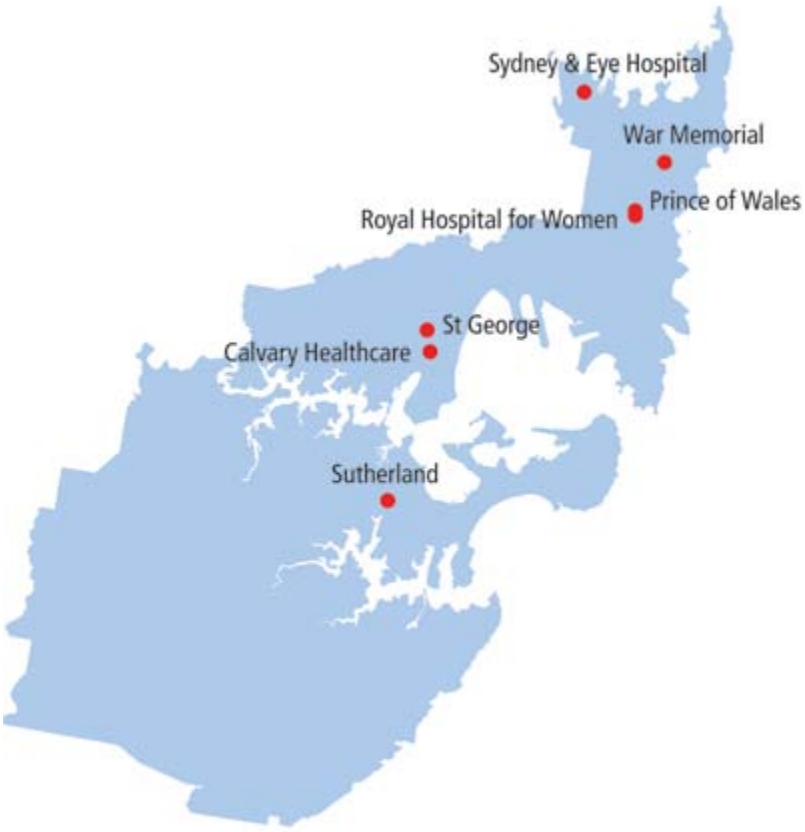
Health
South Eastern Sydney
Local Health Network

# Multicultural Health Service Strategic Plan

2010 – 2012



# FOREWORD

South Eastern Sydney Local Health Network (SESLHN) is committed to ensuring that we have the capacity, knowledge and empathy to meet the needs of our culturally and linguistically diverse (CALD) communities.

We recognise our legislative obligations under the Community Relations Commission and Principles of Multiculturalism Act 2000 and have organisational plans in place that consider the health inequalities experienced by CALD communities.

The Network's commitment to working with communities, clinicians and government agencies to protect, promote and maintain the health of, and to reduce the health inequalities between our diverse communities, is embedded in the interim SESLHN Strategic Plan 2011-2015.

Our day-to-day business and strategies to improve our provision of health care must consider our CALD communities' cultural and language needs and health beliefs.

The MHS Strategic Plan 2010-2012 outlines the work to be completed over the next two years to:

- Build the capacity of SESLHN to respond to cultural diversity
- Identify best practice models
- Foster opportunities for communities to engage effectively with the health service
- Support the implementation of policies and initiatives such as the 'Caring Together' Health Action Plan for NSW

The Strategic Plan realises a stronger role for the MHS in planning to ensure the needs of CALD communities are taken into account.

Stronger relationships will be developed between the Multicultural Health Service and multicultural workers operating within the Network's services and facilities.

I look forward to the successful implementation of the strategies outlined in this Plan including initiatives that focus on better health outcomes. In doing so, I am confident that we will achieve improvements in service delivery.

Terry Clout
Chief Executive
South Eastern Sydney Local Health Network

# INTRODUCTION

The Multicultural Health Service (MHS) is responsible for driving the Network's responsiveness to our culturally and linguistically diverse population.

