QUALITY ACCOUNT:
Community Care Report

2017

Working Together With Trust and Respect

BANYULE
Community Health

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WELCOME

On behalf of the Board of Directors, staff and Community Communications Committee (CCC) we are pleased to present the 2017 Quality Account. The Quality Account builds on previous Quality of Care Reports and has adapted to changes identified by Safer Care Victoria. Banyule Community Health (BCH), welcomes accountability back to its community, with a focus on safe, effective and person centered care. We thank our CCC who have guided us in the development of this account to ensure it reflects our values, and is engaging, accurate and interesting

The report demonstrates the powerful contribution of client stories, experiences and feedback in improving services and developing new models of care. BCH provide a wide range of dynamic and responsive services to the community and understand the importance of integrated, holistic service models. Our services continue to reflect local needs with a focus on vulnerable and at risk communities. Members, supporters and stakeholders can be proud that BCH is dedicated to address inequities in health to ensure improved health outcomes across the wider community.

This work takes BCH in many and varied directions. The past year has seen the emergence of new models of care adding value to the existing services. The breadth and depth of our services enable a truly integrated and connected response. BCH values its deep connections with communities, the acute health system and the social support system. The combination makes community health the perfect platform for service delivery within a changing health sector.

We would like to acknowledge the significant contribution made by Jim Pasinis, who retired as CEO after 27 years in November 2016. Jim can take a great deal of credit for his contribution in shaping BCH into a high performing community health service, with a strong reputation and a truly engaged community. Thanks Jim.

Finally, we would like to acknowledge the dedicated contribution of our staff and volunteers. Their tireless efforts to go above and beyond to make BCH a dynamic and compassionate organisation.

John Ferraro
Chairperson

Mick Geary
CEO

BCH ACKNOWLEDGE THE TRADITIONAL LAND OWNERS, THE WURUNDJERI PEOPLE OF THE KULIN NATION AND PAY RESPECT TO ELDERS BOTH PAST AND PRESENT.

ABOUT THE QUALITY ACCOUNT REPORT

BCH and the CCC are proud to present to the community and Safer Care Victoria, the 2017 Quality Account Report (QA Report). A report is produced each year because it is one of the most important ways that we let the community know about our services, how we are achieving our strategic goals, how we maintain safety and how we work to improve each year.

This year the QA Report is required to be submitted to the Victorian government office of Safer Care Victoria. Established 1 January 2017, Safer Care Victoria oversees and supports health services to provide safe and high quality care to clients.

FEEDBACK ON THE 2016 REPORT

This year 26 people provided feedback about the 2016 Quality of Care Report, which is similar to the number in 2015. Since 2012, the report has been rated 'highly' for its readability, presentation and people's level of interest in articles. As in previous years, people also told us that they enjoyed the "uplifting" photos and client stories. The 2016 report was praised for the amount of information that was presented and the range of services and programs that it covered. Although the majority of feedback indicated that nothing needed to change, suggestions for 2017 included more client stories and more about the work of GPs and Practice Nurses. We are happy to present more information from our medical practice this year as well as client stories.

DISTRIBUTION OF THE 2016 REPORT

Each year the QA Report is made available in the first instance at the BCH Annual General Meeting. It is then distributed within BCH and through external agencies.

- Banyule City Council
- Office for the local Member of Parliament
- Sent to all BCH members
- Web Site
- Client Orientation Packs
- Maternal & Child Health Centres
- Local Libraries
- Off-site Locations e.g. Men's Shed
- Waiting Rooms
- Volunteer Information packs

The majority of feedback in 2016 was from BCH clients who received a copy of the report at BCH, followed by those who got a copy from Banyule City Council.

COMMUNITY COMMUNICATION COMMITTEE

Once again the CCC gave much thought and direction to the content and presentation of the QA Report. We acknowledge and are thankful to the community members who were committed to producing the report in 2016/17.

Alan Cook
Alan Pearce
Eulie Emery
Jim Bogle
Judy Cochrane
Royal Abbott
Yvonne Wai

We would also like to acknowledge and express thanks to those community members who gave their stories to this report.

"It's really important for us as Farsi speaking women to preserve our culture and for our children to see, learn and belong to a group like this."

"We help new mothers to settle in Australia and find new friends for themselves and their little ones."

FARSI PLAYGROUP

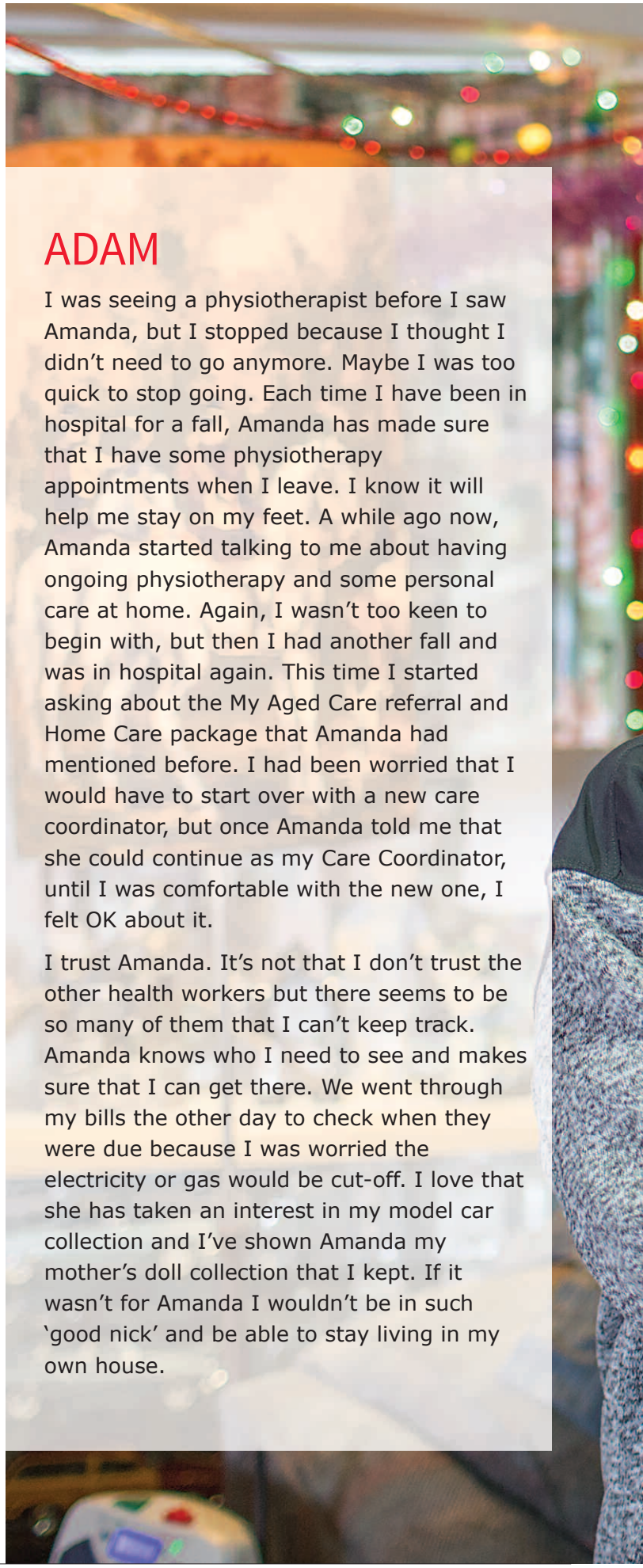
BCH gives us the opportunity to regularly gather together as Farsi speaking women and keep our cultural celebrations. We had Nowruz (the Persian new year) just a week ago and had an amazing time in the children's room at BCH. I wore a traditional dress and brought food as well as other traditional items for the celebration. We felt connected to each other and our culture.

THE TWO OF US

AMANDA

I met Adam earlier this year when the hospital referred him to the Health Independence Program at BCH. I like working with Adam. He's quite a character, a proud Scotsman who grew up in Glasgow playing soccer with his six brothers. I think his overall passion for life is what drives him to want to stay living in his own home. At 82 years old, Adam has Type 2 Diabetes, arthritis in his neck and shoulders, poor mobility and has started having regular falls. The falls have put him in hospital three times this year. As a Complex Care Manager, I work with Adam and service providers so that he can manage his health and social situation and stay in his home for as long as possible. When you have been independent all your life, it can be hard to realise that you may need extra help. Adam is slowly finding out what works for him.

