SUNRISE HEALTH SERVICE ABORIGINAL CORPORATION

SUNRISE WAY

A CONCEPT FOR CHANGE

Sunrise Way Steering Committee
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SUNRISE WAY

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Preface

'Sunrise Way' was a term applied by Ms Irene Fisher, CEO of Sunrise Health Service Aboriginal Corporation, to the as yet undefined way the people of Sunrise communities wanted a health service with a difference – which 'Reclaim the good health and cultural practices (in a health setting) of the past' (6.3.2009) and recognised the need for mental, cultural and emotional wellbeing in the healing process.

Sunrise Health Service was developed to meet the needs of the people in the East Katherine region; 'the Sun-come-up Mob'. The structure was drafted to meet the conditions required for a Coordinated Care Trial. It took over in a planned environment, NT Government facilities, staffing, structures, and biomedical approach with professional dominance of doctors and nurses. While some of the policies and practices have been changed, many have remained, unchallenged. Community members who are involved in the system of community control draw on their own experience of the previous health service delivery model, having known no other. Funding and reporting structures imposed by Government dictate much of the style and content of ACC service, while allowing for little flexibility or innovation. Quality of service is measured according to established standards which are often not appropriate to the remote Indigenous setting.

Sunrise successfully made the transition from Coordinated Care Trial to mature Community Controlled Health Service and is now at a stage to review and renew its structure, commitments and operations. This comes at a time when the World Health Organisation is strongly advocating a return to the principles of Primary Health Care and there is unprecedented interest in and funding for improvements in Indigenous health throughout Australia, in the Northern Territory in particular. Aboriginal Community Controlled Health Services were built on the principles of Primary Health Care. Those principles remain basic to Sunrise Health Service.

Unfortunately, Primary Health Care has been corrupted over time, with one of the major changes being the introduction of 'Selective' Primary Health Care, to fund only those components or programs which appear to be most cost effective in biomedical terms. This process is imposed by control of funding, reporting, and choice of performance indicators by Government. Sunrise had no choice but to be established in that model.

More recently, the Northern Territory National Emergency Response (NTER – the Intervention) was imposed without community consultation in the provision of services through imposition of required programs and priorities which has forced the reduction of some of Sunrise' programs. Over time, top down Government driven policies, programs and priorities have been implemented through financial arrangements and imperatives. Meanwhile Aboriginal health has become relatively worse – gains offset by losses. The newest program, 'Closing the Gap' has subsumed the Intervention, and perpetuates the selective Primary Health Care model.

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In the biomedical model evidence based medicine is applied where evidence has been extrapolated from other populations to the remote Aboriginal community

context without testing across cultural and belief systems. Indigenous culture and practice have been overshadowed by the might of Western medicine.

Sunrise Way was initiated in the Sunrise Health Service executive to review the service's operation since the Coordinated Care Trial and to put Sunrise' policy, practice and development more specifically in context with Aboriginal practice and thinking. The concepts arose from discussions over a period of time within the Board of Sunrise and with senior management, and are expressed in the Strategic Plan 2008-2012. A Steering Committee was formed to provide input, and to oversee the development of Sunrise Way. The Board approved the process and have endorsed the outcomes.

Sunrise Way expands the concept of holistic health care from comprehensive and coordinated to biopsychosocial (Mind-Body-Spirit) with its central cultural theme. It does not criticise the intentions, professionalism, and hard work of those who have built Sunrise, nor does it draw comparisons or describe current practices. Those who are familiar with remote Indigenous health will be fully aware of those practices and the difficulty in achieving outcomes in this environment. Sunrise Way is aspirational and the vision includes retention of good and effective practice, modification of existing practice where this is warranted, and new practices where these are needed in place of or in addition to old ones.

As well as creating a guide for the future of Sunrise Health Service, Sunrise Way creates a road down which funding bodies, secondary and tertiary health service providers and other partners can go forward, with Sunrise, so that the money provided for Aboriginal Health reaches its target in an effective and acceptable way. This is not an entirely new concept and there are precedents for this type of funding in Indigenous health in other developed countries.

According to Sunrise Way, communication within Sunrise and its communities will respect core Aboriginal values, and recognise the importance of different types of relationships – relationships which are the underpinning of contemporary and traditional Aboriginal society.

Sunrise Way will never be complete. It will be reviewed, changed, and validated by the communities and their representatives who form the organisation. It will inform policy and procedures, structures and relationships. It will become a cultural awareness primer. Along with detailed clinical and operational procedures, it will act as a workplace manual for health care professionals employed in or servicing Sunrise community operations. It will be produced in formats for community members with limited literacy up to senior policy makers. These are all living issues, and Sunrise Way will be a living document.

I was fortunate to be Medical Director of Sunrise Health Service at the initiation of this project and was able to start defining the concept. I was then even more fortunate to be given the unique opportunity of a consultancy to bring it to this stage of development. I am humbled that the Board, and the Indigenous members of the Steering Committee have had the confidence in me as a non-indigenous medical professional person to write Sunrise Way and that they have endorsed it in its final stages.

Acknowledgements

Oversight for this document was provided by a Steering Committee consisting of Sunrise senior personnel: Ms Irene Fisher (CEO), Mr Graham Castine (General Manager), Dr Ahmed Latif (Medical Director), Ms Myra Spurling (HR Manager), Ms Louise Patel (Quality and Safety Coordinator), Ms Suzi Demosthenous (Project / Communications Officer) and Mr Anthony Baker (Finance Manager). Each provided input, criticism, and validation from their particular perspectives. I would particularly like to acknowledge the role of Irene Fisher who articulated what was a somewhat nebulous concept, and kept those ideas which emanated from the Board as the guiding framework. Graham Castine put what we were doing into the context of the history and development of Sunrise Health Service, and provided the most extensive and incisive comment on each section as it was drafted. Suzi Demos quietly reminded me of cultural protocols when I needed reminding. Her assistance with information sources, current policy statements, and document production has been invaluable.

I have had support and comment on ideas and concepts from a range of senior Aboriginal Health Workers, Remote Area Nurses, and doctors within Sunrise Health Service at various times. These have never been as formal consultations.

Comments were made on various sections of the draft and at different times by Mr David Lane, Dr Tanya Davies, Dr Malcolm McDonald, Associate Professor Ngiare Brown, Robert Dalton, and Chips Mackinolty. Sybil Ranch at Barunga gave me insights and feedback from the community Aboriginal perspective. Jeff McMullan provided very valuable editorial comment on the near-complete document.

My wife Robin was my note-taker, sounding board, and adviser from her education perspectives of our shared experience in the Aboriginal setting over the past forty years. She is both my anchor and the wind beneath my wings.

Fred McConnel
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Acronyms & Abbreviations

ABCDE	Audit and Best Practice for Chronic Disease Extension
ACCHS	Aboriginal Community Controlled Health Service
ACHS	Australian Council on Healthcare Standards
ACRRM	Australian College of Rural and Remote Medicine
AFPHM	Australasian Faculty of Public Health Medicine
AGPAL	Australian General Practice Accreditation Limited
AGPT	Australian General Practice Training
AHF	Aboriginal Health Forum
AHP	Allied Health Professional
AIDA	Australian Indigenous Doctors Association
AIHW	Australian Institute of Health and Welfare
AHW	Aboriginal Health Worker
AMS	Aboriginal Medical Service
AMSANT	Aboriginal Medical Service Alliance Northern Territory
BIITE	Batchelor Institute of Indigenous Tertiary Education
CARPA	Central Australian Rural Practitioners Association
CARPA Manuals	Treatment manuals for use by nurses and health workers where there is no doctor.
CBW	Community Based Worker
CDAMS	Committee of Deans of Australian Medical Schools
CDO	Community Development Officer
CDU	Charles Darwin University
CHW	Community Health Workers
COAG	Council of Australian Governments
CPD	Continuing Professional Development
CRANA*plus*	formerly Council of Remote Area Nurses of Australia
CRCAH	Cooperative Research Centre for Aboriginal Health
CRH	Centre for Remote Health
CTG	Closing the Gap
DHF (NTDHF)	(NT) Department of Health and Families
DMO	District Medical Officer
DoHA	Department of Health and Ageing
DEEWR	Department of Education, Employment and Workplace Relations
EBA	Enterprise Bargaining Agreement
ED	Emergency Department
EHSDI	Expanding Health Service Delivery Initiative
EQuIP	Evaluation and Quality Improvement Program (ACHS)
FaHCSIA	Department of Families, Housing, Community services and Indigenous Affairs
FARGP	Fellowship in Advanced Rural General Practice
FUSA	Flinders University of South Australia
GP	General Practitioner, General Practice

GPA	GPA Accreditation*plus* (formerly General Practice Accreditation)
GPNNT	General Practice Network NT
H4L	Healthy for Life Program
HC	Health Centre
HR	Human Resources
KH	Katherine Hospital
IMG	International Medical Graduate
KPI	Key Performance Indicator
KRAHRS	Katherine Region Aboriginal Health and Related Services
KWHB	Katherine West Health Board
LiTTLe	Learning to Talk, Talking to Learn
MBS	Mind-Body-Spirit (Biopsychosocial health)
Medevac	Medical evacuation
MHS	Mental Health Service
MSHR	Menzies School of Health Research
NACCHO	National Aboriginal Community Controlled Health Organisation
NGO	Non-Government Organisation
NH&MRC	National Health & Medical Research Council
NT	Northern Territory
NTCS NTRCS	NT (Rural) Clinical School of Flinders University
NTER	Northern Territory National Emergency Response
NTFC	NT Families and Children (of DHF)
NTGPE	Northern Territory General Practice Education
NTOSS	NT Outreach Specialist Service
OATSIH	Office of Aboriginal and Torres Strait Islander Health (of DoHA)
PATS	Patient Assisted Travel Scheme
PGPPP	Pre-vocational General Practice Placements Program
PHC	Primary Health Care
PIP	Practice Incentive Payment
QIC	Quality Improvement Council
RACGP	Royal Australian College of General Practice
RAN	Remote Area Nurse
RDH	Royal Darwin Hospital
RMP	Remote (or Rural) Medical Practitioner
RN	Registered Nurse
SAE	Standard Australian English
SAHW	Senior Aboriginal Health Worker
SHS	Sunrise Health Service
TAHW	Trainee Aboriginal Health Worker
VET	Vocational Education and Training
WHO	World Health Organisation
WWJ	Wurli Wurlinjang Aboriginal Health Service

Executive Summary

Sunrise Way is not an academic study, but is a plan for change based on experience and the aspirations of the people of Sunrise Health Service and its communities. These aspirations are not new, and many of the changes have been tried before. What makes Sunrise Way innovative is the way they have been linked to a Cultural Framework to provide a coherent holistic system. The changes described here are dependent on each other, and there is no suggestion that they can be implemented, monitored, or evaluated in isolation.

The Cultural Framework has three parts. The first is Respect – for culture, for people and dignity, for beliefs. The second is Understanding – of Aboriginal views of health, a holistic view of life including dimensions of Mind, Body, and Spirit, of belonging to their land; of how people live and how this determines health outcomes; of the complexities and difficulties in communication across differences in language, culture, custom, and disability. The third foundation is Commitment – to the central role of Aboriginal people in the delivery of health care; to true Primary Health Care working in teams in the Mind-Body-Spirit approach; to preservation of culture; and to quality. The system becomes coherent when every activity becomes consistent with that framework.

Section One of Sunrise Way deals with concepts within Sunrise. It looks at clinical and organisational issues, and the supporting structures and attitudes to make Sunrise a service covering the widest definition of health with a blend of traditional and Western health care and a broad professional Aboriginal workforce. It is presumed that Sunrise can obtain funds for a remote health service envisaged by people in their community controlled organisation and not one which is tied to someone else's image

First, elements of the Cultural Framework are expanded as the central theme which runs through everything which follows. The Western science-based belief system which underpins Western medicine justifies belief in the priority which is placed on health. Respect for alternate belief systems requires that other priorities also be respected, particularly those related to family and cultural obligations. Sunrise Way is a plan for working with this dilemma to bring about the health outcomes the communities want.

Recognising, acknowledging, and understanding the significant differences between mainstream health care and that in remote Aboriginal communities is at the heart of the second part of the Cultural Framework. Understanding is not the same as acceptance. Some things need to change for improvement in health and life, and Sunrise. Its staff should advocate for that change in ways which communities want. Understanding Aboriginal views of life, the importance of land, relationships, and spiritual wellbeing is critical to the delivery of culturally appropriate health care. The Mind-Body-Spirit holistic view of health and life takes in the desperate issues of mental health, ongoing stress, social dysfunction and the role of traditional healers and healing places.

Transforming Sunrise Health Service demands commitment to the principles which are appropriate to Aboriginal-led, culturally appropriate primary health care teams. Without a functioning team there is no Primary Health Care. Remote health relies on substitution, delegation, and teamwork. It makes sense that to work effectively in a team there should be interdisciplinary sharing of skills, teaching and learning together in the team, in the workplace. This has major implications for the education process. Commitment to learning and quality is a cohesive force in this process.

The Cultural Framework provides the mechanism to achieve a culturally competent organisation. Ensuring that the Cultural Framework is observed and applied in all situations virtually guarantees this. For staff who are not local, introduction to Roper Kriol will provide an added stimulus to understand and appreciate the significant cultural differences which need to be accommodated.

Communication is one component of the second heading of the Cultural Framework. It is both complex and especially important. Communication is basic to the provision of health care. It is therefore considered in more detail. Communication barriers include language, health literacy, hearing and other ear disease related disability, cultural issues, role of questions, belief systems, and ways of thinking about cause and effect. Communication difficulty mostly goes unrecognised. If it is recognised it may not be obvious which of the causes is, or are, at play. Local Aboriginal Health Workers are the key to communication, and this is at the heart of many of the changes in professional health practice in Sunrise way.

True Primary Health Care and the changes of roles and philosophy which this involves will transform Sunrise. Primary Health Care will be extended by the inclusion of Mind-Body-Spirit, community and traditional health practice. The focus of health care will move from acute medicine to preventive health care and healing, from the clinic to the community and replace a selective and programmatic approach with a more holistic set of focal points. Primary Health Care teams are the units of activity so leadership, team building and team maintenance become essential activities. Community based care provides the setting for building shared knowledge across two belief systems. These changes and the need for high standard communication affect the principles of the consultation process in both the community and clinics. The standard but inappropriate GP consultation is replaced by a case conference involving an appropriate Aboriginal Health Worker and from time to time, a traditional healer. Management structures will also evolve to accommodate these changes. The setup, standards, and efficiency of clinics will reflect these changes.

Of the professional groups who make up the Primary Health Care team Aboriginal Health Workers (AHWs) are pivotal in remote Aboriginal health care. Not only are AHWs critical to the team but their elevation in status and expansion of roles as the long term professionals with deep community and cultural knowledge is critical to the change process. Expanded pathways for Aboriginal careers in health include community based health workers, welfare workers, mental health workers, managers and team leaders, Allied Health Associates and Medical Associates in transition to becoming fully registered medical practitioners. Empowerment and leadership skills are part of the change process. Sunrise Way will see Aboriginal people as the

predominant health workforce in each community, and so in control of the business of health.

There will be significant transition in the role of nurses in remote clinics and community health services, from assumed leadership towards support, mentoring, teaching and standards. For AHWs to move into leadership roles and to act as cultural brokers and advocates needs a reciprocal role change for nurses and other non-indigenous health professionals. There is no teaching or preparation for non-indigenous professionals to utilise the skills of cultural brokers, or to appreciate the depth and importance of cultural and community knowledge both in the acute care and extended clinical settings. These reciprocal changes are fundamental to the implementation of Sunrise Way.

Remote medical practice is demanding, isolated, responsible, and challenging but at the same time highly rewarding. It requires appropriate qualifications, and a skill mix including public health, teaching, teamwork and delegation. Sunrise Way requires doctors to work as consultants to the team rather than as the peak professional, to guide, teach, and safeguard standards of care when AHWs and Remote Area Nurses (RANs) are delegating or substituting for the doctor. Training for working with AHWs who are leaders, advocates, and cultural brokers is a necessary part of preparation for the work. This may mean unlearning of established attitudes and practices which have been endorsed by the medical profession over time.

The majority of Allied Health Professionals work from outside Sunrise, so their role is discussed in that context in Section Two. However whether they are part of the Sunrise team or from a specialty service, the Cultural Framework applies, the principles of consultation, delegation, substitution, sharing of skills and knowledge, teamwork, and working through Aboriginal Health Workers are all equally relevant.

Primary Health Care in the community is a subsystem of Sunrise Health Service. The central functions of the system both support and protect the Primary Health Care teams. The cultural framework is the common and unifying force. Conforming to the Cultural Framework and not meeting the needs of the teams and communities is a contradiction. Trying to make teams self-sufficient and self supporting from their remote locations at the end of tenuous communication and supply lines is demoralising and risks negative outcomes. Supporting the learning needs of teams will contribute substantially to the work and infrastructure needs of Sunrise. Supporting an increased Aboriginal workforce involved in areas of health not formerly part of Sunrise' responsibility will raise infrastructure and equity issues. Central policy will need to address these, while supporting the Cultural Framework.

Health care is based on education, and ongoing learning is not discretionary in a health service. Knowledge can be bought, but it is wasteful and inefficient to buy knowledge at the same basic level, use it, then replace it. A Learning Organisation aspires to build on knowledge, find new knowledge, and share knowledge to meet the organisations vision. This is the character of Sunrise Way. Good induction will reduce turnover, and good ongoing orientation will build the depth of knowledge in Sunrise. Cultural learning is as important as clinical learning. Teaching students and junior professionals is investing in Sunrise' future workforce, and in the health of Indigenous people. Involvement in the education of the community will have an

impact on the determinants of health and on attracting young people into the increasing opportunities for careers in health.

Learning is an essential activity throughout Sunrise, but particularly for health care. The Primary Health Care team is the unit of activity in the delivery of health care in communities. Skills and knowledge need to be shared in the team in the remote setting. Teamwork and leadership are essential. The place to provide learning is therefore in the team, in the community. To do this, Sunrise will need partnerships with the full range of education providers, and with a local training organisation. Sunrise' quality agenda provides many opportunities for learning in teams. Many of these are based on using data or on evaluation. These are the beginnings of a research agenda which will allow Sunrise to see if its activities are successful, and what works to improve Aboriginal health. Partnerships in research should be developed with outside organisations as long as they fit with Sunrise' agenda, and adhere to the Cultural Framework.

Quality is also a central theme of activity throughout Sunrise. Sunrise Way questions whether formal mainstream (Western) approaches to quality are appropriate to the work of Sunrise, although they are tied to accreditation and thus funding and teaching opportunities. Sunrise has internal quality tools which can be developed to promote and establish excellence, including performance management and internal reporting structures, with development of specific internal performance indicators. Quality of cultural performance is an essential item. A data system designed for supporting quality and easy to use is essential to meet Sunrise' quality needs. A quality agenda supported by good data will strengthen the connection between quality and learning, teaching, research, induction and orientation.

Section Two looks at the wider systems in which Sunrise is embedded, where it does not have control, but needs to have influence to be able to implement its Sunrise Way and Cultural Framework.

Sunrise does not work in isolation from its environment. Every week there are operational activities within sunrise by health professionals from other organisations and agencies who work in their own ways. Medical specialists and other medical specialty services are essential, but should work harmoniously with Sunrise in accordance with the Cultural Framework and Sunrise Way. These are big and difficult changes in the culture of specialist medicine, and will need the support of their employers or involved institutions. The biggest shift is from paternalistic control of information and services from the level of the specialist institutions to community-based control from the Primary Health Care team.

In addition to the visits of specialists and specialty services onto Sunrise' communities, clinicians reach out to the surrounding services for assistance for patients, for knowledge, for advice and for support. Patients move out of Sunrise' care into the care of other institutions and services. In turn these patients may be sent further afield for care on patient journeys which are outside Sunrise' control, are fraught with pitfalls and need to be monitored by those who have taken responsibility for their health – the Primary Health Care team. To align care throughout the patient journey with the cultural Framework will demand advocacy, and call for cooperation,

collaboration, and alliances to bring Sunrise' influence to bear at the various points along the pathways of these journeys. These pathways lie in mainstream health services. They are in turn influenced by the Indigenous health system, to which Sunrise belongs. Sunrise needs to also exert its influence in this system to promote action in accordance with the Cultural Framework. The wider system of education – of learning and teaching, and academic institutions – also needs advocacy, cooperation, collaboration and influence.

The assumptions underlying Sunrise Way are that the cycle of poor health will be broken by the combination of Community Control, an Aboriginal cultural basis, health delivery in the hands of Aboriginal health professionals, and an approach to health which includes the mind and the spirit. In a few short years Sunrise Health Service has established itself as an innovator in remote Aboriginal health care. Sunrise Way is a further major step in putting Aboriginal people in control of the business of their health in its widest definition. This transformation has the Cultural Framework as the catalyst and theme as long as Sunrise Way can inspire and unlock the resources being directed at Closing the Gap in Indigenous Disadvantage.

Introduction
Overview

Sunrise Way is a concept of defining how Sunrise Health Service (SHS) conducts its health business within the context of its Community Controlled governance and structure. It is a departure from conventional health service practice. Sunrise Way is based on a set of principles (the Cultural Framework) and all activities are harmonized with that. The CARPA Manual remains the clinical guide to patient care, because it is the evidence based and specific to the environment in which Sunrise operates. However the way in which those guidelines are applied is governed by the Sunrise Way. This document outlines those principles, and how they shape preferred service delivery and operations.

Sunrise Way and the Cultural Framework have not been developed as a result of academic study or on the basis of published material. They are based on experience and a belief that they resonate with the prevailing ethos and aspirations of the organisation expressed in the Strategic Plan 2008 – 2012 (see figure 1). These aspirations are not new, but the process of harmonising all aspects of activity with an explicit Cultural Framework appears to be innovative. In that process Sunrise Way will be reviewed, developed and refined, and validated by the communities and their representatives who form Sunrise, and it will refer to the published work of others.

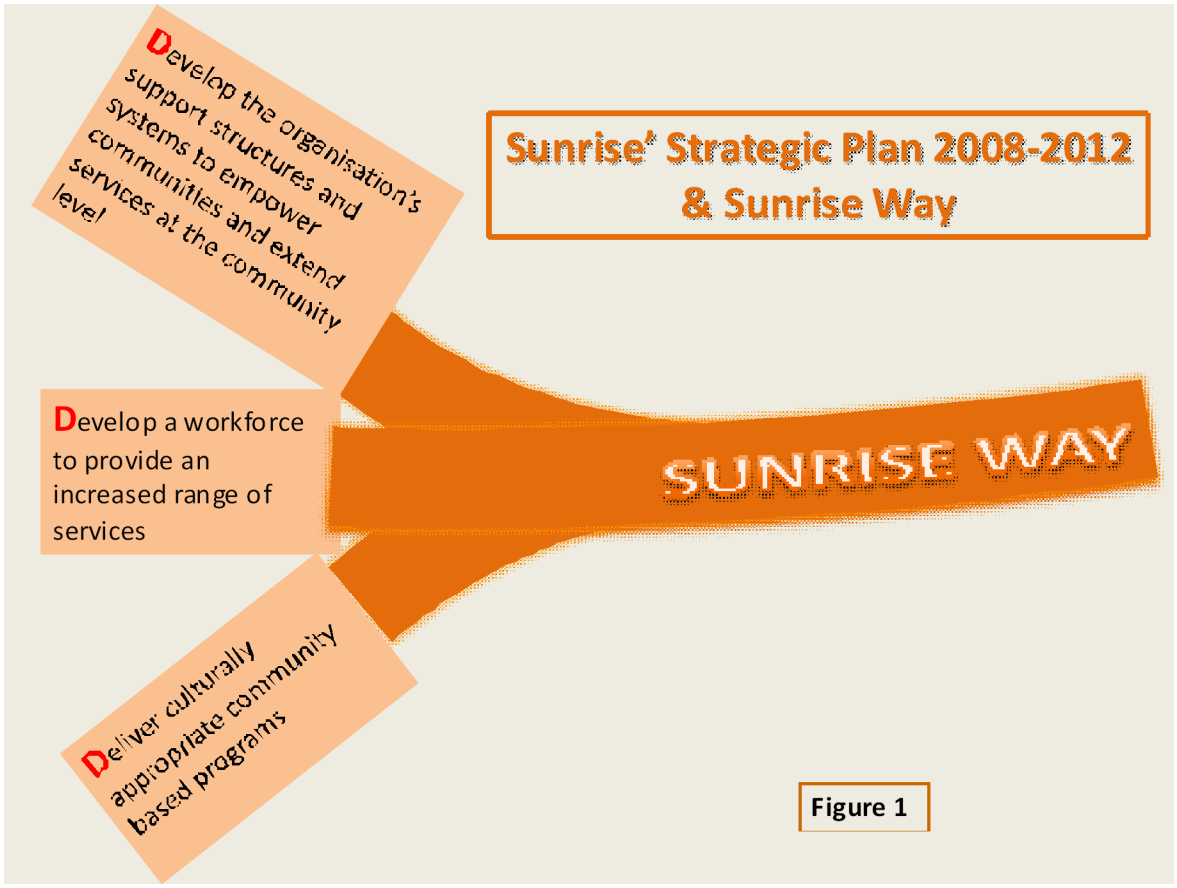

Figure 1
Sunrise Way is based on the directions of the Sunrise Health Service Board in the Strategic Plan 2008 – 2112

At this stage it is aspirational rather than directive. It represents a systematic approach to the work of Sunrise. It recognises the essential role that learning plays in health and health services, the continuing and continual need for learning, and for that learning to be specific for remote settings in the context of Sunrise Health Service.

Sunrise Way recognises that remote is different, that Indigenous health needs different approaches, and that current approaches in remote Indigenous health have generated no appreciable improvement over the past 30 years.

Sunrise Way represents an approach to service provision in Sunrise' group of communities which is in keeping with the culture of these communities, and the aspirations of the people. It builds on past experience, but is not tied to it. It seeks to reclaim the good health and associated practices of the past.

The Sunrise Way Vision

This is not the Vision of Sunrise Health Service, which is expressed in the constitution, but of how to put that vision into operation.

Vision Statement

The vision contained in Sunrise Way is of a health service in tune with its communities culturally, building and using new knowledge which comes from traditional practice and conventional health practice while maintaining the highest quality of health care, using a mainly Aboriginal workforce, particularly at the professional levels, and in control in its dealings with external agencies including funders, health institutions, and service providers.

The relationship between Sunrise Health Service and its communities is expressed in the Cultural Framework. It gives credibility to traditional health practices of the past so communities can reclaim these practices. This will help build an enduring shared knowledge with Western medicine.