A key focus is facilitating equitable health care for people from a CALD background – healthcare which is responsive to their needs and which takes into consideration cultural and language backgrounds, migration pathways and communication barriers.

Our work centres on addressing inequities in access to health services and prevention programs that improve health outcomes.

The MHS has five program areas:

- Bilingual community access
- Refugee health
- Learning, research and workforce development
- Communications and community engagement
- Policy, evaluation and planning

The Service is complemented by hospital-based diversity health co-ordinators, health care interpreters and service specific multicultural health positions including mental health, sexual health, HIV/AIDS, women's health, aged and extended care and health promotion services.

This strategic directions document has been developed in response to organisational and community issues, state and LHN policies and demographic and epidemiological data.

Consultations undertaken in the development of the Plan by independent consultants in October 2008 involved internal and external stakeholders and used a variety of mechanisms including language-specific focus groups.

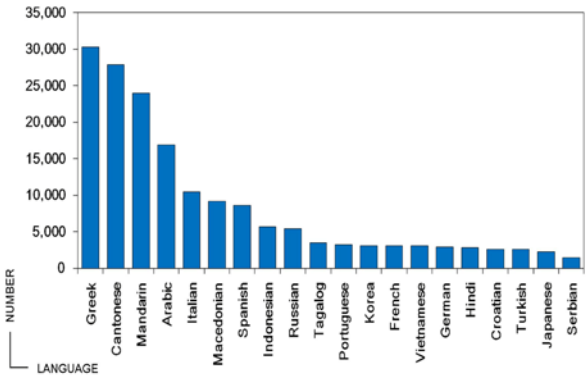
External stakeholders consulted included local government, multicultural and ethnic specific organisations, support groups, refugee groups and facility consumer advisory committees.

Internal stakeholders comprised the leadership of the former South Eastern Sydney Illawarra Health (SESIH), Division of Population Health managers, diversity health co-ordinators, project officers, interpreter services, bilingual staff in multicultural positions and the MHS team.

# POPULATION PROFILE

SESLHN has a large overseas-born population. At the time of the 2006 Census 794,945 SESLHN residents (30% of population) were born in a country other than Australia. In NSW 26% of residents were born overseas.

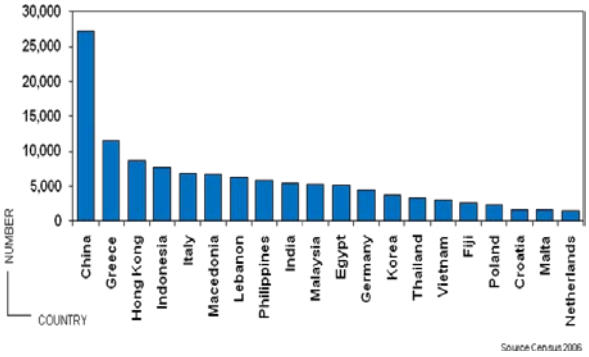
Of these 24% spoke a language other than English at home and 25,949 residents (3.3%) reported that they did not speak English well.




Source Census 2006

*Figure 1: Top 20 non- English languages spoken in SESLHN*

According to the Department of Immigration and Citizenship, 29,903 new arrivals settled in SESLHN in the four years from 2007 to 2010. The number of immigrants arriving within the skilled and family migration streams has increased strongly in recent years, while the number of humanitarian (refugee) settlers has declined.




Source Census 2006

*Figure 2: Top 20 non- English speaking countries of birth in SESLHN*

More languages are now spoken by the LHN's CALD population. The most common 15 languages are spoken by 62% of our CALD population down from 75% previously. As a result of fewer people speaking the same language our communication strategies and service delivery can no longer rely on using the top languages to target majority groups.

According to country of birth data, communities in SESLHN that have grown considerably since the 2001 Census include those born in China, India, South Korea, Vietnam and the South Pacific.

The St George community cluster has the most residents from a CALD background.

In SESLHN the relationship between residents with a low socio-economic background and migration is evident with a high migrant population residing in the more socio-economically disadvantaged local government areas of Rockdale and Botany.