I coordinate Adam's health and social care by being the link between him and all the health professionals he sees. The health system is complex and I make sure Adam receives what he needs smoothly. For example, when Adam is in hospital I advocated for the services he needed to go home safely. These services were only short-term. After his third admission for a fall, I worked with hospital staff to secure ongoing personal care services. After explaining the new aged care system to Adam and giving him lots of information over time, he recently agreed to be assessed for a Home Care package. He was approved for ongoing services. I talk with Adam's Podiatrist and Diabetes Educator and make sure he follows up with his GP when he gets test results or letters. I talk with all the health professionals involved and make sure he gets the best possible care when new needs arise. This means working with hospital staff as well as services in the community.



ADAM

I was seeing a physiotherapist before I saw Amanda, but I stopped because I thought I didn't need to go anymore. Maybe I was too quick to stop going. Each time I have been in hospital for a fall, Amanda has made sure that I have some physiotherapy appointments when I leave. I know it will help me stay on my feet. A while ago now, Amanda started talking to me about having ongoing physiotherapy and some personal care at home. Again, I wasn't too keen to begin with, but then I had another fall and was in hospital again. This time I started asking about the My Aged Care referral and Home Care package that Amanda had mentioned before. I had been worried that I would have to start over with a new care coordinator, but once Amanda told me that she could continue as my Care Coordinator, until I was comfortable with the new one, I felt OK about it.

I trust Amanda. It's not that I don't trust the other health workers but there seems to be so many of them that I can't keep track. Amanda knows who I need to see and makes sure that I can get there. We went through my bills the other day to check when they were due because I was worried the electricity or gas would be cut-off. I love that she has taken an interest in my model car collection and I've shown Amanda my mother's doll collection that I kept. If it wasn't for Amanda I wouldn't be in such 'good nick' and be able to stay living in my own house.

ASYLUM SEEKERS

Community Midwives support women during pregnancy. Their care is shifted to Maternal & Child Health Nurses (MCHN) once the baby is born and until they start school.

In a unique partnership with Banyule City Council, Community Midwives at BCH are also qualified MCHN. The model recognises that for some families, a trusting relationship with a nurse during pregnancy, can influence their future uptake of services.

MEI

Mei is an asylum seeker whose partner had been sent home while she was pregnant. She had no family in Australia and had not yet made any friends. With no income, Mei found it difficult to pay the rent. She had little furniture and nothing put aside for the baby. She had come to BCH looking for furniture and was introduced to the MCHN. Over a few visits she was able to check the health of Mei and her baby. The MCHN organised for some baby clothes, nappies, a cot, pram and a high chair from 3081 Angels.

Following the birth of her baby, Mei observed 30 days of cultural confinement where she and the baby did not leave the house. She was under enormous stress having had her first baby without any connections to family, friends or her Chinese culture. Having met the MCHN a few times before her daughter was born, Mei was happy to set up a schedule of home visits and phone calls. The flexibility of the MCHN to continue to support Mei beyond her pregnancy was essential to the health and wellbeing of mother and daughter.

When Mei started to show signs of post-natal depression, the MCHN was able to give her some strategies to help her get by until she could leave the house. The stigma surrounding mental health in the Chinese culture meant Mei felt great shame and did not want anyone else to know, particularly her partner. With lots of reassurance, however, Mei agreed to see the GP at BCH and the MCHN went with her.

The GP was the second health professional Mei got to know. Over time she and her daughter started to use other services at BCH. The MCHN also made links to the Red Cross for Mei's accommodation when her asylum seeker status changed. Mei and her baby now receive Centrelink payments and importantly, are regular attenders at BCH playgroups that target vulnerable families.

Mei is learning how to seek and use the services that she and her daughter need because of the ongoing advocacy and care coordination provided by the MCHN.

Interpreter usage

Oncall Interpreters and Translators
434 interpreter bookings
January – June 2017

An interpreter was used so that the MCHN had accurate information and Mei could make informed decisions about her care. The interpreter also helped the pair develop a trusting relationship which was important for Mei as she learnt to seek and use the services she needed.

Top 10 Languages	
Arabic	24%
Somali	17%
Mandarin	16%
Cantonese	10%
Farsi (Persian)	10%
Greek	4%
Italian	3%
Turkish	2%
Vietnamese	2%
Chin Haka	1%

3081 Angels joint Winners

Banyule Council Volunteers Awards 2017. A volunteer organisation that provides local children with pre-loved clothes and furniture. A partnership between BCH and the Rosanna Baptist Church.

3081 Angels

July 2016 – June 2017

331 families supported
71 prams
68 cots
26,000 items of clothing
46 car seats
2,000 nappies
2,359 volunteer hours

PEER SUPPORT

Community members contribute at all levels of the agency in the design and delivery of their health services. At BCH there is consumer membership on the Board of Directors and an Aboriginal Mentor to the Board. Community members hold voluntary positions on operational committees and on interview panels for staff selection. They are also integral to the planning and leadership of many community based projects such as Peer Connection, Men's Shed, 3081 Angels, Buna Reserve community garden and Drug & Alcohol Recovery Group.

Q & A WITH A PEER CONNECTION VOLUNTEER

Peer Connection is a telephone support service for people dealing with the harmful impacts of gambling on their lives, their family and loved ones.

Q: Let's start with a little bit about your gambling history?

A: Hi, my name is Simone and I struggled with a gambling problem for 9 years. Gambling was the most enjoyable thing in my life at the beginning. I used to go nearly every day of the week and couldn't stop myself from walking into venues to play the pokies. When I was there, I could zone out from all the other problems in my life and it felt like a safe place to go. But in the end it caused me more and more problems. It dominated my thoughts and I accumulated a lot of debt - because in the end the pokies always win.

82% (18/22) of clients agreed that their situation had improved because they were supported by peers through the Peer Connect program.

As an indicator of recovery, 54% (12/22) of clients said that they felt more comfortable and confident discussing their gambling problem with people close to them after being supported by the Peer Connect volunteer.

Q: Tell me about your turning point?

A: Eventually, I knew I had to change and I hated the way it dominated my thoughts. I was also worried about losing my house and it had started to affect my relationships with my family – I was always angry and irritable and felt guilty about all the secrecy.

I saw a counsellor from Gambler's Help Northern, who helped me change my habits and get my life back on track. It was really hard work. I also "self-excluded" from venues near my house. Self-exclusion is a formal program where once I registered as not wanting to gamble, staff could ask me to leave the venue. The less I went, the less the urges bothered me and eventually they faded into the past. I would never have thought that could happen while I was gambling: but it did.

Once I had been free from gambling for 12 months, my counsellor suggested that I might volunteer for Peer Connection. She thought it would help my own recovery as well as being helpful to others who were still struggling from gambling. I became a Peer Connection volunteer, which means I provide telephone support to people who are currently gambling.

Q: What are the benefits of the Peer Connection Program?

A: In the beginning, it was great for my recovery – it kept me on the straight and narrow and I really enjoyed helping others. Now, 5 years on, I can see how useful it is for people still struggling with their gambling. Peer support is non-judgmental. We've been there and know how easy it is to get caught up in it all. Support from people who have recovered is encouraging and offers problem gamblers a sense of hope – that they can change. There's so much shame and stigma with gambling. It's great for people to talk to someone who knows how it feels and has experienced that guilt and stigma.

Q: What's your tip for people who might have a gambling problem?

A: Get as much help as possible from as many different people as possible – counselling, financial counselling, the Peer Connection Program and peer support groups. Try everything!

Clients have said . . .

"I wouldn't be where I am without the calls."

"I don't feel judged by the volunteer which helps me think through the changes I have to make."

CULTURAL AND SPIRITUAL NEEDS AT THE END OF LIFE

"It's part of our culture to care for our daughter at home no matter how difficult; other people can't love and care for her like we can and she must see the family priest."

Cultural and spiritual needs can underpin the wishes, and expectations, of a client's family to care for their family member in the home for as long as is possible. At BCH, Occupational Therapists (OT), Physiotherapists and Podiatrists work with clients in their homes.