A high quality health service implies continual striving for quality improvement in all areas through ongoing evaluation and action. It needs high quality professional services through recruitment. It encourages retention of the best people through the best possible quality of professional support, training and adaptation to a demanding and specialised area of health care.

The cultural and holistic health interests of communities will be best served when Aboriginal people make up as much of the workforce as possible.

Sunrise Way is a way of empowering the community to take greater ownership of their outcomes – health and social.

Sunrise Way is also a way to ensure Sunrise Health Service is able to provide more appropriate services to its communities, and to advocate for change in other organisations in favour of its members and their culture.

Holistic care, (biopsychosocial care, or Mind-Body-Spirit) and the Aboriginal holistic life approach include the widest range of influences on health. Education in health, education for employment and life choices and for involvement in the development of the community are vital influences – 'Education for health: Health for education'. Health literacy, general literacy and literacy in the language of education and power are essential for community control – for communities to control their own health and the determinants of their own health. Sunrise Way deals specifically with health, while Sunrise Health Service advocates for appropriate and culturally safe education for communities to be able to deal with the full range of social and environmental determinants of health.

Cultural Framework

The Cultural Framework is built on three foundations: Respect, Understanding, and Commitment. These cover the following headings.

Respect for

- Culture
- Individuals
- Human dignity
- Belief systems

- Priority of health care
- Cultural obligations

Understanding of

- Aboriginal view of Health
- Communication
- Aboriginal decision making
- Holistic view of life
- Need for a helping role
- Living in Aboriginal communities, and the determinants of health

Commitment to

- The central, pivotal and unique role of Aboriginal Health Workers, including as cultural brokers
- Preservation of culture
- Primary Health Care
- Interdisciplinary teamwork
- Leadership – of dynamic, functional teams
- Interdisciplinary skills sharing and teaching
- Biopsychosocial (Mind-Body-Spirit) health care
- Public Health perspective
- An informed community
- Continuous quality improvement

The Cultural Framework is the basic unifying principle, and is considered in more detail before dealing with the systems it unites and influences.

The Sunrise Way document is structured around systems.

Sunrise Health Service is a system to provide health care for people in a group of remote Aboriginal communities. Section One of Sunrise Way outlines what that system might look like transformed by Sunrise Way and its Cultural Framework. Practical health care is delivered by health professionals in those communities. This is the most active subsystem of Sunrise. The central description of Section One is what health care would look like transformed by the Cultural Framework, by the application of true Primary Health Care, and by including the complete Mind-Body-Spirit concept. It includes descriptions of changes in Aboriginal Health Worker status, training, career opportunities and roles, and reciprocal changes in how non-indigenous health professionals including doctors and nurses work. It describes moving the focus of health care from the clinic into the community and involving traditional healers, positive traditional health practice, and healing places. Other subsystems are described: the central role of Sunrise management, governance, and support; the interwoven systems of learning, teaching and research, and the continuous thread of quality.

Sunrise Health Service is embedded in wider systems. Section Two describes some of these relationships and how Sunrise would want to see them transformed to improve people's health in cultural safety. The health of people in Sunrise is in part the responsibility of the mainstream health care system. This includes access to specialist services and to acute care at secondary and tertiary levels. It includes how Sunrise Way might transform specialist care, and protect people on journeys through the health system. Sunrise is also part of the Aboriginal Community Controlled Health Services (ACCHS) system which has influence on mainstream health care. Collaboration, cooperation, and alliances within this system will help Sunrise promote the changes coming from Sunrise Way.

The Indigenous Health system controls the funds which would implement Sunrise Way. Influence and support in this system through the ACCHS system, NGOs, and other influential government bodies and academic institutions will help to make Sunrise Way a reality.

SECTION ONE

Transforming Sunrise Health Service

Section One defines by illustration what Sunrise Way hopes to be, and how it would transform Sunrise so that it is guided by Aboriginal culture in its clinical application and in the communities, and supported within Sunrise.

Issues of funding are not addressed. It is presumed that Sunrise can obtain funds for a remote health service envisaged by people in their community controlled organisation and not one which is tied to someone else's image.

CHAPTER 1 BASIC PRINCIPLES

The principles underlying Sunrise Way relate to the culture of the communities, and how Sunrise Health Service needs to be respectful of that culture in all facets of its operations. Cultural safety and cultural competence are learned attributes of outsiders involved in providing those services. The Cultural Framework is the foundation for cultural competence. Sunrise Way is intended not only as a working document within Sunrise, but also as an explanation to many people outside Sunrise, Indigenous as well as non, of the values and attitudes of the organisation and its people

Cultural Framework

(Figure 2)

Respect for:

- Individuals
- Human dignity
- Belief systems
- Priority of health care
- Cultural obligations

Respect is a basic principle which should underlie all human activity systems. At the most basic level each individual deserves to be treated with respect. In the cross-cultural environment of an Aboriginal health service there should be respect for culture, and for the differences between cultures.

Human dignity is precious, regardless of socio-economic, educational, or professional levels. Dignity is at the basis of human rights.

There are alternate, and equally valid, belief systems. The Western science-based belief system is only one. While there may be strongly held opposing beliefs between systems, every belief system and its adherents deserves respect.

Health professionals in the Western health care system place a high priority on the biomedical aspects of health. Not all people share that priority particularly in a culture with a holistic world view, where the psycho-social aspects may be more important for reasons which are historically and culturally valid. These different priorities must be acknowledged for their origins and validity even though the health service might not consider it in the individual's or community's best health interests.

Cultural obligations of Aboriginal people are generally strongly observed. These obligations may be perceived to interfere with best health promoting practice, and with the smooth functioning of the health service. However they are at the core of what it means to be an Aboriginal person, and should therefore be respectfully accepted as part of the service environment.

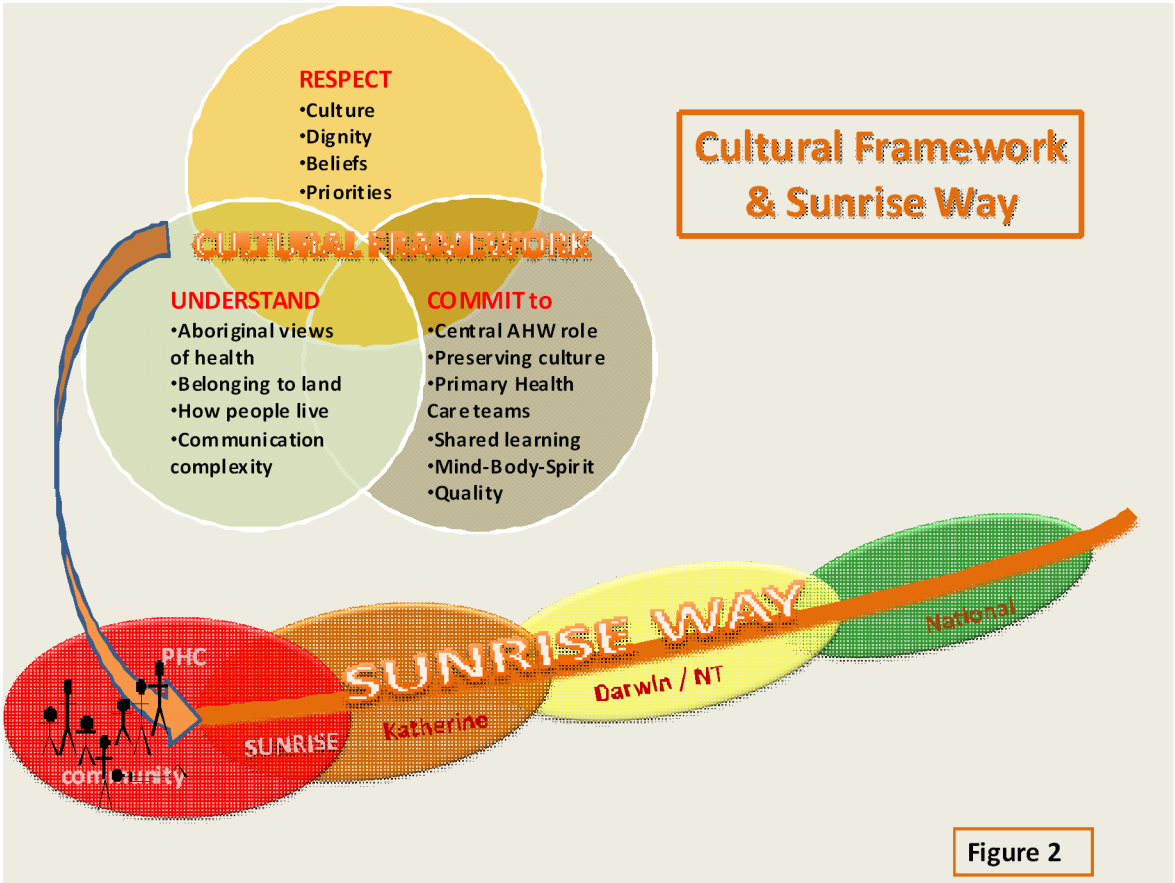

Figure 2
The Cultural Framework is the basis of Sunrise Way, which transforms the way Sunrise Health Service works, and has an influence at every level of the wider health system in which Sunrise operates.

Understanding:

- Aboriginal view of Health
- Communication
- Aboriginal decision making
- Holistic view of life
- Need for a helping role
- Living in Aboriginal communities, and the determinants of health

There are significant differences between main stream health care and health care in remote Aboriginal communities. Many of these differences relate to the issues in the list above. These issues and differences need to be recognised, acknowledged, and understood by non-indigenous people in this environment, as they change how work is done. Understanding is not the same as acceptance. Some things need to change

for improvement in health and life, and Sunrise and its staff should advocate for that change, in ways which communities want

Aboriginal view of Health

An Aboriginal view of health is not only about the individual, it is also about the community. It is a whole of life view, and includes the cycle of life–death–life. It includes harmonious relationships and spiritual wellbeing. It includes relationships with the land, and the need to maintain the land, and those relationships. It includes power over their own lives and decisions. Understanding these views is critical to the delivery of culturally appropriate health care.

Communication barriers

There are a number of **barriers to communication** in Aboriginal health. Language is probably the most obvious, but many of the barriers are subtle, and the inexperienced practitioner may not realise that communication is suboptimal. However, if communication difficulty is recognised it may not be obvious which of the causes is, or are, at play in that particular situation and therefore how to tackle the problem. New ways of working with communities and individuals to circumvent these problems becomes a more realistic option.

Communication barriers include language, hearing and other ear disease related disability, cultural issues, role of questions, belief systems, thinking about cause and effect, and appreciation of life-style and environmental differences. The last of these is discussed below. The others are dealt with more fully in the next chapter.

Environmental conditions

The physical environments which exist in Aboriginal communities may affect clinical presentations, and clinical care. Not every patient is affected by any or all of these conditions, and of those who are, the degree of effect is variable. Only local Aboriginal Health Workers have the intimate knowledge of the lifestyle and living conditions of individual patients and a true appreciation of these effects.

The environment contains strong and pervasive determinants of health. Not all of these can be changed quickly enough to improve the health of present generations. Recognising the need, and advocating for change is very much part of the responsibility of Sunrise Health Service.

1. **Physical environment:**

- Overcrowding - occupation density of houses may be several times that of mainstream Australia. Separation of adults and children, girls from boys, may not be possible, and a child may not have his/her own room.
- Family obligations contribute to both chronic and short term overcrowding as it may not be possible to justify not sharing.

- Poor design and construction of houses may lead to inadequate living spaces, and building may be difficult to clean and maintain. Houses may become used for storage rather than living. Houses may be severely damaged as a result of overcrowding, and psychosocial factors.
- Houses may be scantily furnished. There may not be enough beds so beds or mattresses are shared. There may be blankets but no sheets. There may be nowhere to store clothes, so first up is best dressed. Clothes washing facilities, when available, may be grossly over-worked.
- Housing and living space may be shared with numbers of dogs, the health of which is regarded by non-Aboriginal people as problematic.
- Cooking may be over open fires, there may be no tables or chairs, and little in the way of utensils. Meal times may be erratic.
- Meals may be a matter of grabbing what is available. Food supply may be specifically related to paydays, with days without any food available. Family obligations may contribute to the rapid use of any available food. If there is a refrigerator it may be emptied of perishable food rapidly. Food may be high priced, of limited variety, and poor quality. Take-away food may be the only alternative.
- Health hardware (water supply, showers, toilets, sewage disposal systems, hand basins, laundry facilities, if present and if working) may be overloaded by the overcrowding by people in the dwelling, camping outside, or using facilities because their own have given up.
- Garbage disposal may be rudimentary or non-existent, and refuse, including soiled disposable nappies, may litter the ground and feed the dogs

2 Social and psychological environmental issues:

- Chronic Traumatic Stress Response, to
    - ongoing *situational trauma* of deaths of family members to suicide, self harm, or other injury; to continuing deaths in custody; to police harassment;
    - *cumulative trauma* from frustrations attempting to gain equal access to services; to structural violence from institutionalised racism;
    - *Inter-generational trauma* causing identity crises and fractured family and social cohesion subsequent to forced separations and removals (including incarceration) internalised shame and self hate, and self destructive acts such as violence and self harm (Phillips 2003)
- Poor educational outcomes
- Unemployment, underemployment, pseudo-employment, and menial employment, with frustration of legitimate avenues of important and meaningful employment
- Abuse of alcohol, illicit drugs, substance abuse, and gambling
- Violence and physical, sexual, or psychological abuse
- Welfare dependency and social dysfunction

Aboriginal decision making process

It may take longer for an Aboriginal person to come to a decision than non-Aboriginal people are used to, or find comfortable. This may impact on the length of the medical consultation process for example. Decision making is often accompanied by silence, which is quite acceptable in Aboriginal discourse. Aboriginal people in

groups also take time to reach decisions, by consensus, after everybody has spoken, and spoken enough times to make subtle shifts in position to reach consensus. This may impact on family decisions around serious health issues.

Holistic life approach

Health and illness is not seen as body parts or systems, but the person and their Mind-Body-Spirit, their land, their family, and their relationships. It may be difficult to explain the difference between specialties, and subspecialties, roles in health services, overlapping roles of Government departments and other agencies. It may be difficult to give meaning to issues of justice and equity. Western culture can cut life up into compartments and put it back together at a personal level. This is difficult in the Aboriginal world. It should not be expected that people can cope with this.

Need for a helping role

Communities expect that health professionals will attempt to relieve pain and suffering and acute ill-health with compassion. Clinics and services must continue to do this out of humanity, and also to maintain community confidence. This will then allow Sunrise to fulfil its commitment to health improvement through disease prevention and health promotion.

Commitment:

- The central role of Aboriginal Health Workers, including as cultural brokers
- Preservation of culture
- Primary Health Care
- Interdisciplinary teamwork
- Leadership – of dynamic, functional teams
- Interdisciplinary skills sharing and teaching
- Biopsychosocial (Mind-Body-Spirit) approach
- Public Health perspective
- An informed community
- Continuous quality improvement

Sunrise will work most effectively when its staff share commitment to a number of key features and values for the community they serve. These features and values include:

The central role of Aboriginal Health Workers (AHW)

AHWs are essential for Sunrise Way to work. They are not substitutes for nurses, but bring community knowledge and cultural knowledge as cultural brokers so non-indigenous health professionals can apply their knowledge and skills effectively. They are long term workers and residents in health services and communities and are therefore best able to provide continuity, and to advise and assist new-comers. In the expanded biopsychosocial Primary Health Care they include mental health workers, welfare workers, and traditional healers. They must also step into leadership and management roles.

Preservation of culture

Sunrise Health Service is an Aboriginal organisation, and is built on the needs and aspirations of Aboriginal people. Indigenous people have the right to preserve their unique culture and their cultural identity. People who work for Sunrise should not only respect Aboriginal culture, but should be aware of the potential of Western Medicine to undermine culture.

Primary Health Care

Aboriginal Community Controlled Health Services were built on the principles of Primary Health Care, as they were envisaged in the Declaration of Alma Ata in 1978. Those principles remain basic to Sunrise Health Service.

Sunrise' commitment to Primary Health Care strongly supports the work of Primary Care being carried out by teams, in the community, engaged with the community, providing patient centred care, and coordinating care with services, agencies, institutions and individual service providers beyond the community.

Interdisciplinary teamwork.

The functional health unit in each Sunrise community is the health team, or Primary Health Care Team. (See Chapter 3) It is made up of health workers from a number of disciplines, administrators, and support people. It cannot function effectively as a collection of individuals. Without the team there is no Primary Health Care.

Teams and Leadership:

Teams change, and there are teams within teams. The team leader is the person with the best leadership qualities and the best skills for the task. This needs honesty about personal strengths and weaknesses, and leadership skills. There is no such position as 'primary health care team leader'. Leadership needs to be nurtured and teamwork practiced repeatedly to succeed.

Interdisciplinary skills sharing, teaching, and learning:

The team must learn together, and learn how to work as a team to provide best care. Professional health care is based on learned knowledge, skills, attitudes, and practices. It needs renewal to keep current. It needs to be relevant to the remote community context. Health professionals must adapt to this context before effective care can be provided. Primary care teams work in a shared environment with shared objectives. Remote health relies heavily on shared roles and substitution, and the team needs to share knowledge, skills, and practice. Professional learning at the individual or professional group level is necessary, but the ability to work as a team requires that the team learn together how to provide best care.

The interdisciplinary approach to learning by individuals who have a collective aspiration to create results defines the Learning Organisation (Chapter 6). This collective aspiration underpins Sunrise Way.

Learning is not only for the team. Bringing students and vocational trainees through Sunrise will give them a unique and gratifying experience and increase their likelihood of returning to Sunrise when training is complete. Those who don't return, or do so and move on, take with them an experience of multidisciplinary care. This

can only benefit other communities, and other people, and advertise the opportunities in Sunrise.

Biopsychosocial (Mind-Body-Spirit) approach
Health services provide well for the physical person (biomedical), and react to serious problems of mental health and antisocial behaviour, often calling in outside specialised help. Local Aboriginal people, including AHWs are best placed to work in the psychosocial areas. This means new roles, breaking away from the clinic based service, and greater involvement with traditional practitioners and practices. It involves healing places, cultural contexts, traditional practice, land, and overcoming the effects of racism and history.

Public Health perspective

Public Health is both a philosophy and a set of competencies. The philosophy includes seeing the big picture of health and health outcomes of people's actions, and of health service's and health professionals' actions. It includes seeing and treating the health of individuals in the context of their community and their environment. The tools and competencies for seeing the big picture and the contexts of health are epidemiological and in policy development . These are based on data which needs to be accurate, complete, and relevant. Without commitment to these principles, health services remain at the bandaid stage. Sunrise was established on a population (public) health approach.

An informed community

Sunrise is a Community Controlled Health Organisation, and Sunrise staff need to care about the information the community receives, both the amount and the quality. They must improve health literacy so people can understand the information. Education is a powerful social determinant of health. Sunrise' role is improving health, improving education in the community and for its workforce, through education which is relevant and culturally competent.

There is a cascade of effects which starts at – or before – birth: health for learning; learning for health; learning for life; life-long learning. Sunrise has an essential role at every stage.

Continuous quality improvement

The quality process must involve Aboriginal people of Sunrise. It must be understandable, and meet their needs, and be accepted so they become both committed and actively involved. To be a high quality organisation, Sunrise needs:
Quality staff – recruitment and retention of the best, through best conditions and facilities, and best professional and personal development, for best level of care;
Quality organisation – Accreditation to show standards are being met, but the standards should fit the Sunrise context and Sunrise Way;
Quality performance – based on good data, used well, and measured against performance indicators which first fulfil the needs of Sunrise;
Quality improvement – reflection, quality cycles, action research, and systems research all support the improvement of the quality of service. These skills need to be learned, and sometimes imported.

Cultural Safety/Competence –

Cultural safety in the health system has been defined as the need to be recognised within the system and to be assured that the system reflects something of you – of your culture, your language, your customs, attitudes, beliefs and preferred ways of doing things. It has also been described as causing no assault on a person's identity. The process starts with cultural awareness, of own culture, then sensitivity to the culture of others.

Cultural Competence is a personal measure of capacity to think and act to ensure cultural safety. It is also an organisational measure of the overall capacity to provide a service for diverse cultural groups. It has been described in a continuum from 'culturally destructive' to 'culturally proficient', where the organisation not only ensures cultural safety, but facilitates cultural safety in other organisations.

These values and practices underpin the Sunrise Way Cultural Framework.

Sunrise Way includes strategies for developing and assessing personal competence and methods to include audit of organisational cultural competence in its quality program.

Developing a bilingual workforce

Sunrise' area of activity covers nine language groups, and is bordered by a further seven. It covers five of the 15 defined major mainland Aboriginal language divisions. The common language of the service area is Roper Kriol. It is a spoken language, derived largely from English, which makes it familiar, and in some ways easier for English speakers to learn. There is a written form, but it is not in general use.

Respect for language shows respect for the people who speak that language, and for their culture. Learning Kriol involves learning about culture, and helps to highlight some of the communication difficulties identified previously.

Learning basic Kriol is therefore an important part of Sunrise' cultural program. Even a working knowledge of Kriol can never be a substitute for the lifetime of knowledge of local AHWs

Cultural orientation, cultural mentors

Sunrise Way can be used as a pre-employment introduction for cultural awareness, and can be a part of induction, orientation, and re-orientation programs.

Many new employees in remote health have had their experience of Aboriginal people and culture tainted by the selection of patients presenting in hospitals, and the inability of hospital patients to cope with the institutionalised racism of Western medicine. These perceptions need to be replaced by a true picture of the strengths, resilience, and humour of Aboriginal society. This is best achieved, not gradually by working in clinics, but by immersion in Aboriginal activities on country.

Each non-indigenous Sunrise employee needs a cultural mentor in the workplace, and in the community, with a responsibility to use those mentors particularly in the

early stages of their engagement. This applies equally to staff in the central (Katherine) office as it does to community based employees. Sunrise needs to develop the mentor role, select and train mentors. This responsibility should not automatically fall to AHWs or other Indigenous staff on top of their existing workload, or as part of their cultural brokerage role, although their reinforcement of the mentors' advice would help to cement cultural learning.

Performance management

Culturally competent individuals are crucial to the goals of Sunrise. Performance management of staff needs to address this issue just as much as other areas of work performance. Peer review and community satisfaction are appropriate measures of cultural attitude and competence.

A community development approach

Sunrise is committed to community development to make Primary Health Care a partnership of equals. For equality, the community needs knowledge, and to be able to express their thoughts and preferences and priorities, in spite of the power of health professionals based on their Western Medicine and their history.

Community Control in Sunrise is through the policies of the elected Board. The legal framework and governance structure for the Board are set by Government. Sunrise' community development unit helps the Board to understand that structure, and to think and act in two worlds and two cultures.

Sunrise Way has tried to express what the communities want, as far as the executive and management understand. When the Board agrees to Sunrise Way this means there will be some changes, and how those changes might happen in partnership with communities. Communities need to be fully involved in this process of change, as it will affect the only style of health service some people have ever known.

CHAPTER 2 COMMUNICATION IN HEALTH

There are a number of **barriers to communication** in the Aboriginal health context. Language is probably the most obvious, but many of the barriers are subtle, and the deficiencies may be missed. However, if communication difficulty is recognised it may not be obvious which of the causes is, or are, at play. New ways of working may be more effective than trying to identify and overcome the specific problems.

Communication barriers include language, hearing and other ear disease related disability, cultural issues, role of questions, belief systems, and ways of thinking about cause and effect

Language and health literacy:

Standard Australian English (SAE), with added medical jargon is the usual language of health encounters. This may be compounded by a non-Australian accent or non-standard English structure. Many patients will be articulate in SAE, but may not have the language background, or science background to understand fully the medical concepts or the medical English. Health literacy is a concern in mainstream general practice. People who are articulate in English may have little or no health literacy, and recognise the words but not understand the associated concepts. In the Aboriginal Health context, adequate health literacy would probably be the exception.

Aboriginal English is recognised by some as a separate language, and by all as at least a dialect. It has its own use and meanings of a limited English vocabulary, and its own constructions. To the inexperienced practitioner it sounds like poor English, but sufficiently close for effective communication. However the differences between Aboriginal English and SAE make this assumption very unsafe, particularly in the health context. Aboriginal English is therefore more likely to lead to misunderstanding than a recognisably different language such as Kriol because of the assumption of understanding.

Roper Kriol is the common language of the Sunrise communities. While its origins are from English and traditional languages, the distinction from English or Aboriginal English is usually obvious, and a Kriol speaker may have little if any Standard English capability. Kriol is generally a spoken language, and many (or most) Kriol speakers cannot read the written form. Kriol translations of patient information, notices etc still require oral presentation.

Aboriginal English and Kriol are the home languages of most of the Sunrise communities, but there are many community members for whom the home language is a specific local language, and English, if spoken at all, is the third or fourth language.

Hearing

Ear disease is highly prevalent in Aboriginal people. Ear disease related disability is therefore very common, and has serious implications for health communication.

Hearing loss is widespread, making effective communication difficult. Where communication is about sensitive and personal issues, and voices are lowered perhaps to a whisper this becomes a real problem. Hearing difficulty is accentuated when the language or pronunciation is unfamiliar.

Characteristically, ear infections in Aboriginal people commence early in life (in the first months, or first year) and tend to recur and become chronic. Poor language development is a consequence of this early recurrent interference with normal hearing. This leads to difficulty dealing with abstract concepts, such as in the consulting room or clinic, and in medical discussions, where the Aboriginal patient may be severely disadvantaged.

Ear disease in early life also damages auditory perception and processing skills. Deficits in these areas cause difficulty understanding long or complex sentences, difficulty in differentiating speech messages from background noise, and difficulty in dealing with a series of instructions. These are all important parts of medical encounters.

Culture

Relationships are basic to life, knowing, and communication for Aboriginal people. Many of The cultural issues which confront the Western medical approach arise from the rules of relationship.

Kinship restrictions may prevent one person from speaking in the presence of another. For example a child may not be free to talk in front of an uncle, even though that uncle is a younger child.

A subject may not be able to be discussed for reasons such as gender, ceremony, belief in sorcery as the cause of an illness, prior involvement with traditional healers and so on.

There are issues of who has the right to speak about health, and who has the right to hear what is being discussed, or to take part in the decisions. This is in contrast to the Western approach where the carer or relative is presumed to be able to provide history, and convey information.

While shame or ‘Shame job’ may not have the same emotional force or longevity as oriental ‘loss of face’, it is still a more powerful emotion than Western embarrassment.

Role of questions:

Questions are not used as commonly in Aboriginal learning and discussion, nor in the same way. In some situations the question format may be unfamiliar; in others it may be completely inappropriate. The rhetorical question may be interpreted as a genuine request for information.