Refugees, new arrivals and older post World War II arrivals are considered vulnerable migrant groups.

SESLHN has a large grouping of post World War II economic migrants who due to their age are increasingly using our services.

While new arrivals, excluding many refugees, tend to have a higher level of English proficiency in comparison to earlier migrants, they have a limited understanding of Australian health systems and require support. Older settlers, despite having lived in Australia for some time, often still have poor English language.

# CONSULTATION

## Our Consumer's Perspective

In the development of the plan bilingual health staff conducted focus groups with staff and consumers from CALD communities, the majority of who lived in the Illawarra region of the former SESIH.

CALD communities reported that in the most part they had positive experiences when accessing NSW public health services and facilities.

Factors that hindered their access to public health services and facilities include language barriers, negative community perception, waiting time and waiting lists and access by public transport.

The perceptions and experiences of other community members was the most influential factor for someone not accessing health services.

In general, those interviewed regarded the quality of public health care to be high and most felt their health needs were being met. The exception was refugee communities who felt uninformed about how the health system operates and didn't feel that their health needs were always met.

Most groups had confidence in the public health system but almost all required the assistance of intermediaries to access and navigate the system. Some consumers from refugee communities were not aware of state-wide specialist services such as the Service for the Treatment and Rehabilitation for Survivors of Torture and Trauma or the Transcultural Mental Health Centre.

There was a reported dependency on bilingual GPs and community workers or English speaking family members to access health services.

Being able to converse with medical staff in their own language was said to minimise confusion, ensure confidentiality and was often associated with positive experiences with the health system. However, having an interpreter present elicited concern that the consumer's medical condition would not be kept private within the community where the interpreter and consumer may both reside or have contacts.

While interpreting services were greatly appreciated the availability of interpreters for small and emerging communities was limited and problematic. Access to interpreters for specialist appointments was also difficult or nonexistent as the health care interpreter services only provide service to the public health system.

Rather than using an interpreter, consumers expressed a preference for being given detailed health information in their preferred language. However, many were concerned that they wouldn't be able to understand the entire health message in all its complexity.

Culture is a major consideration for participants and it was suggested that health staff involved in admissions and examination areas in particular should be cognisant of cultural factors such as:

- Fasting periods and the nature of fasting for different communities
- Gender issues especially for female patients who may prefer not to discuss certain health issues with a male clinician or interpreter
- Survivors of torture and trauma who are often hesitant to engage with medical 'authorities'
- Cultural requirements for death and dying.

### SUGGESTED IMPROVEMENTS

Those consulted felt that the public health system could be improved by:

- Providing clinicians with more information about culture and language issues and the impact that it has on communities, families and individuals
- Expanding interpreting services and providing GPs and specialists with access to face-to-face interpreting services, at no cost to consumers
- Improving the process of booking interpreters to minimise inconvenience and waiting times for frontline staff.

## MHS team perspective

At the time of the consultation, MHS staff from the now South Eastern Sydney and Southern and Illawarra Local Health Networks were working under different models as a result of the previous amalgamation of health services. Staff based in Wollongong conducted community liaison and direct service delivery, but Sydney staff were not responsible for the direct engagement of CALD communities.

Staff feedback included:

- Planning activities that address the changing and evolving nature of communities were a fundamental activity of structuring an approach to multicultural health
- A lack of resource flexibility didn't allow staff to meet the needs arising from relatively quick demographic change (eg a lack of bilingual staff to assist emerging communities who may have different language and health care needs)
- Lack of one planning mechanism that brings together the various multicultural positions and responsibilities to enable consistency in the identification of target groups and priorities
- Some participants saw diversity health co-ordinators, who report to their facility management and not the MHS, as a major structural anomaly. Others consider the positions to be an important opportunity and change agents.

## Leadership & staff perspectives

The consultations with diversity health co-ordinators, Division of Population Health staff and key leadership positions in the former SESIH indicated a need for the MHS to continue its leadership role in multicultural health matters and to develop and deliver a set of internal services and programs.