Although a client may be referred for health issues before end of life is of any concern, circumstances can change quickly when clients have complex medical conditions.

SYLVIE AND HER FAMILY

A BCH OT recently worked with an Italian family where the client's care goals shifted from improving her mobility through wheelchair and home modifications to a need for palliative care.

Sylvie had Motor Neurone Disease (MND), a condition that involved progressive deterioration of mobility. At 55 years old, she was living with her mother and brother because she could no longer live on her own. Recently, Sylvie had become more unsteady on her feet and was needing to use her wheelchair, even in the house. It impacted on daily activities, for example eating at the table and going to the toilet.

Sylvie was seeing the BCH OT to prescribe the appropriate equipment she needed to stay as independent as possible.

CARE IN THE HOME AND THE OCCUPATIONAL THERAPIST

Although Sylvie could not regain her independence completely, modifications in her home and to her wheelchair, would improve her mobility. Modifications would also reduce the physical stress on her mother and brother who provided all of Sylvie's care.

For years the family had decided against receiving any home services. Their strong cultural beliefs meant that they expected to provide for all of Sylvie's needs, physically, mentally and spiritually. It was important that the family provided most of the physical care and followed cultural practices. For example, the family priest would come to the house so that Sylvie could receive communion and prayer and be assured of a safe passage to heaven. If the family could not care for Sylvie, they would have felt an enormous sense of failure and shame.

The OT was concerned about the health and wellbeing of Sylvie's mother and brother. They did a great deal of heavy lifting that posed a risk to themselves as well as Sylvie's safety. Sylvie's brother was the only one who could lift her up the stairs to her bed and the shower chair. As a result, he had not had a break for over 18 months.

There were several competing issues that the OT identified and worked through with the family. The OT had to balance Sylvie's specific health care needs with her safety, and that of her mother and brother from the heavy physical activity involved in her care. Any changes to Sylvie's care needed to support the family's cultural and spiritual needs as well as promote mental health and wellbeing.

The OT educated the mother and brother in safe lifting techniques and encouraged them to move Sylvie's bed downstairs. The OT drew up diagrams to guide modifications for the downstairs bathroom, worked with the equipment suppliers, wrote technical applications for funding and provided specialised information for the client to receive priority access.

PALLIATIVE CARE AND THE OCCUPATIONAL THERAPIST

During the time that the BCH OT was involved, Sylvie's condition worsened and a Palliative Care team started to visit the family. It was an incredibly difficult time for the family who did not feel comfortable working with a new case manager or the idea of putting Sylvie in care.

The family had developed a trusting relationship with the BCH OT because they had worked together to keep Sylvie at home, in a way that eased the physical burden, and risk, from heavy lifting. As a result, the family were able to continue caring for Sylvie at home and the family priest visited regularly.

The trusting relationship between the family and BCH OT meant that she was able to act as the main link to the new case manager and successfully introduce some palliative support into the home. The OT said that Sylvie declined rapidly. The challenge was to gain acceptance by the family for some support in the home, within a very short space of time.

Overall, the most important role of the OT was to work in partnership with the case manager to facilitate a smooth transition for the family to palliative care services. The OT organised for quick delivery of equipment such as a hospital bed, responded to phone calls from the family to alleviate their stress, advocated with the family for the involvement of the case manager and palliative care team and talked with the case manager about the needs of the client and the family.

Sylvie stayed home for as long as possible before going into hospital and dying two days later. The family felt that they had done all that they could to keep Sylvie at home, that her spiritual wellbeing was assured and she had a good death.

OUR SERVICES

IN ONE YEAR ...

Medical Practice had 19,662 clients

Gambler's Help Northern had 1,255 clients

Dental services:

- Treated 5,879 teeth
- Routinely extracted 1,173 teeth

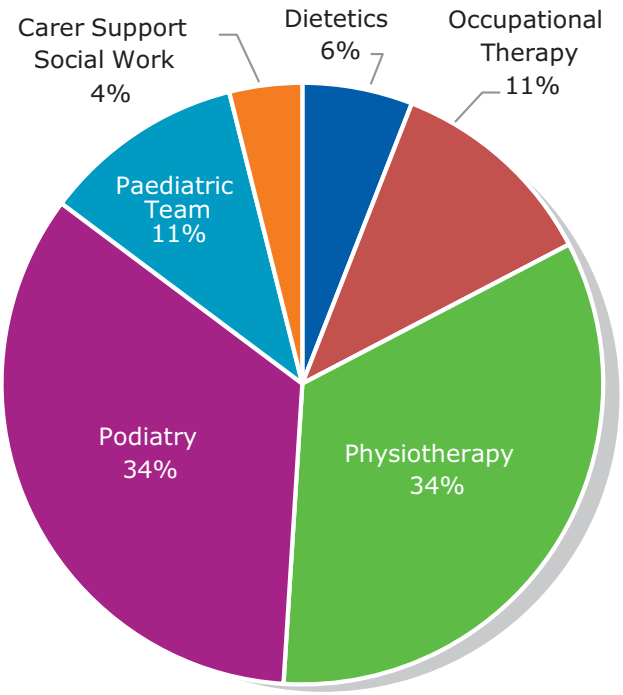
In an initiative of BCH with Swinburne University, a student-led psychology clinic provided 347 counselling sessions.

The Health Promotion Team worked with 77% (37/48) of schools in Banyule

Buna Reserve Community Garden has 46 garden plots

Allied Health Team had 26,356 appointments

Dietetics	1,563
Occupational Therapy	3,009
Physiotherapy	8,869
Podiatry	9,021
Paediatric Team	2,863
Carer Support Social Work	1,031



The role of an Alcohol & Other Drug worker co-located at the Emergency Department at Austin hospital was extended in 2017 to cover weekend demand. There was a 13% increase in referrals in the last financial year to 480, compared to 425 in 2015-16.

West Heidelberg Legal Service had 626 appointments

Emergency Relief and General Case Work had 2,158 appointments

Counselling services had 5,261 appointments

The Green Team diverted 72 kg of landfill by recycling all the printer cartridges

The Men's Shed is run by five Volunteer Supervisors from the local community

1,128 registered clients identified as Aboriginal and/or Torres Strait Islander

FAMILY VIOLENCE SUPPORT

It is well established that legal, health and social issues can cause poor physical health and wellbeing. BCH recognises that providing accessible social and legal services to people experiencing difficulties in these areas is essential to our purpose of improving the health and wellbeing of our community.

In 2016 the West Heidelberg Legal Service (WHLS) employed a lawyer* to work specifically on issues of family violence. In the last 10 months the family violence lawyer has assisted 60 woman who are responsible for the care of 63 children.

Clients have been able to see a lawyer quickly. More than 75% of clients have met with the family violence lawyer within one week of seeking a service. Of these, 11 saw the lawyer immediately or the next day and 11 others were seen within 3 days.

OUR STORY

NIKAU

My husband is a violent man. I took the kids as far away as I could, once they had finished primary school. Although we went to Queensland, he still managed to find us; so we came back to Melbourne. I tried to get onto the public housing waiting list, but found I couldn't because I owed $2,000 to the Office of Public Housing. It was for damage that my husband had done to the old house, which was listed in my name.

I can't tell you how terrified I was. We had no home and weren't even on the waiting list. Although we were at my sister's place, I had 3 teenage kids and a grandchild with me. Where could we go?

Luckily, Berry Street Child & Family Services helped me get a house that I rented privately. It was a struggle to pay the rent and I fell behind when a number of other bills were due at the same time, namely school fees and car registration. I was afraid that we would have nowhere to live again.

It wasn't until the GP asked me how my kids were that I started talking about how my oldest boy wanted to leave school and get a job to help with the bills. I said that living with such an abusive dad for so long had made him very protective of me and the younger kids. The GP was really nice and asked me more about my husband, the bills, where we were living and other things.

FAMILY VIOLENCE LAWYER*

Nikau's GP referred her to the legal service because of financial issues related to family violence. I saw her on the same day.

As well as the $2,000 house maintenance debt, Nikau was $3,000 in rental arrears, at serious risk of eviction and experiencing extreme financial hardship. In addition, she was renting whitegoods and furniture for her house, because she had to leave what she did have at the old house, when she fled from her husband. As we talked more, Nikau said that she also had a court ordered fine for a driving offence.

