunity to learn from others should be encouraged since the “*bus trip to Echuca*” has gone down almost into folk-lore and was consistently referred to as an important milestone during the interviews undertaken for the case study.

Indeed, a common theme when the “*bus trip to Echuca*” was referred to was the building of relationships and trust that occurred by simply being “*on the bus together*”:

You see people differently and out of their environment and I found myself liking people that I had issues with and I realised I had the issue with the position or the organisation and that the person was really nice... (ACCHO staff)

I remember thinking how important these times are. We learnt a lot about what we could do better from Echuca but we learnt a lot about each other (Executive)

This and other case studies, highlight the importance – in the complexity of developing strategies and initiatives – of building and sustaining local relationships.

Engagement and Partnerships with ACCHOs

Key Finding

Hospitals cannot go it alone and engagement and partnerships with local ACCHOs ensure expertise and experiences can be accessed as a means for continuous improvement. These can begin informally and person-to-person but need to be organisation-to-organisation with multiple points of contact if they are to be sustained.

Relationships with ACCHOs are deemed a necessary though not sufficient factor to strengthening culturally responsive care and cultural safety for Aboriginal community members. They provide value for hospitals accessing local cultural knowledge, supporting the AHLO and building cultural competency and safety in the hospital.

The case studies identify that success for improving care for Aboriginal patients is substantially enhanced when strong, trustful relationships with local ACCHOs are in place. The deeper these connections the more able the hospital is to improve cultural responsiveness and cultural safety for Aboriginal people, families and communities. This is due to the fact that such relationships not only build trust but also provide important local knowledge, context and expertise. When this expertise is accessed, community members feel more comfortable in the hospital environment.

There are historic factors (e.g. previous experiences of hospital care) that impact on levels of trust that can be (re)produced between a hospital and an ACCHO but across all case studies there is a focus on developing and advancing these relationships.

Each of the case study hospitals were at different stages in the development of relationships with ACCHOs. Some have developed formal MOUs, others have formed Community Consultative / Advisory Groups with hospital and ACCHO representation. The levels of involvement of local Aboriginal people in governance arrangements varied – as did the effect of such representation. While many hospitals aspired to have Aboriginal Board members, none currently have achieved this.

There is a strong finding that hospitals are more often “going out” and meeting with ACCHOs than reported in the 2011 *ICAP and KMHLO Developmental Review*. They are seeking increased opportunities to “be in each other’s organisations”. There is general acknowledgement that it is the ACCHOs that know best the needs of Aboriginal patients (outside of the patients / consumers themselves) pre, during and post the care provided by the hospital. There was evidence of hospitals beginning processes to build ACCHO organisational capacity. For example, WHCG is providing financial accounting support to Goolum Goolum Aboriginal Cooperative.

Evidence suggests that engagement with ACCHOs can be both formal and informal and, in the early stages of relationship development, informal is most common through person-to-person relationships. Organisation-to-organisation characterises older and more mature relationships. The case studies provide evidence that person-to-person relationships carry a higher risk of relationships not being sustained when one or both of the individuals leave.

The importance of the relationship with the local ACCHO means patients presenting or admitted to the hospital are more likely to have discharge information passed on and the continuity of care enhanced. The case studies demonstrate the importance of the AHLO in facilitating and enabling this relationship.

The department generally has a low presence in health service / ACCHO relationships. However, the WHCG case study highlights regional department (Grampians Region) staff acting as enablers in a local Aboriginal health committee (Wimmera Aboriginal Health Sub Committee).

The ACCHOs reported the importance and value of connecting with local hospitals and this is best highlighted and demonstrated (though not exclusively) in the regional hospitals where there is an opportunity for one-to-one connections. In metropolitan areas the connection is tentative even when there is an MOU in place.

Interestingly, many of the case study sites have MOUs in place with ACCHOs, though these are more of a statement of intent to work together rather than including a set of aims, objectives, activities, roles and responsibilities and a process for review and evaluating the 'health of the relationship / partnership' (Loza and Prince 2007). These are commonly accepted elements of MOUs in business - community partnerships that could be applied to health services.

Critical to building the relationship is the AHLO and Aboriginal health workers within the hospital. AHLOs often acts as relationship brokers since they are both employees of the hospital and members of the community. Further, relationships were working best when the AHLO, having brokered the relationship, remained central to the relationship and continued to be at the table as an expert and key advocate for the community and service:

We could not have a relationship with the [the ACCHO] if it was not for the connection our AHLO has with them. Well at least it would be harder but we recognise this is an extra and sometimes difficult addition to [names AHLO] job (Executive Manager)

I work hard at building the relationship between the hospital and [the ACCHO] but this is critical to building competence and understanding (AHLO)

The ACCHO relationship is a hell of a lot better than ever before. Multiple specific services are running now too. This is all my work (AHLO)

Across the case studies there were the following relationship examples:

- An emerging positive relationship (recognised by the hospital and the ACCHO) from what had been a problematic relationship in the past. Regular meetings were taking place, an MOU was drafted and Board members from each organisation were beginning visits and spending time in each other's organisations. The ACCHO was providing cultural advice to the hospital and the hospital was supporting some capacity building efforts of the ACCHO
- One case study demonstrated a stable relationship between the hospital and the ACCHO with an MOU that neither party referred to any longer but with multiple points of contact across staff in both organisations. Members of the ACCHO were on the Community Consultative Committee (not Aboriginal specific) at the hospital – *"I don't hear about how well the relationship is going or of any problems as they are dealt with at the appropriate level. We know who to ring and what is needed"* (ACCHO CEO)
- One case study had gone from quarterly meetings with ACCHOs to fortnightly meetings and the relationship was utilised to provide advice and expertise for current and future initiatives in relation to Aboriginal health and feedback on patients' needs and experiences
- In metropolitan areas relationships can be described as 'loose connections' that provide value in terms of ad hoc advice and feedback but were not as tightly held by formal meetings. In these locations there is a more informal set of individual relationships with Aboriginal organisations and community members / leaders.

There is some evidence in the case studies of hospital and ACCHO leadership having a much more positive view of their relationship than the AHLO and community members have of the same relationships. It is important for both parties to embed the relationship/partnership across the organisation and inform their stakeholders and communities of the aims, value, and outcomes of the partnership and / or any meetings that take place. While relationships and partnerships can be dynamic it is nonetheless important to have formal structures and a common vision if they are to be sustainable.

The relationships with ACCHOs have provided value in advising on how welcoming environments can be enhanced, cultural safety training can be delivered, capacity building can be enhanced and support for AHLOs can be strengthened. The primary value of building relationships and partnerships between ACCHOs and hospitals is that when partnerships are working well they build trust and (re)produce the kind of bridging social capital that strengthens communities. That is, networks of reciprocity are strengthened and each partner becomes an important resource to the other. These resources include information, knowledge, expertise and capacity.

There is limited evidence in the case studies of the ways relationships and partnerships are strengthening continuity of care processes post discharge. This seems more reliant on the work of the AHLO rather than an outcome of the hospital / ACCHO relationship.

No specific pattern or standard of engagement emerged from the case studies and the spectrum of successful and valuable relationships is broad. As already noted, change in staff within the hospital and / or the ACCHO can leave a good relationship vulnerable or provide an opportunity for a poor relationship (exemplified by low levels of trust) to be strengthened.

AHLOs and a Stronger Aboriginal Health Workforce⁷

Key Findings

The role of the AHLO is deemed crucial to enhancing culturally responsive care and ensuring the cultural safety of patients. As critical roles within the hospital experience and as bearers of cultural knowledge and expertise, AHLOs mostly feel undervalued and neglected. They are the subject and object of community trauma and as such their roles are highly stressful and stress leave are common.

Without sufficient support, legitimacy and acknowledgement of these roles, culturally responsive care and cultural safety become highly vulnerable for Aboriginal patients.

There is poor alignment between the availability of AHLOs and the presentation and needs of Aboriginal patients – that is, AHLOs are employed (generally) from 9am-5pm Monday to Friday and therefore not often available when Aboriginal patients present.

While there have been significant increases in the number of inpatient admissions and presentations of Aboriginal consumers at emergency departments over the last four years, resources do not appear to match the increased service demand. This relates to the low accountability with regard to WIES funding and how it is being utilised to support services for Aboriginal patients.

The presence / visibility of Aboriginal health workers increases cultural safety as reported by patients /consumers.

The AHLO is great. She communicates constantly and always calls to remind me of appointments, but the overall service probably isn't culturally responsive (Community Member and Elder)

We need an AHLO to walk us through all the steps... what are our rights and what are the processes and why and why not things happen while we are in the hospital (Community member and Elder)

⁷ While this section refers specifically to AHLOs, the findings are common to the work of KMHLOs and the term AHLO is inclusive of KMHLOs while recognising the different roles they hold.

McKenna et al (2015) considered the role of Aboriginal Mental Health Liaison Officers (AMHLO). In their study they aimed to describe the development of the AMHLO and describe stakeholder's perceptions of how the role of the AMHLO impacts on the typical journey of Aboriginal consumers. In their analysis the authors identified four roles (initiators, translators, networkers, facilitators) an AMHLO plays within the service setting. The case studies highlight a similar 'pattern' for AHLOs and the breadth of their roles:

- As initiators, AMHLOs assist in initiating the smooth entry of Aboriginal consumers to the health service through valued consultation with clinical staff. The case studies demonstrate AHLOs are often the initiators of relationships and provide smooth entry when called on for patients / consumers into and through the health service
- As translators, AMHLOs broker understanding among consumers and clinicians with the role required to develop trust with consumers to facilitate engagement and to provide support for Aboriginal consumers and their families. The AMHLO was commonly described as the 'interpreter' allowing consumers, their families, and clinicians to better align with each other to address cultural need. The case studies also point to AHLOs acting as translators and interpreters, helping consumers and hospital staff to bridge cultural and language barriers and ensure consumers and their families understand what is happening to them
- As networkers, AMHLOs arrange discharge pathways and coordinate referrals and follow-ups for Aboriginal consumers. The AMHLO's cultural understanding provides a means of maintaining engagement post-discharge. AHLOs have to be great networkers operating within the hospital setting and community / ACCHO setting. While McKenna et al (2015) use the term networker, the case studies suggest this is more a brokering role that exists within and outside of the hospital
- As facilitators, AMHLOs provide continuity of care where engagement is maintained even when consumers are formally discharged from the service. Within the hospital setting, AHLOs are facilitating cultural training, information days and cultural celebrations (e.g. NAIDOC Week).

This typography demonstrates the multiple roles AHLOs have. Further, a typography such as this is useful since roles are not clearly defined in most hospitals and vary (in responsibilities and remuneration) across the case study sites. However, the most significant finding from the case studies is that AHLOs are critical for improving cultural responsiveness and cultural safety in hospitals.

There is evidence in this evaluation of AHLOs who work primarily in the hospital with patients and then extend their work to community. Others are embedded in the community and spend more time there than in the hospital. There are AHLOs who have been working tirelessly for many years in their respective hospitals and know well the vulnerability of the work they do according to the commitment at the CEO/Executive level. Indeed, there is evidence of one hospital making significant improvements in terms of cultural responsiveness and cultural safety at the point of a new CEO being appointed three years ago. What is not known, however, is whether such success is achieved quickly because the CEO has a 'can do' / 'must do' mentality and commitment, or whether after 10 years of hard work by the AHLO, such effort pays a dividend when there is a committed CEO.

Statewide (as reported in the ICAP survey) the generalised views of AHLOs, with regard to the health services they work in, are less than positive, with questions of personal/ professional support and the quality of health service / ACCHO relationships reported as average. As noted previously, AHLOs are a conduit to the community – being community members themselves – and relationship brokers between the hospital, ACCHOs, mainstream health services, patients and the community.

The case studies provide evidence that holding multiple, often undefined roles, creates enormous stress. Over the course of collecting the case study data, many AHLOs were not available due to stress leave, Sorry Business and illness. All AHLOs expressed that they find their roles deeply challenging often feeling under-valued, under-resourced and over-burdened by community need and community trauma. This was mostly due to a perceived inability to meet the demand for their services, lack of recognition of their role and expertise, and in working Monday to Friday 9am to 5pm not being present at the hospital when most patients present – after hours and on the weekend:

We need an AHLO on-call 24/7... After hours and weekend are a big problem (Community Member and Elder)

After hours and weekends is a big problem. There's no AHLO and people don't like to wait. This needs focus (ACCHO Staff)

We know that a lot of the community are showing up after hours and on the weekend, and they might not stay because they don't get that cultural care. Well that's not good enough (AHLO)

If community members have a bad experience, they don't return (AHLO)

Employ AHLOs full time... It's very important... We need people to liaise between us and the doctors (Community Member and Elder)

If there was no AHLO, people wouldn't be sticking around. They're just too scared, and nobody understands (Community Member and Elder)

A lot of people just don't know what assistance is available, and the AHLO helps with that (Community Member)

We need someone to inform us when we are here; what services are available, interpreting medical jargon, explaining procedures and all that (Community Member)

Old people think they're there to die... you have to have someone from the community helping them through that (Community Member)

Consultations led to the following strategies to potentially improve cultural safety for Aboriginal after hours presentations:

- Third-party (Aboriginal Community) agencies supported to deliver on-call AHLO equivalent services after-hours. Multiple community agencies are currently delivering care coordination and case management services across Victoria. It was suggested that with adequate resourcing, these agencies have potential to be contracted as on-call Aboriginal support teams. These teams could provide an after-hours substitute for AHLO services. Outcomes would likely include increased positive Aboriginal patient experiences, reduced LWT cases, reduced DAMA, support for non-Aboriginal health service staff who may rely on AHLO expertise during business hours
- A locum AHLO pool could be established within the department. Members of the pool would be available to be seconded into health services to fill vacant AHLO roles. Outcomes might include reduced risk to patient experiences, reduced burden on existing staff and mutual capacity building (between the health service and the department).

Importantly, across the key themes emerging in the evaluation, the AHLOs have an accountability at both the community and hospital level. AHLOs feel the weight of responsibility for gaining commitment from hospital leadership, strengthening the links with ACCHOs and the community, guaranteeing good care for Aboriginal patients, providing or advocating for cultural training, developing and being a critical part of the welcoming environment and providing key information for monitoring and reporting results:

It's good that we've got an AHLO. They make you feel comfy, and less stressed. The other side don't understand us (Community Member)

The case studies also highlight the importance of these roles to the community. The most consistent theme in the community interviews was that immediate contact with an AHLO has the largest influence in terms of the patient feeling culturally safe.

The evaluation finds that nothing is more important to Aboriginal patients than the attendance of an AHLO to assist, guide, advocate and care for patients. The experience of care for Aboriginal patients in public hospitals is determined by the role and work of AHLOs. This finding needs careful consideration and means more support is required for the AHLOs and should not detract from cultural responsiveness and cultural safety being everyone's business – not just the business of the AHLO.

The evaluation finds a diversity in the expectations within the organisational structure for the AHLOs role with no standardised requirements or remuneration structure. There is a wide variation in salaries and, from the case study data, it is hard to determine how salaries are structured and to what level and what the professional requirements are for the role. Further, the location of these workers varies in that in some hospitals they are part of, or report through to, the Social Work department, while in others there is a line of reporting to the Executive. In one case the AHLO has an indirect report to the CEO:

The AHLOs used to be employed by the department, so they all had the same PDs and expectations. There was a standard and the job was clear. Once they all went to being hired by the individual hospitals, everything changed. All the hospitals changed their PDs, and threw a spanner in the works (AHLO)

The VACCHO is funded by the department to support AHLOs and KMHLOs through the ICAP/KMHLO Network. The network receives funding and secretariat support through the department via VACCHO. A Project Officer position is located at VACCHO to fulfil this role. However, consultations with VACCHO revealed that this position can be difficult to fill. The role requires a specific set of skills from an in depth understanding of the acute health system to advocating for the unique roles that AHLO/KMHLOs hold within their respective organisations.

As a peak body, VACCHO does not provide any direct service which often deters suitable applicants, the transition from a service delivery role to an advocacy role only, can be a difficult one despite the passion and desire to improve outcomes for Aboriginal patients. One of the primary responsibilities associated with the position is the coordination of the ICAP Forum – a two day forum that aims to strengthen and inform the network.