Most comments focused on the need for the MHS to position itself as the major structural support in developing and encouraging within the organisation, innovative models of care that benefit CALD communities and to provide a more tangible and obvious leadership role than it currently does.

Participants felt that the MHS should be advocating in a number of areas such as lobbying internally to enhance the profile of multicultural health, to increase remuneration for staff using languages other than English and to assist with complaints about service access for CALD community members.

Facilitating change in service provision was also considered an important role of the MHS. In particular, by providing resources such as grants, information and high-level participation in projects that facilitate access and develop innovative approaches to heath service provision to our diverse communities.

The MHS was seen as the body to provide for or to compensate for all deficits related to cultural and linguistic diversity within the organisation's operations. This accounts for the broad range of roles attributed to the MHS and the high degree of expertise required of staff and programs.

Among population health managers the overall perception of the MHS was positive. This was negatively affected by a lack of visibility or notable presence of the MHS over the last few years which can be attributed to low staffing levels.

Suggested areas of work for the MHS included development of the following:

- Comprehensive framework to enhance capacity building across the Local Health Network, delivery of cultural competency-based training to the workforce and delivery of a range of cultural competency skills to multicultural workers
- A framework for engaging the community which delivers a clear purpose, level of engagement, preferred approach and expected outcomes - engaging key ethnic community stakeholders in the process to harness and benefit from their knowledge and proximity to diverse communities
- CALD communication strategy and guidelines that direct the effective development of messages and delivery mechanisms to reach ethnic audiences in the area.

Questions that arose in the consultations included:

- Who takes leadership on initiatives?
- How is structural engagement fostered by the MHS?
- How is engagement to be undertaken and at which point are responsibilities transferred from MHS to the respective facility/service?
- What ongoing role will the MHS play after this transfer?

The perceptions and views of staff seem to be based on a limited understanding of the level of resources available to the MHS and the actual resource allocation for multicultural services across the organisation.

## KEY OUTCOMES

The *Multicultural Health Service Strategic Plan* aims to achieve:

- Greater capacity of SESLHN to provide culturally competent care and foster healthy communities
- An articulated and strategic approach that will deliver a framework for development and allocation of clear responsibilities
- Maximised value and efficacy of existing resources and people through a clearer role definition and the provision of expertise and support in the areas of data collection and analysis; development of models of care; capacity building; consultation; resource development, leadership and advocacy
- Approaches and programs that maximise the effectiveness of existing operational paradigms when dealing with CALD clients
- Better access for CALD clients to SESLHN's health facilities and services, maximising health outcomes through the effective promotion of relevant population health initiatives.

# STRATEGIC DIRECTIONS

The strategic directions and the overall framework are supported by a range of initiatives that, once implemented, will support the organisational capacity to meet the current and future health needs of CALD communities.

- Strategic Direction 1: Delivering Multicultural Health Leadership
- Strategic Direction 2: Improving Service Planning
- Strategic Direction 3: Increasing Organisational Capacity
- Strategic Direction 4: Enhancing Community Connection and Engagement

# STRATEGIC DIRECTION 1
## DELIVERING MULTICULTURAL HEALTH LEADERSHIP

Refining the structural and organisational leadership for multicultural health and providing the structural mechanisms to ensure access to practice knowledge, expert resources and service standards.

*NSW Health Goal: Managing health services well*

| Building on current work | | Monitoring Progress |
|---|---|---|
| 1.1 | Provide advice and expertise to all SESLHN services and facilities and have such advice sought | Development of MHS resources and capacity to respond |
| 1.2 | Develop specialist models of care such as the "Refugee GP Hospital Collaborative Care Model" and carer support groups | MHS involvement in key events and initiatives in the LHN. |
| 1.3 | Develop specialist workforce resources in the MHS by recruiting to new positions and enhancing multicultural health worker positions | |
| 1.4 | Seek opportunities to provide perspectives on culture and language diversity and to have input into planning activities across the LHN. | |