I was able to help Nikau by doing the following:

- Successfully advocated to the Department of Health and Human Services for the $2,000 maintenance debt to be withdrawn.
- Lodged an application to appeal and reverse the decision to refuse Nikau's application for priority housing.
- Supported her to access a rental brokerage payment through a housing support service which contributed one month's rent to her rental arrears debt. I had identified Nikau as 'at risk of homelessness'.
- Negotiated with the court for a more manageable repayment plan for the court ordered fine related to the driving offence.

With agreement from Nikau, I worked with the BCH Social Worker and applied for urgent financial assistance through a Family Violence Flexible Support Package. The application was successful and helped Nikau to further reduce her rental arrears, buy essential furniture and whitegoods, pay school fees and other necessities.

Although Nikau's legal and financial concerns had been addressed, it was important that she was able to manage her finances and the stressors associated with family violence into the future. As a result, I referred Nikau to the BCH Financial Counsellor and a general support counsellor, who each specifically work with people in situations of family violence.

**Department of Justice and Regulation Community Legal Centre Family Violence Fund*

ACTION AGAINST FAMILY VIOLENCE

The Family Violence lawyer is one of several initiatives at BCH, that ensures clients experiencing family violence are supported in a timely way. Other services are:

- Co-located family violence worker from Berry Street Child & Family Services
- Co-located Child First worker in Service Access team to facilitate referrals
- Financial counsellors and general counsellors who specialise in family violence.
- Playgroups for families, many of whom have experienced family violence.
- Participation in community events and activities, such as the annual Reclaim the Night walk and the Say No to Violence campaign.

The uptake of support services by people experiencing family violence, is largely dependant on the initial response they receive, when they begin to tell all or part of their story. Clients are most likely to start to reveal their story to a staff member they already trust. Staff could be from any of the multiple program areas of the agency. BCH is committed to ensuring that key staff across all program areas are able to respond appropriately, and recognise when a client may be experiencing family violence.

Executive Managers, Team Leaders and Human Resources staff were trained by Women's Health in the North in the course, 'Identifying and responding to Family violence.' A second training opportunity has been made available in 2017 and is open to all staff.

No-one is "immune from family violence", including BCH Staff. Consequently, a group of staff trained in responding to family violence is also available to support staff who may not, for privacy reasons, want to raise the issue with their respective manager. Specific leave for family violence concerns, such as attendance at court hearings, has also been made available.

BCH is a signatory to the Building a Respectful Community Strategy 2017–2021 developed by Women's Health in the North. It is a commitment coordinate activities to prevent family violence and violence against women by agencies across the northern metropolitan region.

CLIENT FEEDBACK CONTRIBUTES TO CHANGE

RECEPTION SERVICES

In 2017, client feedback contributed to the redesign of BCH reception services at West Heidelberg. Clients told us that the physical separation of general reception services from dental reception services was confusing. There was also an increase in the demand for dental services which meant the stand-alone dental reception area was too small. As a result, the main reception area was re-designed to add dental reception services. The old dental reception area was closed and has been converted into office space. Additional reception staff were trained in dental requirements to ensure adequate coverage of the work-load.

As well as being more efficient, the redesign made it easier for people to find and access BCH services because the waiting area had been tailored to community need (Person Centred Approach, BCH 2015-20 Strategic Plan).

SMS APPOINTMENT REMINDERS

In response to client feedback, a Working Group was established in December 2016 to develop procedures for using SMS for appointment reminders. The BCH Medical Clinic trialled sending SMS reminders to existing clients and telephoning new clients in the morning of their respective appointments. The trial improved client attendance and was adopted by other program areas. The Client Information System that supports other BCH services (Trak-IT) was set up to send automated SMS appointment reminders.

COMMUNITY LEADERSHIP

FOR SEVERAL YEARS THE LOCAL ABORIGINAL COMMUNITY AND BCH HAVE WORKED TOGETHER SUCCESSFULLY. THE WORK WE DO TODAY IS POSSIBLE BECAUSE BCH HAS GONE THROUGH, AND CONTINUES TO GO THROUGH, AN EXTENSIVE PERIOD OF LEARNING AND ORGANISATIONAL CHANGE.

BABARRBUNIN BEEK

'HAPPY PLACE' IN THE LOCAL WOIWURRUNG LANGUAGE

Babarrbunin Beek is an Aboriginal controlled gathering place. BCH and Banyule Council provide support as is determined by the Babarrbunin Beek Committee of Management.

The gathering place provides for the local Aboriginal and Torres Strait Islander community to create a real connection to country. It is an established place of community ownership, where knowledge can be shared and culture celebrated.

"It is a space and land to look after, a place to care for country and build community"

Babarrbunin Beek is overseen by a Committee of Management with membership from the local Aboriginal community. They meet monthly and are supported by the BCH Aboriginal Health Team.

- The committee is Aboriginal controlled, and
- provides guidance and decision making to meet the purpose and aspirations of the local Aboriginal and Torres Strait Islander communities, it
- sets the direction for the development of cultural activities and opportunities within the gathering place, and
- advises BCH and Banyule City Council on matters relevant to the local people.

All community members are invited and welcome to have a voice and influence both local community initiatives, as well as broader local government thinking.

A range of community activities happen at Babarrbunin Beek, including men's and women's groups, cooking and food share activities, holiday activities for children, and cultural education. Larger than most people's homes, it is also a place where families and communities get together to celebrate events such as birthdays, christenings and family days.

BABARRBUNIN BEEK

STORY LINE PROJECT

The story line is a series of panels painted by the local Aboriginal community. They define the outside building of Babarrbunin Beek as an Aboriginal gathering place. Together, the panels are a timeline that tells the story of the Aboriginal controlled gathering place.

The community wanted to be able to recognise Babarrbunin Beek from the street. As it stood before the project, in Olympic Park, West Heidelberg, there was nothing on the building that set it apart.

Lead by an Aboriginal artist, Natasha, the paintings showcase the diverse styles of Aboriginal art. You will find animals, line work, footprints and handprints and Aboriginal symbolism. Half of each panel was completed by local Aboriginal community members. Images of three ribbons were used, by the artist, to link each panel together as a single artwork. Silhouetted trees run along the length of each ribbon. The top ribbon represents sunrise and the beginning of a new day. A middle ribbon is the blue, green colour of the Torres Strait Islander flag and also represents the Darebin Creek that runs through the area. The third ribbon shows the end of a day and a time to rest.

The project provided an opportunity for members of the community to come together and build a greater sense of ownership of the gathering place. People who had not practiced Aboriginal arts in a long time were able to reconnect with this cultural aspect of themselves and for others, it was the first time.

ABORIGINAL HEALTH TEAM

BUILDING CULTURE BUILDS BETTER HEALTH

Aboriginal Health Team

BCH Maternal & Child Health Nurses undertook 84% (75/89) of all Key Ages & Stages assessments with Aboriginal children aged birth – 3.5 years that were carried out in West Heidelberg 2016-17.

BCH provided care coordination for 129 clients with complex care needs in 2016-17 (Integrated Team Care Program for Aboriginal populations; Primary Health Networks).

BCH provided Aboriginal cultural training in 5 kindergartens with a total of 150 children across Banyule in 2016-17.

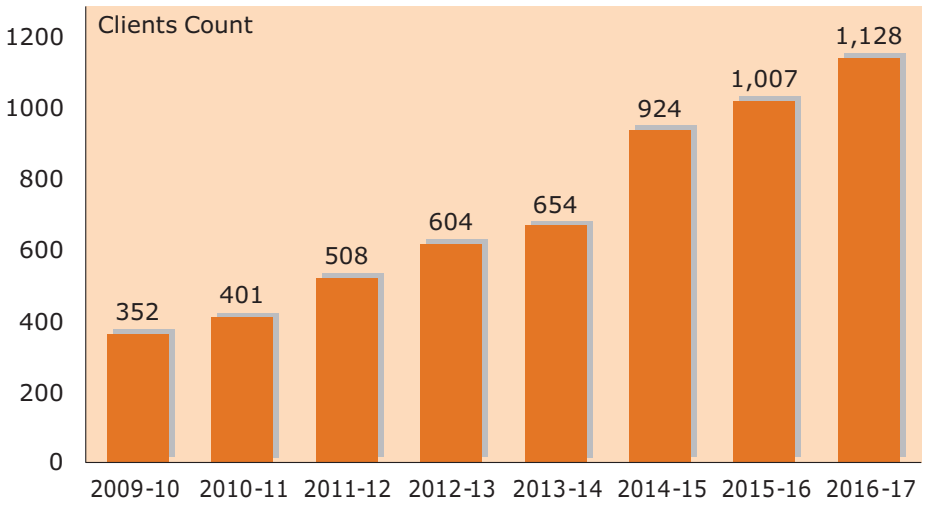
The Aboriginal Health Team delivers a range of community based services that support community members and their families. Building a safe, culturally competent and sensitive service is one way the Aboriginal Health Team strengthen connections to the local community.