In many situations, the question will bring the response which it is thought the questioner wants. Repeated questioning about the same issue (medical history being taken by a succession of health professionals – nurse, doctor, specialist, admitting nurse, admitting doctor) may give the impression that the previous answer was considered incorrect, and needs to be modified. Experience of questioning from non-indigenous authority figures (police, teachers) may lead to answers which will avoid punishment. Western health professionals and most Western patients see the need for honesty in response to questions as part of the confidential health encounter, and as necessary to establish a diagnosis and plan treatment. Where the relationship between health and scientifically based causes is not part of the belief system, delving into intimate knowledge may not only seem unnecessary, but intrusive.

In a society where healers are the ones who know why sickness has occurred, asking questions of the patient and family may seem both redundant, and evidence of poorly developed healing powers.

Silence in Aboriginal discussion is normal. A question may or may not be deemed to warrant an answer, or not at this time. A question may require a decision (particularly treatment question) involving other family members, where the process of Aboriginal decision making by consensus may take considerable time.

Belief systems and traditional practice:

Western health belief is based on the scientific process. Western health knowledge is firmly rooted in science, and has been likened to a religion – 'scientism' – which can tolerate no other view. While there are many Aboriginal people who accept, or appear to accept the Western view, there are many whose thinking belongs to the systems based on relationships, spirituality, and unconditional knowing that things are simply as they are.

Traditional medicine and traditional healing practice have a strong place in the life and belief of many community people despite apparent education and sophistication. Western medical explanations and advice may have no impact and may not provide the answers people are looking for. This is particularly so in mental health.

Thinking about cause and effect:

Scientific thinking follows a process of cause and effect, so that effect can be predicted, or cause can be deduced. A worldview based on implicit belief in knowledge held as a right to know, and which is part of the body of knowledge which has been in existence from the earliest times does not lend itself easily to what Western thought regards as logical thinking. Individuals from this worldview may learn very complex information (because learning and remembering complex detail is

part of their experience), but not make the connections which allows science to develop or correct that information.

The complexity of these widespread barriers will be difficult to address by people who are new to Aboriginal communities, until they have had a long and thorough orientation. Obviously, the people best able to recognise the difficulties and facilitate better communication will be local Aboriginal people, particularly if they also have knowledge of the Western medical system – that is, Aboriginal Health Workers. This was the rationale for the development of Aboriginal Health Workers and their role as 'cultural brokers' – facilitators beyond translators and interpreters.

How this process might be successfully integrated into the Primary Health Care (PHC) setting is covered in the next two chapters.

CHAPTER 3 IMPLEMENTING PRIMARY HEALTH CARE

The Primary Health Care (PHC) team provides continuous, comprehensive, person-centred care in the community. Primary care providers are responsible for all of the members of a defined population: those who attend health services, and those who do not.

Figure 3 shows what Primary Health Care would look like with the changes brought by Sunrise Way.

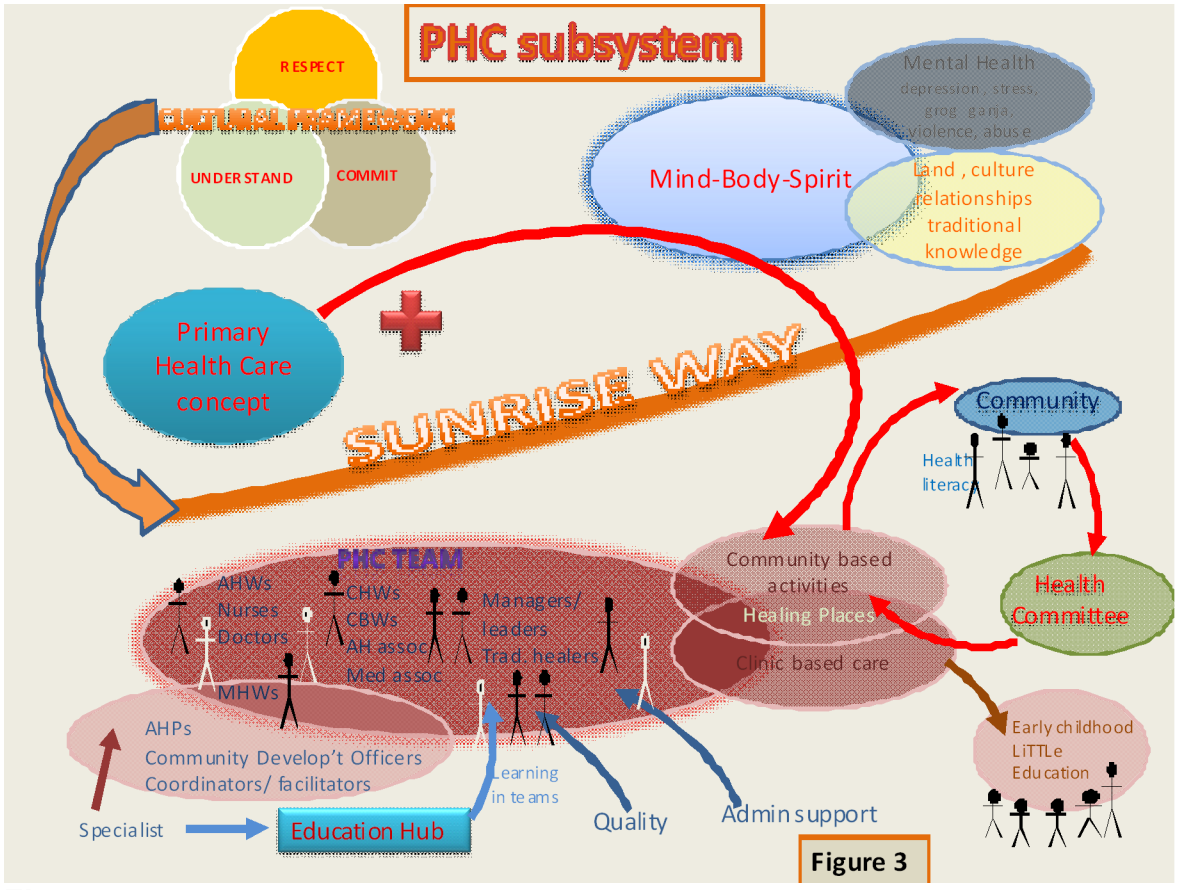

Figure 3
Primary Health Care, plus Mind-Body-Spirit, is the approach which Sunrise Way uses to transform the practices and structures in Sunrise communities to provide patient centred, holistic, community based care.

The primary care team as a Coordinating Hub

(See WHO World Health Report 2008)
The PHC team coordinates the inputs of specialised, hospital, and social services, community based activities, Mind-Body-Spirit and traditional health. This covers local dealings with shire council, schools and other education providers, social welfare groups, the justice system, and government agencies in the community and

regionally. It covers patient care such as investigation, referral, evacuation and travel. It requires that informative, accurate, and timely information is provided on behalf of patients, and that these activities are followed up to a satisfactory conclusion. Where any of these outcomes are not satisfactory, the PHC team advocates on behalf of the community or individual member to ensure that the best outcome is achieved. (See Also Chapter 9)

Health promotion, health education, health literacy, and shared knowledge.

Health promotion is a basic component of Primary Health Care. It is mostly based on the scientific principles of Western medicine. Its application to Aboriginal health and to non-science based thinking has had many disappointing results. Many attempts have been made to make the messages more relevant to Aboriginal people through use of Aboriginal media and advice from Aboriginal Health Workers. In many instances this has resulted only in dressing up Western scientific approaches in Aboriginal clothes, without finding ways to work within a non-scientific belief system. The traditional system holds great wisdom and evidence from very many years of observation. Rather than try to replace this knowledge with Western scientific knowledge through health education, Sunrise needs to work across these belief systems to build a shared knowledge as a vehicle for health promotion. A satisfactory level of health literacy is essential so that useful messages from Western health concepts can be included in the shared knowledge. The place for this discussion is in the community, not in the abstracted and Western context of the clinic.

Health care in the community

In Sunrise communities, health issues for the community, for families, and for individuals should be dealt with in the community setting, where health happens.

Taking health to the people involves changing how people think about health, and about health services. It gives opportunities to improve health literacy of the community so people can take more control over their own health decisions and management.

The community settings in Sunrise also provide opportunities for using appropriate traditional practices, for giving credibility to past practices, and bringing practices from the past back to life, not by rejecting Western medicine, but by building shared knowledge across two belief systems.

Community based practice provides ways of dealing with grief and the Chronic Traumatic Stress Response through a more traditional Mind-Body-Spirit approach.

Working in the community setting requires community based Health Workers and Community Based Workers. Their work must be safe, effective, and properly documented, so that needs, activity, quality, and outcomes can be analysed and acted upon.

Community Health Centres, Clinics, and administration:

'Clinic' is the common terminology in communities. Clinics are places for activities that need certain fixed facilities and vulnerable equipment. Most often they are places of sickness, not of health, and their role tends to be curative rather than health promoting. They sometimes provide privacy and confidentiality which is difficult to ensure elsewhere. However, they also tend to be places of abstract transactions around health, where decisions can be made and actions agreed which are not possible to implement in the reality of the community.

The clinic is a necessary part of the primary care structure, and as such is part of comprehensive, continuous, person-centred care. It provides a point of care in the community when community based care is dispersed or not available.

PHC teams need an administrative centre, a meeting point, and a hub for communication, information storage, coordination, and learning. The clinic provides these venues and facilities. Clinics are managed by a clinic manager, who traditionally has had the administrative responsibility for all health matters in the community. Most often the clinic manager has been the senior nurse, and occasionally a senior AHW. Responsibilities extend from clinical to cleaning, stores to staffing. Generally this responsibility is learnt through an apprenticeship process. The clinic manager has usually had the responsibilities of the team manager. This model does not fit with the Primary Health Care and PHC team model and implementation of Sunrise Way will involve new skills for different people and a transition to a different management structure and approach.

The change to thinking of the clinic as only a part of the health service in a community needs to be carefully managed. The clinic model is the only model of health care which most of the community, and the health care providers, have ever known. People have been encouraged to attend the clinic for all of their health needs. It will take a lot of explanation and discussion to move to a new model.

People who work in primary care teams

The range and numbers of people who form or contribute to Sunrise' primary care teams varies according to community size and characteristics, but may include some or all of Aboriginal Health Workers (AHWs), Remote Area Nurses (RANs), Doctors (visiting or resident or locum), Clinic Managers, Allied Health Professionals (AHPs) (visiting or resident), Community Based Workers (CBWs), Aboriginal Community Health Workers, Aboriginal Community Welfare Workers, Mental Health workers, Traditional Healers, Facilitators (visiting or resident), administrative staff, cleaners, drivers, Community Development Officers (CDOs), Regional Coordinators, and in some cases, visiting specialists. Their work may be entirely, mostly, partly, or rarely in the clinic.

Programs, foci, facilitators, and portfolios

Primary care is comprehensive, and is holistic in keeping with Aboriginal culture. Delivery through programs is a hallmark of Selective Primary Health Care, particularly where these programs are funded separately, and require specific and separate reporting. In keeping with true Primary Health Care, a programmatic structure will be replaced by focal points of activity within a comprehensive approach.

These focal points can and must still be reported on for knowledge of health need and health service outcomes.

The role of coordination around these focal points in each community belongs to the portfolio holder for that area, a responsibility which falls within their holistic approach to the community's and individuals' needs. The role of coordination around these focal points across Sunrise' communities belongs to facilitators for those focal areas (eg ear health and language, child health and development). The emphasis is therefore on assisting Primary Health Teams to work holistically. At the same time, the facilitators need to ensure that reporting in their area of interest is accurate to monitor outcomes. This means ensuring that data are accurate, meaningful and fully reported, as these reports form the basis of evaluation of efforts, and the planning of change.

The change of name to 'Facilitator' is not simply cosmetic, but signals a new style of working and responsibility, from the narrow programmatic approach towards meeting all of the health needs in a comprehensive and seamless way.

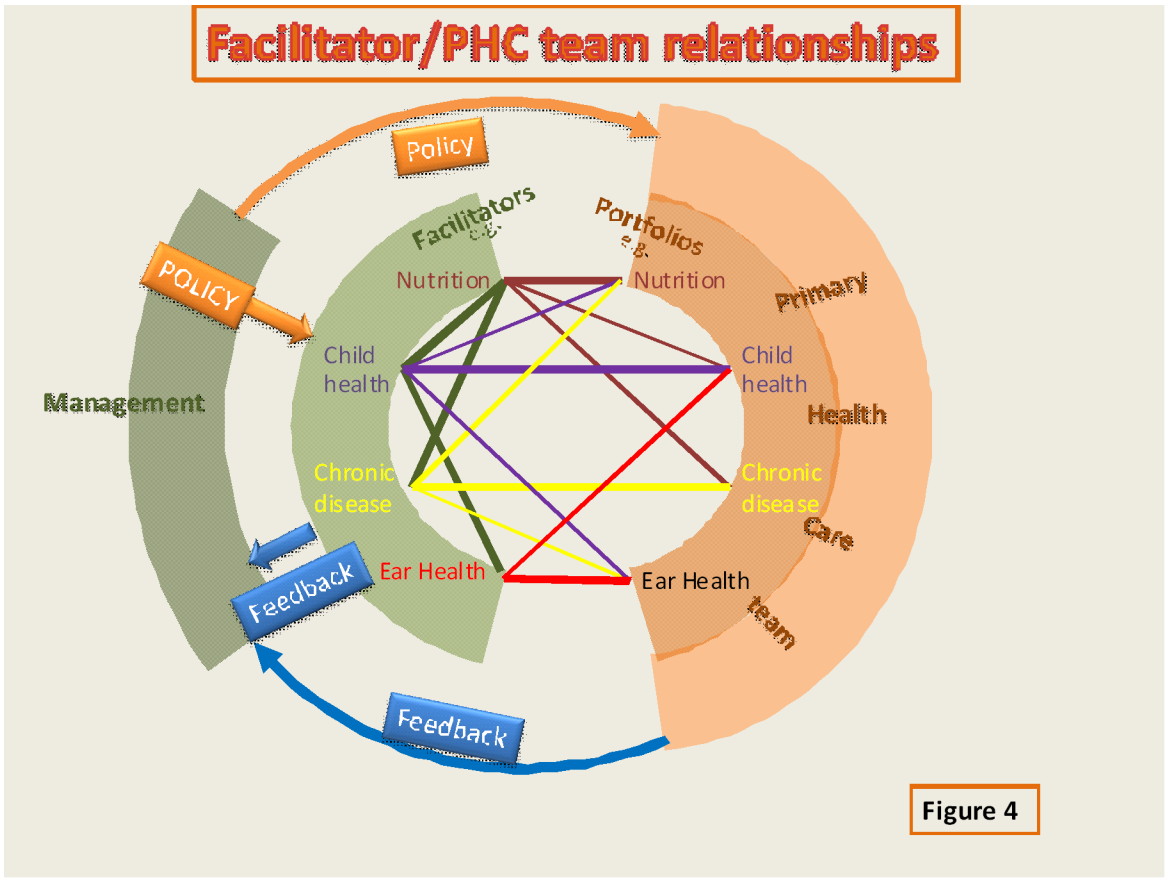

Figure 4
The interactions between management, facilitators, portfolios, and PHC teams is demonstrated with some selected focal areas. Facilitators work as a coordinated team, portfolio holders work within the PHC team, and the interaction between them and each other reinforces the Aboriginal holistic live view.

Teams and Teamwork

No single health care professional has all the skills necessary to deal with the range of problems and presentations experienced in the community. Holistic care can only be provided by teams, working together.

Members of teams need to coordinate their activities to avoid duplication, provide support for patient centred activities, and provide consistent advice. At times, the whole team, including visiting members, may conduct community wide campaigns or projects. At other times small teams from within the team may work on particular problems or smaller projects. Even practitioners working alone are not working in isolation from the support, guidance or directions endorsed by the team. To do all of these things requires teamwork and structures to support the team and for communication.

Teams provide the structure for developing and communicating programs and priorities at the community level, for quality improvement, for learning, and for developing and maintaining cultural competence. They hold the knowledge of what has been tried and failed, of successes, of development and progress.

Non-indigenous health professionals are transient members of remote health service life. Each new team member brings skills and knowledge, and each departing member leaves enriched by their experience. If that person has not worked effectively as part of the team, the team has been denied full access to those skills and knowledge, and the team is not improved for their time in the community.

Local AHWs are the team members best able to provide continuity of knowledge, care, and practice. To do this they need well developed leadership skills, and the status of resident expert in the health of their community.

Building and maintaining teams

Teams do not happen. They need to be built, nurtured, managed, coached, and adapted to changing circumstances. Individual team members need skills and self discipline to fit in to teams, to accept team decisions, and to lead teams. The independent personalities of people who come to work in remote communities do not always lead to the being good team players. Some professionals feel that status or position overrides the need for teamwork. Coaching in teamwork will therefore be a necessary component of the change management required for team building.

Meeting Sunrise' commitment to the pivotal role of Aboriginal Health Workers, and their development towards full participation in, and management of primary care teams will require a very proactive, supportive attitude of non-indigenous staff, as well as the development of leadership qualities for Aboriginal employees themselves. The success of leadership development will set the timetable for team development. This process will start to lift the status of Aboriginal people in Sunrise' operations, and in the community.

The process of team building and team meeting (and teaching and learning in teams) can be time consuming, and be interrupted by pressure of work. These activities are

so important that they need to be supported not only by educators and change managers, but by relief staff to maintain essential services.

Teams need to be managed. They should have rules, or a clearly defined culture. Sunrise Way Cultural Framework is the starting point for developing and checking that the team's culture is in harmony with Sunrise' aspirations. The overall functioning of the team, its inputs and outputs, records and communications is the responsibility of the team manager. This job requires leadership skills, but does not imply leadership of the team.

Leadership of Teams

Leadership is an activity, not a position

Teams are formed to meet objectives. Each objective needs its own set of skills, experience, and knowledge. Each team may be all or part of the primary care team. The team leader will be the person with the combination of the best leadership qualities and the best skills for the task. Knowing who has those skills, or more importantly who does not, requires honesty from all team members about their personal strengths and weakness.

It follows from this that there is no such position as 'primary care team leader'.

Sunrise will need to provide ongoing team and leadership development to make this work. Performance management through anonymous peer review which involves the team provides a confidential way of identifying both strengths and weaknesses.

Teaching and learning for teams – in teams

If health work is carried out in communities by teams, then teaching and preparation for that work needs to be done with the team. This may be by simulation, mock exercises, joint training sessions, or joint professional development activities. The development of a Learning Organisation (see Chapter 6) encourages learning to meet the shared vision of their organisation. Teaching and learning is not confined to clinical issues. Learning management skills, human resources skills including leadership, team building, conflict resolution; cultural knowledge and language skills, could and should take place in the team setting.

Teams and quality

There is growing awareness of the many ways in which care in hospitals may have adverse outcomes, and this has encouraged improvements in standards of quality and safety. The effectiveness and safety of primary care in remote Aboriginal communities has been given much less attention. (WHO). There are some programs which look at effectiveness in PHC, and accreditation addresses administration, governance, and occupational health and safety. (See also Chapter 7). As these issues all relate to teams and how they work, the analysis should also be within the appropriate team. There is also scope for 'research' from reflective practice through to organised academic research which involves the team (See Chapter 6). The biggest challenge in these processes is to include Aboriginal team

members and Aboriginal thinking. The quality industry grew up in large (Western) health institutions. It may be difficult to adapt processes to the Aboriginal setting and be in harmony with Aboriginal culture and belief systems.

The Consultation – Principles

The principles of the Consultation apply in the community as well as in the clinic, even though the circumstances may be different, and there may be other things going on. The Sunrise Way Cultural Framework gives a key role to AHWs as interpreters and cultural brokers in the stages of the consultation which follow.

Triage

The first team member who sees a person for a health related service (including reception staff) needs to find out why the patient is there. If it is for medical reasons, whether initiated by the patient or for recall it is necessary to know what the person understands is the reason for the visit. Relevant observations should be recorded by an appropriate clinician, and appropriate workup done for an acute presentation or for a scheduled review, trying to avoid duplication of reviews.

Initial management

The person's problem should then be managed at the appropriate level of expertise. If the problem is within the scope of an AHW, it should be managed at that level. If necessary, advice may be sought for reassurance, or referral to another level of practitioner might be necessary.

For routine reviews, where there is a requirement for preliminary work up before medical review, this should be completed. A community based AHW or welfare worker /case manager may be the appropriate person to be involved on these occasions.

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Handover

If the next step is advice or referral, or completion of a review, there should be a handover of the patient to the next (appropriate) level practitioner. This is best done verbally, and face to face, but should always be backed by appropriate record entry. Accurate records are required for other team members including AHPs and Community based AHWs, and for other agencies including social welfare providers.

Referral for advice or definitive management.

There should be no rules for a particular hierarchy of referral. That decision depends on availability and clinical judgement. However, where there is a doctor immediately available locally, (s)he is deemed to be medico-legally responsible, and should be involved, even though District Medical Officer (DMO) referral is obviously necessary for patients requiring evacuation. This is simply good teamwork. Professional integrity and self knowledge require that the doctor consult or refer to another practitioner if that is in the best interest of the patient. Patient advocacy might also suggest that another opinion be sought, but this should be done within the concept of team management.

Referral for advice puts the advisor in the role of consultant, so that the advice is given to the person requesting it, and secondarily to the patient. There may be agreement with the course of action, further issues for consideration, correction of management with an educational component, a decision to join directly in the management, or to refer to a higher level practitioner. In any case, the practitioner requesting the advice should record the outcome, and the consultant should verify the record entry. That is, the patient should not be just handed over for the next person to take over care.

Referral may be limited to assistance with a particular procedure, or component of a more complex problem, such as taking blood, inserting an IV line, or advising on a choice of IV fluids. The requirements for documentation are the same as above.

Medical consultation conducted as case conference

Every health related medical consultation should be a conference with an appropriate AHW (preferred) or RAN unless the patient specifically requests a private consultation, **and** the treating practitioner has good clear communication with the patient. Appropriate AHW is defined by gender, kinship, language group, knowledge of the patient, family, and social setting. At times, a traditional healer may be involved in the consultation. Direct specialist advice may be able to be included in the conference.

For some patients a standard GP (General Practitioner) consultation might seem appropriate or adequate. Care should be taken not to assume that, because the patient uses English words and what sounds like reasonable English, there is good understanding. Aboriginal English is common, is linguistically distinct from Standard English, and leads to many incorrect assumptions.

The outcome of the consultation, and any associated management should be discussed and agreed by the doctor, patient, and AHW (or RAN).

Management includes a range of AHW and Allied Health interventions, involvement in community programs, disease specific groups etc, as well as medical investigations, medications, and referrals. It may involve ongoing traditional healing practice. It may require a case manager in the community (community based AHW or Aboriginal Welfare Worker).

Follow up arrangements need to be scheduled, and understood by all. Appropriate professional education for health personnel involved in the consultation should be part of the consultation.

Patient education that the patient can understand should be given in the consultation or delegated to appropriately trained personnel. Duplication of health messages not only wastes resources, but can involve confusing differences in vocabulary, meaning, content, and emphasis, losing the message altogether.

Multiple and intercurrent problems

Patients may have multiple problems, and need to discuss a number of aspects of their own and their family's health. General Practitioners may not be familiar with the

decision making process, and the indirect approach to some issues, and find they need lengthy consultations beyond the standard time allocated in the GP setting.

Many of the less serious problems can be taken back by the AHW/RAN for further management. This process needs to be understood by the team, and explained to and accepted by the community.

Consulting in the Community

Taking the service to the people greatly improves attendance and coverage rates. Informal AHW consultation goes on in the community, but incidents need to be recorded somehow, unless the condition requires subsequent clinic attention. The GP home visit model is even less appropriate in this setting than the standard GP consultation is in the clinic. Men's health activities are good examples of current work away from clinics.

Clinic based consultation increases the efficiency of a stretched and undermanned workforce beset by acute care needs at the expense of proactive interventions. This is a self perpetuating cycle. There is experience which shows that providing a more proactive service reduces the overall workload. This does not remove responsibility for health from individuals in the community, but gives the responsibility for the service back to the community while recognising the realities of life and pressures in the community. Some consultations under the trees, with dogs and kids around might not be acceptable, but mobile facilities such as camper-trailers with appropriate equipment and annexes might provide satisfactory alternatives. Even in very small communities there is an argument for bringing health activities into the mainstream of community life rather than restricting them to the curative, Western orientated and abstracted environment of the clinic.

There is not enough local experience of the variety of consultations, of health care workers, and of possible scenarios to describe in detail how consultations in the community might be conducted. However the principles of the consultation outlined above will still usually apply.

Consulting in Clinics

The conventional use of the term 'consulting' relates most often to doctors, particularly specialists, in the clinic consulting room. AHW and RAN encounters will become structured as consultations, and thought of as such. Consulting in the community will be common-place.

However, in the short term the reality is that the majority of what is referred to as consulting will continue to be done by doctors in the clinic setting. Changes in availability of doctors, and their willingness or otherwise to live on communities will have a strong bearing on this. Visiting doctors generally need the familiarity of the clinic environment to cope with the workload. The team will need to be a willing to try community-based approaches, to experiment, and to persevere. New doctors and locums will need to learn new approaches which have been successfully trialled. For short term locums, it may be easier to continue with the conventional ways.

The clinic consultation should follow the principles for consultation outlined above. It can be argued that the medical consultation in a remote Aboriginal clinic should not follow the pattern of the standard GP consultation for the following reasons:

- The team approach where the team is the treating unit, with the doctor as a part of the team;
- The role of doctor as consultant and adviser to the team or team members rather than taking over full and direct patient care,
- The importance of knowledge of the patient, free of Western assumptions about living environment and social setting; of local and cultural knowledge, and of communication barriers, particularly for doctors who are not long term residents of the community, and therefore,
- The essential role of AHWs working as one with the doctor in a case conference approach;
- The need to plan care which is appropriate, achievable, and understood;
- The underpinning Public Health philosophy and population health approach;
- The importance attached to epidemiology and therefore data and data entry;
- The need for patient records which inform all other health care providers, not just the treating doctor
- The need for transmission of full and detailed information in the interests of best care and advocacy for patients where referral to distant facilities is required;
- Because of substitution, the need to teach AHWs and RANs to provide safe care in the absence of a doctor, and for quality assurance for substituted practice.