The evidence from the consultations and the ICAP survey suggest the forums are important and enjoyed by those AHLOs new to their positions but lose value over time for those that have been in their positions for more than three years. ICAP in its current form is somewhat of a mystery to many of the more experienced AHLOs, who have a memory of the initiative being designed to include direct support for staff. Evidence gathered from AHLOs shows that ICAP is currently not very effective with regard to the support provided to the network in that too many AHLOs are carrying negative views about their role. This suggests there has been a decline from a previous time when the support and associated resources were well-known and had a higher positive impact:

We can't be good little soldiers and just do what we are told all the time. That way of working doesn't help community (AHLO)

I feel like I'm nothing but a sign-off and a fixer to them [the hospital]. I'm sure they don't know what I do really, on any given day (AHLO)

There's supposed to be another worker to help. They were getting one but I don't know what happened (AHLO)

I had help for a while and it was great, but she was just a trainee and had no job at the end of it. So, now it's just me again and I'm burning out. Seriously, I don't know if I can keep working like this (AHLO)

The AHLO has been through a lot. I worry what will happen when she goes (Community Member)

The number of hospital separations and presentations to emergency departments of Aboriginal people reported in the 'Background' section of this report is increasing on an annual basis. Further, it is well established that there are significant increases in the number of Aboriginal people presenting with mental health issues (Australian Indigenous Health/InfoNet 2016). Consultations and case study findings suggest that of particular importance is strengthening the gap in capacity of the KMHLO sector with regard to supporting Aboriginal patients with mental health issues. There are fewer than 10 KMHLOs across the state at a time where the presentation of Aboriginal people presenting at hospitals and health services with mental health issues is increasing. This is a complex area of Aboriginal health and the capacity to meet the needs of patients is limited with so few people employed to assist them and address their immediate and longer term cultural and health needs.

With this evaluation finding, the AHLOs and KMHLOs are critical to the provision of culturally responsive care and cultural safety for Aboriginal patients, the number of AHLOs and KMHLOs and the supports they require to excel and remain in their roles needs attention. The evaluation finds both roles are currently under-resourced and under-valued:

In forums, we all agree we feel like bottom feeder fish, swimming around trying to survive (AHLO)

AHLOs are frontline. That's where everyone goes for advice and help, and that's why they crash and burn (AHLO)

AHLOs need to be warned of the realities of the role. You're gonna see some really sick people. People are gonna be screaming for help, 24/7. It's just constant trauma (AHLO)

It's like the army. You get shot... another one comes along, gets shot... another one comes along... (AHLO)

The AHLOs are great. They work so hard. But, let's get real. We can't be complacent and happy with just that. We need more champions (Hospital staff)

From the interviews with AHLOs and the ICAP survey, it appears that more than half of all AHLOs are Aboriginal women aged 46-55. These individuals are regarded by the community as genuine experts. It is this cohort of Aboriginal health workers that will make the most difference to patient care for Aboriginal people, families and communities. Strengthening the value, reach, legitimacy and expertise across the sector will be important if cultural responsiveness and cultural safety are to be enhanced in Victorian hospitals:

We're not respected, not paid correctly, not recognised for the many years that our profession has been around (AHLO)

We are challenged by a lack of accountability, reliability and trust from others. Plus unclear expectations (AHLO)

The case studies also highlight the importance of strengthening the Aboriginal workforce within hospitals and that Aboriginal people must be present in positions of influence and decision-making:

We need to be normalised. The more of us there are, the more cultural exchange can take place (Community Member)

There could be more Aboriginal staff at the hospital (Community Member)

There should be more Blackfellas working in hospitals. I only saw one once, and she was doing her nurse training (Community Member)

We need Indigenous people in frontline roles, not just admin and background. We need to increase the public visibility of community members in these good jobs (Hospital Staff)

We need Aboriginal people in decision-making roles (Community Member)

The *Koolin Balit Aboriginal Health Workforce Plan 2014-2017* is one of the strategies the department is using to do this. This plan provides a strategic approach to improving Aboriginal health outcomes through targeted strategies that:

- Develop, support and increase the Aboriginal health workforce in mainstream and Aboriginal health services
- Ensure all health service workers are culturally responsive to improve access and service provision to Aboriginal people
- Build on the strong evidence base and establish sector momentum to improve Aboriginal health outcomes.

Specific to cultural responsiveness, actions include:

- › Supporting the implementation of Aboriginal Employment Plans
- › Increasing employment opportunities in public health services
- › Maximising professional development and employment pathways of Aboriginal people in public health and Aboriginal health organisations
- › Supporting the increase of the number of Aboriginal nursing and midwifery graduates through the establishment of an Aboriginal Nursing and Midwifery graduate program
- › Supporting professional development and employment pathways through the Aboriginal nursing and midwifery and allied health cadetships program
- › Strengthening the capacity of mainstream health services managers and supervisors with culturally appropriate supervision skills.

Initiatives have included:

- › Establishing the Victorian Aboriginal Nursing and Midwifery Cadetship program
- › Development of the Victorian Aboriginal Early Graduate Nurses program
- › Upskilling and expanding the Aboriginal health workforce by allocating 388 training grants including nursing, allied health, dental assisting, primary health, alcohol and drugs and management at certificate, diploma and undergraduate level qualifications and skill sets
- › Developing and implementing the Victorian Aboriginal Health Worker Scope of Practice Tool
- › Developing and delivering an accredited Aboriginal Hospital Liaison short course
- › Increasing the number of traineeships in mainstream and Aboriginal health organisations including nursing, allied health and dental assisting and cadetships.

Within these efforts to strengthen the Aboriginal health workforce, 32 health services have developed Aboriginal Employment Plans (AEP). All of the case study sites have an AEP and were provided with funding in 2013 to develop an AEP for the following two years.

It was beyond the scope of this evaluation to measure the outcomes and impacts of this initiative. Other parts of the *Koolin Balit Evaluation* have examined particular aspects of workforce development at the site and sector levels. However, this evaluation finds that strengthening and increasing the representation of Aboriginal employees remains a challenge at the case study sites.

Despite two years of effort, many hospitals are still unable to meet the *Karreeta Yirramboi* one per cent employment target for Aboriginal people. In smaller hospitals this amounts to between 3-5 employees while in larger hospitals the targets are more challenging. Much more analysis needs to be done with regard to the impact of the funding of the AEPs at the service level and specifically with regard to barriers for Aboriginal people in the recruitment process and the systems and processes that support retention and professional development.

This evaluation finds that focussing on the target alone has brought limited success in attracting and retaining Aboriginal employees at the case study sites. Indeed, there are some hospitals that have an AEP and are still recruiting on the basis of merit alone. In much the same way that Aboriginal consumers need hospitals to be culturally responsive when providing health care, Aboriginal candidates and potential employees need the recruitment and on-boarding processes to be culturally responsive. Both consumers and employees (Aboriginal and non-Aboriginal) need to feel culturally safe if they are to remain in the hospital system.

There is some evidence (which should be viewed cautiously since it was not a specific line of enquiry or analysis in this evaluation) that hospitals that show leadership in terms of cultural responsiveness and cultural safety, through understanding the specific cultural needs of Aboriginal consumers, are also achieving positive employment results. Interestingly, most hospitals are still developing ways to better identify Aboriginal employees – either at the recruitment stage or as longer-term employees and enhance their cultural safety. There appeared to be a reluctance for some Aboriginal employees to identify themselves. From the community's perspective, the presence of Aboriginal employees across the hospital employment base, increases levels of trust and cultural safety:

Well it really matters that the hospital employs our people. I want to see my family in there working and then I feel good about the place and going there (Community Member)

I want to know why they don't employ our people and when they do it is always as gardeners or maintenance. We want our people being doctors and nurses and then we get to see them and they understand us (Community Member)

A Welcoming Environment

Key Findings

The first significant experience of Aboriginal patients / community members within the hospital environment is the degree to which the space between the front door and being treated acknowledges Aboriginal people, culture and land.

Aboriginal people place great importance on the display of flags outside the hospital and Acknowledgement of Traditional Owner plaques and local Aboriginal artwork inside hospitals. This has the effect of enabling people to feel they are still connected to land, community and culture.

A welcoming environment plays a significant part in Aboriginal patients having a positive experience and feeling – in the first instance – culturally safe.

At each of the case study sites, hospitals were giving thought to / or focusing on developing a more welcoming environment for Aboriginal patients and their families. Some are just exploring and developing how this can be done while others have already created such an environment. Acknowledgement plaques, Aboriginal artwork and flying Aboriginal flags were commonly mentioned and evident in the cases studies – evidence that aligns well with the listed achievements in CQI reports. From the CQI reports, it is estimated that between 65-75 per cent of hospitals fly the Aboriginal flag. This aligns with the *Loddon Mallee Aboriginal Health Survey* reported in later sections of this report that suggests, of 17 health services in the region, 65 per cent fly the Aboriginal flag:

I think more can be done in a visual sense with the environment... it makes me feel safe (Community Member)

I like that the hospital acknowledges that cultural land it's on... always celebrate NAIDOC and cultural events (Community Member)

We're now seeing more and more cultural recognition through artwork etcetera, and all the acknowledgement of country (Community Member)

For one hospital, this is more than just making the hospital friendlier to Aboriginal people and is creating an environment where asking the identification question becomes easier for staff (with symbolic reminders around them) and where patients are more willing to volunteer the answer. This finding from the case study is supported by Renhard et al (2014) who found that welcoming environments had a significant impact on Aboriginal peoples' willingness to answer the identification question.

Indeed, the case studies highlight the importance of such environments for community members, whether patients or visitors. While they might appear to be symbolic in nature, they nonetheless enhance a sense of being culturally safe, at home, familiar and on country:

All the cultural awareness stuff is local, first and foremost. Even all the artwork and performers we get are telling local stories (AHLO)

It's not always about money... culture doesn't cost much (Community Member)

You know these places have been terrible for us in the past. But now we are unwell due to all that we have gone through and we have to come to these places of trauma and upset more and more as we get older. I like it when I walk up the hospital and see our flag there. I feel proud and I think about all those times before. I like seeing our artwork there and all the whitefellas looking at it and when I see my mob... my people... acknowledged I think maybe this place will look after me (Community Member)

The case studies also highlight the importance of a good relationship with local ACCOs when installing Aboriginal artwork within the hospital. At one site the intention had been good and Aboriginal artwork was installed. However, a local Aboriginal patient was upset when she noticed that the artwork was not local to the area. This led the executive sponsor for Aboriginal health at the hospital to contact the local ACCHO and the original pieces were then removed and replaced with local artwork. The fact that the hospital acted quickly and on the advice and expertise of the local community increased trust rather than see local relationships between the hospital and the local community deteriorate.



Footprints designed by a local Aboriginal artist show the way from the front door to the Warrawee Room at Bairnsdale Regional Health Service. This has created a welcoming environment, and leads people to the Aboriginal Meeting and Resource room that is located in our front corridor beside the office of the Aboriginal Liaison Officer.

Importantly, hospital staff strongly identified cultural responsiveness and cultural safety with the installation of plaques, flags and artwork. However, all interviewees noted that having a welcoming environment sets up an expectation and that cultural safety needs to “*commence in the foyer and be maintained beyond the foyer*”. The case studies provided examples of this happening inside and outside the hospital:

With the environmental stuff it has to feel like there is love. A big flash facility doesn't mean there is love there (AHLO)

Cultural events and immersion is extremely important with local guests and performers (AHLO)

You just walk in and it feels like a big hospital. It could be nicer. More inviting. What about regular open days and community tours/visits? (Community Member and Elder)

This hospital is really great [when someone dies]. They are always flexible to family and community needs, including afterhours visiting, week-long bedside viewings, and other things (AHLO)

Physically... look at VAHS [Victorian Aboriginal Health Service] Fitzroy you'll find the best example. No mainstream place feels that good (Community Member and Elder)

We're seeing more cultural recognition through artwork and Acknowledgements of Country and that makes a big difference (Community Member)

If we're coming to hospital, we have big family, so we need somewhere to be. To sit and have a cuppa and speak about what's happening (Community Member)

In Bairnsdale, Horsham and Mildura there are specific ‘cultural spaces’ that have been or were being created at the time of collecting the case study data. This included gardens, healing spaces and family spaces (see each of the case studies in later sections of the report).

Cultural Safety Training

Key Findings

Hospitals generally view some form of cultural training as important. There are various mechanisms for developing and implementing programs. There is no evidence of particular standards that programs need to meet, though most hospitals have a preference for local providers. The results of such training are only anecdotal as there was no evidence available of systematic capturing of performance and / or outcomes.

Hospitals are looking for more support with strategies / protocols for developing training, contracting providers, determining content and measuring the impact at the service and community levels.

From CQI reporting and the case studies, there is no evidence of a structured, recommended or mandatory approach to cultural training at hospitals. Hospitals are exploring as they go the best way to initiate and / or increase participation in both internal and external programs. They are relying on local contacts (mostly made through the AHLO) and resources for development and implementation. Strategies and mechanisms for delivery are varied and include online / eLearning resources and local service providers (e.g. ACCOs, TOs, Land Councils, etc.).

The Aboriginal cultural training programs delivered in hospitals are driven by AHLOs often with Executive support, and are mostly delivered on an irregular rather than scheduled basis. Many are delivering brief introductory sessions to new staff, as well as additional sessions that provide more local content. No hospitals were found to have a structured or strategic approach to the delivery of cultural training programs nor were they part of a learning pathway within the broader training program in the hospital.

Barwon Health, through the engagement of a local Aboriginal consultant, has developed an extensive 50 minute e-learning training program, which has allowed a large number of staff to participate in training, regardless of location or availability. This e-learning training (or a similar model) might have potential for a statewide roll-out, given that it can easily (and with low financial commitment required) apply core foundational cultural awareness to the workforce. This could be provided in conjunction with more traditional training methods such as in-person sessions. These classroom type sessions are seen as vital to providing contextualisation to the materials.

In Mildura, 400 of 600 staff have been to in-person training delivered by the Aboriginal Health Manager. This format is considered preferable by hospital staff and ACCHOs. Face-to-face contact with Aboriginal experts, although sometimes daunting and confronting for non-Aboriginal staff is widely regarded by community as the key method of training:

Being a training hospital, there is a high turnover, so we constantly lose educated staff and receive new untrained ones... all staff in this place need some level of understanding our people and our culture and our local Aboriginal people are the best ones to provide that (AHLO)

We should have e-learning, so everyone has it there, available. It covers the base knowledge. It would help keep up with staff turnover too (AHLO)

The basic cultural needs and expectations need to be clarified for hospital staff. They need ongoing cultural awareness training (Community Member and Elder)

They should do a course on culture to get ideas on how to help us (Community Member and Elder)

The hospital does need understanding... look at us, not down on us. Be aware of culture. They need regular training sessions (Community Member and Elder)

They need to know we don't just say we are sick for the fun of it. We don't even say it much, so listen when we do (Community Member)

We need to get this across to white fellas we are completely different to them, culturally (Community Member and Elder)

Basic understanding is needed, so we can just participate in society (Community Member and Elder)

These quotes highlight the necessity of cultural training in as much as such training can contribute to the healing (physical, emotional and spiritual) process. Without such training, community members feel less safe and this lack of safety can lead to (further) trauma. Such trauma is known to have an effect on the health and wellbeing of Aboriginal people.

There is a need to review current emerging research – academic and program evaluations - that examines the benefits, challenges and methods for achieving the best outcomes (e.g. Downing et al 2011). Such research should be used to assist hospitals to develop standards and mandatory practices that increase the cultural competency of all hospital staff and enables the measurement of compliance with such standards and strengthen reporting of outputs, outcomes and impacts.

Downing et al (2011) note more comprehensive evaluations of Aboriginal cultural training programs are needed. Their review notes that Aboriginal cultural training based on a cultural awareness model tends to focus on teaching participants about 'other cultures' of people seeking their care. The culture of participants (health workers) and the culture of the health system itself remain unexamined, and are therefore implicitly positioned as the norm. Those who do not identify with this culture are then relegated to the 'other' group – the ones who are different.

In order to respect and protect a person's cultural identity, health workers must be able to understand the processes by which cultural identity is created and shaped. A cultural safety framework works to explicitly and critically explore issues of power imbalance and social inequality.

A culturally safe environment aims to ensure that a person does not feel any assault, challenge, or denial of their identity, of who they are and what they need. Only the person seeking health care can judge whether their identity is being respected and is safe; thus, a cultural safety model ensures no other person, discourse or organisation can ascribe a particular identity to that person. As such, training advocated by a cultural safety model does not focus on learning a culture, but rather focuses on assisting health workers to practice the reflexivity needed to examine their own identity and cultural beliefs and the way in which these might manifest in their interactions with those they are caring for. This shifts the focus of training away from trying to teach about 'Indigenous culture' toward examining processes of power imbalance and identity and can therefore create lasting change among health staff and systems.

Monitoring and Reporting

Key Findings

There is no rigorous monitoring or reporting at the hospital or statewide level of cultural responsiveness or cultural safety. The mechanisms for reporting that are in place are ad hoc, non-mandatory and provide an incomplete story at the sector level with regard to cultural responsiveness or cultural safety.

A key gap identified in the documentation and validated through the case studies is that there is no systematic measurement and collection of information with regard to cultural responsiveness and cultural safety. Hospitals are capturing in ad hoc ways their journey and reporting internally levels of care and improvement in the provision of culturally responsive care for Aboriginal patients. Overall, there is a lack of accountability held at the service and department levels.