Team members have been employed from the local Aboriginal community. A Team Leader supports five members who are employed in the following roles;

- Early Years and Maternal & Child Health Coordinator (funded by Koolin Balit government health strategy) and, Aboriginal Community Development Worker with West Heidelberg Legal Service.
- Aboriginal Outreach Worker and Maternal Child Health Support Worker.
- Caretaker, Babarrbunin Beek Gathering Place (Men's program), also completing the Closing the Health Gap Traineeship (Koolin Balit).
- Cultural Educator in pre-schools and kindergartens in Banyule, Bullen Bullen Program. In 2017 the work extended to a local primary school, Prep – Grade 6.
- Aboriginal Care Coordinator and Supplementary Services (Complex Care). Integrated Team Care Program for Aboriginal populations in the regions of the North West Primary Health Network (PHN) and Eastern PHN.

In 2017 BCH have secured an additional position for an Aboriginal specific role in therapeutic counselling.

REGISTERED ABORIGINAL & TORRES STRAIT ISLANDER CLIENTS



REDUCING THE RISK OF HOMELESSNESS

UNDERSTANDING AND ADDRESSING BARRIERS TO VCAT ATTENDANCE

The VCAT Attendance Project recognised that legal, health and social issues are connected and that a dual response leads to improved outcomes.

The West Heidelberg Community Legal Service (WHCLS) employed a lawyer and a social worker to provide an innovative program for people at risk of eviction and possible homelessness. The risk comes from failing to attend tenancy hearings at the Victorian Civil & Administrative Tribunal (VCAT).

The project also had a research component aimed at informing service responses, both in the legal and health sectors that would reduce the risk of homelessness for vulnerable populations. Knowing about the needs of the target group would enable services to improve client attendance at tenancy hearings, which in turn, is related to more stable housing.

The project identified the needs of the target group and the type of support required to maintain their tenancies.

It is accepted by VCAT that tenant non-attendance at tenancy hearings is high with some reporting it at 80%.[1]

The project supported 29 clients over 2 years, who attended 34/46 hearings. Results represent a 74% attendance rate, almost three times higher than the usual rate of 20%.

It was concluded that tenants are more likely to attend VCAT hearings, when receiving legal and social work assistance.

Demographic data indicated the target group experienced significant disadvantage, eg., 90% had financial instability, 90% were at risk of eviction, 50% had dependent children in their care and over 60% had a physical and/or mental health condition.

The project also shed light on characteristics of clients who did not attend VCAT hearings. Project clients who missed tenancy hearings were more likely to have a mental health and/or physical health diagnosis and past, or current use of alcohol or other drugs.

[1]Justice Iain Ross; President Victoria Civil + Administrative Tribunal. 2010 Discussion Paper Transforming VCAT. (unpublished)

CONTINUITY OF CARE

At BCH we are committed to making sure that the transition and coordination of a client's care between different services is of a high standard, is safe and made as easy as possible for the client.

From 102 clients who visited a Physiotherapist or an Occupational Therapist[1] (2017)

- ✓ 98% were satisfied with their level of involvement in decision making
- ✓ 96% agreed that they were better able to manage their health problem
- ✓ 98% of 127 clients rated the explanations provided by the GP as good-excellent[1]

MARY

I was doing pretty well for my 75 years until the osteoarthritis in my hip got worse. I thought it had spread to my back and then down the other leg. When I vacuumed, I had to stop every five minutes because of the pain. I avoided going out because if the pain got bad I didn't know how I would get home. I thought it would all be downhill from here and was really happy to find out that there were quite a few things I could do to make things easier. I saw my GP and he arranged for me to see a Physiotherapist and an Occupational Therapist (OT). They were able to visit me together at my house.

GP

When Mary told me that her hip pain had increased, I was concerned about the impact it was having on her daily life and that she was becoming isolated from friends and socialising in the community. Having been Mary's GP for 20 years, I knew that living independently in her own home was really important to her.

As we talked more, I realised that Mary mistakenly thought the osteoarthritis had "spread" to her back and the other leg. She thought that because of her age it would only get worse until she couldn't look after

herself anymore. She was very relieved when I told her that although it could turn up in other places, osteoarthritis did not spread that way. I reassured Mary that the pain could have several causes. We could do tests, use medications and, to begin with, see a physiotherapist. I also let her know about how an OT could help her and that it was something she might want to consider now or into the future.

After answering her questions, Mary decided that she wanted to see a physiotherapist and an OT. She was happy for me to share her information for the purposes of referral.

PHYSIOTHERAPIST AND OCCUPATIONAL THERAPIST

Similar information is collected by a Physiotherapist and an OT when a person has problems that stop them doing what they would usually do. For this reason, the BCH Physiotherapist and OT carried out a joint assessment and with Mary, developed a joint care plan. The Physiotherapist took the lead in the home visit and joint assessment.

"I asked Mary about her hip, back and knee pain and how it was affecting her. We talked about the things she likes to do, how she was managing around the house. I asked how she was feeling in herself, particularly as she wasn't going out as often. Mary was also able to confirm the information we had from the GP; namely her medical history and list of current medications."

"I tested Mary's walking as well as her leg strength and balance. Apart from the arthritic hip and weakness around that area, I could reassure her that her other knee and hip seemed fine for someone her age. On finding out that her pain felt worse in the morning and at certain times during the day, the OT asked if getting in and out of bed or the shower was painful. When Mary showed us how she got up from the toilet, I could see that she put most of her weight on one side and was unsteady. I asked Mary to do some other movements and the OT looked in the bathroom and kitchen and asked Mary how she managed the front door step."

"It was evident that the pain in Mary's hip was causing her to walk with a limp and she had been favouring the other leg. The change in the way she walked, caused the pain in her back and the other knee and hip."

MARY'S GOALS AND OUTCOMES

Mary wanted to decrease the pain and be able to walk further, so that she could do the things that she used to do. The three of us discussed what the options were and developed a plan to strengthen the muscle around the hip joint to try and reduce the need for surgery. We also wanted to increase Mary's ability to self-manage her pain, improve her mobility and ensure she was safe doing her normal daily activities. Using the grab rails and walking stick that were ordered for her, in addition to daily strengthening and balance exercises, Mary was able to improve her mobility and manage the pain.

BEHIND THE SCENES

The GP filled in a BCH Internal Referral Form and sent it to the BCH centralised Service Access Team. Having a standard form made sure that all the relevant information was transferred accurately and confidentially between service providers. It detailed Mary's current issues so that she didn't need to repeat her story to get an appointment. The Service Access team put Mary on the waiting list. They also flagged to the Physiotherapy and OT teams that she may be appropriate for a joint assessment because she was waiting for both services.

A Physiotherapist and OT arranged to do an assessment with Mary at the same time so that they could best understand the issues and coordinate her care. Again, it meant Mary would not have to repeat her story and could be assessed for two services in a single appointment.

Before the home visit, the Physiotherapist telephoned to check if there were pets or other things about the house that could make the visit difficult or unsafe for the workers.

Following a thorough assessment, the Physiotherapist and OT were able to develop a joint Care Plan so that Mary knew the things she needed to do and the services she would receive to reach her health goals. As is our usual practice at BCH, the OT and Physiotherapist wrote a letter to the GP about the assessment and the outcomes with a copy of the Care Plan. The Care Plan would be reviewed with Mary in 6 weeks to track progress in achievement of her goals.