Clinic setup – conventional clinic

When consultation occurs in clinics, there are physical and functional arrangements which need to be met to comply with the Sunrise Way Cultural Framework:

- Appropriate waiting space (gender specific if appropriate) – which recognizes that appointment systems are generally not feasible, and that therefore waiting times are unpredictable (beware assumption that patients have nothing else to do, or that patient's see health or the consultation as their highest priority)
- Appropriate reception process,
- Triage (as above) and pre-consultation workup
- Keeping patients informed, and making other arrangements for them if there are unavoidable delays
- Utilisation of waiting time
- Consulting space and treatment facilities sufficient for the conduct of case conferencing as a routine, with appropriate family members and health personnel present, and equipment and privacy for physical examination
- Appropriate facilities for post-consultation investigation, treatment, dispensing, explanation and reinforcement, and health education.

When considering services provided in the community, all of these points still need to be considered.

Efficiency in primary care services.

Efficiency should be primarily a patient centred consideration, and secondarily an organisational one.

Facilities and services should be available in keeping with the natural timetable of events in the community. There should be flexibility of opening hours, and meal breaks, which may require overlapping or broken shifts.

Cultural events including sorry business need to be given due respect, but balanced with the provision of health service to the community. Whether the observance of cultural occasions is fully respectful, is an opportunity for cultural and wellbeing development, or an opportunity for sanctioned time off work will depend on the level of community commitment towards their health service.

Health is not an office hours issue. Abuse of health professionals' time by unnecessary out of hours work is not respectful of them or their contribution to the community. However, there are many opportunities for effective health involvement in the community which only occur out of hours. Flexibility in hours of employment, part time employment, and appropriate numbers of staff help to make such involvement possible.

Health messages which are duplicated by health providers waste both the patient's and the care-givers time. This is made worse by giving inconsistent or contradictory messages, or confusing differences of words, interpretation or emphasis.

Programs and approaches which promote community development and self management reduce the need for both acute care and chronic health care services.

Patient records, community records, and records of the administration and organisation of the health service in the community require an efficient, effective, easily useable computer system which saves time, and promotes best long-term care. The change from conventional to primary care requires that the computer system is developed or adapted to fulfil these criteria.

Efficiency is not only about reducing expenditure, but also about maximising income. A significant amount of Medicare income is available to Sunrise. Increasing efficiency and increasing income both allow Sunrise to provide more or better services for communities, and to obtain more learning opportunities for staff development. Unfortunately most Medicare income is doctor dependent, and this reduces the incentive for work by the most appropriate practitioner instead of the greatest income earner.

Travelling time for visiting health care providers reduces efficiency and adds travel costs. Income from doctors' Medicare charging can be increased by reducing travel time and utilising overnight stays in the community instead of one day trips.

Sufficient appropriate accommodation on communities is a factor in reducing travelling time, increasing numbers of health care providers who live in communities, decreasing one day trips by non-resident team members, and conducting combined, multi-focus events. Innovative accommodation solutions are needed. Solutions should consider both equity, and respect for people working in remote communities. Accommodation should be multipurpose and capable of being shared and should not be left underutilised. In time, appropriate local commercial accommodation will become available.

Standards – housing and clinics

It is difficult to maintain cleanliness and hygiene appropriate to health service facilities is in remote communities. It should not be the everyday responsibility of professional clinical staff to do basic cleaning, although they have responsibility for setting the standard. This standard of cleaning needs adequate numbers of cleaners trained to hospital standard.

Maintenance of buildings and equipment is critical to function, particularly maintaining health hardware (plumbing and sanitation etc).

Similarly, accommodation for health care providers in communities soon becomes unacceptable when standards of cleaning, maintenance and furnishing are allowed to decline. Servicing of short term accommodation would prevent deterioration, relieving visiting staff and health care professionals from house-keeping in addition to their health care work.

Uncomfortable comparisons arise when high standard accommodation is provided for visiting or non-permanent staff on communities while local staff live in substandard accommodation in the community. This comparison is even worse if the accommodation is underutilised. The fact that the best accommodation goes to people who are well paid and transient is a cruel irony.

Innovative alternatives might include mobile accommodation which can be moved when it is no longer needed, and an accommodation complex to suit with well maintained sites. The establishment of such a system might be a development opportunity for the community, local government or Indigenous organisation.

These workplace and accommodation standards are serious issues in recruitment and retention of health care providers to work in Sunrise' remote communities. Even though reliance on imported health staff may diminish in time, high standards in the workplace and accommodation must be maintained in the long term.

If the Primary Health Care Team is to be the heart of the community's health service, then all of the members of the team need to be valued. Encouraging leadership by Aboriginal team members, but providing lower standard facilities does not support equal status in the team. The make-up of teams and their relationships are the subject of the next chapter.

CHAPTER 4 THE PRIMARY HEALTH CARE (PHC) TEAM

The PHC team needs to be cohesive, to work as a unit, to be flexible and dynamic, to allow for substitution and delegation and overlapping roles. It is, never-the-less composed of a number of separate professions. Interdisciplinary learning in teams may eventually blur those professional boundaries and individual practitioners may work more on the basis of competence than on some externally imposed classification.

The main members of the primary care teams at present are nurses and AHWs. Doctors are there for variable times and duration. Coordinators and Allied Health Professionals work with the core team to a variable degree from time to time. Of all of these the only really long-term people are AHWs, with an occasional longer term nurse or doctor.

The Cultural Framework includes commitment to the pivotal and central role of Aboriginal Health Workers, and this group will be discussed first. Recognition and registration have in some ways placed a straight jacket around the development of Aboriginal workers in health – a straight jacket of alignment with Western health practice in Western mainstream settings. There is no intention to denigrate the desire for recognition, qualification, or progress. As with other considerations in Sunrise Way, it is the confining Western thinking which is challenged here.

Aboriginal Health Workers

From the beginning of AHW development there has been a 'Rhetoric – Reality gap' between the role of AHWs as cultural brokers and the status and position they hold in the clinic.

In clinics, AHWs' value is measured in clinical terms – by clinicians whom they work with, (doctors and nurses) whose achievements are clinical and whose standards are clinical. Health worker training does not provide a similar level of clinical expertise at registration. Performance is influenced by both being a part of the community and all of its pressures and dysfunction, of sharing the environmental determinants of health which contribute to the conditions they are trying to work with, sharing the health issues with the community they work with, but being expected to be above all of that in their working life. There is often lack of respect clinically, and organisationally. The role is, or becomes, that of clinical assistant to nurses – the bottom rung in a clinical hierarchy. But the most valuable and unique characteristic of AHWs is to know, understand, and live with the complexity of their community. It is also a complexity which cannot be escaped by going home from work, by going on holiday, or by moving on to another job. Further, the lack of respect from clinicians is reflected in lack of respect from the community.

The role which planners and organisations (like Sunrise) have seen as pivotal has been the non-clinical role – the understanding and interpreting of those complexities

of health in Aboriginal communities. This is the Mind-Spirit component of the biopsychosocial model. Most doctors or nurses work in the biomedical model, and few have any knowledge or experience (or training) of how to use a cultural broker. If AHWs are to rise above the limitations of their present position it is essential that doctors and nurses learn to value and use the cultural broker role.

Aboriginal Health Workers are mostly recruited to work in their own community, although there are no constraints on their mobility. There is a shortage of employed AHWs, but there are trained and registered AHWs who have chosen to opt out of employment in health. This often arises from the demands of the job while living in and with the stresses of community life and the personal experience of Aboriginal health. Low status in organisations and the frustrations experienced are also causes.

Sunrise Way calls for more AHWs in every category and more categories for Aboriginal professionals in the Health Service. It has policies to maximise Indigenous employment, particularly in management. AHWs are the long term professionals of Sunrise, who should maintain the continuity in Primary Health Care teams, and engage the community.

All workers in Sunrise Health Service need good health literacy. All AHWs need a basic understanding of the way health services and their component parts operate – clinics, doctors, nurses, consultations, investigations, acute and non-acute treatment; and basic clinical skills. These are not only the badges of office, gained in the two years up to full registration, but are necessary for information to be transmitted between the community and Sunrise, and the health services beyond.

AHW training and expanded career pathways

In communities, registered AHWs work almost exclusively as general clinicians in the clinic. There is some specialisation in such fields as men's health, and some program responsibility in portfolio areas. Further specialisation to Senior or specialist AHW, or Coordinator is often without specific training and often no longer community based. To become an independent practitioner requires transfer to the beginning of nursing or medicine, to re-emerge on the lowest rung of that profession. Some Senior AHWs have progressed to Health Centre management (see Figure 5).

Aboriginal involvement and the Mind-Body-Spirit model will require new and expanded Health Worker roles and articulated courses to meet the vision of Sunrise Way. Some of these possibilities are outlined below.

Communities need clinical AHWs in all generalist areas, progressing to advanced skills in areas such as acute and emergency care, and specialist skills in clinical areas such as men's health and women's health, maternal and child health. Some specialist clinical areas rely on visiting non-indigenous health professionals, including dental, allied health professional, pharmacy etc. Every community could have access to these skills at Senior AHW level if appropriate training and cross-training was available. For example an AHW specialising in ear health would utilise training in audiometry, and an AHW with an interest in trauma would utilise training in physical therapy and rehabilitation. Progression to independent practice is possible

through the long route through nursing to Nurse Practitioner, through medicine to General Practitioner, or through university courses for Allied Health. Having Indigenous doctors in communities is a major goal, but in reality it is a distant goal.

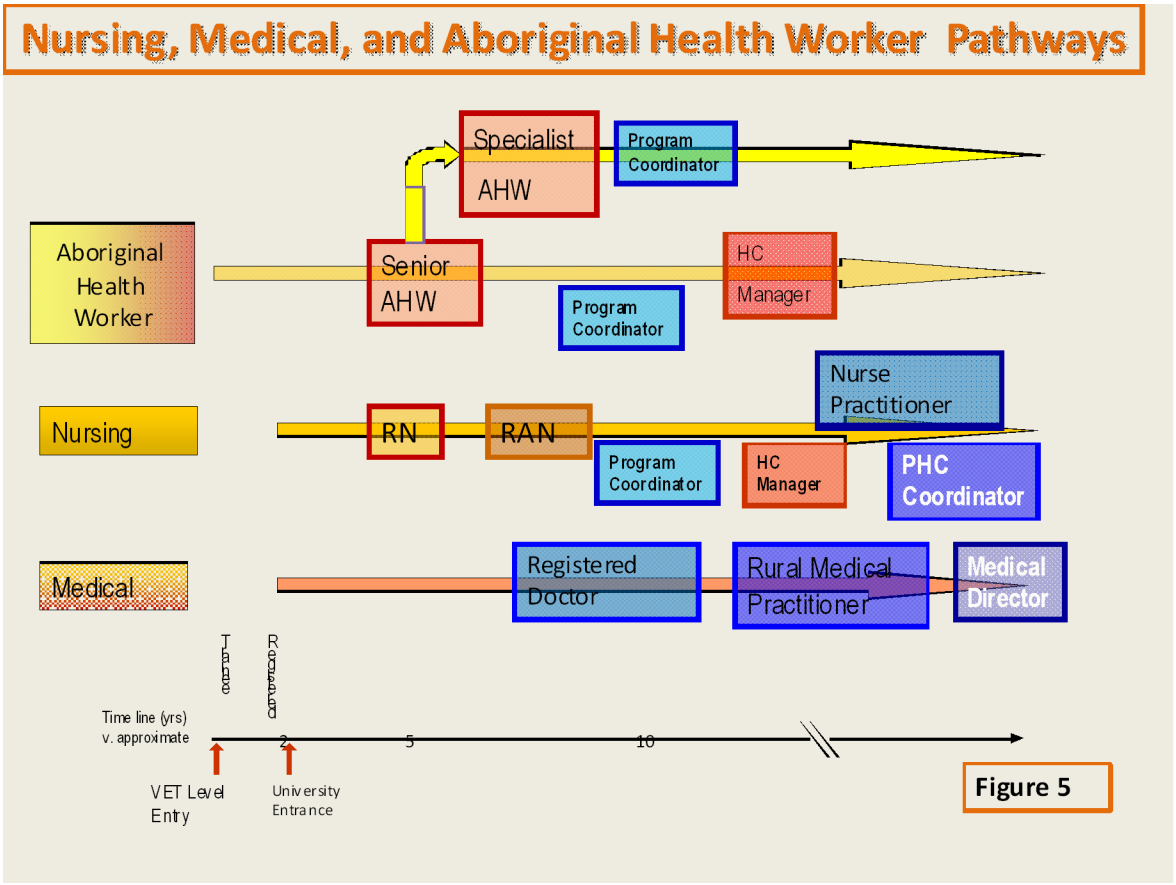

Figure 5.
The timelines are very approximate, but the thrust is that the career choices for Aboriginal Health Workers are limited, and compete directly and not very successfully with nurses. Progression from Senior AHW to RN requires a backwards move to the start of the nursing educational process. There is no pathway for an Aboriginal Health Worker to independent practitioner except through nursing or medicine, both of which are long and academically difficult.

An intermediate position of 'Professional Associate' part way along an articulated pathway for medicine or allied health could bridge the gap between AHW and Indigenous doctor or AHP. These could be practical positions still requiring some degree of supervision for registration. Community based Aboriginal professionals might choose to remain at this level of practice or to complete the articulated pathway to full qualification with unconditional registration to practice in any location.

Substitution (skills normally associated with a higher level of training being performed fully or in part by professionals at a different level of training eg GP for specialist, RAN or AHW for GP – with CARPA) is part of remote care, and likely to be so for a long time. Currently in the Northern Territory (NT), the highest level of substitution available and legally sanctioned is by a Nurse Practitioner, after a long process of specialisation, not all of which is relevant to remote practice. There are very few of these. The Physician Assistant concept is currently being introduced to Australia. A

similar Medical Associate (or other title which Aboriginal health professionals are comfortable with) role might have considerable advantages as a career option for existing AHWs, or for Indigenous high school graduates interested in a career in health. This is the most direct route for Aboriginal people to enter a career in health at a senior level of practice. It presents an opportunity to place Aboriginal professionals in a senior clinical role in communities fairly quickly. The effect that this would have on the dynamics of a non-indigenous dominated health team could be dramatic.

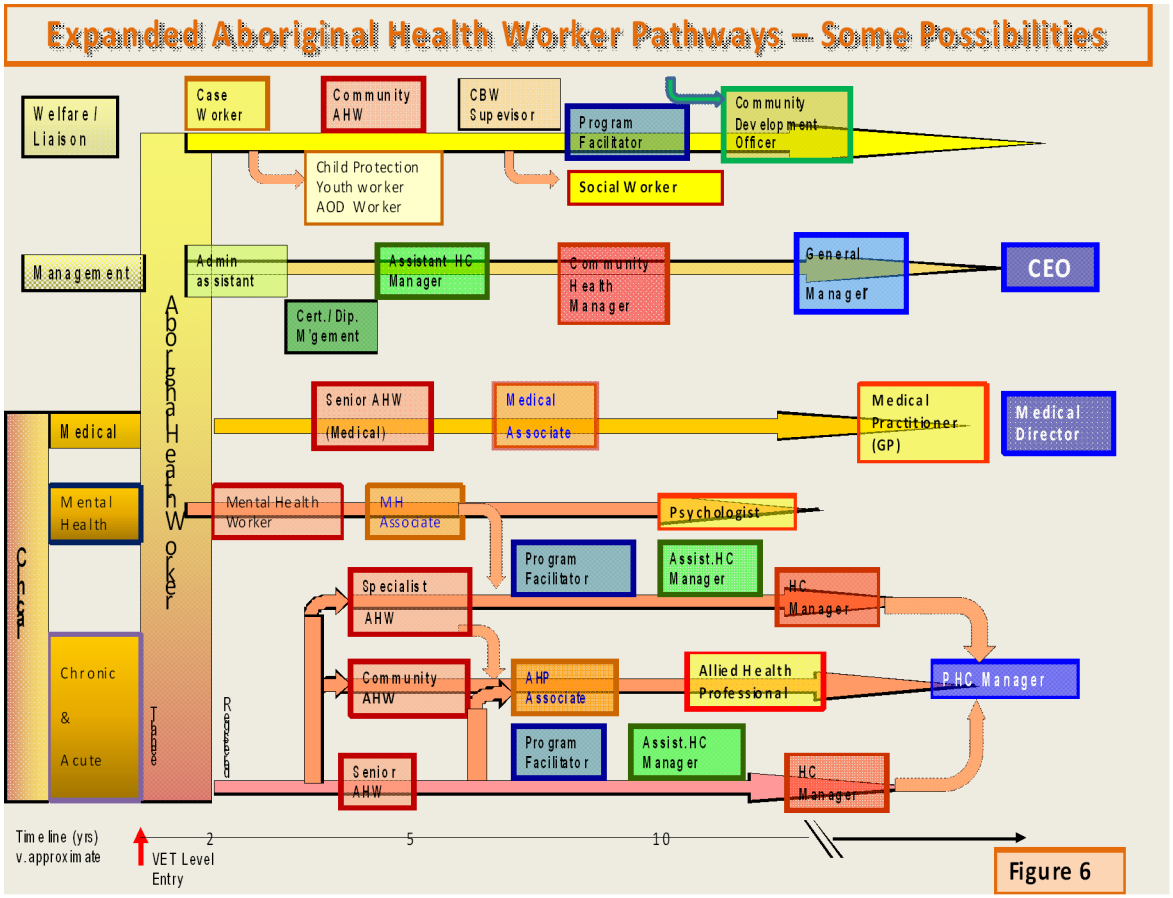

Figure 6

Comparison with Figure 5 timeline indicates that an AHW who trains to the level similar to a Medical Associate can take up that senior clinical role, under supervision, more quickly than through any other process. The development of consultation in the community allows for a further transition for the concept of Health Centre Manager to Community Health Manager, and provides management opportunities for all streams of AHWs to pursue the widest career choices, and to become managers within Sunrise. There are other career opportunities such as educators, team facilitators and HR managers which have not been included in this figure.

As well as clinic-based AHWs, another clinical stream would work predominantly in the community, or between the clinic and the community in areas such as case management, chronic disease management, aged care, physical activity, nutrition, environmental health, early childhood families and parenting, alcohol and other drug

programs, mental health and counselling. Health care taking place in the relevance of the community setting opens the way for AHWs in Sunrise to move beyond the clinic setting, but retain their clinical activity in case management, as cultural broker in the medical consultation, and on the out-of-hours emergency roster. These community positions in particular would be involved with traditional practices and traditional healers and healing places. This stream would extend from Community Based Workers with life experience skills or base-level certificate, up to Senior Health Worker. Progression in this stream would include management roles, project officers, coordinators/facilitators, and community development. Community based activities in early childhood language development fit well with ear health, maternal and child health, and working with families in the community setting. They are an essential first step for the development of language skills for life. The LiTTLe program (Learning to Talk, Talking to Learn) indicates the importance Sunrise places on this community based approach.

Senior AHWs could develop special expertise in specific areas in Allied Health and work with and under supervision of graduate AHPs, in addition to the 'Professional Associate' path in a similar model to the transition from SAHW to Medical Practitioner.

The Mind-Body-Spirit approach to health care includes a major component of mental health. Mental health desperately needs to become part of the work of Sunrise. There are roles for Aboriginal Health Workers in the medical (psychiatric) model, the psychological and wellbeing model, traditional healers, family therapists, counsellors etc. These are all positions which will function almost entirely in the community. They are also difficult positions where kinship can be expected to cause vulnerability for AHWs, dealing with issues such as suicide, grief, depression, violence, and abuse.

A Community Welfare stream would work in the community and in liaison with the clinic services and include child protection, domestic violence protection and amelioration, and other welfare issues in conjunction with justice and other agencies. While this is not necessarily a health worker role, there is a need for basic health skills and good health literacy. This would facilitate the integration of streams in interdisciplinary care, and in interdisciplinary learning.

Additionally, there should be a management stream including receptionist and administration[1], and development positions such as project/program coordinator/manager, Assistant Community Health Centre Manager on to such current management positions as Health Centre Manager, Primary Health Care Manager, General Manager, or CEO. The development of managers for health services needs to be a deliberate and adequately resourced process. Undertrained and inexperienced managers are set up for failure. Establishing assistant manager positions (full-time in larger communities, in conjunction with other duties in the smaller communities) allows this career progression.
(See also Figure 6)

[1] Receptionists and administrative officers need some level of knowledge of the health service structure and function , and should have first aid skills at least. These are career entry points for Trainee AHWs who do not want to continue in the clinical steam (but not for TAHWs who can't make the grade).

Some AHWs have struggled with training and have either dropped out, or been credited with skills they have not really achieved. Rather than persist with unsatisfactory work (thereby further reducing the respect for AHWs) these trainees could be diverted into Community Based Work (CBW), requiring a reduced skill set, but which still utilises their knowledge of the function and structure of the health service. CBW is also a direct line of recruitment for non-academic people with life-experience and life-skills to become involved in the health of the community.

The effectiveness of expanded roles and classifications of AHWs will depend on the effectiveness of the PHC team and the role of AHWs in the team. None of the developments suggested in the roles, responsibilities and status of AHWs will happen spontaneously. They will need to be planned, implemented, and nurtured. Empowerment of AHWs to take on leadership roles needs to be a deliberate process. The changes in relationships between AHWs nurses and doctors (and other non-indigenous people involved in the health and welfare of the community) will be profound. The transfer of power will require careful management, based on a similar deliberate process of learning how to use cultural brokers, and how to work differently in the health care setting. In addition, nurses and doctors will need to be active in the process of skills transfer – teaching, supervising, mentoring, and encouraging, sometimes in areas where they are unfamiliar or have little expertise. These changes need the skills of experts, specifically brought in for this purpose. They are too important to be left to chance, or to people without this experience.

Empowering all AHWs to become team players and leaders should be a prerequisite of the change process - empowered with the courage and confidence in their cultural and community knowledge and its importance to inform or challenge doctors, nurses and other non-indigenous health professionals without having to be asked. Empowerment in these areas does not mean unrealistic clinical confidence. True teamwork requires honest appraisal of strengths and weaknesses. Change also requires doctors and nurses and other health professionals with understanding, appreciation, and techniques for working with AHWs in new roles, and the acknowledgement of those roles. Only when these processes have been implemented can other team building and skills learning be done effectively. Learning the skills of teamwork and team building can only be done with the relevant team in the team's own setting. This process is circular and complex and needs a deliberate and well planned process of change.

The changes in the roles and relationships of nurses and doctors to enable the development of AHWs, and to work in the new structure are considered in the next two sections.

Remote Area Nurses

Remote Area Nurses (RANs) are an integral, essential, and highly valued part of the Primary Health Care team, the management team in communities and in Sunrise, and in the processes around quality assurance. Their roles have a long history and an important place in Aboriginal health. These roles will undergo important changes as Sunrise Way is implemented. These changes will give committed RANs the

opportunity to achieve real satisfaction in remote Aboriginal health outcomes, but the changes will also need to be introduced with care.

Empowering Aboriginal Health Workers will change the dynamics of teams and change the roles of health workers away from predominantly substitute nurses towards cultural brokers, interpreters, advocates, and community agents. The knowledge RANs require of the community in order to be effective will come from their community's AHWs during induction and orientation. The skills to work with AHWs in this extended role will require specific instruction in readiness for the move into the PHC team environment.

RANs use extended nursing skills in acute care, health programs and public health. The peak example of the expanded skill set is the Nurse Practitioner, who will be able to provide autonomous practice in the clinic and Health Centre setting. RANs will have the ongoing important roles of clinic management, data collection, data integrity and quality processes for some time.

However it is in the clinical area that RANs make the greatest contribution now, and will continue to do so, although in modified ways.

Acute care

RANs provide first line acute care in clinics, and at emergencies outside the clinic such as motor vehicle accidents. The paramedic role is part of RAN in-service training, although newly appointed nurses may have not yet acquired those skills. Much of the clinic based acute care is substitution for medical practitioners, where standing orders for routine problems are provided in the form of the CARPA Manuals, and non routine situations are handled by consultation with or referral to a doctor. There is a wide range of competence of RANs (and others!) depending on training, qualifications, experience, and attitude.

The after-hours services provides by Sunrise clinics rely heavily on RANs, and the need to maintain these rosters is one of the reasons for multiple RANs in communities, particularly when senior AHWs are in short supply.

An important consideration for remote health, and Sunrise, is maintaining safe practice when RANs are using an extended skill set, and providing safeguards for the situation when an inexperienced or inadequate RAN is in the position of providing acute care. Induction, orientation, and training programs are important, but so too is teaching and direct supervision of acute care practice.

When there is no doctor on duty or call in the community, acute care practice is guided by the CARPA Manuals, and beyond that by the District Medical Officer (DMO) on call, via telephone consultation. When there is a doctor on duty in the clinic or community, there is probably a medico-legal presumption that the doctor will be involved by supervision, consultation, or referral. The DMO may still be the most appropriate person to provide management advice, with the local doctor's agreement. Should the doctor not agree, the RAN has to consider the need for alternative action on the basis of advocacy for the patient. This should not happen in well established teams with good team work. When providing substituted care RANs

are taking responsibility not just for the acute episode, but for the other requirements of good clinical practice, including documentation, follow up and necessary transmission of pertinent and meaningful patient information.

Sunrise Way may change some areas of nursing practice on communities, but the provision of acute, emergency, and afterhours care will still require the highly professional services which RANs provide.

Program activities and community activities

Most program activities in most Sunrise clinics are organised by RANs. The demands of acute care reduce the ability of clinics to carry out these programs to their full extent. When practice is extended into the community setting, and program coordination is replaced by facilitation around focal points, chronic disease management, surveillance, and public health activity will change from nurse-led towards AHW-led. Community contact and engagement would also become primarily an AHW role.

In most communities portfolio responsibilities also suffer from the day-to-day pressure of the clinic workload. Portfolios are predominantly related to non-acute health care issues, and will be more appropriately managed in the community by AHWs when there are AHWs available for these roles.

Practice style

The principles outlined in Sunrise Way for consultation in the community and in clinics, involving triage and handover, case conferencing of consultations, and joint management will require significant change in the way RANs work. (See chapter 3). Working with doctors at various levels, particularly locums and specialists, will require commitment from RANs to persist with Sunrise' preferred style, and support the commitment to the Cultural Framework.

Teams, leadership, and management

RANs are generally accustomed to taking the management roles in clinics. The emphasis on teams, team building and developing leadership skills of AHWs may be new for RANs. There will be new challenges from being mentors for AHWs as they take on these roles in teams and in management, but also opportunities to achieve the satisfaction of the personal development of AHWs and a new and improved style of community involvement.

Teaching and learning

Although the roles of RANs will evolve with the implementation of Sunrise Way, RANs will continue to have a major role in the health care of communities, as members of Primary Health Care teams, and as important clinicians particularly in acute care. The emerging role of high importance will be that of nurturing AHWs into fuller roles in the team, of preceptorship of newer RANs as they come into teams, of

oversight of clinical and other standards, and of supporting the practical clinical teaching and professional development of RANs and AHWs in the team.