Some of the reporting mechanisms in place are outlined here.

1. WIES funding (as noted in this report) provides hospitals with a 30 per cent loading for Aboriginal patients. The reporting and linking of this funding to either Aboriginal health outcomes or to the funding for Aboriginal health positions and staff could not be identified in the case studies. Indeed, the case studies highlighted ambiguity at the service level with regard to WIES as a means to strengthening Aboriginal health outcomes or performance monitoring.
2. This report has already noted that the CQI tool is used by some but not all hospitals. For the case study sites using the CQI tool, there is some evidence that the process of self-reflection can be valuable – especially when the guidelines for using the tool are stringently followed as they were in the case of BRHS.

There is substantial variation in the way the tool is used to capture progress (including who is involved in populating the tool) and then how the report is used in a continuous improvement process. Many case study sites suggested the CQI tool was onerous and difficult to use and there is a general feeling that the department should analyse in detail the CQI reports it receives and then publish an annual outcomes report inclusive of actions, improvements and progress at a sector level.

A generalised finding is that the CQI tool, CQI process and feedback from the department to the services need review. A simpler and mandatory reporting process for cultural responsiveness and cultural safety was a common suggestion.

3. *Quality of Care* reports are a mandatory reporting requirement for hospitals and are published annually. These provide information on the quality and safety systems, processes and outcomes of the health service. The primary audience of these reports are consumers (patients), carers and the health service community. The department recommends health services consult with consumers, carers and community members and/or community advisory committees about the specific content of their annual Quality of Care report.

As part of this evaluation, the analysis of a sample of *Quality of Care* reports demonstrates that many services report according to the department's recommended guide and that two key areas of reporting the impact of the quality of care for Aboriginal people are 'Consumer participation' and 'Diversity'. Some hospitals use the CQI KRAS to report performance. These, however, mostly include descriptions of initiatives and provide very limited detail. An internal review of 41 Victorian health services 2013-14 *Quality of Care* Reports noted the following as good practice examples:

- A Senior Aboriginal Hospital Liaison Officer at St Vincent's leading groups of clinicians on a walking tour of the Fitzroy area to improve cultural understanding of Aboriginal health care issues
- A long-term partnership between Ballarat Health Service (BHS) and the Ballarat and District Aboriginal Cooperative (BADAC), through the formation of a MOU
- BRHS meeting with the GEGAC on a fortnightly basis to support care partnerships for Aboriginal clients
- A procedure which included information about the correct procedure for 'asking the question' and correctly recording Aboriginal status at Melbourne Health
- WHCG passing on referral or discharge information to Goolum Goolum Aboriginal Cooperative and other Aboriginal health care organisations to assist with ongoing care after discharge.

The evaluation finds that *Quality of Care* reporting has little utility value for measuring and reporting cultural responsiveness and cultural safety since there is no consistency in measurement or application of measures and too little detail on strategies and outcomes.

4. 4. As already noted, a health services' Statement of Priorities is the key measure of accountability and performance in a single year between the department and health services. Analysis of the reported actions for 2014-15 identified two actions that were non-mandatory but to which health services could commit and had relevance to Aboriginal people / patients:
 - *Improving every Victorian's health status and health experience*: where health services identify service users who are marginalised or vulnerable to poor health, and then develop interventions that improve their outcomes relative to other groups. Aboriginal people were included as an example of a marginalised group along with people affected by mental illness, people at risk of elder abuse, people with disability, homeless people, refugees and asylum seekers
 - *Expanding service, workforce and system capacity*: where health services identify action to increase employment of Aboriginal people in mainstream health services in line with the strategic objectives of Koolin Balit and Karreeta Yirramboi workforce participation targets.

Table 5 provides a summary at the statewide level of services by region and the percentage that committed to each action.

Table 5: Summary of 2014-15 Statement of Priorities Undertakings by Region for Aboriginal Outcomes

Percentage of services taking up the action	Improving every Victorian's health status and health experience	Expanding service, workforce and system capacity
% of Metropolitan Health Services undertaking	56%	44%
% of Regional Health Services undertaking	50%	67%
% of Sub-regional Health Services undertaking	50%	60%
% of Local Health Services undertaking	18%	27%
% of SRHS Health Services undertaking	17%	6%
% of Health Services by Region (Barwon South)	18%	27%
% of Health Services by Region (Gippsland)	10%	40%
% of Health Services by Region (Grampians)	33%	8%
% of Health Services by Region (Hume)	20%	20%
% of Health Services by Region (Loddon Mallee)	40%	27%

While the number of health services making commitments was less than 60 per cent overall some of the reported actions for identifying Aboriginal service users and developing interventions that improve their health outcomes included:

- Boort District Health providing dental camps to Aboriginal consumers in the north of the state in partnership with Mallee District Aboriginal Service
- Colac Area Health in partnership with Wathaurong Aboriginal Cooperative integrating the Aboriginal community health nurse outreach program into the community services team and scheduling regular visits and participating in team meetings and forums
- Mercy Public Health improving rates of Aboriginal identification and improving cultural safety of the workplace at both sites through ongoing cultural safety training
- Mildura Base Hospital reviewing its ICAP plan by December 2014 as well as improving access for Aboriginal people through completion of the Aboriginal Healing Centre by March 2015.

The nature of reported actions to increase employment of Aboriginal people in mainstream health services is in line with the strategic objectives of Koolin Balit and Karreeta Yirramboi workforce participation targets. Initiatives and commitments included offers of Aboriginal traineeships in the areas of nursing, allied health, dental assistant and administration; development and implementation of Aboriginal Employment Plans; education and training with respect to cultural competencies and developing culturally aware and inclusive workplaces.

As with other reporting measures, the analysis mostly highlights gaps. Some regions have low commitments to the two actions. Some health services, known to have detailed actions relevant to the two key priorities, have opted not to report them within the Statement of Priorities. For example, Ballarat Health Service, which is known from other reports (e.g. *Strengthening Clinical Care and Pathways Aboriginal Cancer Care Project: Final Report 2015*) to be placing significant efforts and resources into improving care for Aboriginal people, does not include this in *Statement of Priorities* and CQI reporting. Reviewing these two reports alone might suggest the service is not as active in this space as it actually is.

This evaluation notes that for 2016-17, there are two actions that have relevance to Aboriginal health and that these actions, along with all others in the *Statement of Priorities*, will be mandatory for the next 12 months. These are:

- Improve the health outcomes of Aboriginal and Torres Strait Islander people by establishing culturally safe practices which recognise and respect their cultural identities and safely meets their needs, expectations and rights
- Develop and implement strategies that encourage cultural diversity such as partnering with culturally diverse communities, reflecting the diversity of your community in the organisational governance, and having culturally sensitive, safe and inclusive practices.

The evaluation finds that many health services may not know what culturally safe and inclusive practices are and, if they do have some ideas, will be uncertain about how to implement them and even more uncertain about how to measure them. Further, while many health services are establishing partnerships with ACCHOs, ensuring such partnerships are effective will be challenging without measures as will building culturally sensitive, safe and inclusive practices. Support from the department to enable, facilitate and measure outcomes will be vital.

Finally, during the course of the evaluation, the Loddon Mallee region (Department of Health and Human Services) undertook an initiative that sought to collect some baseline data and benchmark cultural responsiveness across the 17 health services in the region. The Aboriginal Health Survey was developed, administered and reported for all 17 health services in the region. The survey and follow up interviews demonstrated a wide variation of commitment and interest in providing culturally responsive care across the region. The findings are well aligned with this evaluation.

Some services acknowledge a commitment to wanting to do more but not knowing how or what to do. Drawn from this survey and interview findings, a framework for culturally responsive practice in health services was developed (Table 6). The framework shows how specific actions align to the three broad domains.

Table 6: Loddon Mallee Culturally Responsive Framework

Domain	Description	Actions
Environment	Environment provides a culturally safe building/ space that incorporates Acknowledgement of Traditional Owners	<ul style="list-style-type: none"> Flies Aboriginal Flag Signage Artwork Traditional Owner / Acknowledgement plaque Use of Traditional Owner language (e.g. room names)
Support & Engagement	Support systems are embedded for Aboriginal people as part of the organisation and as partners	<ul style="list-style-type: none"> Employ an AHLO Aboriginal Advisory Committee Aboriginal person on the Board Aboriginal person on Quality Committee Employ Aboriginal volunteers Engage with the Aboriginal community or ACCO in a positive relationship
	Education and training are in place to change the culture of the organisation	<ul style="list-style-type: none"> Cultural awareness / cultural safety training delivered to staff
Governance	The organisation's leaders demonstrate understanding of and commitment to culturally responsive services	<ul style="list-style-type: none"> Board support demonstrated in strategic plans, annual reports, etc. Executive support demonstrated through communication to staff Signed Statement of Intent Actions identified in Statement of Priorities
	Relevant policies and plans in place for implementation and accountability	<ul style="list-style-type: none"> Aboriginal Health Plan Continuous Quality Improvement tool (CQI) Aboriginal Employment Plan Diversity Plan

As noted, this framework for cultural responsiveness and cultural safety has strong alignment with the key findings from the case studies undertaken as part of this evaluation. It is noteworthy that the survey will now be undertaken every two years and will report improvements to the 17 health services in the region.

This section and the findings from the case studies highlight significant gaps in measurement and reporting of cultural responsiveness and cultural safety. There are a number of reporting opportunities health services can take up – some mandatory and some voluntary – but without a clear set of indicators and measures it is not possible to determine improvements at the statewide level.

Summary

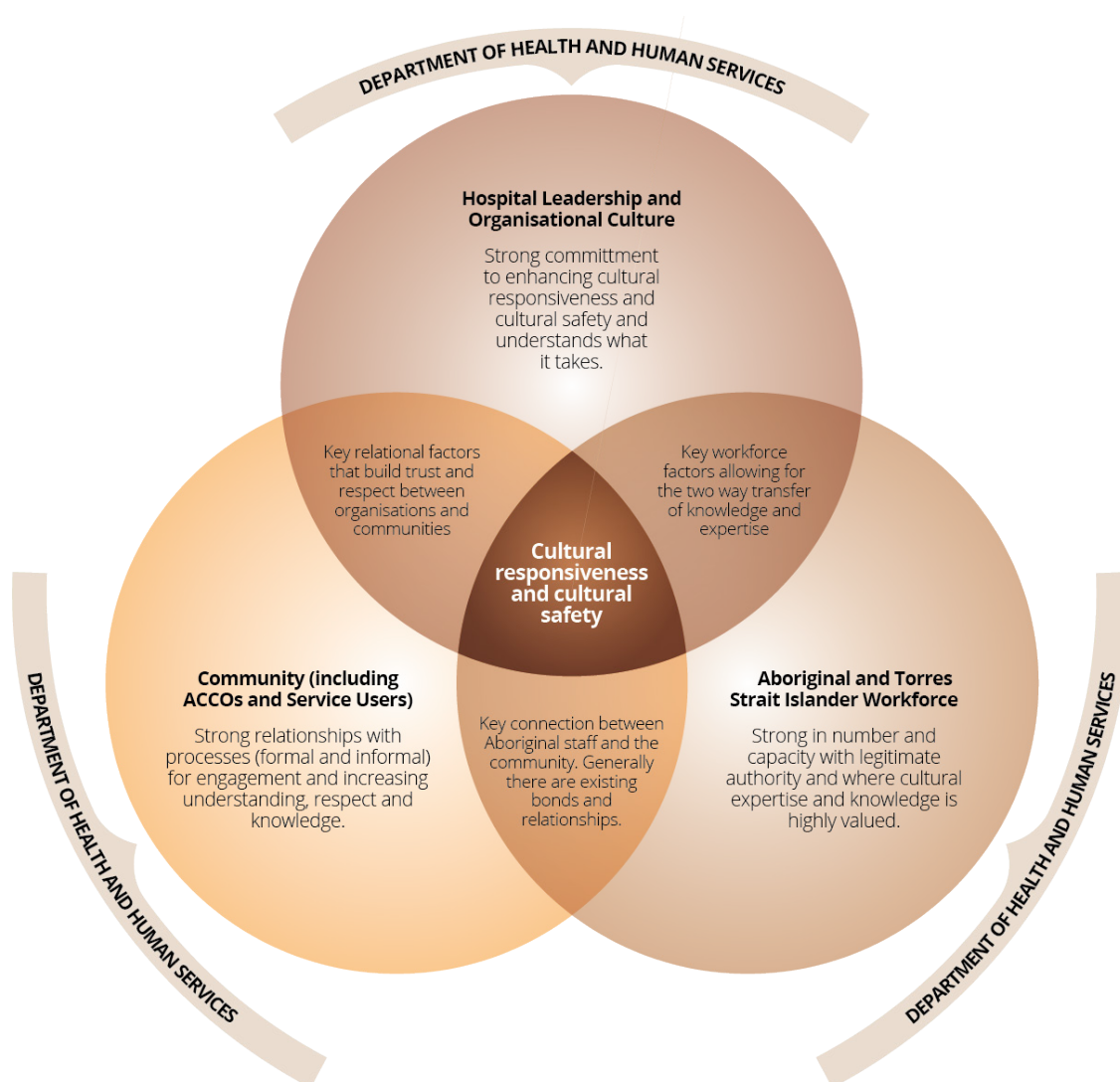
From these six findings it is evident that there are three domains of change that influence a hospital's ability to provide culturally responsive care and cultural safety for Aboriginal patients. These are:

1. Hospital leadership and organisational culture
2. Aboriginal and Torres Strait Islander workforce
3. Aboriginal community relationships – including local ACCHOs, Traditional Owners and Aboriginal patients.

The findings of the evaluation suggest that the stronger the relationship between each of the domains, the more culturally responsive care and cultural safety is enhanced. The domains provided a useful mechanism by which to measure each case study and are defined in Diagram 10 below.

The outer dimensions of the domains represent the enabling environment that the department can take to bring pressure onto the domains in order to increase congruence and strengthen the relationship between the three domains. This might include policy levers such as WIES funding, project funding, standards and resources for cultural safety training, strengthening the AHLO / KMHLO network, regional support, accountabilities, and initiating stronger monitoring and reporting across the hospital sector.

Diagram 10: Cultural Responsiveness and Cultural Safety Domains of Change



As improvements are made or strengthened in each domain (facilitated or not by the department) more congruence occurs between the domains. With neglect and / or lack of focus and vision, domains can move away from each other and the space for cultural responsiveness and cultural safety to thrive diminishes. The case studies demonstrate these relationships well.

3.3 Have the Healthcare Experiences of Aboriginal People Changed Over Time?

Key Findings

It is not possible to measure at the statewide or hospital level Aboriginal patient experience – and specifically changes over time. The Victorian Healthcare Experience Survey (VHES) shows some promise but will need some refinement if it is to provide valid and reliable data regarding cultural safety for Aboriginal patients.

While the current VHES data is problematic it suggests Aboriginal patient experience (inpatients and presentations to ED) is significantly worse than for non-Aboriginal patients.

The VHES data demonstrates higher levels of satisfaction of care for Aboriginal patients than the level expressed in community interviews.

Currently, a key source of patient experience data is the VHES⁸. There are two surveys that aim to measure the experiences of patients presenting to the emergency department and inpatients. The surveys are detailed with 92 questions in each of the two surveys and allow a wide range of people to provide feedback on their experiences. These surveys are distributed to randomly selected eligible participants in the month following the hospital admission or the emergency department attendance. Participants can respond either online or by pen and paper with a freepost return.

Comprehensive quarterly results for individual health services and campuses are reported online, and are accessible by Victorian health services and department employees. It should be noted that the VHES is a new form of measurement of patient experience and currently asks if the patient is Aboriginal and / or Torres Strait Islander. There are no questions specific to Aboriginal and Torres Strait Islander patients. However, as part of this evaluation, data was examined across a small set of questions within the emergency department and inpatients surveys. These questions are outlined in Table 7 below.

⁸ The Victorian Healthcare Experience Survey (VHES) collects data from a range of healthcare users of Victorian public health services. The survey is conducted on behalf of the department by Ipsos, an independent contractor. Ipsos provided the data and analysis included in this section of the report.

Table 7: VHES Survey Questions Analysed

Emergency Survey	Inpatients Survey
Overall, did you feel you were treated with respect and dignity while you were in the ED [Emergency Department]?	Overall, how would you rate the care you received while in hospital?
Overall, how would you rate the care you received while in the ED?	Do you feel that you were listened to and understood by the people looking after you in hospital?
Do you feel that you were listened to and understood by the people looking after you in the ED?	Overall, did you feel you were treated with respect and dignity while you were in hospital?
Were you ever treated unfairly for any of the reasons below?	Were you ever treated unfairly for any of the reasons below?