1. Practice Accreditation and Improvement Survey (PAIS) Royal Australian College of General Practitioners, 2016

FROM HEALTH PROMOTION TO TREATMENT

PAEDIATRIC SERVICES

BCH provides services across the continuum of care aimed at social, mental and physical development of children aged 0-16 years. To achieve the best outcomes for children, BCH works with their families, carers and other supporting services such as kindergartens. Vulnerable families can have complex needs and BCH coordinates a range of flexible service options to best meet these needs.

Lowanna has been coming to BCH for at least seven years and in that time has built a strong network of support for her family.

LOWANNA AND HER CHILDREN

Apart from going to hospital to give birth, I didn't regularly use any pregnancy or baby services until my third baby. I did see Elischka, a BCH Community Midwife and Maternal & Child Health Nurse (MCHN), a few times when my oldest boy was 3 years old. I went because the GP said it would be good to keep track of his growth and development. My boy was doing fine so I didn't see the point in going again.

COMMUNITY LED CULTURAL GROUPS – HEALTH PROMOTION

By the time my second child was 2 years old I was running Aboriginal cultural dance classes in one of the community rooms at BCH. The group was great and as a cultural educator through dance, I was able to help my kids and others learn and be connected to their heritage. A lot of people came to the group and we performed at special events like NAIDOC week.

PLAYGROUPS - EARLY INTERVENTION

One day when I was seeing the GP I bumped into Elischka in the waiting room and we got chatting. She hadn't met my second boy and the oldest had grown so much. I decided it would probably be good to check their developmental progress so I made an appointment with her. I'm glad I did because my second child needed some help to catch up with the other kids in terms of speech and movement.

Elischka got the ball rolling and talked to my GP. She also made an appointment with me to see the GP and he referred us to the Paediatrician at BCH. The Paediatrician was really thorough and even talked to staff at the child care centre that my son went to. We also saw the BCH Speech Therapist and Occupational Therapist and my son ended up doing the 'Ready Set School' group with them. He goes to school now but there is no way he would have been ready to start without the help he got from the Paediatric team.

CHILDHOOD IMMUNISATION - PREVENTION

I really, really hate injections and Elischka and the Practice Nurse in the medical clinic were great in helping me get the kids immunised. I don't think I made it easy for them. I wasn't good at attending appointments and they basically had to do it when I was there for other reasons and feeling brave enough to sit with the kids.

ALL THE SERVICES WE NEED IN THE ONE PLACE – CONTINUITY OF CARE

It's convenient for me to come to BCH because we get all the services that we need in the one building. I have one child who 'doesn't take' to many people but he is always happy to come here. I think it's because he knows Elischka and the GP and we've done the dancing group here so he knows the place.

MANAGING DEVELOPMENTAL AND HEALTH CONDITIONS - COORDINATED CARE

My third pregnancy was really difficult. After he was born my son had lots of surgery in his first five months. If it wasn't for Elischka I wouldn't have been able to manage. She went to appointments with me and helped me talk to all the other health professionals and understand what was going on. It helped me make the decisions about his care that I needed to.

It was such a relief to take him home but I was also really nervous. We were referred to the Paediatrician at BCH. The GP, Paediatrician and Elischka helped us get specialist Early Intervention services because he had cerebral palsy. Elischka worked closely with the Disability Case Manager, which made me feel like I wasn't missing anything. I called Elischka whenever I was worried about anything or if I thought the kids were sick. She would talk me through the options I had. We even have my sons' Case Conference meetings with the Early Intervention team at BCH. My house is too small to have them there and I can bring the other kids to the meetings too.

OUTCOMES

With my fourth and fifth pregnancies I went to all the appointments and did the tests and check ups because I know it's better to get any help that's needed early. I have two girls now with the three boys. My oldest boy is at high school. My next boy is doing well in primary school after he did the 'Ready Set School' group. My third son is doing really well at a special developmental school. The BCH Paediatrician, Elischka, the GP and the school all work together so that my son gets everything that he needs. One of my girls will start kindergarten next year and the other will still be at home with me.

I guess like most families we need different services at different times, or for us, sometimes, it seems like it's all at once! All I know is that Elischka and all the services at BCH work together so that we can stay healthy and if we get sick we can get the help we need.

DENTAL SERVICES

STERILISATION OF EQUIPMENT AND NEW STANDARDS

In 2016 BCH set up a Sterilisation Working Group to ensure full compliance with new Australian standards for sterilisation, physical space and equipment, (AS/ NZS 4187: 2014). The group has completed a gap analysis, undertaken three detailed risk assessments and is implementing an action plan to enable full implementation of the standards over a 5 year period starting December 2016. The Medical Practice have trialled the use of disposable equipment and found it efficient and effective and will continue with this approach. Other services at BCH are looking into centralising sterilization services to improve efficiencies. Dental services have implemented new policies and procedures and installed new equipment, such as a Batch Washer.

DIAGNOSTIC X-RAYS IN DENTAL SERVICES

BCH has recently purchased equipment to carry out OPG Diagnostic X-rays in Dental Services. An OPG X-ray is a wide X-ray that shows teeth of the upper and lower jaw in one picture. It even shows the position of teeth that have not yet surfaced. Previously clients needed to have X-rays carried out at an outside location. Clients would then attend BCH dental services again to consult with dental staff about the results and decide on the best course of treatment.

The ability to obtain instant X-ray images at BCH has improved diagnosis and the timely provision of dental treatment. Clients have reported that it is more convenient for them. The work-flow and efficiency has also improved because diagnostic information is available at the time of treatment planning. Each X-ray image can be claimed through Medicare, allowing for additional funding revenue once the initial outlay of equipment purchase has been paid off.

PRIMARY SCHOOLS

A BCH oral health screening program, delivered in local primary schools, has improved the oral health of children and increased attendance at dental services. Graduate Oral Health Therapists from BCH conduct 'mouth checks' with children.

Health Promotion staff deliver a "Clean, Eat and Drink Well" education session that they developed in collaboration with BCH Dietitians.

Tooth decay is five times more prevalent in children than asthma and has been linked to chronic health conditions later in life. In 2016-17, BCH visited 10 schools and 1,600 children received class room based education on oral health.

Oral health screening was carried out with 659 children. Of these, 9% were referred to a dentist because of possible decay. At the time of follow up, 46% of the children referred for the possibility of decay had visited a dentist, either at BCH or privately. In one school, 12 children from the 45 screened (26%), had suspected tooth decay.

The high level of decay among students and related follow up visits to the dentist, suggest that addressing oral health by visiting schools impacts on the health and wellbeing of children.

Perhaps one of the best indicators of improving outcomes from a population health perspective is that all participating schools integrated oral health and the BCH program into the curricula for future years. It also demonstrates a high level of satisfaction from participating schools.

EARLY CHILDHOOD SERVICES

In 2016-17, the Smiles 4 Miles program (Dental Health Services Victoria) was delivered to 12 early childhood services with a total of 782 children who took part in the program. Twenty one teachers were trained in oral health and parents were able to attend.

CLIENT FEEDBACK

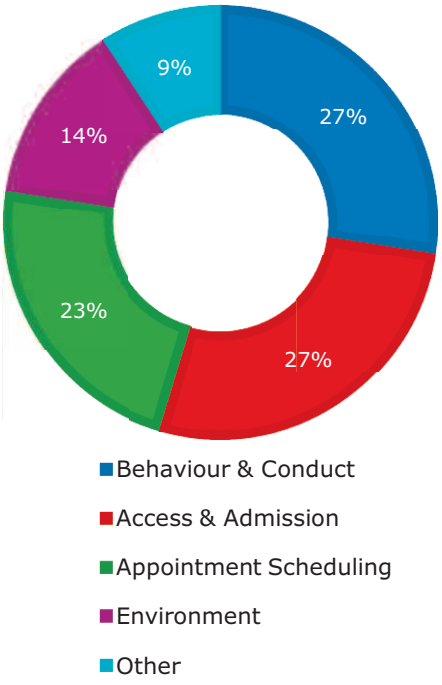
COMPLAINTS

BCH uses feedback from clients to improve services and to uphold client rights to make formal complaints. From January to December 2016 there were 85 episodes of consumer feedback. Of these, 22 were formal complaints, 55 were compliments and 8 were suggestions. Although there were ten fewer complaints made this year compared to 2015, the range seems to have stabilised at 20-30 since 2014.