Recruitment, deployment, workforce flexibility

Despite general workforce shortage, nurses continue to be available for recruitment and deployment to remote communities. Whether this situation persists will depend on what incentives are provided for competing areas of shortage in hospitals and aged care. Working and living conditions for RANs on remote communities are often arduous, and less than comfortable. The changing role of RANs with the implementation of Sunrise Way may attract RANs, but it may also alter the feeling of being essential to the health and safety of communities. That new role might not bring the same acceptance of 'doing it hard'.

Remote Medical Practitioners (RMP)

Doctors are an important and powerful professional group in Primary Health Care, but often they are among the visitors rather than the permanent fixtures. The other health professionals who are visitors to communities will be discussed elsewhere.

How Sunrise Way progresses will depend on how doctors accept changes and work within Sunrise to adopt and adapt to new practices. It will depend heavily on the availability of stable, longer term doctors to reduce reliance on short term locums, and allow the changes to become the standard of best practice for Sunrise. Some of these changes are very significant, such as the change from hands-on clinician for all patients to consultant, supervisor, teacher, team member and contributor, and co-clinician for selected cases.

Some members of the community will not be comfortable with these changes in the customary role and image of the doctor. This part of the change process will also need deliberate planning and management.

Qualifications

Skills and Training

A doctor working for Sunrise is working in a remote environment where the full breadth of clinical skills can be expected to be called on at some time, but many of them infrequently. Isolation and communication difficulties mean that timely referral is difficult and specialist advice may be unavailable. Investigations on site are very limited so a doctor needs good clinical skills and acumen. Procedural skills may also not be called on frequently, if at all, but the underpinning knowledge of procedural medicine (obstetrics, anaesthetics, surgery, emergency) will be essential. The closest to appropriate training currently available for these positions is a rural and remote training where the curriculum and assessment have been developed towards these conditions (ACRRM – Australian College of Rural and Remote Medicine). General Practice qualification supplemented by rural and remote qualifications and experience is also reasonably appropriate (FARGP). But specific remote area training (not readily available) and experience is required in how to work with, take direction from, and use effectively the specialised skills and knowledge of Aboriginal Health Workers, and work in a remote Primary Health Care team.

Cross-cultural knowledge / Indigenous health

The Indigenous environment requires the doctor to have a good grounding in the principles of cultural safety, cross cultural practice, and to have experience or specific training in Indigenous health. It is a basic requirement that doctors have empathy with Indigenous people and support their struggle towards good health and the preservation of their culture.

Population health

Sunrise clinical services have been built on a population health approach. Therefore experience or qualifications in Public Health are highly desirable for doctors, with the ability to extract and interpret statistics, and explain them to other staff and the community. An interest in research to further develop Sunrise' programs and directions would be a bonus.

Living

Doctors may live on a community, fly-in fly-out, or drive-in drive-out with overnight stays of one or more nights or on daily basis, may job share, or rotate with other doctors through placements, or be a long or short term locum. The choice depends on the doctor's preference, and those of family. In general terms, Sunrise' preference is in the order given, but flexibility from both Sunrise and doctors is important.

Doctors have a privileged position in communities, and are generally afforded much respect. Boundary issues for doctors are important, but they are not all the same as in more open communities. Cultural mentors should guide doctors between isolation from the community and cultural induction and familiarity. Sunrise' Cultural Framework should be seen as the guide.

Income generation

Doctors have the highest Government (Medicare) earning potential of any of the health professionals in Sunrise. Many of the high end fees are actually designed to enable private practitioners to employ practice staff to prepare patients for medical review. The income generated from these consultations is therefore part of the support of Sunrise staff, and has been calculated into Sunrise' overall revenue. Medicare charging is therefore not discretionary for salaried doctors, but is an important part of their employment. Sunrise does not see or use these processes as revenue cows to be milked, but does need to obtain recompense for medical activity when this is justifiable. In some instances, access to this revenue might be seen as a disincentive to the devolvement of clinical roles to the appropriate level of competence, but this should be a reason to look for other ways of generating Medicare income rather reverting to inappropriate practice.

Consulting

The consultation is regarded as the cornerstone of general practice. In Sunrise' communities, the standard GP consultation may be less appropriate. The principles of the consultation, and the preference for community based (as opposed to clinic

based) health work have been outlined previously. Case conferencing with an Aboriginal Health Worker as interpreter and cultural broker should be normal practice.

Primary Health Care Team

Unlike nurses and AHWs, doctors may have an involvement with a number of PHC teams, short or long term, intermittent or regular. This places each doctor in a different relationship with each team. The principles will be the same but the maturity of development of the team, the length of stay of the doctor, and the needs and size of the community will make each team different. The doctor is often thought of as the clinical leader of the Primary Health Care team, but real teamwork requires that the most appropriate person will lead the team at any given time. Doctors need to be comfortable with this process, and be honest in their self appraisal and self-knowledge. The PHC team in the community (and clinic) is the basic work unit, and team building is an essential part of work. Every doctor must relate to and work with each relevant PHC team. An experienced doctor might be expected to take on a mentoring role within the team, and to act as a role model in the observance of the Cultural Framework. While leadership is not the doctor's given role or right, a lack of leadership or undermining the leadership of others would be seen as inconsistent with Primary Health Care and the Sunrise Way. As with other members of the team, the doctor will participate in the performance management program which will review technical and clinical performance and meeting their training profile. It will also review cultural performance, teamwork, leadership, and community acceptance through a process of peer review.

Learning and teaching

The team needs to learn together in an interdisciplinary environment, and knowledge and skills need to be freely acknowledged and shared. Doctors have certain high-level knowledge and skills which are needed by other team members for the substitution which is essential for clinical coverage, and to release doctors for their consultant and teaching roles. Doctors need to impart that knowledge and those skills. Experience and theoretical knowledge of teaching and assessment and willingness to be involved in practical teaching are therefore important for doctors.

From time to time there will be Vocational Trainees (GP Registrars) in clinics, as well as medical students, and people training in other disciplines. Familiarity with processes of supervision and assessment of registrars and students will be a valuable skill for doctors.

Specialists are expected to teach and pass on skills to the team. Where these skills extend the role of the remote medical practitioner they are both a privilege for the doctor and a benefit for the community, and should be pursued whenever possible.

Doctors will not always have easy access to Continuing Professional Development (CPD), and while this may be in theory the doctor's responsibility, Sunrise will facilitate this process to the best of its ability and resources. However, the remoteness and isolation of Sunrise clinics means that doctors need to make special efforts to remain up to date. Renewal of emergency skills on a regular basis is essential, (minimum three yearly) preferably in the interdisciplinary context of the clinic team. Exchange with other doctors in hospitals, in communicable diseases

units, general practice, or other AMSs (Aboriginal Medical Services) are all appropriate methods of CPD. Opportunities to maintain procedural or specialty skills in hospitals or private practice on either an ongoing or interval basis would fit very well with the philosophy of Sunrise. Involvement in quality activities and research are other aspects of CPD which will benefit both Sunrise and the individual doctor.

Delegation, substitution and responsibility

Substitution by RANs and AHWs for the clinical role of doctors is normal practice in remote medicine when there is no doctor in the community. Distance techniques such as DMOs on call support the on-site staff. Substitution also occurs when doctors are present, and is a great opportunity for reinforcing the skills needed for clinical coverage. In these settings the remote doctor acts as a consultant to the team rather than as the treating practitioner. This is a novel role for primary medical care doctors in this country. At times, the RAN or AHW may have specialised skills in advance of the doctor so that their expertise is appropriate to clinical leadership at the time. However, this does not mean that the doctor does not have an important role in the team process, and the doctor on site bears the medico-legal responsibility so must be kept informed of progress. The doctor also has the responsibility for the standards of referral, for appropriate transfer of patients, for standards of documentation for hospital admissions, for follow-up of specialist advice and hospital discharge, and for advocacy on behalf of the patient when there are problems on the 'patient journey'. Delegation, substitution and working as a consultant will free up the doctor's time for supervision, teaching, specialist consultation, and a range of the important but not urgent activities which often get left undone.

Public Health approach

Public health is both a philosophy and a discipline. There is sometimes a tension between the public health and the curative patient centred roles, with the eventual course being a compromise or balance between the two. The point of balance is dependent on the specific set of circumstances. Sunrise doctors need a public health mind-set and focus for their work. Good clinical acumen is an important component of the compromise.

As a discipline, public health has a set of relevant tools. These include epidemiology, collection and analysis of data, techniques of surveillance, community interventions for outbreaks and conditions of rising or excess prevalence, disease prevention, and environmental health. Acquiring these skills should be part of the training profile of Sunrise doctors. Specialty training in Public Health Medicine is possible in the Sunrise clinical setting.

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In the public health approach the doctor assigned to a clinic or a group of clinics has overall responsibility for the health of the members of the community to which he or she is assigned, those who attend the health service and those who don't. This requires the doctor to be vigilant to health data that come from the community. Where prevalence of important conditions is less than expected compared with other similar settings the doctor should ensure that cases are not being missed. Where prevalence is in excess of expectation or is rising, the doctor should be able to instigate public health investigation or intervention as required and develop and implement a management plan. The doctor whenever necessary should guide the health team in investigation and management of conditions which require special

attention. Doctors take direction from the Medical Director, but should take the initiative within Sunrise' established organisational requirements and activity, procedures and protocols.

The doctor works in the context of a community controlled organization, and there is a health committee in each community as well as members of the Sunrise Board. The doctor has a duty as part of the team to communicate effectively with the committee and the Board member, to help improve health literacy and to participate in the process of building shared knowledge from fusion of traditional and Western health knowledge.

Role of the Remote Medical Practitioner in Sunrise

The role of the doctor in the team and in the organization will change and mature over time, according to the doctor's background, skills, and aptitude. There are a number of stages in that change.

Every doctor commencing work in Sunrise, regardless of previous experience, needs induction to the process of triage, co-consultation and consultant role that have been described here, to the importance and use of cultural brokers, and to cultural awareness. The doctor needs to be prepared to take advice from other team members on how to adapt to to Sunrise' consultation style and way of working. The doctor should be guided through these requirements in Sunrise' clinics by other members of the team.

With more experience, the doctor should become more involved with the team in planning work, in quality improvement, and in responding to public health issues. More attention should be given to teaching and supervising standards of substituted care.

A longer term and experienced doctor should take more responsibility for teaching students and vocational trainees, for public health surveillance and research, and for the ongoing directions and development of PHC teams, and of Sunrise Health Service.

The doctor's role is not static. Each community will be at a different stage of readiness for the mature medical role. An experienced doctor in a new community will tend to work at an earlier stage of maturity, but should progress rapidly through these stages if the community and team are receptive.

Quality

Living in a remote area has certain risks. However, it has been shown that the safety of healthcare in rural areas can be as good as or better than in urban settings. The nature of remote medicine is extremely variable and guidelines may be more appropriate than protocols. Protocols are used to eliminate error, but unlike in major hospitals, the sources of error in remote medicine have not been sufficiently studied. An alternative approach to quality and safety would be to maximise knowledge, skills, flexibility and preparedness. This approach demands ongoing learning by doctors, but also the ability of the team to work as a well trained and integrated unit. Quality processes such as critical incident reviews, morbidity and mortality reviews in

the team and learning in the team setting are therefore an essential part of quality remote health care.

Aerial Medical Service (NTAMS) and District Medical Officers (DMOs)

The relationship of remote clinics to DMOs is one of the most frequent and important of the PHC team's external relationships. The DMO fulfils the consultant role where medical care is delegated and substituted to RANs and AHWs, and where medical evacuation is likely. The DMO is inconstant, at a distance, with little up-to-date knowledge of the community, or of the clinician, or of the patient. The DMO does not have knowledge of how Sunrise operates, or our values. Despite these difficulties DMOs provide a vital service. Recruitment of DMOs is difficult, and the on-call requirement can be onerous. Involvement of DMOs with their own 'patch' is diminishing with the development of more Community Controlled Health Services and employment of community based GPs, and outsourcing of DMO on-call duties.

NT Aerial Medical Service is a retrieval service based on specialist protocols around acute care. It has little of the flexibility required for remote medicine, and is protocol driven to a standard which limits its capacity to consider the social and human needs of patients, or to use generalist medical practitioners to provide a basic service, as remote medicine requires. Even more so than DMOs, NTAMS does not know, and is constrained from recognising Sunrise' values.

Sunrise doctors need to be aware of these limitations and to advocate on behalf of their patients.

The relationships with NTAMS, Department of Health and Families (DHF) and DMOs are explored further in Chapter 9. However the future of this service in Sunrise area of operations will impact significantly on the role of Sunrise doctors.

The difficulty in recruitment of DMOs in the Government sector, the development of community controlled regional hubs, and the values inherent in Aboriginal Medical Services (AMS) indicate that the DMO system cannot remain unchanged. AMSs in the NT have mostly provided an office hours service, and the lack of shift and on-call work has been one of the attractions for recruitment.

Doctors who are best placed to provide the most appropriate level of DMO type consulting service to communities, and to negotiate with the retrieval service are those who know the communities, the staff, and the values. This, and the changes to the DMO system indicate that Sunrise and other Katherine Region health services may need take on some level of out-of-hours and on-call work or that doctors are employed locally specifically for that purpose. A two tier retrieval service (Katherine based Aerial Ambulance for lower priority evacuations and transfers) would limit doctors' role to that similar to current DMOs. This raises recruitment issues, and training standards and experience for participating remote doctors. Sunrise Way's values suggest that these local DMO and retrieval developments be actively pursued and implemented in order to harmonise this crucial aspect of health care with the Sunrise Cultural Framework.

Medical recruitment

Recruitment of doctors is very difficult. Recruitment of doctors who share Sunrise' values and will be prepared to stay is not likely to be any easier, at least in the near future. Appropriate supervisors with commitment to Sunrise' values will be needed to utilise GP Registrars and prevocational placements (PGPPP) of junior doctors, so that Sunrise Way's values are not diluted by the turnover of short term junior doctors.

In remote health there has been a seller's market for doctors for some years and the increase in funding for Indigenous health, and visa restrictions for International Medical Graduates (IMGs) will exacerbate these problems in the short to medium term. Feminisation of the medical workforce, appreciation of life-style balance instead of overbearing vocational commitment, competing salaries and conditions for other remote jurisdictions have all contributed to the shortage of doctors prepared to commit to remote Indigenous health. Many of the available doctors are looking for a high locum fee, a tourist experience, an item on their CV, or a short cut to settling in urban Australia.

Long term solutions include increasing the pool of students and junior doctors who have experience working in Sunrise and have been inspired to return (the Kimberley experience). Sunrise must develop a reputation for challenging but fascinating work, with flexible arrangements and opportunities for academic, research and professional skills enhancement. This will provide opportunities for marketing by word of mouth (which has been the most successful form of advertising in remote health) through avenues which appreciate and target the values Sunrise is looking for.

Short term solutions mean competing with other services. What can Sunrise offer which other services don't? High salaries are not effective in attracting committed doctors, although adequate and comparable remuneration is required. Flexible living and working arrangements are essential. Housing must be of suitable standard, well maintained, and on communities may need to be serviced. Conventional housing is not the only possible consideration, and high class mobile homes may represent a better alternative. The ability to job share, to maintain a home in Katherine and a home on a community, the flexibility to rotate through other employment in Katherine and the NT for respite or skills maintenance, the ability to trade salary for extended leave, part-time community work academic work and research – all of these need to be explored and be on offer without restrictions of a specific set of award conditions. There needs to be some preparation of costs and total packages to allow for marketing and negotiation. Once prepared, a marketing campaign rather than simple advertising will be required.

Doctors are not the only staffing consideration for Sunrise, but they are a key and expensive group in a health service, and one which will need to be enticed from other places for some time to come. In economic terms, high rates of turnover represent a high rate of depreciation of a costly asset. In terms of human and intellectual capital, new staff require costly educational and experiential inputs. Rapid turnover does not allow that investment to mature, and requires repeated new base-level investment.

Other visiting health professionals

Sunrise employs a number of health professionals whose role involves working in a number or all of the communities from a central base in Katherine.

Input from visiting professionals is important for the community, and for health. Involvement with the PHC team is therefore also important. Visiting professionals need to take their cue from the team, from the team's priorities, from the team's ways of doing things. For the coordinators whose work is currently mainly clinic focussed (men's health, women's health and child health) team involvement should not be a problem. Other coordinators such as nutrition, physical activity, environmental health and aged care can do much of their work without involving the clinic, but their involvement as facilitators with the PHC team will be essential.

Health care in the community will increase both the need and opportunity for facilitators and PHC teams to work together, allowing facilitators to become more effective. Developing new roles and courses for AHWs will provide the opportunity for facilitators to be involved in PHC team's local learning and action, to have more capacity for developing skills of all PHC team members in their particular area of expertise, rather than trying to do the job on their own. Further opportunities then arise for facilitators to work together in ways which promote a holistic approach rather than programmatic, and for PHC teams to apply that holistic approach in the community.

There are also other health professionals including medical specialists, dentists, allied health professionals, and regional program coordinators who visit Sunrise communities. (See also Chapter 8). Ideally, these health professionals should work in a similar manner with PHC teams, but while Sunrise can decide how it wants its own employees to work, external visiting professionals are guided by their employing organisations. Sunrise has the choice to negotiate change in the way these visiting professionals work within Sunrise to comply with the Sunrise Way, or to dispense with these services and source them from elsewhere. It is not acceptable continue with services which do not comply with Sunrise Way, and therefore undermine the changes needed for a culturally appropriate health service. The PHC team is the coordinating hub for the health care of each community, but in dealing with services supplied by outside organisations, government and others, it is Sunrise Health Service as an administrative entity which needs to negotiate, or to make those decisions.

These central functions of management, administration, and support of Sunrise Health Service are vital to the coordinated development of Primary Health Care in communities, to the ongoing educational process, and to all of the common functions across the service area. These functions are the subject of the next chapter.

CHAPTER 5 SUNRISE' CENTRAL ROLE

The Katherine office of Sunrise provides the normal corporate functions of policy formulation, management, finance, administration, human resources, data management, reporting, compliance, and representation. It also provides a range of functions related to its service goals. Service is provided in communities at a distance from Katherine in remote sites, so there is also a coordination function which can only be provided centrally. This is seen in Figure 7.

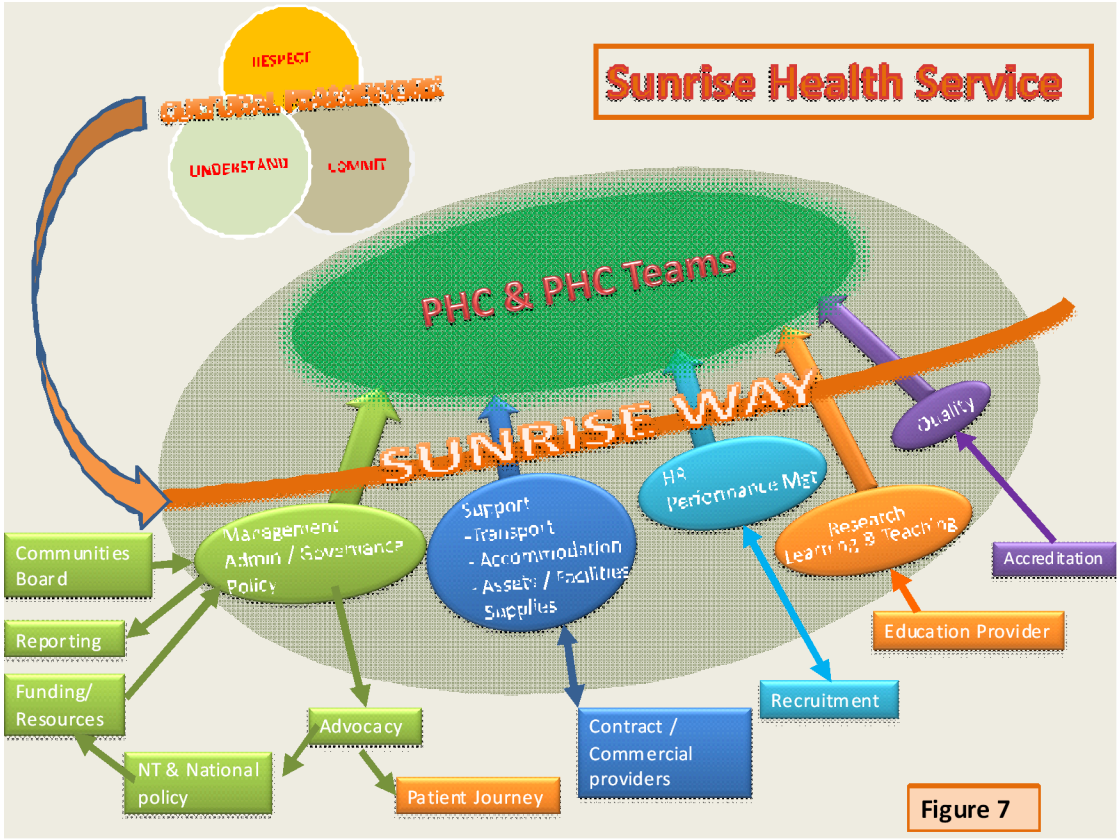

Figure 7
The cultural Framework and Sunrise Way govern the relationships within the organisation centrally, and with the PHC teams.

Corporate functions are predominantly mandated by corporate legal responsibility, and by the terms and conditions of funders. These conditions are difficult to change, but to implement Sunrise Way there has to be an examination of all of these processes to see where there is any room for adjustment towards the Cultural Framework, particularly in policy and human resource management. How Sunrise would want to align externally imposed structures with the Cultural Framework is addressed in Chapter Ten.

Central office staffing

Minimising corporate staff in favour of service provision is important, but there is also a need to ensure that there is a training program for Indigenous people to move into administration and management, and a requirement that non-indigenous employees in this area have cultural mentors to guide the decisions and planning which affect how service is provided.

Supporting the service goals of community health centres and services is therefore an essential role of the central organisation. That support will be counterproductive if it, too, is not aligned with Sunrise Way and the Cultural Framework. Central staff and policies must demonstrate **commitment** to Sunrise Way. It is often easy to forget that policies should include **respect** for individuals and their work needs, and that the coordinating and support functions in the central organisation need to respect the difficulties under which remote staff work. **Understanding** the environmental conditions and belief systems of Aboriginal communities can influence employment policies and practices. The following support areas are not comprehensive, but cover most important service functions.

Support for Primary Health Care

Katherine based staff must support the concepts of Primary Health Care, and the pivotal role of Aboriginal Health Workers if Sunrise Way is to flourish in communities. The Cultural Framework must not simply be given lip service – it must become the credo for all activities.

Community development

The development and support of the Sunrise Board, and their role and duties in the corporate governance of Sunrise has been a successful central function. Implementing Sunrise Way will also call for a major community development effort. Community Development in Aboriginal health is a relatively recent introduction from work in third world countries, where it appears to have had good results. It may not have been as successful in the Australian context, and it is therefore appropriate that introducing Sunrise Way not take community development methods for granted, but look for ways which fit the setting. This may need specific anthropologist expertise. There are many community development and capacity building approaches already going on in communities to the point of development fatigue. People working in the implementation of Sunrise Way will need to work collaboratively with Primary Health Care teams to ensure the right information is given at the right times to match local developments. The level of health literacy in the community will be important for the uptake of new ideas and the ability to express opinion, so the involvement of senior AHWs in the process of community engagement will be important.

Workforce – recruitment and retention, conditions, housing

Implementation of Sunrise Way will depend on recruiting the right type of people, and keeping them with the lowest possible turnover. It is hoped that the concept of Sunrise Way will be its own best selling point, and that it will also attract people who want something more than short term employment. In order to accommodate the right type of applicant, Sunrise needs to have the degree of flexibility which will meet

the needs of professional people willing to give a new approach a go. That flexibility needs to be assured before negotiation with potential recruits. Recruits who are dissatisfied need to be listened to early, before they have had enough and leave. Again flexibility is needed to be able to address those dissatisfactions. This is not a call for a blank cheque, but for extreme flexibility within a capped employment package. High staff turnover means a much higher cost to Sunrise in orientating new staff to positions, in starting from baseline every time to develop the skills needed for working in PHC teams, and the cost of disruption to the implementation of Sunrise Way by the repeated re-entry of professionals with old ideas, attitudes and training which are not aligned with Sunrise Way. Flexibility in employment packages needs to include flexible housing provision and leave etc.

Recruitment and retention of Aboriginal Health Workers and other Aboriginal employees needs to be accelerated to meet the expanded roles and services in Sunrise Way. There is a limit to the number of potential employees available or with the capacity or an interest in health in each local community. There will be a need to attract people from towns to work in communities with which they have a relationship, but this will require the provision of housing. Providing housing for AHWs from outside but not for those from the local community is inequitable, and would be a source of extreme dissatisfaction on communities, and Sunrise will need to address this issue creatively.

Aboriginal employment issues

Maintaining Western standard work schedules in the face of family issues, their own health, and community pressures is one significant issue in Aboriginal employment in Sunrise. This occurs both on communities and in the Katherine office. Unexpected absences in the Katherine office break the support links which are tenuous enough, but vital for the efficient and effective functioning of remote services. Creation of overlapping part time positions may help to ease this problem while creating a larger trained pool of Aboriginal employees. Building this flexibility in to working arrangements would allow Sunrise to emphasise responsibility to the job and to others dependent on their job. This could be helped by having the employee responsible for arranging the cover for their absence. Insisting on compliance with the terms of an EBA is problematic, and without draconian discipline results in a *laissez faire* situation of intermittent attendance.

Learning

Sunrise Way calls for a significant learning component in Primary Health Care, and throughout the organisation. Learning needs to be coordinated and monitored, and this is a central function. Nearly all PHC learning needs to take place in the PHC team setting with teaching teams travelling to communities. This part of the learning process may well be best organised by an external training provider with appropriate local teachers and facilitators or from educational institutions with local knowledge. New roles and new ways of working will require new learning packages, and close collaboration with both education providers and industry regulators. Learning in PHC teams on communities needs to be supported by providing relief staff to accompany teaching teams to quarantine learning time for the whole team without the interruptions of acute care callout. Katherine office needs to specify the content of

learning packages for a range of activities, from acute clinical care to orientation, team building, and implementation of new work practices, from clinic cleaning to housing maintenance and servicing needs. Design and development of learning packages should be done professionally, and include assessment and evaluation.

With an increase in the number of students in the health professions there is increasing opportunity (and pressure) for students and vocational trainees within Sunrise. These students are Sunrise' potential future workforce and should be regarded as an investment opportunity. Coordination of placements in Sunrise communities is a central responsibility, but may be outsourced.