Responses to each survey were examined for the period January - December 2015. This was the first time a full year of data was available. The total number of responses over this period were 14,000 and 47,500 for emergency and inpatients respectively with a representation of Aboriginal and Torres Strait Islander patients being approximately 0.7 per cent for both surveys.

The data was analysed across the four key questions for each survey comparing responses for Aboriginal and / or Torres Strait Islander people versus non-Aboriginal people. Key findings from the analysis are:

- › 70 per cent of Aboriginal patients claimed they were treated with respect and dignity in ED compared with 81 per cent for non-Aboriginal patients
- › 77 per cent of Aboriginal patients rated the overall care they received in ED as positive compared with 85 per cent for non-Aboriginal patients
- › Only 58 per cent of Aboriginal patients felt they were listened to and understood by the people looking after them in ED compared with 74 per cent for non-Aboriginal patients
- › 24.5 per cent of Aboriginal people felt they were treated unfairly while in ED compared with 10 per cent for non-Aboriginal people
- › Over 91 per cent of Aboriginal inpatients rate the care they received while in hospital as positive while 94 per cent of non-Aboriginal patients rated the care they received as positive
- › Over 78 per cent of Aboriginal inpatients felt listened to and understood by the people looking after them in hospital compared with 82 per cent for non-Aboriginal patients
- › 87 per cent of Aboriginal inpatients felt they were treated with respect and dignity while in hospital compared with 91 per cent for non-Aboriginal patients
- › 84 per cent of Aboriginal inpatients felt they were not treated unfairly while in hospital compared with 91 per cent for non-Aboriginal patients.

There are recognised limitations with the VHES in terms of measuring Aboriginal patient experience. The first is that the survey itself is large and demands certain levels of literacy and numeracy and it is well known that both are barriers to Aboriginal people receiving good healthcare. Second, the current sample size of Aboriginal and / or Torres Strait Islander patients is relatively small compared to the percentage of Aboriginal and / or Torres Strait Islander patients presenting to ED and inpatients at most health services (as reported in the Background section of this evaluation). The low response rate might reflect the complexity and length of the survey.

Further, if the survey is to be used to measure Aboriginal patient experience there needs to be tailored questions that explore in more detail the importance and experience of – for example – a welcoming environment, whether they were asked if they were Aboriginal and / or Torres Strait Islander, whether a AHLO was available and beneficial to their experience and the degree to which they felt culturally safe.

That said, the VHES can be accessed by all Victorian health services and infographics generated for their service across questions. With some refinement (or a separate survey for Aboriginal and Torres Strait Islander people), the survey could be an important tool for the department and health services in terms of measuring progress. When the data is analysed against the views of almost 100 Aboriginal patients and community members that were interviewed for this evaluation, it seems that the quantitative data is more positive than qualitative experiences described:

There's no proper support for us. They don't have the right strategies
(Community Member)

I wanna go to a hospital and not be stigmatised or targeted. I just want the best possible service, like everybody else gets... and I wonder why we don't get it (Community Member)

Across the interviews, Aboriginal people state a sense of alienation and lack of belonging when using public health services, identifying an apparent lack of strategies and processes to correct this. Community members stated mainstream / western practices were unsuitable for them and were dismissive of cultural needs:

Everybody works within a box, but they need to realise that their box isn't right for everyone. There needs to be more flexibility. Things need to be done in different ways, to suit different and diverse people (Community member)

... Not many people are doing well, so this place should have some sense of social justice. But they don't (Community Member)

Although many examples of basic improvements are reported, including “lots of artwork” and “Aboriginal flags out the front” and “always celebrating NAIDOC”, there are often barriers identified which maintain a sense of disenfranchisement amongst many Aboriginal people:

They are doing more than they ever have here. There's still a lot of nasty people there though (Community Member)

I've experienced going to hospital... and feeling like I'm left until last and I wondered if it was because I was Aboriginal. It was really daunting and upsetting, and I never went back (Community Member)

Racism was often spoken about and community members agreed that education must be embedded across the health system to increase the baseline knowledge of the health workforce, therefore improving the hospital experience (cultural safety):

Cultural awareness must be embedded all over, and an ongoing practice... They should do a course on culture to get ideas on how to help us... they need to understand their racism (Community Member)

The hospital does need understanding - look at us, not down on us. Be aware of culture. They need regular training sessions (Community Member)

We have different needs to mainstream community, and it's important that it's respected. But I don't think they have a great understanding (Community Member)

We need to break down the principles of health, and start getting culturally appropriate care (Community Member)

Aboriginal patients stated strongly that the hospital system is not designed for them, the systems and policies are not reflective of their needs and that the department could do more to enable changes to the system:

There is no real awareness from DHHS regarding AHLOs and the big picture. The workforce just isn't supported (Hospital Staff)

The Government are supposed to help us... It's supposed to be helping (Community Member)

Government needs to be telling hospitals what to do with the money. They need to gather community voices and opinions and make hospitals more accountable for change (Community Member)

3.4 Measuring Cultural Responsiveness and Cultural Safety

Key Findings

Current indicators, measures and reporting are inadequate and incoherent and need further development to support more rigorous monitoring and reporting of hospital efforts to improve cultural responsiveness and cultural safety for Aboriginal people and families.

Measures for cultural responsiveness and cultural safety could include: Organisational Leadership, Welcoming Environment, Patient Experience, Partnerships with ACCHOs, Aboriginal Health Team is Respected, Cultural Safety Training and Aboriginal Workforce Development.

A common theme in this evaluation was the gap in monitoring and reporting. The CQI tool works well where hospitals are diligent in following the process and are committed to improvement. Evidence of such diligence and commitment is low and this is due to the fact that such reporting is non-mandatory. There is also a view that *“nothing is done with the reports at the department level”*.

However, in the next 12 months, hospitals will be faced with a set of mandatory actions that will require significant attention.

First, there are two mandatory actions in the 2016-17 *Statement of Priorities* for hospitals to meet:

- › Improve the health outcomes of Aboriginal and Torres Strait Islander people by establishing culturally safe practices which recognise and respect their cultural identities and safely meets their needs, expectations and rights
- › Develop and implement strategies that encourage cultural diversity such as partnering with culturally diverse communities, reflecting the diversity of your community in the organisational governance, and having culturally sensitive, safe and inclusive practices.

Second, the *National Safety and Quality Health Service (NSQHS) Standards: Version 2* to be introduced in 2018 have strengthened the requirements across a number of standards for the provision of culturally responsive care⁹. The draft standards currently include:

- › The governing body ensures that the organisation's safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people
- › The health service organisation implements and monitors strategies to meet the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander people

⁹ See the following link for information and fact sheets on the new draft standards. These provide information for health services committed to enhancing cultural responsive care and cultural safety for Aboriginal patients.
<https://www.safetyandquality.gov.au/our-work/accreditation-and-the-nsqhs-standards/improving-care-for-aboriginal-and-torres-strait-islander-people/>

- The health service organisation has strategies to improve the cultural competency and cultural awareness of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients
- The health service organisation demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people.

Standard 2: Partnering With Consumers

- The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs.

Standard 5: Comprehensive Care

- The health service organisation has processes to routinely ask patients if they identify as Aboriginal or Torres Strait Islander, and to record this information in administrative and clinical information systems.

The findings from this evaluation, when shared, will assist those hospitals that are yet to establish and embed culturally responsive and culturally safe practices in their services – that is, meet the mandatory actions in the 2016-17 *Statement of Priorities* and the new (NSQHS) Standards when introduced.

In terms of measuring cultural responsiveness indicators and measures contained in Table 8 emerged from the evaluation – and specifically with a view to increasing accountability, monitoring and reporting. Hospitals could report against these indicators and measures on an annual basis including providing evidence – with potentially Aboriginal community (e.g. local ACCHO and/or AHLO) verification. Further, this set of measures and indicators could be part of the revision / changes required to address the gaps and limitations of CQI reporting. In meeting these indicators and measures hospitals will be better placed to comply with the new NSQHS Standards and the mandatory actions in the 2016-17 *Statement of Priorities*.

The development of the indicators and measures has been informed by the voices of those Aboriginal people (patients, community members and hospital and ACCHO staff) that participated in the evaluation. The indicators and measures align with the definitions of cultural responsiveness and cultural safety as articulated by Aboriginal people (Table 8). The indicators and measures have also been informed by the strategies and actions that hospitals have developed and that Aboriginal patients, community members and staff suggested were important.

While there are numerous indicators and measures they are presented as a suite for the department and services to consider and they are interdependent with no one indicator working well in isolation of others.

The department and services could use the indicators and measures for monitoring and reporting purposes as well as informing a process of continuous improvement at the service and statewide levels.

At the hospital level the indicators and measures can be used to guide action and demonstrate compliance. They also allow for the self-reflection approach of CQI reporting to be maintained (with improvements) and ensure indicators and measures do not become a generic checklist for hospitals to tick off. This is important since it allows for community driven, creative actions and strategies to emerge. The case studies provide some evidence that self-reflection (inclusive of community voices) supports new, context specific ideas.

At the department level, there is a leadership role. For each of the indicators and measures, the department can use the information and findings of this report to facilitate change and be an enabler to hospitals improving culturally responsive care and cultural safety for Aboriginal patients. Examples could include:

- Fact Sheets including suggested strategies for addressing indicators and measures
- Hosting CEO, Board and senior leadership forums for developing best practice and addressing indicators and measures
- Developing surveys for reporting Aboriginal patient experience and monitoring and reporting progress at the hospital and statewide levels
- Monitoring and reporting Aboriginal employee satisfaction through existing (e.g. People Matter surveys) or new mechanisms
- Supporting hospital reporting through the improved CQI reporting and developing a statewide and annual *'Improving Culturally Responsive Practice Report'* (Practice Report).

Such an approach aligns well with the recommendations that emerged from the Duckett Review.¹⁰ The department has accepted in principle all the recommendations of the review, with work already underway to implement them. Better, Safer Care, Delivering a world-leading healthcare system sets out how the government and department are addressing the entirety of the Review's recommendations under four areas of emphasis:

- Setting the goal that no one is harmed in our hospitals
- Supporting strong leadership in hospital governance - with good clinical leaders, an effective Board and rigorous oversight
- Sharing excellence across our health system - so that where one hospital does something well, others can follow suit
- Collecting great data about patients' experiences and feeding that back across the system to improve patient care.

10 *Targeting zero, the review of hospital safety and quality assurance in Victoria* was commissioned by the Minister for Health following the discovery of a cluster of tragically avoidable perinatal deaths at Djerriwarrh Health Services. The review was a detailed and extensive analysis into how the department oversees and supports quality and safety of care across the Victorian hospital system. It consulted widely, seeking the views and experiences of patients, clinicians, hospital managers and boards about how to make Victoria's healthcare systems safer.

Monitoring and reporting against the indicators and measures in Table 8 would be important for the department and hospitals as they further develop approaches to providing culturally responsive care and ensuring Aboriginal patient experience is culturally safe.

Table 8: Measuring Culturally Responsiveness and Cultural Safety

Indicators	Demonstration Measure
1. Commitment to culturally responsive care for Aboriginal patients at the highest level of the organisation	<ul style="list-style-type: none"> ➤ An Executive 'sponsor' is appointed to champion cultural responsiveness and cultural safety ➤ Regular reporting to Executive/Board of cultural responsiveness and cultural safety for Aboriginal patients. Report could include: <ul style="list-style-type: none"> ➤ Revenue and expenditure for Aboriginal health programs and services ➤ Activity and progress to date ➤ Patient data (e.g. admissions, ED presentations, DAMA, LWT) ➤ Data on patient experience (e.g. survey, analysis of complaints).
2. There is a welcoming environment for Aboriginal patients and families	<ul style="list-style-type: none"> ➤ Aboriginal flags fly outside the hospital ➤ Local Aboriginal artwork is displayed in the foyer ➤ Acknowledgement of Traditional Owners are displayed in the entrance / foyer ➤ Smoking ceremonies or similar events as determined by communities at the hospital ➤ Participation in events and cultural days of significance (e.g. NAIDOC Sorry Day).

Indicators	Demonstration Measure
3. Aboriginal patients are identified and supported and their experiences captured	<ul style="list-style-type: none"> › Identification system including the associated policies, procedures and/or protocols are in place › Frontline staff have received cultural safety training › Regular and reported review of the identification system and levels of compliance › Percentage of identified patients that have been assisted by an AHLO › Rates of DAMA and LWT (Aboriginal compared to non-Aboriginal) monitored and reported › Patient experience of feeling culturally safe are measured and reported.
4. Partnerships are developing with local ACCHOs and Aboriginal communities	<ul style="list-style-type: none"> › MOU in place with local ACCHO with partnership aims and actions, roles and responsibilities included › Scheduled meetings with local ACCHO(s) take place (and include multiple staff) › Annual review against actions and refreshing of MOU › Celebration of achievements.
5. Aboriginal Health Team is acknowledged and respected for their expertise	<ul style="list-style-type: none"> › Professional development plans are in place for members of the team › AHLOs and other Aboriginal team members report feeling supported › AHLOs and other Aboriginal team members report feeling culturally safe › Aboriginal Health Teams have direct reporting responsibilities / access into the Executive Team.
6. <i>Cultural Safety Training</i> is a priority for the organisation	<ul style="list-style-type: none"> › Targets are set annually to ensure staff have undertaken cultural safety training › Training is structured within the organisation's broader learning pathway / platform › The value of the training to employees is measured and reported.

Indicators	Demonstration Measure
7. Aboriginal Workforce Development	<ul style="list-style-type: none"> ➤ An Employment Plan / Strategy for recruitment, retention and career pathways for Aboriginal people is established ➤ Karreeta Yirramboi targets are met and extended ➤ Aboriginal employee satisfaction is measured (e.g. People Matter survey, retention of staff).






4. Case Studies

The following case studies were developed alongside each of the hospitals and with specific focus on the experiences and opinions of Aboriginal staff, community and patients. It is evident that in Victorian public hospitals there are no consistent or benchmarked approaches to delivering culturally responsive care. Each hospital appears to be on its own individual journey and each is at a unique point in the journey. **The case studies do not assess or evaluate the performance or quality of the individual settings.** Rather, the case studies are an illustration of the broad and complex differences in approach which are experienced by the Aboriginal community as either barriers or enablers to accessing health care.

What these stories demonstrate is a difficult experience for Aboriginal people, and one in which the evidence for positive change and progression relies heavily on the proactive strategies of the service. The expertise of Aboriginal people has been purposefully sought to inform the case studies and the case studies are the communities' story as much as they are the story of the hospital.

At each case study site interviews were undertaken with hospital CEOs, Executive leaders, nursing staff, AHLOs and Aboriginal health workers, Aboriginal patients and community members. Interviews were also undertaken with ACCHO CEOs and staff. In all case study sites there was evidence of hospitals making efforts to improve cultural responsiveness and cultural safety.

Each of the case studies has been analysed by identifying key themes and then conducting a meta-analysis that linked key patterns and trends across the case study sites. This allowed case studies to be defined according to points on a journey across the overall criteria. The ranking developed is as follows.

CRITERIA RANKING				
 Recognise	 Acknowledge	 Initiate	 Implement	 Embed
Recognise the needs.	Acknowledge the context.	Initiate some actions for improvement.	Implemented what's working.	Embed culturally safe practices.
Think about a trip.	Plan the journey.	Start the journey	Enjoy the view	Keep going...

4.1 Bairnsdale Regional Health Service

It was a no brainer. There is a local need for better services, so we need to be present in community all the time (CEO)

Bairnsdale Regional Health Service (BRHS)

Aboriginal population (regional)	1,332 (3.2% of total regional population)
Traditional Owners	Gunai Kurnai
Key ACCHO	BRHS has a long-standing relationship with Gippsland and East Gippsland Aboriginal Cooperative and strong developing relationships with Lakes Entrance Aboriginal Health Association, Lake Tyers Health & Children's Service and Moogji Aboriginal Council East Gippsland Inc.

Self-Reported Progress in CQI

CQI reports have been completed from 2013-15 and demonstrate consistent progress and improvement – though it should be noted that reported achievements (scores) against the KRAs in the CQI are lower than the state average. This is purposeful as a means to recognising the work still to be done.

Relationships with ACCHOs has been a strong objective, and outcomes across the three reports demonstrate strengthening relationships. BRHS has stated goals and subsequent achievements in this area, showing a significant growth in health service - community sector relationships. This is achieved through regular meetings and a commitment to being in the community and *“not waiting for the community to come to us”*.