100% of clients/carers who gave their contact details were sent an acknowledgement of receipt of the feedback (17/17). BCH procedure stipulates that an acknowledgement should be sent within 3 working days. Similar to results from last year, there was 92% compliance in 2016. 100% of complaints were resolved within the two week time-frame stated in BCH procedure, with the majority taking 5 days.

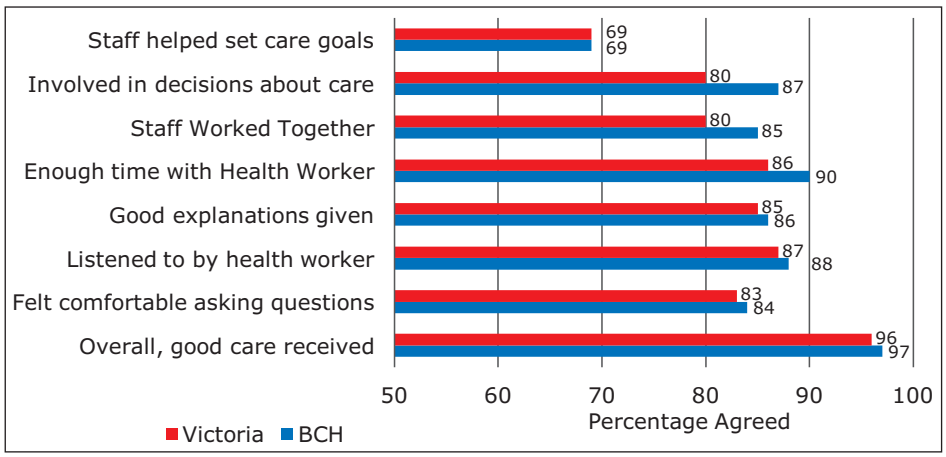
Unlike previous years, there was a relatively equal distribution across the three most frequent types of complaint. Access to services, in particular time spent on the wait list, was of concern to 27% of complainants. The same number of complainants (27%) complained of poor behaviour, mainly from staff. A further 23% of complaints were about scheduling of appointments. Scheduling of appointments has rarely been raised as a complaint. Client feedback is routinely monitored and a review in June 2017 demonstrated no further complaints of this type. It is likely that re-design of reception services at West Heidelberg and a period of staff training in new systems, caused some initial problems with scheduling appointments. Client feedback in 2017 suggested that it was no longer a concern.

For the third year in a row there was a greater number of compliments compared to the number of complaints. 64% of feedback was for compliments; 26% was complaints and 10% were suggestions. The majority of compliments, 83%, were in the area of "good care provided."



VICTORIAN HEALTHCARE EXPERIENCE SURVEY

In 2016, 108 clients from BCH completed the Victorian Healthcare Experience Survey (VHES). Client feedback from the VHES is particularly useful for quality improvement because for the first time, agency performance can be benchmarked against other community health services. BCH performed favourably in most areas compared to other community health services statewide. BCH had a survey response rate of 20% compared to a statewide return rate of 16%.



127 clients who saw a GP were surveyed for accreditation[1] of the BCH medical clinic in 2016.

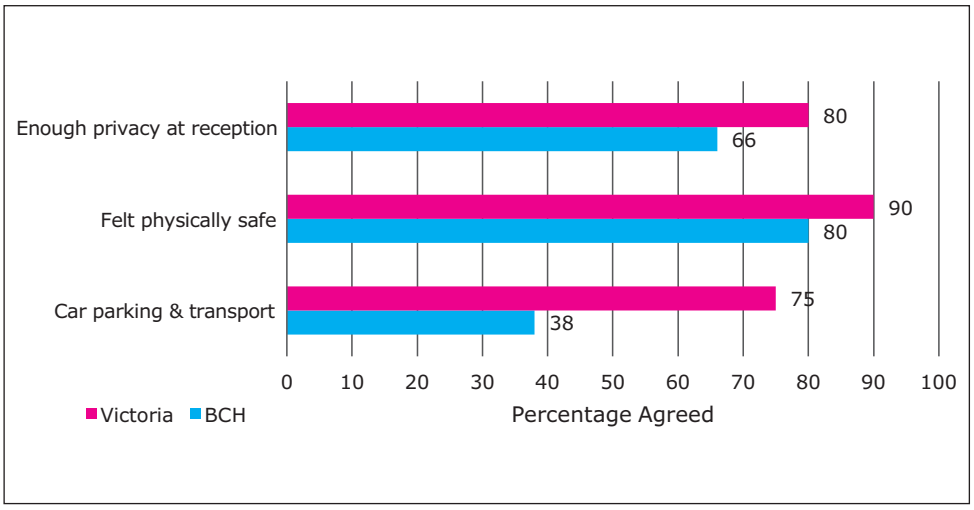
98% rated the GP as excellent to good at

- listening to their concerns and fears
- explanations of their issues

95% of all patient ratings about BCH

AREAS FOR IMPROVEMENT

Regardless of high performance there are always areas for further improvement. BCH is working towards improving our performance in the areas of privacy and physical safety in the reception areas. Improving the car parking and transport to BCH services is beyond the ability of the agency, however, options of co-location and off-site service provision are always being explored.



1. Practice Accreditation and Improvement Survey (PAIS) Royal Australian College of General Practitioners, 2016

ACCREDITATION ACTIVITIES

Although accreditation against some standards in 2016-17 focussed on specific services, many agency wide systems and practices were included because of the integrated nature of services at BCH.

FULL-CYCLE

- ✓ Royal Australian College of General Practitioners (4th Ed.) Standards for General Practice [October 2016] Australian General Practice Accreditation Limited (AGPAL)
- ✓ Included Practice Accreditation and Improvement Survey (PAIS)
- ✓ Commonwealth Home Support Program (CHSP): Home Care Standards. [May 2017] Australian Aged Care Quality Agency.

MID-CYCLE

- ✓ Quality Improvement Council Health & Community Services Standards [mid-cycle June 2017; full accreditation September 2015] QIP
- ✓ National Standards for Quality Health Services; Stds.1,2&3 Dental Services [mid-cycle June 2017; full accreditation September 2015] QIP

COMMENDATIONS

(Standards for General Practice)

Std 3.2 Education and training: Criterion 3.2.1 Qualifications of GPs

Std 1.7: Content of patient health record: Criterion 1.7.2 Health summaries

RECOMMENDED ACTION

In 2017 BCH completed work to ensure staff and volunteers had three yearly Police checks in order that the agency was compliant with the following standards:

HOME CARE STANDARDS

1.2 Regulatory compliance

1.6 Risk management

1.7 Human resources management

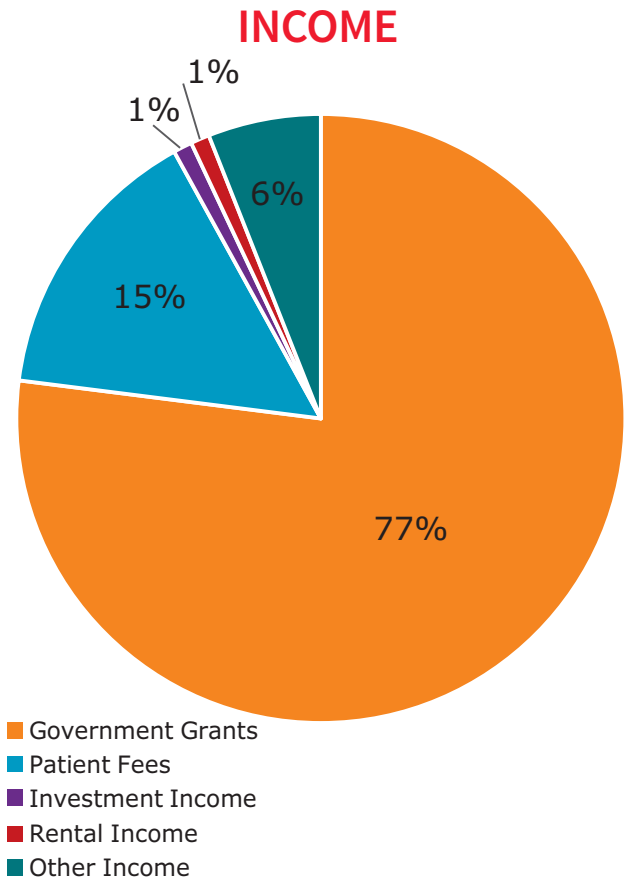
RESULT	TARGET	ACTION
Completed (July 2017) 100% of members on the BCH Board of Directors (BOD) have a three yearly Police check.	It is a CHSP requirement that the BOD and Executive Management have a 3 yearly police check. All Executive Management had current Police checks. No members on the BOD had a current Police check.	1. Inform the BOD of the requirements and send the documentation. 2. Complete Police checks 3. Review BOD Recruitment Policy and Procedure to include a process for 3 yearly checks.
Completed (May 2017) 100% of Allied Health staff who work with adults and Therapy Clinical Supervisors have a three yearly Police check.	It is a CHSP requirement that all staff with client involvement have 3 yearly Police checks, including Clinical Supervisors.	1. Inform Clinical Supervisors and adult Allied Health services staff of the requirements and send the documentation. 2. Complete Police checks.
In Progress (June 2017) Position Descriptions describe the need for a 3 yearly Police check.	Position Descriptions outline the requirement for a 3 yearly Police check. Currently PDs state a Police check is only required at recruitment. PDs specifically for BOD members, CEO, Executive Managers, Team Leaders, Clinical Supervisors, (June 2017)and Allied Health teams.	1. Position Descriptions to be updated with new requirement. 2. Re-issue Position Descriptions to staff for sign-off
In Progress (June 2017) 100% of BCH employees and volunteers have a three yearly Police check.	Any staff employed prior to 2015 did not have a current 3 yearly Police check. All staff are required to have a 3 yearly Police check.	1. Executive Management have approved all BCH employees and volunteers have a 3 yearly Police check. 2. Review the Police check Policy and Procedure. 3. Human Resources develop staff re-call processes. 4. Complete Police checks

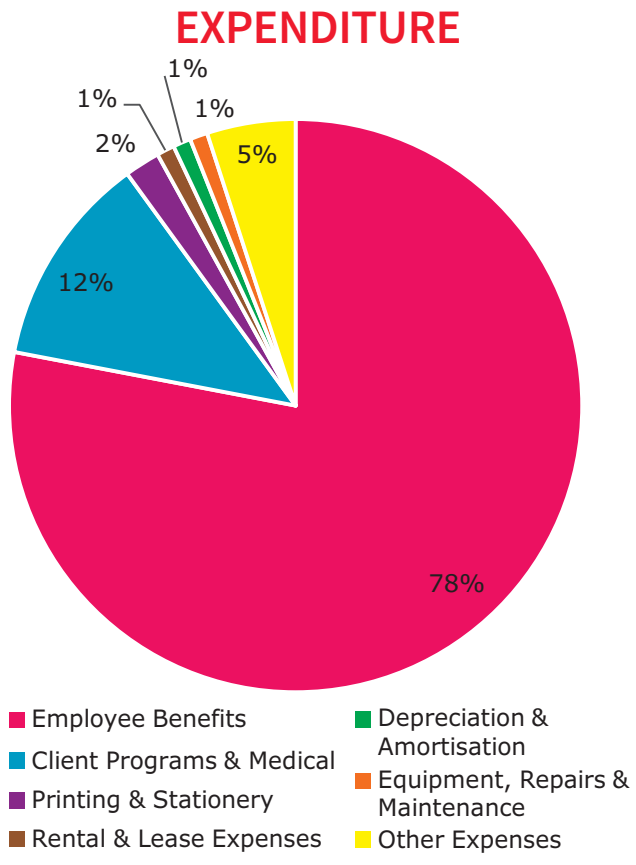
2017 FINANCE SUMMARY

A summary of income and expenditure at BCH for the last financial year is provided below. The full BCH Annual Report and Financial Statements are available online at www.bchs.org.au/annual report and will be sent to BCH members.

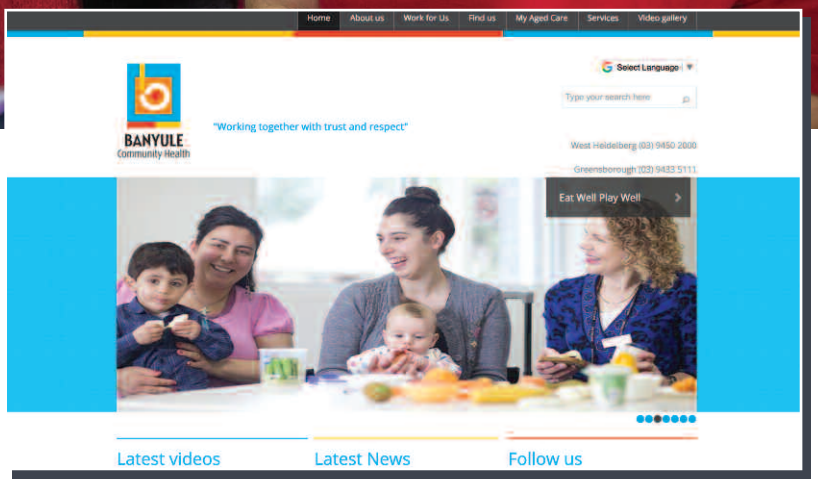
With over 200 staff and 90 volunteers and over 15,000 registered clients, BCH is a large and complex organisation. We have consistently operated within budget and similarly to 2015-16, our income and expenditure in 2016-17 were in the order of $16M

Income	Financial Year 2016/17	
Government Grants	12,195,656	77.0%
Patient Fees	2,322,415	14.7%
Donations	9,463	0.1%
Investment Income	216,325	1.4%
Rental Income	109,195	0.7%
Other Income	981,151	6.2%
TOTAL INCOME	**15,834,205**	**100.0%**
Expenditure		
Losses on financial assets	29,123	0.2%
Employee Benefits	11,507,195	77.5%
Depreciation & Amortisation	209,846	1.4%
Client Programs & Medical	1,737,461	11.7%
Lease Expenses	101,340	0.7%
Motor Vehicle & Travel	59,392	0.4%
Repairs & Maintenance	132,631	0.9%
Rental Expenses	61,157	0.4%
Equipment Purchases	29,698	0.2%
Consultancy Fees	115,690	0.8%
Printing & Stationery	211,977	1.4%
Cleaning Expenses	113,506	0.8%
Other Expenses	535,726	3.6%
Finance costs	4,817	0.0%
TOTAL EXPENSES	**14,849,559**	**100.0%**
SURPLUS / (DEFICIT) for the year	**984,646**	





HOW TO FIND US



GREENSBOROUGH

Pauline Toner Centre
3/25-33 Grimshaw Street, Greensborough
Ph: 9433 5111 Fax: 9435 8922
Opening Hours:
Mon – Fri 8:30am-5:00pm

WEST HEIDELBERG

21 Alamein Road, West Heidelberg
Ph: 9450 2000 Fax: 9459 5808
Opening Hours:
Mon – Thur 8:00am-6:00pm
Fri: 8:00am-5:00pm

YOU CAN ALSO FIND US ONLINE BCHS.ORG.AU

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ACKNOWLEDGEMENTS:
The Commonwealth Home Support Programme supported by the Australian Government Department of Social Services. Visit the Department of Social Services website (www.dss.gov.au) for more information.
Although funding for the Commonwealth Home Support Programme (CHSP) has been provided by the Australian Government, the material contained herein does not necessarily represent the views or policies of the Australian Government.
Mental Health Nursing Incentive Program at the BCH medical clinic is funded by Eastern Melbourne PHN and the Australian Government.

hacc home and community care
A JOINT COMMONWEALTH AND STATE/TERRITORY PROGRAM PROVIDING FUNDING AND ASSISTANCE FOR AUSTRALIANS IN NEED

Gambler's Help
gamblershelp.com.au
Gambler's Help North & North Western
1300 133 445
gamblershelpnnw.org.au

Australian Government
Department of Social Services

State Government Victoria

Contact

TWENTY SEVENTEEN - 2017

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BANYULE
Community Health