Support

Service coordination

Provision of services to communities requires considerable coordination. Much of this is done by the service providers themselves, and often at the expense of the time available to provide their service. A centralised coordination function within Sunrise (a logistics coordinator) would make more service time available. External service providers (specialists, other health services) also impact on the working arrangements within Sunrise and create inefficiencies and congestion within clinics or on communities. They not only overload Sunrise facilities, but also overload communities with demands for attendance or involvement in activities. Coordination of external services can ensure that teaching is provided to teams in communities, that appropriate Sunrise staff are in attendance to assist, learn, and collaborate on care for the community, and encourage consistent approaches to patient care and education.

Transport

Hand in hand with service coordination is the provision of transport between communities and between them and Katherine. Much useful service time is lost in travelling the distances which are necessary within the remote Sunrise area of coverage. Some coordination will require flexibility of health professionals. This flexibility needs to be negotiated as part of working conditions. Generally, the people who most use transport are Katherine based, so this coordinating function should be centralised.

Accommodation

Accommodation on communities compounds the problems of coordination of services and coordination of transport. Sunrise is unlikely to ever be able to provide sufficient exclusively Sunrise accommodation on the ground to allow for the efficient use of transport, or the effective overlap of professional expertise for Primary Health Care. Creative solutions to on-site accommodation need to be found, and people travelling to communities will have to respect the constraints of remote area living for provision of health service. These solutions may require development and use of caravan park style complexes with mobile accommodation units, with the possibility of tent towns for larger community health related occasions. Accommodation which is exclusive to a particular professional group should perhaps be a thing of the past, but with appropriate alternatives in place. It would be expected that health

professionals who subscribe to Sunrise Way and Sunrise Cultural Framework would have the flexibility to compromise.

Supplies

Everywhere, the supply chain to remote communities is tenuous. It is non-existent to some communities for many months of the year. Supporting supply lines in a timely manner is an essential part of the support of service, and breakdown in supply has perhaps the greatest potential to undermine both the morale and the service on remote communities. Increasing requirements for increasing staff, increased services, and increased learning, will put greater and greater pressure on supply, and create more opportunities for error. The difficulties of remote service provision sometimes lead to errors and lack of timely ordering. Central coordination of supply must continue to live with those problems and provide the maximum security of supply possible as Sunrise Way is implemented, and change is underway.

Facilities

Health facilities on communities (Clinics/Health Centres) will have a less central role when activity becomes more community based, and when the Mind-Spirit aspects of health are addressed in the community. There will be a need for centralised working, learning, and collaborating space for all health workers, and the important acute care function and consultation functions will continue. Bringing facilities into line with these changing needs is a central function. So is providing alternative facilities for community based work. Setting standards for appropriate cleaning and maintenance of facilities is a central function although the work itself may be able to be subcontracted to another employer such as Roper Gulf Shire, or to private enterprise. Sunrise has reason to critically examine the adequacy, location and function of community facilities because they are remnants of a previous health service, built and maintained by an organisation which no longer works in them and has no apparent empathy with Sunrise' changing needs.

Records

The record systems, including patient records, have both central and peripheral components and uses. The requirements of the patient record system are addressed in Chapter 7. The need to support those remote systems is paramount. The record system is an essential tool for the Primary Health Care process. Continuity and speed of access are now requirements of the normal working environment. Maintenance of the system, backup systems, and rapid repair have to be guaranteed. These are central office responsibilities to support the remote communities. Access to the epidemiological data, and to clinical notes for the supervision of standards is required centrally. The clinical record system needs to interface with the corporate system for communication within Sunrise and between Sunrise and external bodies. These internal and external data linkages will become increasingly important as Sunrise Way moves Sunrise into a new era of funding and outcomes reporting.

Advocacy

The PHC team has a responsibility to advocate on behalf of their community, and of individual patients to obtain best care. For patients on a treatment journey from their home community through other health services, the PHC team should retain the responsibility for monitoring their journey, and advocating for their best care. The

Katherine office has a role in monitoring on behalf of the PHC team, and taking up the advocacy when this is necessary. There are other issues affecting the delivery of Primary Health Care on communities which come from policies or actions of external organisations. Katherine office has the responsibility to advocate on behalf of the community in these situations. In particular, Sunrise' role as a culturally competent organisation includes not only maintaining a culturally safe environment, but promoting cultural safety within other organisations.

Quality

Quality systems, including incident reporting and investigation, monitoring against selected criteria, and audit of process and outcomes are important throughout Sunrise. While monitoring and audit can and should be done within each PHC team, central surveillance is part of the overall quality system, and the incident reporting process has an organisation-wide application. Sunrise Way strongly supports the quality process, but full Aboriginal involvement is needed and this may mean significant restructuring of the process based on Aboriginal understanding and process. Quality improvement requires knowledge of Sunrise' performance, the development of action cycles for improvement, with implementation and evaluation. These processes all involve some form of research, and the development of knowledge. The following chapter deals with the processes of learning, teaching, and research.

CHAPTER 6 LEARNING, TEACHING, AND RESEARCH

Sunrise works in a unique environment where most people joining the organisation have to learn new skills and attitudes. Sunrise Way is quite different from the standard approaches to health care in hospitals or mainstream practice. It is also different from much usual practice in Aboriginal Medical Services. It therefore requires both new learning, and the un-learning of previous practice, concepts, and attitudes.

All clinicians have specialised learning in health. All need to maintain skills and knowledge in a world of changing knowledge and practice, and to increase their knowledge to keep pace with new knowledge. Increasing experience alone is not sufficient for career progression in any health Service, including Sunrise. Life-long learning is expected of health professionals, and is needed for professional registration. Learning is therefore core business of health services. Sunrise also expects that its people improve their understanding of the cultural aspects of their work, and that they actively look for ways to improve Sunrise' operations and performance.

Teaching and learning are not confined to the professional or clinical aspects of Sunrise' own employees. Students and professional people extending their skills need the type of experience which Sunrise can give. This is investment in Sunrise' future workforce. There has to be a strong interest, involvement, and advocacy for the development of young people through the education system if Sunrise is to develop clinicians, community developers, workers in welfare, and managers from within Sunrise communities.

Successful outcomes in health are built on partnerships with patients and the community. Without the literacy of health this continues to be a one-sided process of advice taken on trust, and direction. Sunrise therefore has a role of providing learning and teaching for our communities, and the building of shared knowledge and understanding.

Learning organisations

The Learning Organisation is an aspirational concept which involves the whole of the organisation, and leads to people learning so as to meet the shared vision of their organisation (see http://www.infed.org/thinkers/senge.htm). Developing a learning organisation is more difficult than implementing a training plan, but the benefits are likely to be greater and more enduring. One challenge for Sunrise is to ensure that the shared vision and shared learning which are central to a learning organisation truly involve both the Aboriginal and non-indigenous members of the organisation. Another challenge is the turnover of non-indigenous staff, which creates the need for having to start at the beginning again and again, and reduces the capacity to develop the maturity of the process. The continuity exists in the Aboriginal community who

control the organisation, and in the Aboriginal workforce, but the compelling task is to harness this continuity for the growth of Sunrise.

Teaching, Training, and Assessment

As a professional organisation Sunrise needs professional skills in health, management, and community development. These skills need to be up to date. People need tools for work (IT skills etc). Much of this learning can be built in to a training plan which is delivered on a regular basis. Specific training plans or components for specific professional groups can be identified, and specific training plans developed for individuals. The skills which are taught in the training process will mostly be applied in the Primary Health Care team setting, therefore the training should also be provided in that multidisciplinary setting wherever possible. This does not mean that everybody has to take part in all training, but other team members should be aware of what training is being provided. When a team member returns to the team and back to business as usual despite having new skills, it destroys morale and team building, so this should not be part of the training program.

Assessment is an essential part of the teaching and training process. It serves a number of functions. What to teach depends on what the person or team already knows. To know if teaching has been effective requires comparison with prior knowledge at least. Some skills or competencies need to be demonstrated and acknowledged. Assessment does not simply mean exams, and there is a widespread fear of assessment both by learners and by teachers. The Sunrise training plan should aim to change attitudes towards assessment.

Sunrise needs to be sure there are skills, knowledge, and attitudes for cultural safety and cultural competence. The Cultural Framework needs to be part of the shared learning of the organisation. It is essential that people have direct experience of the Aboriginal living context. Some understanding of local language helps develop respect for culture, and reinforces some of the communication issues presented in the Cultural Framework.

Approaches to teaching and learning within Sunrise

There are many teaching and learning opportunities within a service organisation. It is important that all people in the organisation have access to the learning opportunities they need or want. To include Aboriginal people in the learning process, Aboriginal learning styles, cross cultural scientific learning, and the effect of scientism must be taken seriously. Standard teaching methods may be less useful where there is lower competence in the language of learning, need for two way learning, and the need to code switch. This may require alternative methods of learning. The usual in-services and formal approaches may not be suitable for Sunrise. One-on-one mentoring, supervising and preceptorship may be more useful, combined with elements of a training plan, and with learning in teams. Working in teams is the basic approach of Primary Health Care, so learning in teams seems most appropriate.

Some professional development requires record of attendance at presentations and conferences for ongoing professional registration. These are personal obligations for professionals, but there are also obligations on Sunrise to facilitate this.

Sunrise' quality program (Chapter 7) provides many opportunities for learning, not only to use the tools of data and epidemiology, but also to apply those tools to evaluation, and to Primary Health Care practice. This is one form of research. There are more formal and academic types of research and all of them have golden opportunities for learning.

Knowledge which people bring to Sunrise is to be shared through teaching and learning. Withholding knowledge to retain power does not fit with the Cultural Framework. As with traditional knowledge, there is an appropriate time and place to pass knowledge on to others who are ready to take the responsibility of that knowledge. Sharing knowledge involves teachers and learners, and these positions have responsibilities, so the process needs to be taken seriously.

In the workplace Sunrise needs a starting point for the training process, needs to plan for basic competence, and needs to be able to measure progress. The starting point is the skill sets of a professional qualification. Extra training is needed for the skills to work in the remote, Indigenous, Community Controlled Health Service environment. The Sunrise Training Plan should provide those extra skills. Each individual employee should have a training profile which identifies the gap between the skills they have and the skills they need. The training profile should also include the skills and knowledge the employee wants for personal and career development. Some form of assessment is needed to find out what skills a person brings to the job. This may be examination of CV, or references, or review at probation. The performance management process can be used to assess progress towards the Sunrise training goals, and the personal training profile. Cultural competence needs to be a big part of the Sunrise training plan, each individual training profile, and assessment.

Induction and Orientation

These are words which are sometimes used interchangeably, but the concepts are quite different.

Induction is a once only process for new employees at the beginning of their work with Sunrise. It involves familiarisation with the workplace, learning the most important rules and regulations, procedures and protocols (where to find, how to use, must do's and must not do's). It is the time to acquire the basic tools for the job such as how to use the computers, how to arrange transport. It may include an assessment of competencies and developing a training profile. For all non-indigenous health professionals there will need to be specific instruction on how to work effectively with Aboriginal Health Workers, how to take direction, criticism or advice on cultural issues and in relation to knowledge of local and personal issues. Induction is the time to be specific about performance expectations, including compliance with the Cultural Framework, and professional performance on the job. It may be the time to discuss the teaching and learning opportunities in Sunrise. It is the time to be very clear about the expectations of the probation period and of performance assessment. Induction leaves a lot of detail to be covered, and a lot of gaps to be filled in.

The supervisor is formally responsible for these tasks. They will be covered informally by the other team members (either Primary Health Care or central organisation). A preceptor is a work colleague who has been made responsible for the day to day process. Part of this ongoing induction will be a specific program to recognise the specialised skills of AHWs and to work constructively with AHWs. A mentor provides a less formal, nurturing role – a trusted friend and advisor. A cultural mentor is also needed for non-aboriginal and for non-local employees. Cultural induction requires a formal process arranged by the supervisor or preceptor. Both Supervisor and preceptor need to report on the progress of the employee during the probation period and at the end of probation. the employee and mentor need to be comfortable with each other, so selection of a mentor may take time.

The extended induction process should provide a new employee with an understanding of the limitations placed on their professional and cultural activity, and clearly define the clinical privileges and accepted scope of their own practice. The team should encourage working in the team, the recognition of superior skills, and of gaps.

Cultural induction is a formal requirement for Sunrise employees. It should start with the Cultural Framework. Rapport with local community members should begin with a process of 'immersion' in community life in non-work-related activities such as a weekend fishing or hunting trip. A more formal process of introduction to culture and language may have to await the availability of a course. Learning Kriol is not a component of induction.

Orientation (and Reorientation) is a process of building values, of coming to understand why we do what we do, rather than how. Orientation should start with understanding community control, community centred and person centred care, and Primary Health Care. It should provide an overview of Aboriginal health, and the different approaches needed in remote Aboriginal communities. It should explain the different extent and nature of disease, and their environmental and social causes. It should emphasise and teach the public health approach, and what makes remote health different. Orientation includes building cultural safety and competence, and reinforcing the bilingual approach. It includes the empowerment of AHWs and learning to use their special skills. The philosophy and practice of teams, of management, and of managing change should be emphasised along with the culture of learning, and of quality. It should introduce concepts of quality cycles, results, and application.

The first introduction to these concepts might work best in a group of new employees.

Orientation also includes ongoing discussion of these issues. the main place for these discussions should be in teams on communities There may also be opportunities to do this in town, with a group of experienced or longer term staff, but the reality of working in the community will challenge the theoretical teaching of the classroom.

External education providers

(see also Chapter 9)

Learning and training can be provided by Sunrise itself, but much of it will rely on other vocational training or academic providers. Sunrise needs to be in control of this content to make sure it meets the needs of Sunrise staff and communities. This might mean purchasing training, or rejecting free offers if they do not meet needs. Sunrise will develop relationships with a range of institutions to promote and provide learning opportunities and training. These will include VET (Vocational Education and Training) programs, universities and related institutions such as Flinders NT Clinical School, Charles Darwin University (CDU), Centre for Remote Health (CRH), Batchelor Institute of Indigenous Tertiary Education (BIITE), professional and vocational training organisations such as NTGPE (NT General Practice Education), GPNNT (General Practice Network NT), CRANA*plus* , RACGP (Royal Australian College of General Practitioners), ACRRM and AFPHM (Australasian Faculty of Public Health Medicine). Sunrise would use those relationships to advocate for appropriate learning opportunities where appropriate courses are not available, or need to be adapted. Sunrise would advocate for learning to be multidisciplinary, and on the community in teams, either face-to-face or by distance mode.

Vocational training for General Practice has accreditation standards for training sites and supervision. Sunrise needs to decide if compliance with these conditions is cost effective for the benefits they might bring, either in the short or long term; however the vocational training within Sunrise will help build the learning organisation and bring benefits for those not directly involved as long as the team and multidisciplinary approaches are maintained.

Similarly, students from other health disciplines and other institutions will help build the learning culture, involve teaching and learning opportunities, and bring fresh ideas into the teams. Vocational trainees and students who have good experiences will be encouraged to come back to work at Sunrise.

Visiting specialist and specialty teams must provide learning opportunities for staff on Sunrise communities. This may be for teams in the workplace, by distance and IT mode, by reports and follow-up on patient care, reports which not only provide essential clinical information, but reports (notes, letters, discharge summaries) also designed to teach.

Academic and vocational organisations are always looking for placements for students and trainees. This is only going to increase in the future. This gives Sunrise the opportunity to work with these institutions to build strong relationships on Sunrise' terms for the benefit of both Sunrise and the institutions. The students and trainees who experience Sunrise and its programs are potential recruits for the future – recruits who are already familiar with the Sunrise Way.

Sunrise Way and Research

Sunrise is aware of the past abuses of research institutions whereby information about Aboriginal people was collected solely for the purposes of increasing scientific knowledge and enhancing the researcher and research institution. Protecting Sunrise communities from this form of predatory research practice is essential.

At the same time, Sunrise wants to know how best to provide health services for its communities, and what is the best management of health problems. Finding those answers requires some form of research either by trial and error or something more formal. Finding out Aboriginal solutions to problems is a priority area for Sunrise. The process of finding out goes under many names, but all are covered by the broad term 'research'. This includes literature search, reflective practice, evaluation, quality improvement, epidemiological analysis, as well as things like drug trials. The process of finding out will not be intrusive or abusive if it conforms to the Sunrise Cultural Framework.

Much of what is done in Aboriginal health has been taken from Western medicine and management settings, and is based on Western scientific culture. Many of these approaches may be inappropriate, or incorrect. Research may need to be developed or adapted specifically to meet the needs of Sunrise and its communities, as with quality management, consultation style, and health promotion. These culturally appropriate approaches, and the results of finding out, need to be shared with a wider audience. This is part of being a culturally competent organisation.

Sunrise will develop a research agenda of things which need to be found out, and the priority placed on them. This may be done within Sunrise with outside help or in partnership with research and academic institutions. It may become part of student and vocational training activity. It may attract bright inquisitive and committed practitioners to work in Sunrise and help build the learning organisation.

Research is part of the learning organisation, part of the teaching and learning process, and part of quality management. Whatever the process of inquiry, the guiding principle will always be found in the Sunrise Cultural Framework.

Quality and the Learning Organisation

Quality is the reason for accreditation, for the Quality Improvement Cycle. Quality is everybody's responsibility – of individuals, clinician or not, and of the organisation. Partly, it is preventing error, but it is also about the best knowledge, skills, flexibility, and preparedness. Eliminating error can be very restricting – guidelines, protocols, clinical privileging, prohibition, limitation to cut down the possibility of error. This is best suited to the ordered and contained world of hospitals (and airlines, and industrial enterprises). Increasing knowledge, skills, flexibility and preparedness is much less restricting, and better suited to the unpredictable and hugely variable world of remote health. Learning is about increasing knowledge and skills and this will happen best and be best supported in a learning organisation.

Learning and teaching in the community

Health literacy is necessary for individuals and the community to become partners in their health care, and to build a shared knowledge around health. The process of building health literacy should not be restricted to the consulting room or the clinic. There must be an all-of-community approach. Where health is not people's first priority in life, there is no guarantee that the literacy of health will diffuse from parents to children or patients to the wider community. There is little hope of encouraging automatic health promoting behaviour and compliance with treatment without health literacy.

Children's education is limited by health conditions including ear disease, anaemia, chronic infection, and poor nutrition. Sunrise has an obligation to prevent or treat those problems and overcome their effects. The education system in Sunrise communities does not start until these conditions have caused their damage, and does not always consider the effects of these health problems on children's ability to learn. Sunrise does not have the power to change the lack of classroom amplification, a curriculum which is not relevant, nor teaching practice which ignores Aboriginal learning styles and uses a foreign language of education. But Sunrise is a representative of the community, and these issues are health and culturally based, so Sunrise has both a legitimate role and an obligation to advocate for better standards and systems through involvement and advocacy with the education institutions. Sunrise has an obligation to be involved in prevention of early childhood health problems, promoting parenting practice, language readiness, and infant and early childhood practice to give children the best start in life. And Sunrise has an obligation to see that health practices and health teaching in schools relate to these issues and cover them comprehensively.

The outcomes of education are of vital interest to Sunrise for its own sake. Sunrise is committed to Aboriginal Health Workers as the linchpins of the service, and for the majority of Sunrise employees to be Aboriginal. Unless there is a sufficient pool of people with enough education to fill those positions at all levels of the organisation, Sunrise can never achieve its goals.

CHAPTER 7 QUALITY MANAGEMENT

Sunrise' Vision includes being a quality driven organisation. This means that Sunrise must have a clear plan of quality management which includes everybody, and expects everybody to take an active role in the quality process. It will be based on good information and data. There must be a commitment to this plan right from the top. It means that Sunrise must have an organisational culture of quality with a general and genuine desire to achieve the best possible outcomes for communities. This is a product of the Learning Organisation. This will mean that in every aspect of Sunrise' activity people will be looking for quality.

Quality Assurance and Quality Management are relatively recent management concepts in Western society. They have been developed and refined in Western industries including the health industry. They are part of science based thinking. Aboriginal people may not understand or be comfortable with them. Therefore it should not be regarded as automatic or necessarily appropriate to apply these practices and ideas to Sunrise' activities. The quality process must be meaningful in Aboriginal terms if Aboriginal people are to move into the management and senior clinical positions in Sunrise, and if teams and teamwork and leadership are to become the basis of Sunrise' work. Traditional Aboriginal practices are based on evidence – evidence and observation of the seasons, the times to hunt and to fish, the child rearing and kinship practices for example. Sunrise has the opportunity to build shared knowledge on how evidence plays its part in developing best practice.

Accreditation

Accreditation is the formal processes of quality management and is regarded as an essential benchmark for a health service. The need for accreditation is driven by incentives (payment available if accreditation is present, availability of subsidised professional staff) and sanctions for non-compliance (exclusion from major program funding). Generally these are Government funded incentives, and are designed for the mainstream community. They were not designed with remote, or Indigenous, or Community Controlled health services in mind. Sunrise has no short term option but to go along with these processes if it is to gain access to the funding opportunities and other advantages. But Sunrise must find ways to adapt these processes to local needs and to harmonise with Sunrise Way so that in the longer term Sunrise has the knowledge and experience to influence these processes.

There are three levels of accreditation which Sunrise is currently engaged in or contemplating:

- Accreditation of health clinics and medical practices through AGPAL (Australian General Practice Accreditation Limited) or GPA (General Practice Accreditation) for access to a range of Practice Incentive Payments (PIPs) and ability to conduct certain types of practice (including mental health teams) and raise certain charges for services.
- Accreditation by training authorities (Australian General Practice Training – AGPT) and medical colleges (RACGP, ACRRM) of clinics and medical

practices and supervisors/trainers (doctors) for vocational training for general practice and rural medical practice, and for attachment of junior doctors for community based experience (PGPPP). All of these provide junior medical workforce to health service or practices at either no cost, or with very heavy subsidy. (*Accreditation for other disciplines has not been explored*)

(In both of these settings, the criteria for accreditation are based on conventional General Practice which has been argued (Chapter 3) as being an inappropriate style of medical practice for Sunrise communities, and which does not recognise the necessity for and desirability of culturally appropriate delegated or substituted professional care.)

- Organisational accreditation through EQuIP (Evaluation and Quality Improvement Program) (ACHS – Australian Council on Healthcare Standards) or QIC (Quality Improvement Council). These are more specific to the organisation than the clinical activity, although some organisational criteria are included in AGPAL accreditation. The Office of Aboriginal and Torres Strait islander Health of DoHA (OATSIH) is encouraging modification of these accreditation standards to be more applicable to ACCHSs. Experience so far suggests that the changes under consideration would not satisfy Sunrise Way.

Other external quality and reporting frameworks

Statutory Reporting Frameworks

Sunrise and all other health services funded through OATSIH, are required to report against a range of standards. These cover management structures and governance, financial outcomes, program outcomes (process), and health outcomes. This reporting is tied to ongoing funding, and appears to be more about compliance and accountability than quality of service or outcomes for communities. Sunrise could use these reports for its own internal quality processes. The Aboriginal Health Forum (AHF), comprising OATSIH, NT Dept of Health and Families (DHF) and AMSANT (Aboriginal Medical Services Alliance Northern Territory) developed Key Performance Indicators (KPIs) for common reporting. They do not necessarily harmonise with the Sunrise Cultural Framework and Sunrise Way.

To a large extent this collaborative process was overtaken by the externally imposed reporting requirement and KPIs of the NTER (Northern Territory National Emergency Response – 'The Intervention'), the complete antithesis of Primary Health Care and the Community Controlled philosophy.

Further reporting requirements relate to other funding sources. The most elaborate of these is the federally funded Healthy for Life (H4L) program, which has another range of process and clinical reporting criteria. The program is competitive, and well funded, but comes with an extensive reporting requirement. If covers only certain areas of activity, and is a prime example of Selective Primary Health Care.

Salvaging Sunrise control of the monitoring of the quality of its performance from these processes creates a major challenge.

ABCDE (Audit and Best Practice for Chronic Disease Extension - MSHR) is a formal external quality audit of clinical activity to which Sunrise subscribes for only one clinic. It is unlikely to be able to be adapted for an individual service or community, although the methodology might be sound. What place it has in Sunrise Way is therefore yet to be determined.

In house and informal quality programs

Performance Management

Sunrise Health Service' performance is only as good as the performance of its people. It is possible to adapt the Performance Management program from an administrative function tied to minimum standards against technical job criteria into the centrepiece of quality attainment for the service. It can be transformed from a measure of technical adequacy to a measure of excellence. It can support the learning organisation, and provide the platform for continually reinforcing and keeping alive the Cultural Framework and the Sunrise Way. The addition of anonymous peer review allows attitudes and cultural sensitivity to be positively examined and developed. The application of this same process to external service providers (clinicians including specialists – see also Chapter 8) gives Sunrise a tool for both examining and improving the service to our communities, and for promoting Sunrise' standards to the wider community. (See also Chapter 10)

Collaboratives

This program is available to practices and services to help clinicians to identify areas for reflection within their work, offers assistance with identifying and collecting relevant data, and with analysis and interpretation. It also provides benchmarking of that practice's activity or outcomes against a group of similar practices. While this is essentially a Western quality process, it is a suitable and established vehicle for team based reflective practice, and should be considered as a possible starting point for Primary Health Care teams to become engaged with the quality cycle in their own setting.

Sunrise needs criteria for its organisational performance in terms of its own mission and vision. Sunrise Way could contribute to internal evaluation. Sunrise' could then measure its own cultural competence in its overall achievement in promoting cultural safety and awareness within its operations, and in advocating and spreading its principles and experience more widely.

Data recording, management, retrieval and utilisation

An efficient, user friendly, reliable computer system is an essential tool for quality management. It must be able to record useful data, and encourage its recording through simplicity of function. Data must be able to be accessed and retrieved reliably and where it is needed (in the community) in a form which is both reliable without and able to be understood by all members of the team. The use of this data,

quickly and locally, should then generate shared knowledge within the Primary Health Care team, and subsequently the community whose data it is[2].

The computer system must be able to record clinical information reliably and simply to support high quality patient care, interface easily with patient care systems used by other institutions providing health care for Sunrise people, and provide reliable and simple internal and external communication and access to educational and reference material.

Secondarily, the data then must be able to fulfil Sunrise' quality program (including accreditation) and the medico-legal requirements of information storage.

Thirdly, the system needs to be able to provide clean data reliably and simply to comply with the necessary reporting requirements. A program which makes this use more important than community ownership and Primary Health Care use is not in harmony with Sunrise Cultural Framework and The Sunrise Way.