Situated in East Gippsland, on Gunai Kurnai Country, Bairnsdale Regional Health Service (BRHS) is a regional hospital where there is a growing local Aboriginal population of 3.2% (2011 Census). There are four regional ACCHOs that provide BRHS with the opportunity to engage with community to enhanced culturally responsive outcomes. The ACCHO's in the region are: Gippsland & East Gippsland Aboriginal Corporation (the primary service situated in Bairnsdale); Lakes Entrance Aboriginal Health Association (servicing the nearby coastal community); Lake Tyers Health & Children's Service, and Moogji Aboriginal Council East Gippsland Inc.

Aboriginal people living in the region suggest that Bairnsdale has not been known for its inclusive attitudes towards local Aboriginal people and communities. They therefore acknowledge the importance of the work BRHS is doing in changing community attitudes more broadly.

SUMMARY OF CONSULTATIONS (ABORIGINAL IN BRACKETS)

Aboriginal Community members	10
Health Service staff	8 (4)
ACCHO staff	6 (4)
Total consultations	24
Total Aboriginal consultations	18

[The CEO] is excellent. She's brought great change since she has been here. Things are different now (ACCHO staff)

Having [The AHLO]'s presence is really valuable. Her, plus [The CEO], equals new progress (ACCHO staff)

The leadership has “opened its doors for community engagement”, as well as allowed the long time employed AHLO (16 years) to be seen as a leader and a legitimate expert in Aboriginal health and culture. The AHLO, in the decade prior to the appointment of the current leadership, suggested she was only ever supported by community mentors and cultural leaders.

The previous CEO is viewed by staff and community as not having been supportive or understanding of the necessities for cultural safety, and therefore the AHLO had “carried the community through the hospital experience”, at the ongoing risk to her own wellbeing. Now, under a committed CEO, the AHLO and entire hospital workforce see community values and protocols becoming commonly accepted in the health service. Where once the AHLO was not given the freedom, legitimacy and resources necessary to be visible in and supportive to community, there is now a push from leadership for BRHS to “be and stay in community forever”. This is reflected in the list of key strategies developed over recent years and acknowledged by the community as working well with regard to their needs:

- The Blue Wren (a local culturally significant icon) is now a well-known and recognised BRHS symbol
- Elders and community had extensive input into the environmental design improvements of the hospital
- BRHS pharmacy provides self-funded medication to all discharged Aboriginal patients
- Aboriginal specific resources, such as internal and local health promotion materials, are readily available throughout the hospital, and are being utilised at a high rate
- Strong relationships with all four local ACCHOs are made possible by monthly collaborative meetings being held out in community
- All staff now wear lanyard cards with cultural information, and those who have undertaken cultural training are identifiable by a Aboriginal, Torres Strait Islander and Australian flag badge

- Extensive policy and procedure upgrades focus on better community outcomes – for example when Aboriginal patients are identified their file is ‘tagged’ with an Aboriginal flag sticker
- Cultural awareness training in place with inclusion in all new staff orientation / induction
- ‘Asking the Question’ promotion is prevalent throughout wards, and foundational training is delivered by a local expert
- Inter-hospital checklist includes specific Aboriginal measures to ensure patient identification and cultural information is passed-on to metropolitan health services receiving BRHS patients
- Bi-monthly specialist sessions in ACCHOs have seen a significant increase in patient registrations and attendance and Did Not Attend (DNA) decrease by 90 per cent
- Upgraded focus on screening, assessment, and care planning tools.

The “*crowning glory*” in the list of activities and achievements is the allocation of resources and focus being placed on the Aboriginal Health Program, in the form of the Warrawee Room. The Warrawee Room provides a culturally safe place for patients, family members, and Aboriginal Health Workers to meet in comfort. As the name suggests (Warrawee is a Gunaikurnai term meaning ‘come, rest a while’) is a non-clinical space specifically designed and furnished for comfort and peace. Adjoining this space is the Aboriginal Health Program office. These crucial community spaces are both located near to the main hospital entrance and can be found by following Aboriginal designed footsteps that lead from the foyer to the room. This, plus the recent recruitment of Aboriginal specific roles, has been met with great appreciation from the community and staff:

They move [The AHLO] from the old back office to [The Warrawee Room] and it all changed (Community Member)

It's just so nice [in The Warrawee Room]. We have families come here to meet, rest, eat... even have a sleep. Lots of ACCHO staff have a break here too (Hospital staff)

Enhancing and complimenting the newly prioritised and supported Aboriginal Health Program, are several new additions to the physical environment around the hospital. The exterior to the main entrance is framed by an Aboriginal sculpture, flags, and gardens. Also, as the community move throughout the buildings, they are met along the way by several pieces of art which display and promote local culture, and create a welcoming atmosphere.

The utilisation of local cultural experts for the delivery cultural awareness education is given high importance by BRHS, and ongoing and regular training sessions are taking place. These formally scheduled sessions are central to the professional development of BRHS staff, but the ongoing community engagement is also a critical avenue for cultural education, as staff are being regularly exposed to the reality of Aboriginal issues and community context. Working with the four regional ACCHOs, and holding regular community events with cultural focus, is strengthening the foundations of BRHS’s effort to improve cultural responsiveness and ensuring cultural safety:

Community involvement in the training is good (Community Member)

All the cultural awareness stuff is local, first and foremost. Even all the artwork and performers we get are telling local stories (AHLO)

BRHS are focused on tracking their improvements, and through the utilisation of the CQI tool, hold annual meetings to monitor progress and ensure the CQI tool is thoroughly completed and all relevant parties are informed and included. Key staff state that this is a vital event for the ongoing improvement of Aboriginal health in BRHS.

Notably, BRHS self-report against the CQI KRA's is lower than the statewide averages, yet the service appears to be achieving better results than most. There is a sense that, within this modest self-rating, BRHS is acknowledging that it are still early in the journey toward cultural responsiveness and cultural safety. Whilst the CQI tool is utilised to its full potential, members of the working group do believe that the CQI format could be enhanced in terms of fluidity, simplicity, and evaluation.

The Aboriginal Program Manager spoke on behalf of the group and indicated there is a sense of enjoyment surrounding the CQI workshops, as the broader health service becomes more reflective about Aboriginal health, and successful goal-setting. A particularly positive and valuable outcome of the CQI workshop is the continual strengthening of ACCHO relationships and partnerships.

The change in leadership at BRHS has allowed for a shift within the health service, which is the largest employer in the region, and as such is influencing progression beyond the four walls of the hospital and into community. This is demonstrated by the local Aboriginal community's reports of a new feeling of positivity and safety in their health experiences. Where once the community regarded the hospital as a negative or difficult place to be, they are now seeing a shift toward BRHS becoming a legitimate place and location for community events and gatherings.

Uncle Freddie [pseudonym] had always said that when he died he wanted to die at home in his community. He was a regular visitor to his local hospital and all the more so as his health deteriorated in his later years. He would often joke with the hospital CEO that he would never die "in this place". But as his health deteriorated, day visits became overnight stays and soon during one such stay preparations were made for Uncle Freddie to return to community for the final time.

As preparations were being made for him to go home Uncle Freddie met the hospital the KMHL and his wife: "what are we doing here... I will stay" and so it was that he passed away with his family in the care of the hospital staff. Unprompted and perhaps without authority, a hospital employee went outside and lowered the Aboriginal flag that always flies at the hospital to half-mast – ahead of the family leaving the hospital.

What the community says...

Hospital attitudes have changed. It used to be redneck and horrible. There is a noticeable improvement in communication with the community (AHLO)

We have a really great relationship with the hospital. BRHS is helping to fund our anti-smoking program, which is going great (ACCHO staff)

We're now seeing more and more cultural recognition through artwork etcetera, and all the acknowledgement of Country (Community Member)

I'm just seeing people [hospital staff] being nice (Community Member)

The hospital has changed in the last 15 years. We've seen a lot of progression here. More cultural stuff happening (Community Member)

The [Warrawee] room, and all the flags and stuff, [the AHLO] has been fighting for years, but they've been doing more lately (Community Member)

[The CEO] is a lovely person! Makes us feel very welcome. Always says hello. Before, it wasn't like that. Never... (Community Member)






Community are hearing about the change, then seeing when they come in (Community Member)

Our rapport with the hospital is becoming really really solid. In the last couple of years, there's been a lot of work done. It has enhanced the community's relationships between the hospital and ACCHO (ACCHO Staff)

[The CEO] came at just the right time. Big change! She's got a really great style. She's open, and allows experts to advise and inform programs (ACCHO Staff)

The 10 community members / patients that were interviewed were all aware and articulated the recent changes that had taken place. This demonstrates that when there is strong leadership with a commitment to journeying with the community, the community is left in no doubt about improvement – even those less visible than the Warrawee Room and the footsteps leading to it. There is a sense from the community interviews that Aboriginal patients feel culturally safe now in the BRHS and if not they certainly feel more safe than they did previously.


CRITERIA RANKING


 Recognise	 Acknowledge	 Initiate	 Implement	 Embed
Recognise the needs.	Acknowledge the context.	Initiate some actions for improvement.	Implemented what's working.	Embed culturally safe practices.
Think about a trip.	Plan the journey.	Start the journey.	Enjoy the view.	Keep going...

High Level Commitment

 Demonstrated commitment to improving Cultural Responsiveness

 Committed CEO / Executive


 Reporting goes to the highest level Executive

 Organisation has systems and processes that embed cultural responsiveness


 Aboriginal Board member/s


Aboriginal Workforce Development

 AHLO is employed


 AHLO is supported through professional development

 AHLO is deemed to be an expert

 There is a commitment to recruitment, retention and career pathways for Aboriginal people


 Policies and practice supports the recruitment, retention and career pathways for Aboriginal people


Engagement and Partnerships with ACCHOs

 There are strong relationships of trust in place

 MOU/s

 Aboriginal advisory committee/s

 Aboriginal people and communities deemed to hold expertise in Aboriginal health

 Processes to build ACCHO capacity

Cultural Safety Training

 Cultural awareness training available

 Targeted training for key staff

 Multiple platforms are used strategically

 Advanced to cultural safety training

A Welcoming Environment

 Plaques, artwork, flags

 Asking the question protocol

 Identification is monitored and measured

Monitoring and Reporting

 Captures the journey and reports internally

 Uses CQI tool

 CQI tool is used to drive progress

Summary

Bairnsdale Regional Health Service has achieved (in the opinion of the community and deemed by this evaluation), what appears to be best practice in public hospital cultural responsiveness. From this case study, the critical elements to foundational success can be determined, and perhaps applied to any other health service, given consideration to local context. At its core, BRHS has moved to a position where **progressive leadership, genuine Aboriginal expertise**, and a **commitment to Community engagement** are all in synergy and highly operational. Cultural responsiveness is embedded within BRHS in that nothing is done without consideration of its effects on Aboriginal patients. Therefore, cultural safety is increasingly being felt/experienced as an outcome by community. Not only do Aboriginal community members feel they are still on Gunai Kurnai country when they are within the grounds of the hospital, all community members might feel they are on Gunai Kurnai country when they enter the hospital.

4.2 Dental Health Services Victoria (DHSV)

“Aboriginal health is an overt commitment.” (CEO)

Dental Health Services Victoria (DHSV): Statewide service

Aboriginal population (regional)	37, 991 (0.7% of total Victorian population)
Traditional Owners	Main campus is on Wurundjeri Country
Key ACCHO	Victorian Aboriginal Health Service (VAHS)

Self-Reported Progress in CQI

All CQI submissions, 2013-14-15, report ongoing strengthening of ACCHO relationships, the Aboriginal Advisory Committee and program innovations.

With its main campus (Royal Dental Hospital Melbourne – RDHM) located in Carlton (inner Melbourne), on Wurundjeri Country, and services spread throughout Victoria, DHSV is a well-established service for Aboriginal people across the state. DHSV is a recipient of Koolin Balit initiatives, but has independently been progressing its Aboriginal programs for over 10 years.

Lots more patients go there, so they must be doing something right
(Community Member)

Through a “top down leadership style”, developed over several years, DHSV has established a progressive organisational culture with a set of values and principles (e.g. ‘respect’ being a core and over-arching principle for DHSV, creating a focus on disadvantaged cohorts) which ensure high standards of service, including a dedication to the Aboriginal community. There is a sense of journey about the organisation, which has gone through changes, all the while remaining present to and for the Aboriginal community. An internal assessment of Aboriginal community connection and support led DHSV to identifying that there were very few Aboriginal people accessing the services and no partnerships or formal connections with ACCHOs. Access issues and complaints of negative service experiences, led to the development of an Aboriginal Advisory Committee, and the hiring of an AHLO in 2007.

SUMMARY OF CONSULTATIONS (ABORIGINAL IN BRACKETS)

Aboriginal Community members	10
Health Service staff	7 (1)
ACCHO staff	1
Total consultations	14
Total Aboriginal consultations	11

DHSV has implemented innovative practices, such as doubling over 10 years (from 5 to 10) the number of Aboriginal early childhood services participating in targeted children's oral health programs, which significantly increases the accessibility for Aboriginal communities to dental healthcare.

Key milestones have included:

- In 2007 the appointment of an AHLO and the appointment of an Aboriginal Community Development Worker in 2009
- In 2010 DHSV signed the Statement of Intent to Close the Gap and established the Aboriginal Oral Health Reference Group
- In 2012 DHSV launched the Indigenous Dental Assisting Traineeship and in 2013 the Aboriginal Employment Program
- In 2015 DHSV launched the Aboriginal Patient Liaison Traineeship and signed a two-year MOU and held a joint Board meeting with VACCHO.

Importantly, all Aboriginal clients of DHSV are priority-listed and do not go on waiting lists or charged according to general costing. As part of their community access strategy, DHSV has pioneered an Aboriginal student pathway program which sees dental graduates and other student roles being brought through the service with full executive support, and in partnership with community and academic organisations. DHSV acknowledges that this has been a long process of trial-and-error, but has persisted, and is now seeing great overall program success, evidenced in several dental graduates returning to their communities as dentists. All graduates are celebrated at an annual ceremony attended by DHSV senior clinical and Executive staff, plus State dignitaries and University leadership. Graduates are encouraged to become advocates for community:

Dental [student] program failed at first but is coming back thanks to support from key staff. It is essentially an affirmative action program with full Board and Executive support (Hospital Staff)

Support for Statewide ACCHO dental services, as well as mainstream Aboriginal health programs, are ongoing, as are multiple remote/mobile/satellite dental programs in various regions. Notably, the relationship between DHSV and VAHS Dental (Fitzroy) is a strong and positive one. Through a long-standing partnership, which sees VAHS clients being referred to DHSV for emergency and other treatments, and DHSV staff being placed at VAHS, there is strong evidence to show that community outcomes are being improved by this type of health service agreement.

Supporting this, is the fact that DHSV housed the VAHS dental service for some time (including VAHS staff) at the RDHM, whilst renovation works were taking place. Although some reports of staff disquiet were noted, being that a short-term placement in a large mainstream hospital may have been difficult, a solid service delivery was maintained through a difficult time, due to the well-established relationship:

We work closely with VAHS. We have a surgeon there once a month and have an emergency agreement, which means patients get sent straight to DHSV from VAHS if their situation is deemed an emergency (Hospital Staff)

AHLO services at RDHM are well-regarded, and were increased recently, with the appointment of a trainee Aboriginal Patient Liaison Officer. This traineeship was completed and at the commencement of the evaluation, there was one part-time AHLO. Being placed at the main reception counter, the AHLO is without privacy, and has no immediate client-friendly space, apart from standard meeting rooms. As Statewide programs and initiatives are increased, and the improvement of Aboriginal patient identification gets more effective, the workload and necessity for Aboriginal expertise also increases:

Employ AHLOs full time... It's very important... We need people to liaise between us and the doctors (Community Member)

[The AHLO] is a bridge between service and community. She has personally created significant change (Community member)

The physical environment of RDHM is immediately striking, as the main entrance and foyer is filled with exhibits of Aboriginal artwork. Many of these pieces have been produced as part of in-house cultural activities and, as such, they tell the story of DHSV's journey with the community. Dental vans, which travel through regional areas to provide dental services to communities in need, are also 'decorated' with Aboriginal artwork and are essentially mobile billboards for community health. Cultural artwork and performance is a normal and regular part of a welcoming environment at DHSV:

We do CQI and ICAP because we see the importance (Hospital Staff)

An external Aboriginal consultant has delivered several cultural awareness sessions at RMDH, but there is a sense that staff turnover may necessitate a more regular and tailored approach to training and awareness. RMDH is a training hospital and therefore sees a large number of new staff coming and going.

DHSV commitment to cultural responsiveness and cultural safety operates alongside rather than within Koolin Balit support, and DHSV make decisions based on need rather than funding. Its ability to provide support to individual community members, as well as ACCHOs around the state, suggests systems can be changed to benefit Aboriginal communities without creating deficit in mainstream programs. Strategic approaches, based on clear needs, have taken hold and flourished in the service.