| What will be done over the next 12 months | | Monitoring Progress |
|---|---|---|
| 1.5 | Develop a multicultural services framework that includes the role of dedicated multicultural health workers across the LHN | Comprehensive framework developed in consultation with stakeholders |
| 1.6 | Develop service level agreements with hospital networks to ensure an ongoing commitment to the multicultural services framework | Evidence of commitment by targeted services to the multicultural services framework |
| 1.7 | Develop a partnership agreements guide to be used when working with internal partners to clarify expectations and appropriate and meaningful support from MHS. | Guide is used to identify working processes and responsibilities of parties. |

| What will be done in the next 2 years | | Monitoring Progress |
|---|---|---|
| 1.8 | Use the multicultural services framework to prioritise resource development and skills acquisition strategies to increase access to multicultural expertise | Multicultural services framework is used effectively in the networks to harness multicultural expertise |
| 1.9 | Undertake a research project that investigates outcomes for CALD communities against at least one of SESLHN's key performance indicators | Achieving an audience for insights and learning from research projects |
| 1.10 | Support project partnerships with high level external stakeholders, such as universities, to enhance knowledge and best practice in multicultural health | Involvement in partnership projects that deliver enhanced knowledge and best practice evidence |
| 1.11 | Develop internal forums to provide a multicultural health focus and to highlight SESLHN best practice in multicultural health | MHS forums are well regarded and well attended |

# STRATEGIC DIRECTION 2
## IMPROVING SERVICE PLANNING

Supporting service planning that is informed and responsive to the changing nature and needs of CALD clients, including consideration of equity issues.

*NSW Health Goal: To provide the health care people need*

| Building on current work | | Monitoring Progress |
|---|---|---|
| 2.1 | Provide a focal point for information and expertise to support multicultural health initiatives | MHS builds its profile to inform staff of its capacity to provide support and expertise |
| 2.2 | Develop and disseminate population profiles that identify demographic and epidemiological trends for CALD communities | Up to date population profiles available |
| 2.3 | Equip diversity health co-ordinators and designated multicultural health staff with the information and tools necessary to influence service planning | NSW Multicultural Policies and Service Program (MPSP) objectives embedded in LHN and facility planning activities |
| 2.4 | Integrate multicultural legislative and policy requirements into planning processes | |

| What will be done over the next 12 months | | Monitoring Progress |
|---|---|---|
| 2.5 | Develop the MHS's capacity to provide advice that reflects the increased diversity in cultures and languages in the Area | Development of diverse cultural expertise that promotes the MHS' capacity to provide support and advice |
| 2.6 | Conduct annually a priority and agenda setting workshop for health services targeting CALD priority populations | Holding a workshop to inform multicultural health priorities |
| 2.7 | Promote multicultural health priorities to facilities and programs based on demographic and epidemiological evidence and consultation | Documenting priority populations and promoting CALD communities |
| 2.8 | Support the development of multicultural health implementation and evaluation plans to fulfil the LHN's requirements under the *NSW Multicultural Mental Health Plan,* the forthcoming *NSW Multicultural Health Policy and Strategic Plan*, the *NSW Refugee Health Plan* and the *CALD Carers Framework* | Implementation plans developed and embarking on implementation<br><br>MHS an active and important partner in service planning |

| What will be done over the next 2 years | | Monitoring Progress |
|---|---|---|
| 2.9 | Develop and manage a process to capture ethnicity data, which is consistent and complements other planning data, to deliver an accurate picture of service provision and service needs for CALD communities in SESLHN | Regularly collate ethnicity data and inform key stakeholders |
| 2.10 | Introduce and promote a requirement for new and reviewed policies and programs to identify cultural and linguistic diversity has been considered and included | Cultural and linguistic diversity considered in policy and program development in SESLHN |

# STRATEGIC DIRECTION 3
## INCREASING ORGANISATIONAL CAPACITY

Increasing organisational capacity to deliver culturally competent services and address health inequities for CALD communities