Internal monitoring and Performance Indicators

There are many aspects of quality within Sunrise which can be monitored, continuously or from time to time, to improve outcomes for health and for the welfare and wellbeing of the communities and their members. Clinical issues can be approached through morbidity and mortality meetings with the team, clinical audits and incident and near miss reporting. How much quality activity depends on available resources and balance. Emphasis on quality activities when health care is deficient through lack of resources is a hollow exercise.

Quality monitoring can include the activities and attitudes of visiting specialists and specialty groups, and aspects of external institutions' care of Sunrise people to ensure that people from Sunrise communities receive the best available care, in keeping with Sunrise Cultural Framework. Sunrise as a Primary Health Care provider has the responsibility to advocate for that quality of care and resourcing. Monitoring of these processes requires the development of Performance Indicators which can be reported on from within the data being collected, and for the collection of additional data where this is considered necessary and feasible.

The role of learning and teaching, research, induction, and orientation in quality

These have been covered more fully in Chapter 6. The point to be made here is that these are all activities which are essential to the quality of Sunrise as an organisation and its performance.

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[2] Community control of its own data is an important issue. Government uses data collected about communities to justify bids for funds, but in the process paints communities as in need because of inferior health, inferior environments, inferior living conditions, inferior education etc. The communities and their people are characterised as inferior. If the community were to exert control over their own data, they might be empowered to characterise themselves as disadvantaged, left out of an equitable share of resources, and disenfranchised, but not inferior.

People within a learning organisation try to fulfil its vision. Sunrise' vision is quality driven. Those people will search out what they and the organisation need to know to improve performance and outcomes. The organisation and the people within it will want to share their knowledge and help others to learn. This is teaching.

They will want to find the best ways of achieving good outcomes. This is research.

People who join Sunrise should know that quality and competence are among the important values, and that it is expected that they will be given the best possible opportunities to achieve those values, starting with a clear introduction to their workplace, and the tools to do their job. This is induction.

People working within Sunrise will be given a deep understanding of what it means to work in a quality-oriented community controlled service providing best care within remote Aboriginal communities. This is not a simple task, and requires time, patience, self-awareness, and commitment. It is not an instant or one-off process. It is ongoing through the duration of connection with Sunrise. This is orientation.

SECTION 2

Relating to external services and agencies

Section One approached Sunrise Way free from thoughts of funding and program control. It presumed that Sunrise' had obligation-free funds available to build an Aboriginal Primary Health Service as Sunrise wants. The reality is that none of this will happen without the cooperation, collaboration and support of the services, organisations, institutions, funders and policy makers who form the environment in which Sunrise exists. Section 2 deals with how Sunrise uses external clinical services, and tries to align them with Sunrise Way. It deals with how the external environment can be influenced through cooperation and collaboration to recognise and support Sunrise Way. It deals with important allies and influence which Sunrise will need in this process, where funds for Sunrise Way might come from, and how those funds might be justified.

CHAPTER 8 SPECIALIST SERVICES, AND SPECIALISED SERVICES

Many services on Sunrise communities are provided by health professionals not employed by Sunrise. These services include direct clinical care to patients, consultation and management advice, diagnostic, and educational services. Some provide assistive devices such as hearing aids and glasses. There are services providing screening for specific diseases. Some are narrow and sectional, others have a broad community focus. All have a firm view of the importance of their own service, often to the exclusion of others. The very fact that these are specialised services makes them difficult for the PHC team to resist or ignore. Often the service is wanted, but not the insensitivity with which it is provided.

For Sunrise to work in the best interests of the health of its communities, the relationship with these service providers should move from one of passive receipt of externally planned and delivered services, to services delivered according to the needs and sensitivities of the Sunrise communities.

Specialist Outreach

There are a number of specialist services to communities. They do not cover all sub-specialties. Some are provided at the request of Sunrise, others are provided according to the specialists' understanding of need, or their availability. Almost all of these services are provided in the style which the specialist dictates. Sunrise accepts these services with gratitude, and generally without question.

Sunrise aims to increase the effective specialist input to its health care in remote communities. This will have a number of benefits. Patients will have less need for travel away from home for specialist consultation, and are more likely to receive regular specialist care when this is necessary. Continuity and quality of care following community based consultation will improve, as will individual and community outcomes. There will be better servicing of communities, more recognition of unmet need and strategies developed to meet those needs. Management decisions will be influenced by knowledge of the local community and living environment. There will be benefits for remote clinics, with fewer travel arrangements to make, with more learning opportunities for clinical staff, and transfer of important clinical skills. It is more cost effective for a specialist travel to travel to the community than transport a number of patients to the specialist and improves attendance rates. It provides learning experiences for specialists which translate into better patient management in hospitals. Specialists generally enjoy this type of practice, and derive significant job satisfaction.

Specialist surgeon Prof. Phil Carson wrote to visiting or new specialists in 2002, "Providing specialist services in the context of remote community visits requires a different philosophy, approach and innovation if specialist expertise is going to be most efficiently used and widely distributed. To maximise the availability of expertise

involves a substantially different model than that commonly practiced in major urban centres which focuses on individual patient care by a continuously available specialist workforce."

Specialists providing community based care, familiar with and committed to the Sunrise Way principles will recognise the needs and autonomy of patients, and will understand Sunrise' community controlled structure and governance. Specialists will be able to see patients together with local health staff so that social background and communication barriers are recognised and considered in management. The burdens of travel and dislocation which hospital based care imposes on the patient and their family will be considered in the cycle of consultation and review. The patient's primary health care team will be involved in more than arranging transport, providing referrals and signing patient travel (PATS – Patient Assisted Travel Scheme) forms. Discharged patients specifically needing specialist review and follow up may be able to be seen in the community by an appropriate generalist specialist or speciality team. Ongoing patient management will include effective reference to the local health care providers, so there is local input or update, and appropriate workup for review. Specialised problems like End Stage Renal Failure and severe Rheumatic Heart Disease will be managed in the context of the patient's community. The patient's other problems are more likely to be fully considered when tertiary level management cannot be avoided.

The specialist centred current model of care is illustrated in Figure 8 and the main features of patient and primary health centred care are represented in Figure 9.

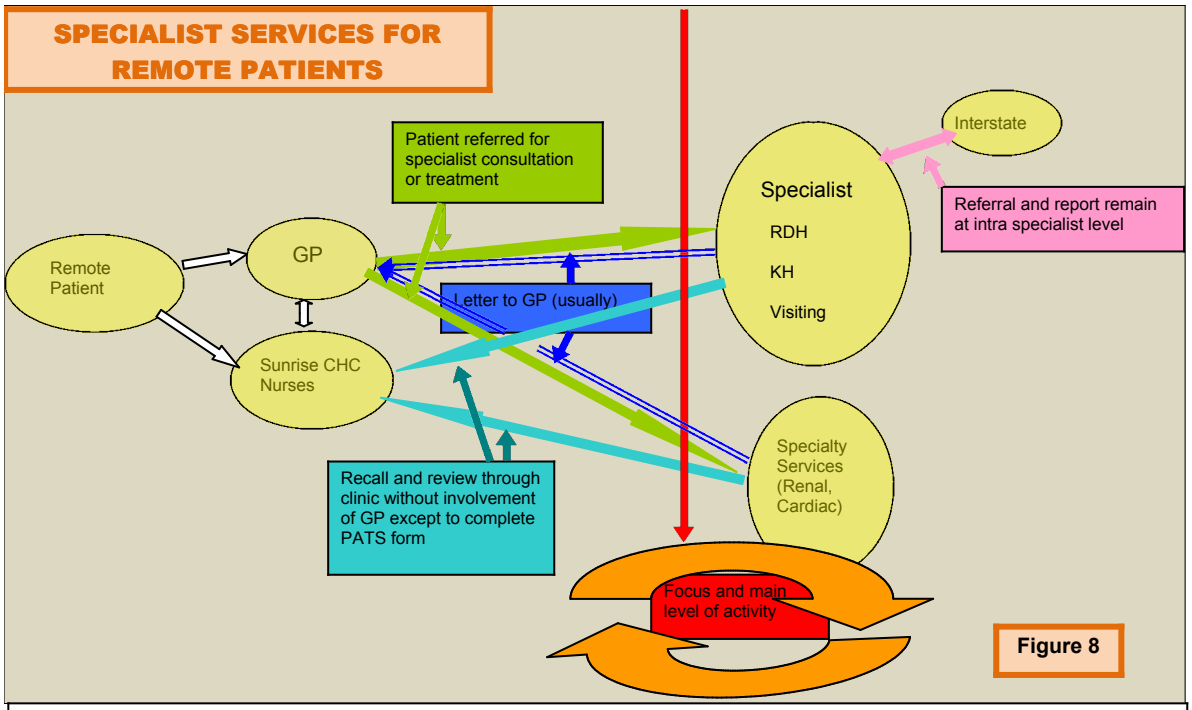

Figure 8
Current specialist services to remote communities are organised by specialists and specialist services according to their view of the needs of communities and patients, and managed according to their specialty view. The communication systems are often circuitous, and are specialist centred rather than patient centred.

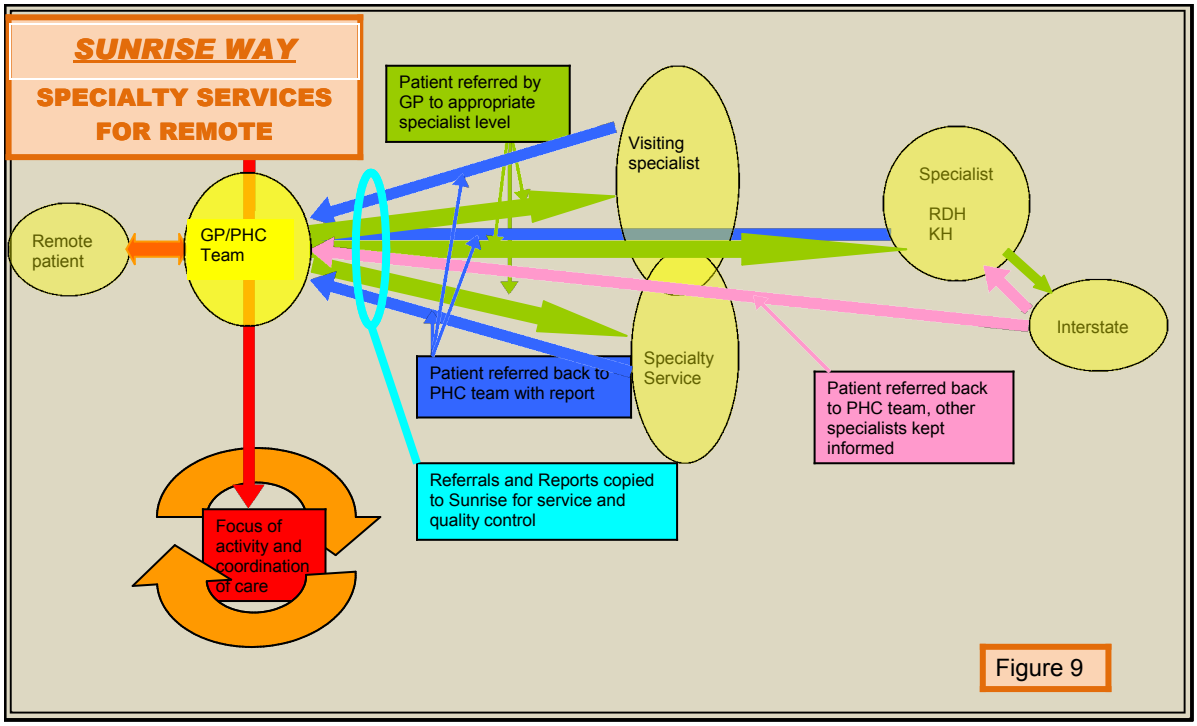

Figure 9
In Sunrise Way the focus of activity and coordination of care moves to the Primary Health Care team, and specialist and specialty services provide the type and level of service which the community and patients need in cooperation and consultation with the PHC team who take the responsibility for the health and well being of their community.

Sunrise wants specialist services which are in harmony with the Cultural Framework, and with Sunrise' community controlled structure and governance. This will involve a change for specialists, PHC teams, and for communities. Before a specialist agrees to provide a service to Sunrise communities there should be commitment to these principles. In Chapter Nine the application of these principles to specialist care in hospitals is also discussed.

Obligations and responsibilities

There are obligations and responsibilities which fall on all service providers in this framework.

For Sunrise:

Sunrise should support specialists in every way possible to provide the level of service the specialist has agreed to supply. This may include providing ground transport, acceptable accommodation, adequate and appropriate support staff, coordination and transport of patients, and computer access. Sunrise should support the teaching and learning process and provide reasonable technical support; should

provide statistical information and access to review specialty outcomes; and should involve specialists in the planning process in their specialty areas.
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For specialists:

Sunrise Health Service should invite Specialists to provide a service to a designated community or communities according to an agreed schedule of visits. All arrangements for delivery of services should be coordinated through Sunrise office in Katherine. The patients are members of communities served by a health service which is controlled by those communities. Patients belong to their community, not to the specialist or the specialist's affiliated organisation.
The Primary Health Care team are the specialists in management of patients in the community setting. Patients remain in the care of the PHC team or return to the care of the team. Specialists should work with the PHC team, including the community's doctor. Specialists see patients and their communities infrequently, so have limited knowledge of their environment and cultural issues. AHWs are an essential member of the consultation team in this context. A specialist may advise review or referral, but the PHC team may have good reason not to comply with that advice. The specialist should provide expert advice as a consultant to the team. For example, an explanation should be given to the treating doctor when the specialist changes a patient's treatment. This should happen in consultations, in the patient's record, in letters, reports and in discharge summaries. Every opportunity should be taken to teach as well as inform. Specialist reports, or at least preliminary notes, should be entered directly into patients' computer records. Reports should be timely, and in electronic format to go straight into the clinical record. Referral should give the specialist enough information to make a preliminary assessment of investigations needed before a community visit. This assumes that the referral will be read by the specialist when it arrives, that it is acknowledged and there is a response.

When a specialist agrees to provide to a service to a community this should include being accessible for consultation and advice by phone or e-mail, or scheduled case conference. In some cases a teleconference might be a better option than referral letters and reports.

If at all possible, patients should have their specialist services in their own community. When specialist reviews are necessary, they should be done by a visiting generalist or specialist from a related discipline if this will reduce the need for travel and review outside the community. Chart reviews, PHC doctor reviews, case conferences, or other forms of distance technology may all be used to give appropriate specialist input. Portable technology should be used wherever possible to remove the need for patent travel.

PHC team obligations

If possible, the community's usual doctor should generate specialist referrals. There should be a genuine need assistance with diagnosis and management, and advice beyond the expertise which is locally available. The referral should give the specialist enough information to be able to outline initial investigation and treatment before seeing the patient.

Preparation for specialist visits should make the most efficient use of specialist time, and provide consistent support by AHWs and other staff. Patients should be appropriately prepared and worked up. There should be quarantined teaching time for the team. Patients for specialist review should have had a preliminary medical review of some sort to see if the review is still necessary or if the patient's problems have changed significantly and require further investigation.

The PHC team is responsible for following up specialist advice and recommendations, but compliance with advice is not mandatory when local considerations warrant otherwise. However when a decision is made to vary from the specialist advice, this should be documented. Overall compliance with specialist advice should be part of the internal review and monitoring of PHC clinical performance.

Changes in specialist work practices

There will be changes for specialists to work in these ways, for the terms of their contracts with their tertiary level institutions, and for methods of payment. These changes are suggested but not detailed in Prof. Carson's letter. The consultant role requires time and availability for their remote patients and PHC teams in addition to community visits, similar to the relationship between consultant and registrar in the hospital. Specialists will need to become familiar and comfortable with working in a team and making use of the local, social, and community knowledge of the PHC team, particularly AHWs in the consultation and management processes. This consultation process should be run as a case conference, as described for the remote doctor (Chapter 4). New thinking may be required not only for specialists but also for their specialist colleges for conducting patient reviews as chart reviews, PHC doctor reviews, delegated reviews by other specialists, case conferences, or using other forms of distance technology. Dealing with referrals by providing preliminary advice on investigation and workup is not unfamiliar practice for specialists working with registrars in teaching hospitals, and for some interstate specialists in private practice, but extending this to the remote community setting would be new. Some of these specialist-rural doctor relationships are already seen in Australian rural practice where a high level of personal communication develops between a regional specialist and a rural private practitioner on an informal basis over time. The Sunrise environment should not rely on the chance development of informal networks, but needs this to be systematic and to become the expected and agreed practice.

Expanded specialist roles

The teaching role for specialists is not a new concept, but the demands of the consulting role have left little time for teaching. However there would be fewer referrals, and those would be better presented and worked up if there were more teaching done, and the changes outlined in this chapter were implemented. It is appropriate for visiting specialists to have an active interdisciplinary teaching role with the team. This may include skills transfer and procedural skills training. It may also include advice or supervision of research projects relevant to their discipline.

A specialty service for their communities of interest is a natural progression from specialist visits. A specialty service includes taking responsibility for the quality of

service in that discipline for a community or group of communities. The specialist should be aware of the epidemiology within their discipline, and by comparison with aggregated data, be aware of the level of unmet need (undiagnosed, untreated, referred but not attended). The specialist should monitor or the outcomes of management of episodes of disease or take part in PHC team audits. Chronic diseases which are relevant to their discipline should be monitored. Outcomes which are not as good as expected should lead to teaching for the team or individual clinicians where indicated.

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Specialist should be involved in performance management for the PHC teams they advise, particularly the multi-source feedback (MSF) or peer review component. This will help to highlight learning needs. Appraisal of specialists' performance on teamwork, cultural awareness, and patient satisfaction is also important for the quality of the service..

Specialist workforce implications.

This level of service would appear to demand more specialists than are available. However, the increase in teaching, the distance consultation and pre-visit work-up of referred and review patients improve the efficiency and effectiveness of specialist visits. The specialist's teaching role would be repetitive given high turnover of staff, but more teaching might reduce staff turnover particularly when Sunrise develops towards becoming a learning organisation, and is resourced to fulfil the learning needs. There is little difference from teaching registrars and junior doctors in teaching hospitals.

The specialist's team

Specialists are often accompanied by their registrars as part of the registrar's training. Training in rural and remote service delivery and cultural awareness is important for registrars, and they need to understand and learn the consultant role in this setting. Specialist care on remote communities this should be high quality care delivered or directly supervised by specialists who are experienced in the care of Indigenous patients in their community setting. That care is part of the agreement between Sunrise and the individual specialist, so a registrar should not provide care for patients unless supervised by that specialist, and agreed by Sunrise.

Some specialists request that their nursing support accompany them on community visits to make the visits run smoothly and more efficiently by trying to transplant the hospital based consulting process into the remote clinic. It would be preferable for accompanying staff to take the opportunity to learn how to work in the PHC team. They could release PHC team members to give input to the specialist, and to learn from the specialist in the consultation.

There are sometimes accompanying Allied Health Professionals such as audiologists, sonographers, optometrists, or other therapists included in specialist visits. The consultation process for these should follow the format of Sunrise Way consultations, and use AHWs to ensure appropriate cultural approaches, and to facilitate communication.

Locally based specialists.

At this time, Mental Health is the only discipline with a specialist who is resident in Katherine and servicing the area. The possibility of a Katherine Hospital based community physician, paediatrician, or emergency physician has been canvassed in the past. Regional specialists jointly supported by Aboriginal Medical Services present another possibility worth consideration. Whoever employs the specialists, their involvement with Sunrise communities should comply with Sunrise Way and the recommendations set out above.

Dental services are provided on a visiting basis from Katherine, or interstate. These services should also take the opportunity to train Aboriginal dental therapists, and chairside assistants who can also provide the cultural input to improve communication and management. In the past there was specific training for AHWs as dental health workers. This is another opportunity for Sunrise to improve the health of its communities while broadening the scope of AHW training and employment.

Visiting Allied Health Professionals (AHP).

Individual AHPs and AHP teams from different disciplines travel to Sunrise communities. These include audiologists, audiometrists, physiotherapists, occupational therapists, speech pathologists, early intervention teams, aged care assessment teams, psychologists, and dental therapists. They come from DHF, NGOs, and through other Katherine and Darwin based Primary Health organisations. These services should also support the principles of working through AHWs and interdisciplinary teaching.

Katherine ACCHSs jointly employ Regional Coordinators in renal disease, eye health, and sexual health to provide services throughout the region, including to Sunrise communities. These arrangements should be upgraded so that the principles of Sunrise Way and the Sunrise Cultural Framework are included.

Conclusion

This chapter has considered the services delivered by outside health professionals on Sunrise communities. A framework has been set out so that those services provide maximum benefit for the health of Sunrise people and for the standard of care provided by Sunrise itself. The next chapter looks at how the health care can be improved and made more culturally acceptable for people when they are away from Sunrise communities, or on a health journey beyond Sunrise' area of control.

CHAPTER 9 CLINICAL AND OPERATIONAL RELATIONSHIPS

The hierarchical relationship with external services disempowers Primary Health Care. Sunrise does not have direct control over external services provided for Sunrise communities and community members. Cooperative networks instead of hierarchies empower the PHC team to use their coordinating role on behalf of their community and to advocate for best care for community members. Sunrise and the PHC team have a duty to be watchful and to intercede on behalf of community members while they are in the hands of other services, and to follow up on inadequate services provided to community members. Sunrise will be able to promote care in keeping with the Cultural Framework where cooperative and collaborative clinical and operational networks have been established.

DMOs and NTAMS

District Medical Officers (DMOs), and the NT Aerial Medical Service (NTAMS) are routinely consulted by RANs and AHWs for advice when there is no doctor in the community, and when there is a need for medical evacuation. Sunrise doctors also consult DMOs in similar circumstances. DMOs, NTAMS and retrieval are now centralised in Darwin.

DMOs have less and less direct knowledge of Sunrise communities, of the local staff and their competencies, and of local conditions and sensitivities. Their responses are protocol driven. Many of these protocols arise from Emergency Departments and Emergency Physicians who have no direct experience of remote conditions. This may be a safe approach, but it can be over-cautious, and can be very disruptive to the lives and welfare of people on communities.

Patients are generally retrieved by planes staffed with flight nurses with specialised knowledge in aviation medicine, and with the addition of retrieval medical teams with expertise appropriate to the nature of the patient's problem. The flight nurses may be familiar with the geography and airstrips of many Sunrise communities but some of the retrieval medical teams will have no such knowledge. This chain of PHC team, DMO, retrieval team creates a number of points where misinformation and miscommunication can occur, and where patient centred care is replaced by protocol driven care.

DMO recruitment difficulty has lead to outsourcing of DMO duties to interstate doctors, and even doctors overseas. Higher levels of equipment technology on planes requires increasingly technically trained operators, whether or not there is any need for that level of equipment for the patient being transported.

Sunrise should have an independent relationship with Remote Health (DHF), NTAMS, and the retrieval service to advocate for culturally safe care of patients based on the Sunrise Cultural Framework.

Care based on local knowledge and treatment closer to home would be more aligned to Sunrise Way. Sunrise should provide an office-hours medical consulting service for Sunrise communities provided by Sunrise doctors. With the cooperation of Katherine West Health Board (KWHB) this could be developed into a regional 24 hour service, as well as the distant and impersonal emergency services. A local retrieval service for lower priority medical evacuations such as a regional Aerial Ambulance Service would supplement this. High priority cases would still require the sophisticated Aerial Medical Service. AMS doctors tend not to work outside normal office hours but there is room for a great deal of flexibility in developing a regional service.

Sunrise patients outside Sunrise

The patient journey (Figure 10) starts from referral, through travel by Medevac or PATS, to Hospital as an inpatient or outpatient, through hospital care, discharge, return to community, resumption of care and follow-up. It is a difficult journey which rarely goes smoothly or with full satisfaction. It is a particularly stressful journey for Aboriginal people in a remote community, who have few little available money and difficulty dealing with the Western bureaucratic system. Their powerlessness can only be expressed by opting out of the journey when things are too overwhelming. . The Primary Health Care team is the coordinating hub. One of their roles is to get the best reception, treatment, and communication from Hospitals. They can do this by following the best referral process and giving the best referral information. . Another PHC team role is advocacy for the management of their patients. This needs up-to-date knowledge of what is happening on the journey through some form of tracking system, and by keeping in touch with the people managing that journey. Sunrise may need to have a clinician in Katherine with a specific role of monitoring, liaison, advocacy, and intervention for patients on that journey; to educate and promote cultural safety and the Sunrise Way.

Katherine Hospital

Katherine Hospital is the main external contact for patients from Sunrise communities. Some are Medevacs (acute or semi-acute retrievals) following DMO consultation. The rest are for specialist outpatient clinics, X-rays and ultrasounds, operating theatre, or for childbirth. These journeys are arranged in advance with the Patient Travel system or direct patient transfer by Sunrise for the closest communities where PATS does not apply. It needs patience, understanding, tolerance, and organisational skill to get remote community members through this maze.

These processes should be culturally safe and patient centred. Sunrise and the Primary Health Care team will need all of their influence, education, and advocacy to achieve this. Electronic systems have been introduced but must be fully utilised to improve the outcome for patients on these journeys. But they will not make the system patient-friendly without the monitoring and advocacy of the Sunrise PHC team.

Many patients are transferred from Katherine Hospital or bypass Katherine to Darwin for diagnosis and management of a wide range of both acute and non-acute conditions. A local DMO and retrieval service could achieve treatment closer to home if Katherine Hospital had more appropriately skilled and experienced staff, improved diagnostic facilities, and better specialist support via distance technology.