DHSV completes the CQI tool annually, as their Executive believe it is another opportunity to document the story. DHSV routinely self-reports lower than the State average (something that seems common is hospitals with a deeper commitment), indicating a realist perspective of the long-term aspirations and a refusal to rest on laurels:

The whole thing [DHSV] is designed to be sustainable and not individually dependent. The values are embedded throughout the organisation (Hospital Staff)

Doris [pseudonym] was an Aboriginal dental assistant at DHSV. She had successfully got into dentistry, and was on track to having a great new career. Suddenly, an unexpected family trauma occurred and Doris could not work or study because she had to look after the family. In one day of passing the hat around and rallying behind Doris, DHSV raised a large fund to help her.

Despite the efforts of DHSV, which has seen Aboriginal patient numbers increase from 50 in 2007-08 to over 1,000 in 2014-15, there is still a journey to be travelled in terms of community members feeling safe and comfortable using the service. Interviews with community members highlighted the gap between what is being initiated by DHSV and how community members experience the service – though clearly many more Aboriginal people are experiencing the service.

What the Community Says

There's always a bit of anxiety coming in to the Dental Hospital around flexibility. Lots of country mob come in and if they're a bit late, they lose their appointment. You miss three, and get told to go elsewhere for service
(Community Member)

When you come and have treatment, it's a good experience (Community Member)

We have different needs to [the] mainstream community, and it's important that it's respected. But I don't think they have a great understanding
(Community Member)

Some things are nice, like I saw an Indigenous fellow playing didgeridoo, but in terms of getting your teeth done? No (Community Member)

The AHLO is great. She communicates constantly and always calls to remind me of appointments, but the overall service probably isn't culturally responsive (Community Member)

It just feels like a big hospital (Community Member)






We need an AHLO to walk us through all the steps – what are our rights? What are the processes? Why and why not things are happening
(Community Member)

The doctors need to understand and learn, so Government needs to stop spending money on useless stuff and boost the workforce in every hospital ... (Community Member)


Get Indigenous people involved in program development (Community Member)

We don't understand, and they don't understand, so how can there be good outcomes? (Community Member)


CRITERIA RANKING


 Recognise	 Acknowledge	 Initiate	 Implement	 Embed
Recognise the needs.	Acknowledge the context.	Initiate some actions for improvement.	Implemented what's working.	Embed culturally safe practices.
Think about a trip.	Plan the journey.	Start the journey.	Enjoy the view.	Keep going...

High Level Commitment

 Demonstrated commitment to improving Cultural Responsiveness

 Committed CEO / Executive


 Reporting goes to the highest level Executive

 Organisation has systems and processes that embed cultural responsiveness


 Aboriginal Board member/s


Aboriginal Workforce Development

 AHLO is employed


 AHLO is supported through professional development

 AHLO is deemed to be an expert

 There is a commitment to recruitment, retention and career pathways for Aboriginal people


 Policies and practice supports the recruitment, retention and career pathways for Aboriginal people


Engagement and Partnerships with ACCHOs

 There are strong relationships of trust in place

 MOU/s

 Aboriginal advisory committee/s

 Aboriginal people and communities deemed to hold expertise in Aboriginal health

 Processes to build ACCHO capacity

Cultural Safety Training

 Cultural awareness training available

 Targeted training for key staff

 Multiple platforms are used strategically

 Advanced to cultural safety training

A Welcoming Environment

 Plaques, artwork, flags

 Asking the question protocol

 Identification is monitored and measured

Monitoring and Reporting

 Captures the journey and reports internally

 Uses CQI tool

 CQI tool is used to drive progress

Summary

Dental Health Services Victoria (and the Royal Dental Hospital Melbourne) was described by one community member as *“willing to step out of the comfort zone”*. Indeed, DHSV has taken a number of steps to improve cultural safety for patients and invested resources to do it. There is a genuine effort to embed good practice and it is not clear why this is not yet reflected in patient experience or community reflections. DHSV might want to explore further this since the reflections of a small number of community members does not seem to reflect the efforts over time DHSV has committed to.

4.3 Wimmera Health Care Group

Employment opportunities for Indigenous people within the hospital would be awesome. A comforting environment for community members to visit like a community lounge area. Depending on the circumstance the patient or member should be asked out of courtesy to have the Koorie Liaison Officer present if possible and consensual (Community Member)

Wimmera Health Care Group (WHCG)

Aboriginal population (regional)	345 (1.7% of total regional population)
Traditional Owners	Jadawadjali, Worjobalwk, Jaadwa, Jupagulk, Wergaia
Key ACCHO	Goolum Goolum Aboriginal Cooperative

Self-Reported Progress in CQI

WHCG has – at times – completed CQI reports without submitting them to the department.

On Jadawadjali Worjobalwk, Jaadwa, Jupagulk, Wergaia Country in the Wimmera Region, Wimmera Health Care Group (WHCG) in Horsham is in what might be classified as early engagement with regard to cultural responsiveness and cultural safety. This is not to say, attempts for improvement have not been made in the past and the work of the Wimmera Primary Care Partnership (PCP) and the *Towards Cultural Security* Project under Koolin Balit funding needs to be acknowledged. It is hard to measure the impact of this project but there is evidence to suggest that their collaborations and actions (certainly the sponsorship of the Executive visit to Echuca Regional Health and facilitating increased cultural awareness training – see below) have provided some tangible and intangible benefits (at the hospital and community levels).

With a strong regional Aboriginal community presence and good early signs of strong and developing partnerships, WHCG is seeking to continue to improve the care and safety of Aboriginal patients. There is significant support for this within the Executive and the Board and the Executive sponsor for Aboriginal health is highly committed to improvement and acknowledges the expertise for such improvement sits within the community.

SUMMARY OF CONSULTATIONS (ABORIGINAL IN BRACKETS)

Aboriginal Community members	13
Health Service staff	6 (2)
Wimmera Primary Care Partnership	2
ACCHO staff	5 (5)
Total consultations	24
Total Aboriginal consultations	20

At the organisational level, WHCG has a high awareness of its local Aboriginal community and for discovering the challenges that need to be met to bring change within the hospital for their cultural safety. Given that the hospital is in early stages of developing culturally responsive practices, it is noteworthy that there are several strong steps being made and a recognition that there are many more to be made along the way.

The relationship between the hospital and the local ACCHO (Goolum Goolum) is strengthened by the fact that the ACCHO CEO is an ex-Executive of WHCG and therefore has a strong understanding of process and need for engagement across both organisations. The relationship is strengthening further by Board members from each organisation spending time with each other and in each other's organisations. Further, WHCG is building organisational capacity of Goolum Goolum – specifically in the area of bookkeeping and financial accountability. The hospital is keen to extend this support for the capacity building efforts.

The Wimmera Aboriginal Health Sub-Committee (WAHSC), co-chaired by Goolum Goolum and WPCP leads the implementation of the Koolin Balit initiative across the sub region and meets quarterly. It is facilitated by the department (Grampians Region) and is attended by WHCG key staff, local government, WPCP, Community Health, Uniting Care, Primary health Network and ACCHO staff. Stakeholders are supportive and local initiatives are developed and/or promoted through this committee. There is no specific hospital committee:

There could be more Aboriginal staff at the hospital (Community Member)

I feel it's doing a great job as it is. Maybe having a liaison officer present at all times when you have an Indigenous client in. I find that Indigenous people struggle to understand what a health professional is trying to say, so having a person there that can break it down for them to help them understand would be great (Community Member)

The AHLO program at the hospital has gone through some changes in recent years, with a long-serving non-Aboriginal AHLO retiring two years ago, and an Aboriginal AHLO becoming the sole worker after two years of working within a dual operation/team. Community report some particular difficulties with the program and feel that there should be a more prominent positioning of the AHLO (currently the office is based in a separate building at the back of the hospital grounds) and presence (due to various factors, the service has not been available regularly). Local Aboriginal people feel that they should be able to access the AHLO service more readily and are becoming frustrated. The AHLO has significantly contributed to several positive outcomes, including the strengthened relationships with the ACCHO, as well as post/anti-natal Aboriginal services:

The Wimmera base hospital is driven by cutting costs and improving their profits well before any cultural considerations. Their orientation for new staff doesn't always include cultural training and, if it does, it's tokenistic... They need to embed cultural inclusiveness in everything they do so staff are proud to work there. Our community want to work there and feel safe to identify. It's all gammin at the moment. (Community Member)

An area the hospital continues to be challenged in is with regard to workforce development and while there is a 2013-2015 Aboriginal Employment Plan (AEP), the hospital still struggles to gain traction with regard to employing Aboriginal people. The AEP was set to be updated at the time of developing this case study but there was little evidence that attraction, recruitment and retention of Aboriginal staff was a specific area of focus or that strategies were embedded.

Currently efforts are being made to improve the physical environment of the hospital, to include a more prevalent Aboriginal representation in artworks and in the general atmosphere. First attempts to install artwork led to some learnings as the hospital was criticized by the community because the artwork was not local. However, trust was built by the fact that the hospital acted quickly to remove the artwork and has worked with the local community to commission local artists and artwork.

Given the local Aboriginal population is significantly higher than the State average, there is a genuine desire for the hospital grounds to be more representative of local communities and cultures. WHCG is looking to Echuca Regional Health for inspiration, where the current CEO is a former-employee of WHCG and where the recent hospital upgrades incorporate large-scale Aboriginal art and design. These take pride-of-place in several key hospital areas. This inter-service communication has been supported (financially and non-financially) by the WPCP and ACCHO, and should result in good community-led initiatives and outcomes:

*I think more can be done in a visual sense with the environment
(Community member)*

*Action and progress only happens due to outside pushing from other
services. (Community member)*

Cultural awareness training at WHCG has occurred piece meal over several years, with mixed reviews from staff. WPCP has led the provision of cultural awareness training for Community Health, hospital and Uniting Care staff. WPCP funding was secured specifically for training and two separate project workers have led the WPCP TCS project from 2010-2016, but only one consultant, Traditional Owner has been delivering the cultural awareness training from 2014-2016. Some staff report that these sessions were a valuable one-off opportunity to learn about Aboriginal history, while others reported feeling intimidated and uncomfortable by the sessions. No long-term training plan has been developed at WHCG, which is a specific recommendation of local community members who feel that the general awareness level in hospital staff is low and in need of addressing.

Aunt Jocelyn [pseudonym], an Elder, has seen a lot of changes in her town, and the hospital was one place she could see these changes regularly, given her ongoing health issues. Since she was a child, Aunt remembers feeling different and even unwelcome at times, when visiting the hospital. Even though she reckons the place is getting a whole lot better lately, especially the NAIDOC events and celebrations, she still feels like the hospital is built for white people, and just can't seem to get comfortable there.

What the Community says:

It's just a typical hospital (Community Member)

Some workers are great but others can come across ignorant and rude (Community Member)






They just see you as number not a person (Community Member)

I like that the hospital acknowledge the cultural land it's on; always celebrate NAIDOC and cultural events and when being referred they action it straight away (Community Member)

There's no proper support for us. They don't have the right strategies (Community Member)

I can see they are trying to make things better but it takes time for what they do to get noticed and for us to feel different about it [Community Member]


CRITERIA RANKING


 Recognise	 Acknowledge	 Initiate	 Implement	 Embed
Recognise the needs.	Acknowledge the context.	Initiate some actions for improvement.	Implemented what's working.	Embed culturally safe practices.
Think about a trip.	Plan the journey.	Start the journey.	Enjoy the view.	Keep going...

High Level Commitment

 Demonstrated commitment to improving Cultural Responsiveness

 Committed CEO / Executive


 Reporting goes to the highest level Executive

 Organisation has systems and processes that embed cultural responsiveness


 Aboriginal Board member/s


Aboriginal Workforce Development

 AHLO is employed


 AHLO is supported through professional development

 AHLO is deemed to be an expert

 There is a commitment to recruitment, retention and career pathways for Aboriginal people


 Policies and practice supports the recruitment, retention and career pathways for Aboriginal people


Engagement and Partnerships with ACCHOs

 There are strong relationships of trust in place

 MOU/s

 Aboriginal advisory committee/s

 Aboriginal people and communities deemed to hold expertise in Aboriginal health

 Processes to build ACCHO capacity

Cultural Safety Training

 Cultural awareness training available

 Targeted training for key staff

 Multiple platforms are used strategically

 Advanced to cultural safety training

A Welcoming Environment

 Plaques, artwork, flags

 Asking the question protocol

 Identification is monitored and measured

Monitoring and Reporting

 Captures the journey and reports internally

 Uses CQI tool

 CQI tool is used to drive progress

Summary

Wimmera Health Care Group is developing a strong commitment to better practice and has moved even over the life of developing this case study to improving cultural responsiveness. Given the considerable history of AHLO services in the hospital, and the presence of a strong and capable local ACCHO, there is increasing probability that WHCG will further progress the journey it is now on.

Currently, the community speaks of a hospital which essentially does not welcome their cultural identities and needs, though the environmental improvements being developed by WHCG are seen as positive by the community who are looking forward to seeing more Aboriginal employees: *“Aboriginal staff numbers are low [and] without obvious reason other than hiring practices”* (Community Member).

4.4 Mildura Base Hospital

These old people, they've seen a lot. They've experienced a lot of racism. So, it's real important that someone is finally listening to them (Elder)

Mildura Base Hospital

Aboriginal population (regional)	2,291 (4.4% of total regional population)
Traditional Owners	Latji Latji
Key ACCHO	Mallee District Aboriginal Services (MDAS)

Self-Reported Progress in CQI

Achievements listed across successive CQI reports include signing an MOU with MDAS, large-scale local art projects, a maternity program, a strong and consistent cultural awareness program, the implementation of an Aboriginal Employment Plan, inclusion of Aboriginal materials in the new staff induction and the establishment of the new Aboriginal Health offices and facilities on hospital grounds.

In North-West Victoria on Latji Latji Country, Mildura is one of several Murray River townships with large Aboriginal populations, and correlating community services and programs. With an Aboriginal population four times (as a percentage) the metropolitan community, there is a comparably higher local visibility and prevalence of Aboriginal people and culture, which echoes into the presence of well-established and locally growth-driven Aboriginal services.

SUMMARY OF CONSULTATIONS (ABORIGINAL IN BRACKETS)

Aboriginal Community members	25
Health Service staff	8 (4)
ACCHO staff	6 (6)
Total consultations	39
Total Aboriginal consultations	35

The Mildura Base Hospital, managed by Ramsay Health, has been taking a journey to enhance cultural responsive care and cultural safety for several years now. As the organisation structure technically extends overseas (Ramsay Health being an international company), local expertise is sought via the Community Advisory Board, which includes two local Aboriginal representatives. The Executive team are on-board with a strong and committed champion reporting through, and even providing guidance, to the CEO; allowing the Aboriginal Health Manager / Senior AHLO to perform at a genuine advisory capacity. This has opened up the opportunity for the community to be heard and seen in a positive way. Interesting is the fact that the community states that there has been a significant shift in the recognition and respect of local Aboriginal people in the local health services and that there has been a far slower progression in terms of respect for Aboriginal people in the general public. With the health service being such a large local employer there is great potential for the improvements in health to filter into the regions broader identity and values:

I wanna go to a hospital and not be stigmatised or targeted. I just want the best possible service, like everybody else gets (Community Member)

We are expected to come to the hospital and respect the doctors and nurses and staff. Now, we need that respect back (Community Member)

Local Elders agree that the hospital has gone from a negative and feared place, to a space which makes more legitimate efforts toward the Aboriginal community; although the hospital is still in a teething phase regarding cultural safety. Perhaps a sign of the hospital's commitment to improve and adapt is the 'Hello my name is...' program. The program was developed as a result of one particularly negative experience of an Aboriginal grandmother who was left confused by multiple poor communications on the ward and mistakenly left with her grandson. She was later called by the hospital and threatened with a Department of Community Services intervention if she did not return to the hospital for further treatment.