*NSW Health Goal: To deliver high quality services*

| Building on current work | | Monitoring Progress |
|---|---|---|
| 3.1 | Develop training modules and tools to enhance service delivery for CALD patients, clients and residents utilising adult learning principles and considering technology such as e-learning programs | Strong evidence of MHS input in key service delivery areas |
| 3.2 | Facilitate development of and access to interpreting services and multilingual resources | Evidence of SESLHN staff using information and resource expertise of MHS |
| 3.3 | Support diversity health co-ordinators with their change management role | Developing training modules as required |
| 3.4 | Direct and undertake issue and process-based research to identify service needs for CALD communities and best practice in meeting these needs | Evidence of relevant research activities |

| What will be done over the next 12 months | | Monitoring Progress |
|---|---|---|
| 3.5 | Develop a capacity building framework for building cultural competence in SESLHN and identify key priorities for action | Achieving commitment to priorities |
| 3.6 | Develop a diversity health component for the SESLHN management orientation intranet portal | Effective use of portal to promote diversity health |
| 3.7 | Develop capacity to increase community liaison and engagement | Increased community liaison capacity |

| What will be done in the next 2 years | | Monitoring Progress |
|---|---|---|
| 3.8 | Develop and implement strategies to respond to key priorities for action, identified through the capacity building framework | Developing programs to build the LHN's cultural competence |
| 3.9 | Seek to address support and integration issues of overseas trained health professionals recruited to SESLHN | Increasing levels of support for, and confidence in, overseas trained health professionals |
| 3.10 | Document and profile best practice approaches in culturally competent service delivery | Best practice in service delivery for CALD patients and clients becomes synonymous with SESLHN |

# STRATEGIC DIRECTION 4
## ENHANCING COMMUNITY CONNECTION & ENGAGEMENT

Building the capacity of SESLHN to connect with and engage CALD communities so that the service is informed by, and responds to, the access and service quality issues that are currently being experienced by these communities.

*NSW Health Goal: To keep people healthy*

| Building on current work | | Monitoring Progress |
|---|---|---|
| 4.1 | Provide strong community engagement and service development with CALD communities | Strong community links and service development maintained |
| 4.2 | Support SESLHN staff in their community engagement activities with CALD communities | Increased capacity to engage with specific community activities |
| 4.3 | Target attention and support to new arrivals, refugees and other vulnerable minority groups through targeted programs such as the 'GP Hospital Collaborative Care Model' for refugee communities | Having support and co-operation between diversity health co-ordinators, MHS and staff working in multicultural health to address inequity |
| 4.4 | Assist with community contact and pathways to reach communities for specific health projects such as falls prevention, HIV/AIDS and mental health | Innovative projects addressing new and emerging populations and population health issues |

| What will be done over the next 12 months | | Monitoring Progress |
|---|---|---|
| 4.5 | Develop MHS' capacity to further community engagement activities through the facility and facility consumer advisory committees | Evidence that engagement with CALD communities has improved |
| 4.6 | Develop a Network-wide consultation mechanism that brings together stakeholders and services to provide a focus on health issues of CALD communities | Having an effective consultative mechanism in place to assist in the development of priorities for CALD communities |
| 4.7 | Initiate a mechanism to provide information across SESLHN that serves to profile and promote multicultural health services and initiatives | Communication about MHS services increases information requests and contact with Service |

| What will be done in the next 2 years | | Monitoring Progress |
|---|---|---|
| 4.8 | Develop mechanisms to engage and consult with vulnerable groups such as refugees, new arrivals and carers | Achieve effective input from vulnerable groups |
| 4.9 | Develop in conjunction with staff working in multicultural health, relationships with external service providers such as Divisions of General Practice and aged care services to establish an information and consultative pathway | Evidence of increased interaction with primary health care and service providers |
| 4.10 | Enhance capacity, together with other stakeholders, to deliver health information in a range of formats that meet the language and literacy needs of CALD clients, and which utilises appropriate dissemination strategies | Demonstrating ongoing capacity to deliver health information that is relevant to CALD communities |