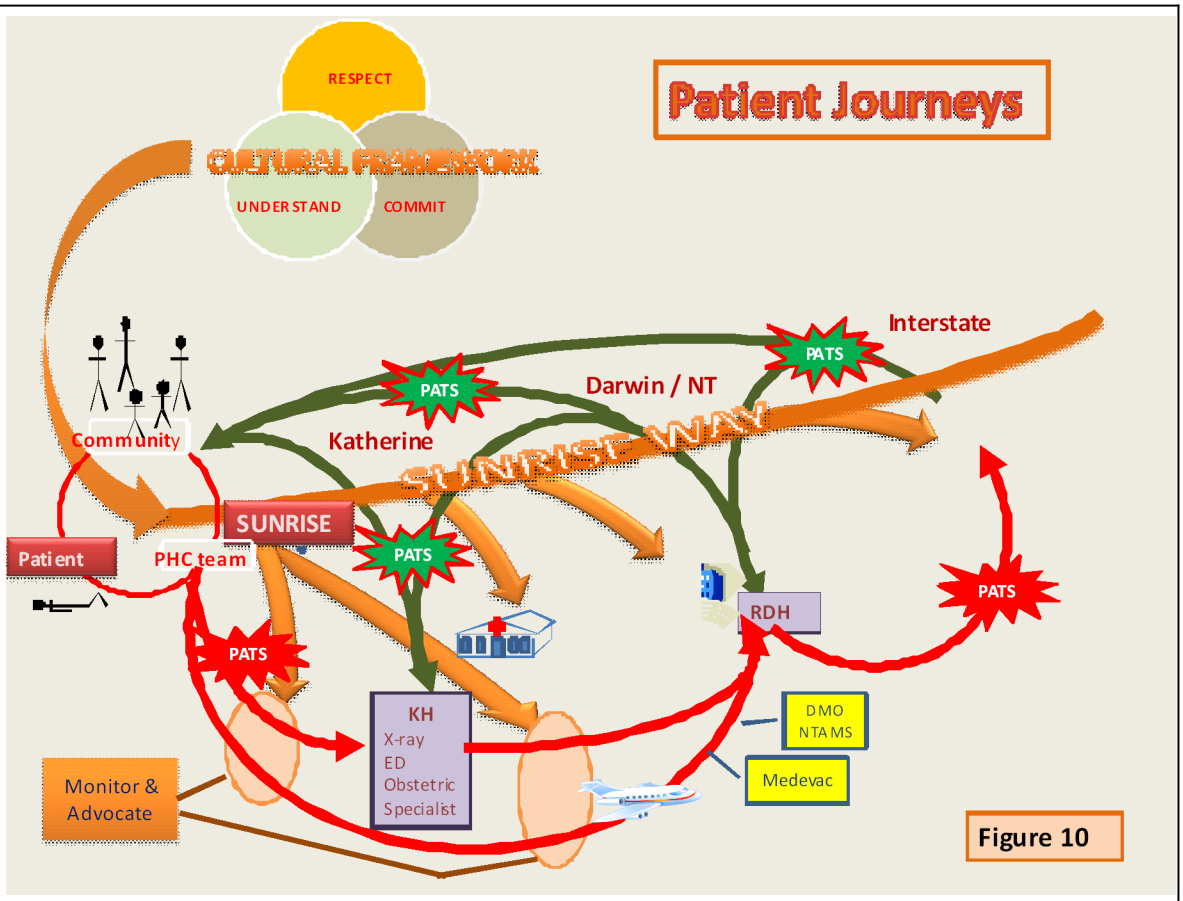

Figure 10

The patient journey is complex, extremely variable, and subject to many external conditions. Decisions are made along the way by people with little knowledge of the issues in the Cultural Framework. PATS is involved in decisions at a number of points, but many of them are made by people with no clinical knowledge of the importance of the journey, severity of the condition, or the circumstances of patients.

Sunrise should advocate for these improvements to local services to be able to provide care for Sunrise patients close to their homes.

Visiting specialist services in Katherine suffer from some of the same insensitivities as those described for specialists on communities. The hospital outpatients system and environment is daunting for remote community patients. Communication is unreliable under these circumstances. These factors lead to social and family disruption and non-attendance. Replacing hospital based specialist services with community visits is ideal, but not always possible or timely.

Ideally, Sunrise' Cultural Framework should apply to the care which is provided by visiting specialists in Katherine in a similar way to that described for community visits (Chapter Eight). This would include support and advocacy on behalf of the patient by family or appropriate AHWs. A Sunrise liaison clinician directly involved in the process of PATS administration and specialist clinics could provide a safeguard for wellbeing of Sunrise' patients. The involvement of AHWs in specialist consultations in the Hospital is even more important than in the community. For AHW or family escorts there would need to be a change in PATS guidelines, or some alternative measure to meet the ideals of Sunrise Way.

Other DH&F services

There are other patient contacts with Katherine Department of Health and Families' agencies. Where these are provided on the community they are dealt with in Chapter 8. These agencies and services include Mental Health Team, NT Families and Children (NTFC), Communicable Disease Control, Aged and Disability Services, Early Intervention team, Oral Health and Dental Services, and Hearing Services. Where these involve non-medical attendances, the Patient Travel pathway generally does not apply, and there is another set of difficulties to overcome. Many of the services provided to people on communities happen without involvement or knowledge of the PHC team.

Sunrise and the Primary Health Care team have another advocacy role ensuring that the Primary Health Care team maintains appropriate involvement in the care of patients using these services.

Renal Services including dialysis are co-located with Katherine Hospital. There is a particular need to build an inclusive approach for renal patients and their families which recognises and supports Sunrise' Cultural Framework and the Primary Health Care team.

Wurli Wurlinjang and NGOs

Community patients also use non-Government services and agencies in Katherine. Many patients attend Wurli Wurlinjang Aboriginal Health Service when they are in town, and some of the specialist consulting services are provided there. The electronic information sharing system does not provide for Primary Health Care responsibility for the care of these transient patients. a high level of dialogue between Wurli clinicians and Sunrise Primary Health Care teams is needed continuity of care, and sharing of information. Building strong networks between these two organisations at every level will produce better outcomes for Sunrise patients. Wurli is best placed to monitor the Katherine part of the patient's journey from a clinical perspective, but this will require negotiation.

Regional Coordinator services for Eye Health, Sexually Transmitted Infections and Renal Disease also work out from Wurli, and reinforce the need for strong regional networks.

Katherine provides the major Nursing Home and Residential Aged Care facilities for the region. There are few information links between these services and Sunrise

PHC teams. Networking with these institutions will also provide more positive outcomes for Sunrise people, and their families.

Royal Darwin Hospital, and Inter-hospital Transfer

Some sunrise patients are transferred from Katherine to Royal Darwin Hospital (RDH), and some are evacuated directly to RDH from their community. Follow up specialist or subspecialist care might be necessary in Darwin or Katherine. The PHC team often becomes reduced to an administrative travel and referral agency for these patients. AMSANT and other peak bodies such as GPNNT are involved in developing policies for these circumstances, but these bodies do not advocate to the extent of Sunrise Way on behalf of remote community people.

Patient centred approaches should also be developed with RDH and other health care agencies and supporting services in Darwin. The inertia of the larger institutions and their need to provide a 'one size fits all' service for non-indigenous as well as remote Indigenous patients makes this task more difficult.

The small number of patients transferred interstate have even more special needs where the involvement and advocacy of the Primary Health Care team is more needed, but less likely to be heard or effective.

Regional health alliances

Regionalisation of Aboriginal Health Services is currently underway in the NT. This may give a better local framework to advocate for culturally appropriate and best quality outcomes for Sunrise people and support Sunrise Way. A working arrangement between Sunrise, Wurli and Katherine Hospital would provide monitoring and better coordinated care for Sunrise patients. An agreement with Katherine West Health Board could provide more doctors for building a regional DMO service.

A regional alliance could develop opportunities for short and long term formal and informal rotations of health professionals for wider experience and learning, add flexibility to remote professionals' work conditions, and provide opportunities for skills refreshers for remote health professionals in the hospital setting. This could promote inter- and intra-disciplinary learning and contact. Hospital doctors on short rotations through Sunrise would be exposed to the Cultural Framework. This could promote understanding, acceptance, and even implementation in other places including Katherine and Royal Darwin Hospitals.

KRAHRS (Katherine Region Aboriginal Health and Related Services) is a local organisation set up initially to provide regional Allied Health services. It is developing its role into corporate support and project management, and could be an appropriate organisation to operate such an alliance.

AMSANT and Sunrise Way

Sunrise is a member of AMSANT (Aboriginal Medical Services Alliance Northern Territory). AMSANT's role in the development and implementation of Sunrise Way

requires special comment. Sunrise Way is specific to Sunrise Health Service, and many of its directions are new. AMSANT is the peak organisation which speaks on behalf of NT AMSs including Sunrise, and may therefore be presenting approaches which Sunrise no longer supports. AMSANT may also be advocating to Sunrise activities which are not consistent with Sunrise Way. Sunrise will need to promote Sunrise Way within AMSANT, and seek their support.

Communicare

Sunrise uses clinical software which is operated by an external commercial company – Communicare. Making changes to Communicare is both difficult and costly, and certain changes are accepted only if a Western Australian reference group agrees. In Chapter 6 were listed the requirements of the program to meet the emerging and changing priorities and primary community accountability of Sunrise Way. It is probable that Communicare will need further development to meet these emerging conditions. Some flexibility will have to be negotiated with Communicare for the system to meet Sunrise' needs. Having a commercial company with a reference group which may not share Sunrise' philosophy providing an essential and critical tool for a Community Controlled Health Service creates some contradictions which must be resolved.

Learning, Teaching, and Research.

Sunrise has limited relationships for teaching. Medical students are placed under the John Flynn Scholarship Scheme. Students from Flinders University NT Rural Clinical School in Katherine visit communities. There are Allied Health and nursing attachments both organised and ad hoc. Menzies School for Health Research provides the ABCDE quality program at one clinic. Nurses attend externally provided professional development courses in Katherine. Aboriginal Health Workers attend professional development events in Katherine, and Batchelor Institute (BIITE) provides site visits as part of its AHW training program. There are some inter-disciplinary professional development events but operational requirements of clinics mean that only a representative number of remote clinicians can attend.

Demands for teaching within organisations such as Sunrise are increasing. Charles Darwin University's Health Sciences courses are increasing in number and their enrolments of students is increasing. An overall increase in the number of health science places in Australian tertiary institutions means there are more demands for work experience. All of these students are potential recruits to remote and Indigenous health. The numbers of medical student places are increasing rapidly. Many of these are Rural Bonded Scholars who are required to undertake rural training and rural service. The full medical course in Darwin will put further pressure on student placements in the Territory. Sunrise can benefit from placing junior doctors under the PGPPP scheme, and vocational trainees (GP Registrars) under AGPT. These medical placements provide registered medical practitioners at no cost to Sunrise, with the capacity to produce income for Sunrise through Medicare billing. Experience elsewhere shows many of these doctors return if they have had a good learning experience.

Chapter 6 talked about learning and teaching for individuals and the organisation. There is a strong case for learning in teams in communities. Some new roles for

AHWs, including tertiary qualifications similar to Physician Assistant do not have appropriate courses at this time, but learning in the workplace should be the preferred model.

Sunrise needs to provide professional support for this education process but will also need external education providers for the additional resources and expertise for learning and teaching which target Sunrise' specific needs. The workplace changes proposed in Sunrise Way mean that current 'off-the-shelf' training packages may no longer fit Sunrise' requirements.

Academic institutions such as Flinders NTCS, CDU, BIITE, NTGPE, MSHR and CRCAH will need to be brought into partnerships. Specific policies will be needed for student visits and placements, not to restrict access, but to ensure cultural safety, and that the visits also benefit Sunrise in both the short and long term.

Working with academic institutions provides opportunities for Sunrise to develop its own agenda of enquiry and evaluation of the outcomes of Sunrise Way. These inquiries must be sensitive to needs of Aboriginal communities, and to use culturally appropriate methods. Research institutions will want Sunrise to become involved in research. Having a research agenda makes it easier for Sunrise to participate only in programs which support Sunrise' needs.

Sunrise is looking for ways to provide a more appropriate service for its communities, to improve health outcomes. This cannot be achieved in isolation from external service providers and organisations. Working relationships with those providers at the service level should be consistent with Sunrise' Cultural Framework.

CHAPTER 10 IMPLEMENTATION – THE WAY FORWARD

In the preceding two chapters cooperation, collaboration, and consistent approaches for service delivery In the NT and Katherine region have been discussed. But Sunrise Way will not be implemented locally until it has support and funding from the highest levels. Sunrise' funding, budgets, reporting, and methods of working depend on policies and relationships at national and Territory levels. This chapter deals with the world in which Sunrise Way would flourish. (Figure 11)

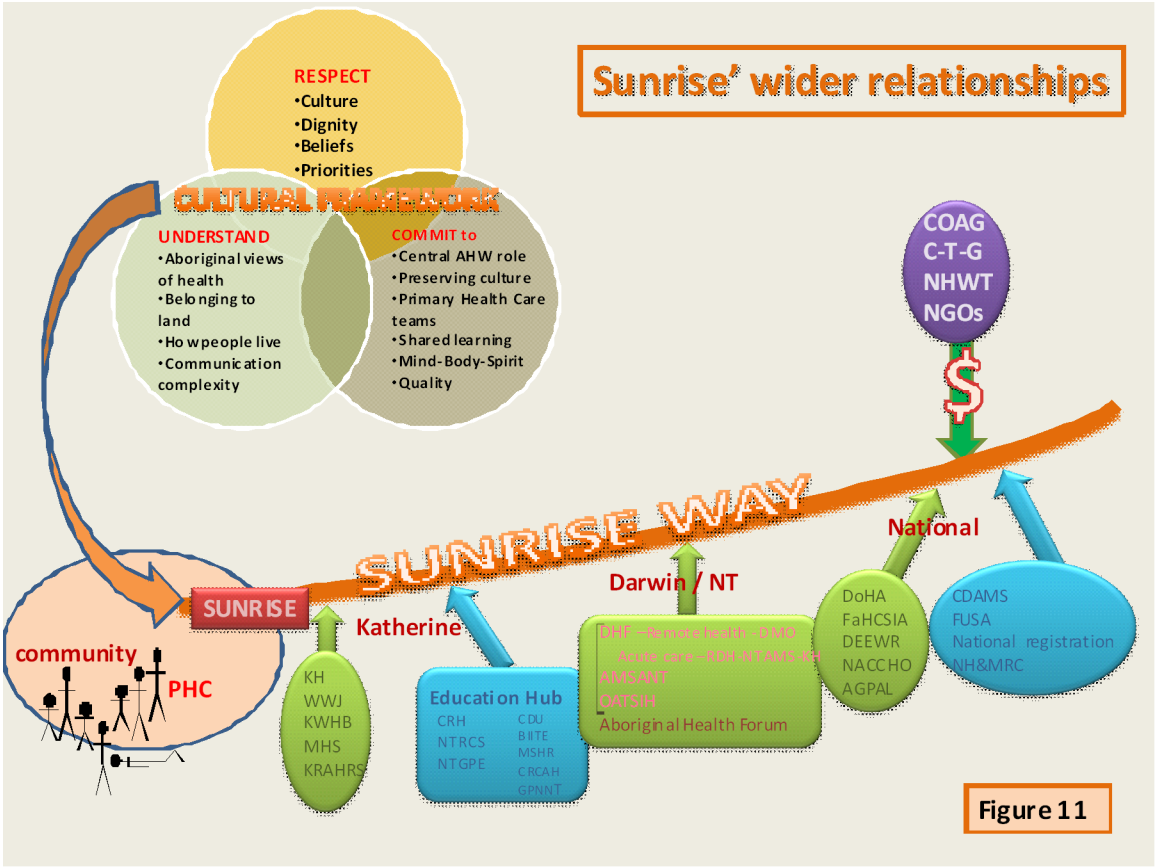

Figure 11

The implementation of Sunrise Way requires support and acceptance at every level of the health system. The resources needed to transform Sunrise Health Service are in other's hands. The Cultural Framework through Sunrise Way can bring that support.

At the national level:

The principal agency of Australian Government influencing health care in Sunrise communities has traditionally been the Office of Aboriginal and Torres Strait Islander Health (OATSIH) within Department of Health and Ageing (DoHA). National priority programs in health developed with DoHA, and National Health and Medical

Research Council (NH&MRC) are advanced through OATSIH. OATSIH represents the Australian Government in the funding arrangements between Australian Government, Northern Territory Government, and Sunrise. OATSIH meets with NT DHF and AMSANT in the NT Aboriginal Health Forum.

Other funded programs which the Australian Government promotes, and which impact on Sunrise are administered through the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA).

Programs which are individually funded take the form of Selective Primary Health Care. Both OATSIH and other DoHA funding come with separate requirements for reporting against their targets. Where FaHCSIA programs have been taken up, separate reporting frameworks are in place. For Sunrise to implement a new approach involving community control and primary health care as suggested in Sunrise Way and the Cultural Framework requires direct support from these funding bodies.

The Northern Territory National Emergency Response (NTER) brought a new era of relationships with the Australian Government, and to a lesser extent with the NT Government. The main department implementing NTER is FaHCSIA, but also Department of Education, Employment and Workplace Relations (DEEWR) and DoHA. Reporting on health has involved Australian Institute of Health and Welfare (AIHW). The arrangements under NTER limit the scope for community control and its expression through Sunrise Way but the transition from NTER provides an opportunity for Sunrise to promote an innovative holistic approach to the health care of Sunrise communities. These transition arrangements are being administered through OATSIH as the Expanding Health Service Delivery Initiative (EHSDI) which is now incorporated into Closing the Gap, developed for and endorsed by the Council of Australian Governments (COAG).

Closing the Gap

COAG has followed up on the intent of the NTER to establish ways forward to overcome Indigenous disadvantage on a wide range of parameters including health, and has set timetables and funds to do so. Many of the developments independently outlined in Sunrise Way would appear to be in line with the agreed National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes between the Commonwealth, State, and Territory Governments, signed off in March 2009. Four of the five priority areas of that Agreement are covered substantially by Sunrise Way:

(a) Preventive Health: to reduce the factors that contribute to chronic disease through: effective anti-smoking campaigns; and integrated alcohol, drug and mental health services.

(b) Primary health care: to significantly expand access to and coordination of comprehensive, culturally secure primary health care, allied health services and related services.

(d) Patient experiences: to ensure access by Aboriginal and Torres Strait Islander people to comprehensive and coordinated health care provided by culturally

competent workforce within a broader health system that is accountable for Indigenous health needs, in genuine partnership with the people and communities they target; and to build service reach and influence to re-engage the most vulnerable Indigenous people into mainstream and targeted health services.

(e) Sustainability: to increase the number of Aboriginal and Torres Strait Islander people in the health workforce, reform and improve the supply of the health workforce generally including the adoption of complementary workplace reforms, create sustainable program and funding models, measure performance and ensure that services are responsive both to national targets and local community needs.

Hopefully Sunrise Way will be considered in the development of '... a national framework agreement to secure the appropriate engagement of Aboriginal people and their representative bodies in the design and delivery of accessible, culturally appropriate and quality primary health care services' within 2 years (of the release of the Close the Gap document in June 2008). Hopefully there will be enough flexibility in that framework agreement to allow for the implementation of Sunrise Way at a later stage of the 'Close the Gap' program.

A number of other National reports support the directions taken by Sunrise in developing the Sunrise Way.

Productivity Commission Report into Overcoming Indigenous Disadvantage (OID) 2009. The OID report has indicated that little has changed in recent years in Aboriginal Health, and that it has worsened in some respects. The 'things that work' outlined in that report and recommended as the way forward are very much in keeping with the broad direction of Sunrise Way, and the connections between health outcomes and all other aspects of community life and wellbeing that Sunrise Way embraces.

The National Health and Hospital Reform commission (NHHRC) report 'A Healthier Future For All Australians' was released in July 2009. It calls for all funds to be aggregated in a single funding body, the National Aboriginal and Torres Strait Islander Health Authority (NATSIHA) to purchase and commission health services that are effective, high quality, culturally appropriate and meet the needs of the people, their families and communities. They want to invest more to help 'close the gap', to strengthen Community Controlled Health Services, and to train and recognise an Indigenous health workforce and a workforce for Indigenous health.

The pace of change in the past two years has been hectic. Although Sunrise Way appears to meet the ideals of these approaches and to be an obvious target for funding, Sunrise' faces a big challenge to get a hearing and to convince these Departments before some other program or proposal is selected. The National Aboriginal Community Control Health Organisation (NACCHO) is an important organisation for Sunrise in this regard. So too is the Australian Indigenous Doctors Association (AIDA). Block funding for the whole program, or as a pilot program centred on Sunrise Way would allow implementation to start. Figures provided in the OID report indicate that Sunrise communities constitute about 10% of Aboriginal people living in very remote areas of Australia, where the Sunrise Way approach

might be appropriate. Sunrise would therefore be a suitable representative sample for an evaluated trial.

Once Sunrise Way is recognised at Australian Government policy and funding level the door is open to develop learning packages around AHWs as cultural brokers and expanded and new AHW roles, and specific qualifications in remote Indigenous health. These would involve Universities, Faculties of Health Sciences, Medical Schools and professional Colleges nationally. They, too, will have to be convinced that the Sunrise Way direction will be worthy of the investment, particularly if it is an isolated or pilot project. Evaluation will be an important part of these processes.

At the Territory level:

Sunrise would like to be able to influence attitudes and policy within the Territory to implement Sunrise Way. This would become possible with national endorsement and support. Aboriginal Medical Services Alliance NT (AMSANT) is the representative body for ACCHSs in the Northern Territory. AMSANT presents an Indigenous perspective to DHF in the development of Territory Aboriginal health policy. OATSIH is generally a partner in that process, and one formal and important meeting ground is the Aboriginal Health Forum. Sunrise would like AMSANT to support Sunrise Way and promote its implementation.

Support at the Territory level would assist Sunrise to change relationships with RDH and Aerial Medical Services (NTAMS) in favour of patients on their journeys, and for patient centred policies and practices which are culturally appropriate.

Institutions of learning in the Territory have an important place in what educational services are delivered, how and where. Sunrise would like to have access to learning which is specific for the opportunities in Sunrise Way, provided locally. Without national endorsement and support Sunrise' case is unlikely to be heard. This is a time of new developments in medical teaching in the Territory, new arrangements for AHW training, and the availability of extra funds to expand the Aboriginal health workforce. Sunrise Way could help to shape those directions.

At the Katherine Region level:

Sunrise would like to collaborate with the other Aboriginal Medical Services (WWJ and KWHB) to provide seamless Primary Health Care for people who move from one service to another briefly or for extended periods. Information needs to be shared easily for both planned and acute care. Sunrise would like to be able to rely on that collaboration to monitor patients on a health journey to or through Katherine. Shared use of resources such as Allied Health Professionals makes good sense, but the principles of Sunrise Way and the Cultural Framework should be applied, at least when in Sunrise communities. Joint responsibility for a DMO style emergency and out-of-hours consultation service would give local patients best care close to home.

Sunrise would like to relate to and collaborate with Katherine Hospital to ensure patients receive culturally appropriate care when hospital visits become necessary. Sunrise would like this care to be aligned with Sunrise Way and would like to see the care monitored by Sunrise liaison health workers, or in collaboration with the other

AMSs. Sunrise would like PATS and specialist clinics to operate in a way which is culturally safe, and aligned with Sunrise Way.

Implementation of Sunrise Way on communities needs the cooperation of other DHF services. Protection of children from abuse and neglect, dealing with domestic violence, mental health issues, drug and alcohol abuse are all part of the Mind-Body-Spirit approach of Sunrise Way and need support of the relevant agencies.

Improving the environmental and social determinants of health needs the cooperation of other NT Government departments, notably Justice, Housing, Education, and Police. Roper Gulf Shire has involvement in areas in common with Sunrise, particularly aged care and early childhood services. It is very important for Sunrise and the implementation of Sunrise Way to have contract services in communities and to have accommodation facilities for expanded staffing, community focussed roles, and teaching on communities.

Jawoyn Association has a special relationship with Sunrise, and the success and implementation of Sunrise Way will depend on Jawoyn's continued and active support.

Sunrise Way advocates learning for PHC teams in teams on communities. To support this Sunrise would need locally organised educational services using local expertise, or teachers with good remote experience and knowledge. Sunrise would like this to be for all health services and all health workers in the region. It should be linked to academic institutions to provide the breadth of courses and qualifications needed to implement Sunrise Way.

Learning Experiences and flexibility of working would be easier if health professionals could move seamlessly from one health service to another for brief or extended periods. A common employing alliance covering Katherine Region, and including Private General Practice, private Allied Health practice, Katherine Hospital and the AMSs might be able to do this with economies of scale.

The bright pool at the bottom of this cascade is the full implementation of Sunrise Way and the best possible Mind-Body-Spirit health for the Sun-Come-Up Mob. The concluding chapter will recap this story and the central role of the Cultural Framework.

CHAPTER 11 FINAL OVERVIEW

Sunrise Health Service has a short but proud history. In response to the disastrous and deteriorating health of the Jawoyn people in the east of Katherine an innovative process of health care was established as a Coordinated Care Trial in 2002. In 2003 Sunrise Health Service was formed. Sunrise has had the direct and strategic benefit of partnerships with the Fred Hollows Foundation, the Honda Foundation, and the Thorpe Fountain for Youth, and together with its partners, Sunrise has begun to turn the health situation around. After five years the Board of Sunrise has responded again to the changing environment of Indigenous health with a strategic plan "to build the strength of the community to engage in, and lead health activities, to develop the organisation's support structures and systems to empower communities and extend services at the community level, and to develop a workforce to provide an increased range of services and deliver culturally appropriate community based programs". Sunrise Way is an outcome of these instructions, and provides a way forward for Sunrise Health Service.

Sunrise Way, the document, describes a health service to meet those aspirations. It does not describe the current system. It deals with subsystems within Sunrise Health Service, and includes the wider systems in which Sunrise operates, and depends on for resources.

Sunrise Way, the concept, is a transformation based on explicit values and on an understanding of explicit issues in Aboriginal communities and life. Together these are called the Cultural Framework. The intent is not just to make Sunrise a culturally safe workplace, but to transform Sunrise into an organisation where cultural safety and cultural competence are an inevitable outcome of its basic structure and function.

The assumptions underlying Sunrise Way are that the cycle of poor health will be broken by the combination of Community Control, an Aboriginal cultural basis, health delivery in the hands of Aboriginal health professionals, and an approach to health which includes the mind and the spirit.

This story written here can bring the desired transformation of Sunrise Health Service at the community and central levels, by implementation of a cultural framework. The transformation is through Sunrise Way. The outcome would become the way in which Sunrise runs its service and how it relates to and works with the wider systems providing services and resources. Community control of policies and services comes from relationships, moral suasion, and evidence.

The wider systems include facilities and services in Katherine involving cooperation, collaboration and agency. Darwin based systems also include funding and policy at the Northern Territory level. National systems provide the overall policy settings and the resources which come to Sunrise directly or indirectly. This includes the

resources being made available to Close the Gap in Indigenous Disadvantage, including in health outcomes.

To achieve the outcomes which Sunrise Health Service wants, Sunrise Way needs to be heard and responded to at all of those levels.

The Patient Journey pathway runs unseen through this picture –. Sunrise can provide high quality primary health care for communities and individuals in a broad holistic model. To achieve that requires extensive and sustained education in new ways and for new positions, cooperation and change from external service providers coming in to communities, and strong central support. The patient journey beyond Sunrise can be facilitated and protected by relationships with other services which are guided by Sunrise Way.

To achieve the outcomes which Sunrise wants for its people, Sunrise Way needs to be heard and responded to at all of those points on the patient journey.