The resulting program requires all staff to introduce themselves with "Hello my name is" and explain what they are doing whenever they approach a patient. Originally a UK initiative, the program has injected a "human touch" to the hospital experience and is well-regarded by Aboriginal patients as enhancing cultural safety:

I hate it when they just come and go without saying anything (Community Member)

My experience was terrible, but I'm glad something positive has come out of it (Community Member)

In a region so dramatically impacted and traumatized by missions and the forced removal of children, it is a significant moment when a group of Aboriginal Elders will happily attend a meeting at the hospital and feel comfortable. The group also congratulated the hospital staff on their Aboriginal program developments – particularly the new buildings and spaces. Designing (with cultural specificity) and constructing a new building for the Aboriginal community, with spaces for Aboriginal staff, is a significant milestone for Mildura Base Hospital. These developments amplified the existing visual statements of flags and artwork, to create a legitimately welcoming health service:

They are doing more than they ever have here. There's still a lot of nasty people though (Elder)

If we're coming to hospital, we have big family, so we need somewhere to be. To sit and have a cuppa and speak about what's happening. This place is good for that (Elder)

We are getting there I think. Got this awesome building, but the team could be way bigger. (Hospital Staff)

There's still some resistance to what we are doing from some staff. Recently an Aboriginal patient died in the hospital and the family all came, and one of our staff complained about the mess and said, 'oh my god you need a cage out there!' (Hospital Staff)

We know that a lot of community are showing up after hours and on the weekend, and they might not stay because they don't get that Cultural care. Well that's not good enough. (AHLO)

Mildura Base Hospitals sees the majority of Aboriginal presentations occurring outside of business hours, when there is no AHLO services available. This is leading to large numbers of people that do not wait in the emergency department and inpatients that DAMA. The Senior AHLO is working on solutions to this issue and is hoping to create a new role within the service:

There should be more Blackfellas working in hospitals. I only saw one once and she was doing her nurse training. (Community member)

We need Indigenous people in frontline roles not just admin and background. We need to increase the public visibility of Community members in these good jobs. (Hospital Staff)

With Aboriginal staff numbers increasing, supported by the presence of a Koolin Balit funded Aboriginal Employment Officer and a strong relationship with MDAS (which increases local and regional community access to high quality services), Mildura Base Hospital is becoming increasingly responsive to its Aboriginal responsibilities. However, Aboriginal staff numbers are currently low and the efforts to recruit more community members will no doubt be welcomed by the community if successful:

They might need cultural awareness but it's not even really that. It's more like, we're asking questions and we just need answers. We always get told to wait wait wait, and made to chase around for information (Community Member)

Everybody works within a box, but they need to realise that their box isn't right for everyone. There needs to be more flexibility. Things need to be done in different ways, to suit different and diverse people (Elder)

The cultural awareness training at Mildura Base Hospital takes place on a regular basis and is currently being delivered by the Aboriginal Health Manager. Key staff and departments have received the training and targeting the entire workforce. The proactive and supported work of the Aboriginal Health Team is ensuring that community voice is heard in all areas of the hospital and strategies in place to improve Aboriginal health outcomes:

We believe that completing the CQI tool gives us a good regular opportunity to discuss progress and keep Aboriginal issues on the big table (Hospital Staff)

Annual completion of the CQI tool is undertaken by key staff and is seen as an opportunity to check progress and map out new and/or updated actions. Notably, the self-ratings are modest, but consistently increasing, which indicates a greater level of commitment and ambition, given that there has been plenty of successful work done in recent years.

Vinnie [pseudonym] was a young local Aboriginal man who passed away in ICU after major trauma resulting from a car crash. Vinnie's family is large, and was present at the hospital every day, and for several days following his passing. Making things easier on the wards was the availability of the Aboriginal Health office on the hospital grounds, in which Vinnie's family could convene in peace, and have comfort. The family would take it in turns to go in small groups to the ward, while the others stayed back and looked after each other. After his death, Vinnie's name was written on the memorial wall outside the office, along with the many other dearly departed locals who had passed before him. His family can now visit the memorial anytime and know that their story is remembered by the hospital and community.

What the Community says:

We used to have about five code greys/blacks [aggressive incident] per week, but it's down to about one per month now, so something must be changing (Community Member)

We should have e-learning, so everyone has it there, available. Cover the base knowledge. It would help keep up with staff turnover too (Community Member)

The communication style in health is clashing. We need to meet and speak a bit first (Community Member)






If community members have a bad experience, they don't return (Elder)

Mildura is a backwards and racist town (Elder)

We are expected to come to the hospital and respect the doctors and nurses and staff. Now, we need that respect back. (Community Member)

Family is the key. Our definition of family, and the way we operate- the various elements of that. Broader society needs education on that (Community Member)


CRITERIA RANKING


 Recognise	 Acknowledge	 Initiate	 Implement	 Embed
Recognise the needs.	Acknowledge the context.	Initiate some actions for improvement.	Implemented what's working.	Embed culturally safe practices.
Think about a trip.	Plan the journey.	Start the journey.	Enjoy the view.	Keep going...

High Level Commitment

 Demonstrated commitment to improving Cultural Responsiveness

 Committed CEO / Executive


 Reporting goes to the highest level Executive

 Organisation has systems and processes that embed cultural responsiveness


 Aboriginal Board member/s


Aboriginal Workforce Development

 AHLO is employed


 AHLO is supported through professional development

 AHLO is deemed to be an expert

 There is a commitment to recruitment, retention and career pathways for Aboriginal people


 Policies and practice supports the recruitment, retention and career pathways for Aboriginal people


Engagement and Partnerships with ACCHOs

 There are strong relationships of trust in place

 MOU/s

 Aboriginal advisory committee/s

 Aboriginal people and communities deemed to hold expertise in Aboriginal health

 Processes to build ACCHO capacity

Cultural Safety Training


 Cultural awareness training available

 Targeted training for key staff

 Multiple platforms are used strategically

 Advanced to cultural safety training

A Welcoming Environment

 Plaques, artwork, flags

 Asking the question protocol

 Identification is monitored and measured

Monitoring and Reporting

 Captures the journey and reports internally

 Uses CQI tool

 CQI tool is used to drive progress

Summary

A common feature of the case studies is amplified at Mildura Base Hospital in that positive progress and achievements do not get full expression in the voice of the community. The efforts are valued but the hospital is still seen as a place that is not completely friendly to Aboriginal people, families and communities. The hospital is already undertaking many of the initiatives the community suggested were important. However, given the history and trauma of the community, it may take a longer and sustained effort for trust and cultural safety to be fully realised and recognised.

4.5 Northern Health

Leadership is not always supportive. There's lots of unfinished business, staff turnover, and funding loss. We hit our heads on the glass ceiling all the time
(Hospital Staff)

Northern Health (NH)

Aboriginal population (regional)	1,429 (0.9% of total metropolitan population)
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Traditional Owners	Wurundjeri
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Key ACCHO	Victorian Aboriginal Health Services (VAHS)
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Self-Reported Progress in CQI

Based on the 2013 and 2015 CQI reports (2014 was not submitted), the key stated achievements remain as the Northern Health Aboriginal Advisory Committee (NHAAC) being operational, multiple environmental improvements (artwork and events), recognition of the Koori Maternity Service as best practice (Minister for Health's Award for improving indigenous Health – Closing the gap, December 2016), and the roll-out of more cultural awareness/competency training. However, inconsistent reporting and multiple leadership changes make it difficult to capture the progress at Northern Health.

CQI Reports highlight the signing of the *Statement of Intent to Closing the Gap*, policies and procedures with regard to 'Welcome to Country' and 'Asking the Question' and the involvement of staff in the celebration of NAIDOC Week. Most of this has been, and remains, driven by the AHLO.

In the outer north of Melbourne, on Wurundjeri Country, Northern Health has inherited an important responsibility for Aboriginal health, given that the metropolitan Aboriginal population has gradually been moving north of the city. While Northern Health has always had a significant multicultural local demographic, there is now a clear necessity for the Aboriginal community to be fully considered and included.

SUMMARY OF CONSULTATIONS (ABORIGINAL IN BRACKETS)

Aboriginal Community members	14
Health Service staff	8 (4)
ACCHO staff	(3) CHS staff
Total consultations	25
Total Aboriginal consultations	18

In the Northern suburbs, not many people are doing well, so this place should have some sense of social justice. But they don't (Community member)

Northern Health has made several significant attempts to progress toward more culturally responsive practice. However, efforts were reported as being hindered by a failure to establish sustainability measures for continued progress when leadership change occurs. A number of CEO's have come and gone in recent years, each bringing and taking with them their own style of leadership, with the accompanying attitudes and principles that were driving programs:

There have been lots of changes. Leadership and exec are different now, so Aboriginal health is not a priority anymore. It falls beneath other medical issues in priority (Hospital Staff)

The Aboriginal health team has lost their exec relationships and buy-in (Hospital Staff)

The problem is that cultural safety is not built into organisational practice. There is no stability at the top with three CEOs in two years and that causes disruption and distraction. Without passion at the top things fall by the way side (Executive)

For some time, Northern Health had a Koolin Balit funded Koori Maternity Officer (KMO), who worked within the maternity team to support Aboriginal families with their journey. This staff member was widely-regarded as highly competent and successful in her role. However the program was closed, and the staff member lost. Shortly after, the program was restarted, but without the staff member present the program has been unable to regain momentum. This decision is not understood by the community and viewed as directly impacting the cultural safety of Aboriginal families accessing maternity services:

The KMS program was defunded and they lost a good worker. They started it up again, but she was already gone (Community Member)

I actually had a great experience having my baby there. They saved my child, and then really looked after us. That was all because of the Koori Maternity Worker, but she was made redundant ... (Community Member)

Northern Health are funded to develop and implement an agency wide Home and Community Care Active Service Model and Diversity Plan. The Aboriginal community has been identified as a key priority population group for their service with strategies to better engage with the Aboriginal population group. The plan aims to better support Aboriginal people accessing services in Northern health and in the community when they return to their homes.

In partnership with Northern Area Mental Health Service (NAMHS), who deliver the mental health programs within the Northern Hospital, there is also a KMHLO assisting for Aboriginal clients that present at NAMHS. Notably, while the Northern and NAMHS staff operate collegially and as one Northern team, they are under different management structures and the KMHLO and AHLO face different challenges in their work. For the AHLO the lack of support and acknowledgement of the increasing demand for her services is a source of frustration. For the KMHLO, there is the level of demand for services and the ongoing trauma of working within acute mental health and with distressed patients and families.

The Wadamba Wilam partnership between NAMHS, VAHS, and several Northern mainstream mental health agencies is the only ACCHO partnership identified at the Northern and is widely regarded as innovative and best-practice in Aboriginal multi-service mental health models. The partnership provides intensive outreach support for Aboriginal people experiencing enduring mental illness.

Northern Health also has good links with Plenty Valley Community Health Service which is co-located at the hospital and both services work together to assist Aboriginal clients to access acute and community based services.

The Northern Health Aboriginal Advisory Committee (NHAAC) is a network of senior hospital staff (including mental health) and representatives from local councils working with Aboriginal communities. The NHAAC meets quarterly and is growing with external stakeholders being invited. The focus of the NHAAC is recent times has been to improve the monitoring of 'Asking the Question' and development of a smoking ceremony space.

Further, there has been an Aboriginal representative on the Patient Experience Community Advisory Committee (PECAC) which involves ten community members with representation also from Burma, Iraq, Turkey, and North Africa. This committee meets bi-monthly with the CEO and the Northern Health Board. The minutes from the NHAAC are tabled at the PECAC and this would seem to set up strong governance and accountability around Aboriginal health outcomes. However, there is no longer Aboriginal representation on the PECAC creating a significant gap in Aboriginal representation at the CEO / Board level.

Indeed, the primary finding from this case study was the degree of influence senior leadership in a large metropolitan hospital can have on progress with regard to culturally responsive care and cultural safety:

Leadership must facilitate and endorse the required changes and reflect the necessary behaviour and attitudes from the top down (Hospital Staff)

We start work on projects... begin to gain momentum... then lose it
(Hospital Staff)

Although reports such as CQI and Quality of Care will show a considerable list of achievements over time and changes in leadership – including but not limited to flags, artwork, health promotion materials and program resources - there is little evidence to show that there is any consistent Aboriginal-specific program (or over-arching hospital culture) which has held a strong and supported position in the organisation.

The most sustainable aspect with regard to Aboriginal health is the longstanding AHLO and certainly from the community perspective the most critical element of specific services offered to Aboriginal patients. As CEOs and executives have come and gone, so too have the nature and amount of support offered to the AHLO. The additional burden of being restructured several times and having inconsistent program supervision, has proved challenging for a small program.

Without full support and resources which match the expected output and performance of the program, the AHLO has been motivated through a sense of community dedication and commitment. It is to the AHLO's credit (as found in other places) that the community opinion of the hospital has not dramatically changed during times of leadership change and restructure when the commitment to Aboriginal health diminished. Reputation is maintained through the personal networks, trust and social capital the AHLO has built in the region and community over several years. While this is to the hospital's reputational benefit, there is risk, nonetheless, that such favour runs out:

[The AHLO] is the key. I go straight to her. She knows all the right info and tells me all the stuff I need to know, like who to speak to and that. She is someone with influence. (Community Member)

If there was no AHLO, people wouldn't be sticking around. They're just too scared, and nobody else understands (Elder)

[The AHLO] is really stressed. It's all too much (Elder)

The koori team just isn't supported (Community Member)

The limited cultural awareness training being delivered at Northern Health includes introductory cultural awareness sessions, and 'Asking the Question' sessions. This too is the responsibility of the AHLO. It has been successful and valuable in various service "hot spots" where Aboriginal clients are visiting most, and several discussions with leadership have taken place in recent years, however no ongoing program with a strategic approach has been developed. With a high turnover of staff, and the low availability of the AHLO, there is little chance for cultural awareness to spread broadly across the health service and take root in organisational values without added support and resources:

The ALO has a lot of pressure to perform outside of her role (Hospital Staff)

We have tried to develop a sustainable process for diversity, but lost momentum with the previous CEO leaving (Hospital Staff)

CQI reporting has fluctuated in recent years, as leadership changes and restructures continuously take place. There is a sense that the achievements that have been made can be easily lost with the continuous shift in organisational structure and the changes are clearly disallowing overall progress which in turn is creating discomfort for Aboriginal staff. This discomfort is easily transferred to patients, as the AHLO has limited capacity.

In terms of community / patient views one of the key factors to having a sense of being culturally safe is being a regular and getting to know – feeling familiar – with the place, space and people.

Uncle Billy [pseudonym] has had a long relationship with the Northern Hospital. He has a chronic illness that means he has to visit regularly for treatment – as he has for over 10 years, so he has a pretty good personal view. Uncle Billy reckons that when he first started coming in for treatment, he was regularly typecast as a drunk and domestically-abusive Aboriginal man, because he was identified on his file, and his illness was consistent with what many alcoholics may experience. Even though Uncle Billy isn't even a drinker, and has a strong and loving relationship with his wife, he felt that his Aboriginality led several hospital staff to mistreat him.

Now, years later, Uncle Billy has a really great relationship with the hospital. All the ward staff know and love him, as he and his family are well-known regulars who have had the opportunity to become familiar and accepted. Sometimes cultural safety just comes with time

What the Community says:

Northern Health's performance is not good at all (Elder)

A lot of people have had a bad experience at Northern Health (Community Member)

I've been admitted to the Northern three times now, and each time I had a negative experience (Community Member)






Aboriginal people coming from country areas are terrified of this hospital. They're really very frightened because there's nobody there for them that knows them. The Liaison Officer is vital. [The AHLO] is the best (Elder)

I get a feeling like I'm left until last and I wondered if it was because I was Aboriginal. It was really daunting and upsetting, and I never went back (Community Member)

They should do a course on culture to get ideas on how to help us because they have no idea right now (Elder)

The hospital does need understanding... to look at us, not down on us. Be aware of our culture. They need regular training sessions (Elder)

CRITERIA RANKING


 Recognise	 Acknowledge	 Initiate	 Implement	 Embed
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 AHLO is deemed to be an expert

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 Cultural awareness training available

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 Multiple platforms are used strategically

 Advanced to cultural safety training

A Welcoming Environment

 Plaques, artwork, flags

 Asking the question protocol

 Identification is monitored and measured

Monitoring and Reporting

 Captures the journey and reports internally

 Uses CQI tool

 CQI tool is used to drive progress

Summary

According to the community, the Northern Hospital represents a large and very complex organisation with only the AHLO as a resource specific to Aboriginal care. Internally, hospital staff also view the AHLO as the key resource. Multiple leadership changes have impacted on the progress and focus of cultural responsiveness and demonstrate the fragile nature of progress in any organisational setting and how quickly gains can go into a state of atrophy when leadership loses momentum and commitment to particular initiatives. The case study also demonstrates how a long-standing AHLO of high skills, capacity and community connection can – at least in the short term – incubate the hospital against negative impacts.

Finally, as noted earlier, it should be acknowledged that the Koori Maternity Service is indeed a significant service and received the Minister for Health's Award for improving indigenous health – Closing the gap during an awards ceremony in December 2016. This provides a strong platform for extending and embedding good practice and learnings across other service areas within Northern Health.

4.6 Barwon Health

Health Services often struggle with knowing what to do, and how to make it work. We just get left holding the baby (Hospital Staff)

Barwon Health

Aboriginal population (regional)	2,204 (1.02% of total population)
Traditional Owners	Wadawurrung
Key ACCHO	Wathaurong Aboriginal Co-operative

Self-Reported Progress in CQI

From 2013 to 2014, Barwon Health report several achievements, including the development of an MOU with Wathaurong Aboriginal Co-operative, draft protocols for Acknowledgement of Country, installation of flags and plaques, proposals for events, an Aboriginal Employment Plan, and the development of an e-learning cultural awareness package. Also reported are ACCHO collaborations and an increase in Aboriginal staff and patients.

On Wadawurrung Country in Geelong, an hour west of Melbourne, Barwon Health is a large regional health service covering much of the South Western district. Being based in the second largest city in the State, Barwon Health has a unique combination of being both metropolitan and regional in character, with the Aboriginal community being reflective of this diversity and mostly being traditionally from elsewhere.

SUMMARY OF CONSULTATIONS (ABORIGINAL IN BRACKETS)

Aboriginal Community members	23
Health Service staff	7 (2)
ACCHO staff	2
Total consultations	32
Total Aboriginal consultations	25

When [the previous AHLO] left, things dropped-off (Hospital Staff)

It's really difficult to support and understand the Aboriginal program (Hospital Staff)

The AHLO team have been moved around different departments and not coped with it. I reckon they've been on stress leave more than they've actually been at work (Hospital Staff)

The Aboriginal Health Program at Barwon Health has experienced significant identity changes in recent years which have, in conjunction with leadership and structure changes at high levels of the hospital, created disruption to the AHLO program. The previous program was staffed by a long-standing and highly driven AHLO who created a significant legacy around her presence in the health service with much of the program resting on this one AHLO's abilities. Given that no sustainability measures were put in place, when the AHLO left, much of the ongoing Aboriginal support in the hospital dissolved. The hospital was left without an AHLO for approximately two years.

Once a new AHLO was recruited and an extra AHLO came onboard, there significant challenges to replacing the once substantial program. Multiple changes in program management and Executive leadership created further disruption to support and resources and this has left Aboriginal staff feeling culturally unsafe and the community ultimately not receiving a continuous and driven service.

More recently the Chief Operating Officer (also Acting CEO during the development of this case study) has pushed hard for change and in early 2015 started developing a Reconciliation Action Plan (RAP) which was launched in July 2016. The Reconciliation Action Plan Working Group was continuing to meet and monitor the implementation of actions at the time of the development of the case study. Some of the key initiatives the community can expect to see as a result of actions in the RAP are:

- › An engagement campaign to increase identification of Aboriginal patients
- › An area/space dedicated to provide a family room for Aboriginal families and named in Wadawurrung language
- › Aboriginal artwork at all Barwon Health sites
- › Extension of the Aboriginal Hospital Liaison service.

While this has demonstrated high level support, for some (Aboriginal and non-Aboriginal staff) the change has actually been too rapid:

Recent over-zealous leadership has burnt a lot of people. It was too much too soon, and heaps of other departments have been confused and marginalized by some hasty decisions (Hospital Staff)

I reckon [previous leadership] heart was in the right place, but a lot of big calls were made that haven't sat well with many people (Hospital Staff)

It is noteworthy that the KMHLO is housed within the Mental Health department, and not directly experiencing the same issues as the AHLOs. The KMHLO service is running smoothly, and with strong support from management.

Whilst Barwon Health reports a large amount of activities which demonstrate dedication and progress, the community do not feel like the service is becoming more culturally safe. Large-scale initiatives like a RAP and a Cultural Awareness Training Strategy (e-learning packages designed specifically for the health service) have been strong public statements of commitment and developed in collaboration with community. However, workforce difficulties were considered to be hindering the overall progress with the development of so many Aboriginal actions causing confusion and some stress. Several individuals who have been responsible for the management and/or coordination of the Aboriginal program felt they had been working without any clear direction. Staff in departments with acknowledged Aboriginal responsibilities felt that *“things are not currently running at full capacity”*, but continue to enjoy *“strong working relationships”* with external organisations and services, which the previous AHLO had established.

The Aboriginal programs rely purely on internal advocacy, so they operate based on the knowledge and skills of whoever is in charge on that day. There's no structure or guidance from the Department (Hospital staff)

There is no real awareness from DHHS regarding AHLOs and the big picture. The workforce just isn't supported (Hospital Staff)

The Government are supposed to help us. I worked in Aboriginal Affairs, we started it. It's supposed to be helping! (Elder)

We've never had big numbers of Aboriginal patients, but we do have good processes in place, to get things sorted ourselves (Hospital staff)

The above-mentioned e-learning packages are a particularly positive and valuable initiative, developed by a local Aboriginal consultant and in collaboration with many Elders and experts. This training is available to all staff in two options: a general cultural awareness package and a package targeted at leadership. This e-learning has been widely-regarded as innovative and something which could potentially be implemented by all public health services.

AHLOs are great. They work hard. But, let's get real. We need way more Aboriginal staff working here (Hospital Staff)

We need Aboriginal People in decision-making roles (Elder)

Let's not be complacent. Let's keep things moving (Hospital Staff)

In CQI reporting, Barwon Health reports the development and signing of an MOU with the local ACCHO, Wathaurong Aboriginal Co-operative. In fact the MOU was reviewed and renewed in May 2015 when both CEO's signed it. Interviews with local Wathaurong staff and hospital staff confirm that the organisations, at least in principal, are committed to working together to deliver culturally responsive services to, and improve the health and wellbeing of, Aboriginal communities.

CQI reports also stated the implementation of an Aboriginal Employment Plan (AEP) as an achievement. There are currently (reported) 24 Aboriginal employees within Barwon Health. However, the AEP has faced some difficulties in successfully identifying all current Aboriginal staff and has had only one trainee successfully complete their course but was not continued into permanent work for reasons that were not identified. Environmental upgrades, such as flags and plaques, and AHLO team branding, are the central achievements:

We are improving. By no means are we 'there', but we are improving
(Hospital Staff)

Government needs to be telling hospitals what to do with the money. They need to gather community voices and opinions (Elder)

Richard [pseudonym], a middle-aged Aboriginal man, moved to Geelong from Perth a few years ago. In his home town, he used the Aboriginal Health Service regularly and preferred not to go to hospitals because his Mum had died there. When he got to Victoria, he naturally went and signed up to his new local ACCHO. Richard found the ACCHO to be very welcoming and responsive to his needs, and soon met most of the team, who became his new community and friends.

One Sunday, while mowing the lawn, Richard stood on a rusty nail. He knew the ACCHO was closed, so he raced to the hospital ED. When he got there, he felt very uncomfortable and lonely. The triage clerk got him straight through to see the doctor, who was able to take care of the wound and send Richard off home. As he was driving home, feeling very stressed by his visit to the hospital, Richard noted that the hospital didn't feel like a safe and welcoming place like the ACCHO, and wished that there could've been an Aboriginal person there to help him.

What the Community says:

Barwon Health have all the right intentions but no idea how to deliver
(Community Member)

We need to break down the principles of health and start getting culturally appropriate care (Elder)

Cultural awareness must be embedded all over and an ongoing practice
(Elder)

We need to be normalised. The more of us there are, the more cultural exchange can take place (Community Member)

You gotta make sure Aboriginal people have access to the workforce (Elder)






I find it hard to go to the public [health] service because of a lack of cultural responsiveness. But [the ACCHO] is good (Community Member)

If Government are actually serious about 'closing the gap', then why can't they change this stuff? (Community Member)


I find the clinical care here is really great, but the cultural safety just isn't there. Like, I was told that identification was for 'real Aborigines' (Elder)

It's not always about money. Culture doesn't cost much (Elder)


CRITERIA RANKING


 Recognise	 Acknowledge	 Initiate	 Implement	 Embed
Recognise the needs.	Acknowledge the context.	Initiate some actions for improvement.	Implemented what's working.	Embed culturally safe practices.
Think about a trip.	Plan the journey.	Start the journey.	Enjoy the view.	Keep going...

High Level Commitment

 Demonstrated commitment to improving Cultural Responsiveness

 Committed CEO / Executive


 Reporting goes to the highest level Executive

 Organisation has systems and processes that embed cultural responsiveness


 Aboriginal Board member/s


Aboriginal Workforce Development

 AHLO is employed


 AHLO is supported through professional development

 AHLO is deemed to be an expert

 There is a commitment to recruitment, retention and career pathways for Aboriginal people


 Policies and practice supports the recruitment, retention and career pathways for Aboriginal people


Engagement and Partnerships with ACCHOs

 There are strong relationships of trust in place

 MOU/s

 Aboriginal advisory committee/s

 Aboriginal people and communities deemed to hold expertise in Aboriginal health

 Processes to build ACCHO capacity

Cultural Safety Training

 Cultural awareness training available

 Targeted training for key staff

 Multiple platforms are used strategically

 Advanced to cultural safety training

A Welcoming Environment

 Plaques, artwork, flags

 Asking the question protocol

 Identification is monitored and measured

Monitoring and Reporting

 Captures the journey and reports internally

 Uses CQI tool

 CQI tool is used to drive progress

Summary

Barwon Health is an example of the difficulties hospitals face when there is an expectation to deliver substantial outcomes without clear internal guidance or standards. With a RAP in place there is now a level of internal reporting and accountability. The commitments in the RAP offer much promise for Aboriginal people in the region and should – given the definitions provided by community – improve cultural responsive care and cultural safety.

4.7 Alfred Health

Honestly, in my 15 years here, I can only recall one Aboriginal patient
(Hospital Staff)

Alfred Health

Aboriginal population (regional)	394 (0.4% of total regional population)
Traditional Owners	Bunurong / Boon Wurrung
Key ACCHO	VAHS
Total Aboriginal Separations 2016	TBC number and percentage
Total Aboriginal Presentations to ED 2016	TBC number and percentage

Self-Reported Progress in CQI

CQI reports for 2013-14 show multiple environmental improvements, including flags and plaques, cultural days of significance celebrations and a dedicated AHLO office. Strategic initiatives include signing of the Statement of Intent to Closing the Gap, a Workforce Development Framework collaboration with Monash Health, identification training and specific client pathway processes developed in collaboration with Traditional Owners. Identification is mentioned several times throughout the CQIs and appears to be regarded as particular focus.

On Bunurong Country, based on the southern fringe of inner Melbourne, Alfred Health is in a part of Melbourne not recognised as having a large Aboriginal population or Aboriginal community presence. This may be somewhat misleading given that over 400 Aboriginal people living in the area are only a slightly smaller percentage of the regional population when compared to more well-known areas in the northern suburbs, and only slightly lower than the State percentage. This perceived invisibility of the Aboriginal community at Alfred Health might suggest there is little need and little regard for culturally responsive care or cultural safety. Indeed, securing interviews with Aboriginal patients and community members was particularly challenging for this case study.

SUMMARY OF CONSULTATIONS (ABORIGINAL IN BRACKETS)

Aboriginal Community members	5
Health Service staff	9 (1)
ACCHO staff	4 (3) CHS staff
Total consultations	16
Total Aboriginal consultations	7

Although several key steps have been taken by Alfred Health toward cultural safety, including the completion of many of the CQI KRAs, there remains a clear gap in the overall awareness of Aboriginal health in the hospital. Several key staff display genuine dedication, and are driving the majority of reported achievements. However there is no apparent sense within the service that Aboriginal health is currently a key focus to be embedded within business practice. The Alfred has seen several fluctuations in progress due to leadership changes and the general priorities of the service and struggled to achieve sustainability of effort. Key staff believe the shifting priorities of leadership may be a barrier to fully embedding Aboriginal health practices and programs:

Executive changes had led to some changes in priorities of the health service. Aboriginal health is always there, but we need more depth across and within the organisation (Hospital Staff)

The Exec needs cultural awareness training because if we don't do anything out here on the ground, nothing happens. There's no understanding of the need (Hospital Staff)

Although being a metropolitan hospital and within reach of VAHS, Alfred Health has no formal relationship with any ACCHO – though at the time of writing the case study some are being developed. Community health services are the key identified community health pathway for Aboriginal clients. These services have specific Aboriginal support staff and programs and are regarded as the preferred access pathway, locally. Also within Alfred Health's organisational structure are several other external agencies and services, one of which is a Carer Service which also has an Aboriginal support staff member.

Alfred Health has a set of Aboriginal-specific policies and procedures which extend across all of its agencies and services, including Welcome to Country, Acknowledgement of Traditional Owners policies and the Alfred Aboriginal Health and Diversity strategies:

[The Aboriginal Hospital Advisory Committee] was initially successful, but community stopped coming (Hospital Staff)

The Aboriginal Health Advisory Committee has previously operated regularly, but a sense of difficulty around administration and attendance led Alfred Health to abandon the committee in favor of membership on a local regional committee, run by the Local Aboriginal Network (LAN). This group is the key reference and advisory point currently and proving useful.

There is a Reconciliation Action Plan (RAP) in development (to be launched in early 2017) and this process has its own committee. The process of engaging with community experts – which had been challenging in the past – has been enhanced through the development of the RAP with Elders and key Aboriginal staff within and outside of Alfred Health involved. Cultural awareness training and Aboriginal employment are key focus areas of the RAP.

The 2016-2020 Patients Come First strategy and plan will also be a large project for development in 2017 having been endorsed by the Executive and Board as the case study was developed. The strategy includes a large service wide RESPECT staff education program inclusive of supporting the needs of Aboriginal patients and families.

Several Aboriginal patient identification initiatives are listed as CQI achievements, including a clinical pathways project developed in collaboration with local Traditional Owners. The impact of these initiatives appears minimal as staff report that there is no set process for identification and no visible promotion or endorsement for any specific Aboriginal health measures:

There is a focus on generally low socio-economic status patients, but no specific Aboriginal focus (Hospital Staff)

There is no specific process for identifying Aboriginal patients. If they request the Liaison, that's what flags them (Hospital Staff)

The AHLO program has been staffed by several individuals over recent years and is currently operating with one AHLO. At the time of the development of the case study, a second AHLO was on maternity leave and the hospital had been unable to back-fill the position. The current AHLO is well-regarded by community and hospital staff, and as many AHLOs are is undertaking tasks well beyond the requirements of the position description:

[The AHLO] is great. She really goes the extra mile (Hospital Staff)

I worry that [the AHLO] is over-worked. We really need more help, maybe a KMHLO ... (Hospital Staff)

Several modes of delivering cultural awareness training are reported by Alfred Health. Additional to the patient identification initiatives, new staff orientation, a 'Working with Aboriginal Patients' package (AHLO pamphlet), and one account of a speech given to staff by a local Elder are all regarded as being successful. The Caulfield campus has also engaged a consultant to deliver cultural awareness – as did all Alfred Health Carer Services sites.

While some staff suggested there is a small and rarely-seen local Aboriginal community, it is acknowledged that many Aboriginal patients (and often their families) travel from country region for critical care and procedures. This is where Alfred Health holds a strong positive reputation for cultural responsiveness. The ability for Alfred Health to provide sensitive care to patients in terminal and critical situations is well regarded and trusted – this was reported at two case study sites from within regional Victoria.

This may be influenced by patient information coming from the sending service to the Alfred. Whatever the reason, there is distinctive evidence that Aboriginal patients from country areas have a good experience.

Aunty Carol [pseudonym] is an Elder from rural Victoria. Her husband, Uncle Noel, was always a strong and healthy bloke. He was a bricklayer by trade, and hardly sick a day in his life. When Aunty Carol saw that Uncle Noel had flu symptoms and was weak, she was worried and took him to the GP. After a few tests and scans, and a few days waiting, Uncle Noel received the news that he had a form of aggressive terminal cancer, and must travel immediately to the Alfred – to Melbourne.

Aunty Carol, Uncle Noel, and their kids and grandkids “all but moved in” to the hospital and were supported through those few last weeks as Uncle Noel faded away quickly. Local Aboriginal services were coming and going the whole time, as were AHLOs and various family and community.

Aunty Carol felt like her family was respected and that they were able to make the most of the situation.

What the Community says:

We know there's big numbers going to ED, but lots are homeless so they can't be tracked (Community Member)

[The AHLO] has so much to get done (Community Member)






We had to go the Alfred for the final days of my husband's life and they were great (Community Member)

The Alfred might have a bad profile or just a low profile. Don't get as much attention as someone like St V's. (Community Member)

There have been some bumpy times with AHLOs in the past. A bit erratic. I think it may have put the Alfred behind (Community Member)

We are in the hospital!! (Community Member)


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 Uses CQI tool

 CQI tool is used to drive progress

Summary

Alfred Health, through all its various changes in leadership and staffing, has not yet been able to maintain a comprehensive focus on cultural responsiveness and cultural safety. As with other case study sites, the CQI reported actions do not seem to be well acknowledged or understood within the service. With increased accountability through the NSQHS Standards and Statement of Priorities, the RAP and Patient Comes First – as two key initiatives for launch in 2017 - provide an opportunity for reporting and accountabilities since cultural responsiveness for Aboriginal people is no longer discretionary. This case study demonstrates the need for capacity building initiatives to support Alfred Health and other health services.

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