Renal Services Strategy

Aiming for world’s best practice
Minister’s foreword

When a senior elder from Umbakumba was diagnosed with renal failure four years ago, the only option for him was to relocate to Darwin for treatment. Today he is living back in his community on Groote Eylandt and, with the help of his wife, managing with dialysis in his own home.

The poor health status of Aboriginal Territorians is well known and the impact of renal disease is irrefutable. From many years living out bush, and since then, I can recall too many faces of friends whose lives have been dislocated or who have died as a result of chronic kidney disease.

As our Building Healthier Communities framework articulates, addressing Aboriginal ill health and disadvantage, including renal disease, is one of the Northern Territory Government’s highest health priorities.

We have already made great progress with new renal units at Palmerston and Tennant Creek, leading edge equipment for Darwin, Nguiu, Katherine, Tennant Creek and Alice Springs; and home dialysis services at Galiwinku on Elcho Island, Umbakumba on Groote Eylandt and Maningrida. $900,000 has been allocated to expand services in Santa Teresa and on Goulburn Island.

Getting the balance right between treatment, education and prevention is crucial.

The Department of Health and Community Services (DHCS) and its professional and community partners have, I believe, produced a renal services strategy that has the right mix of practical solutions and vision. Its priority areas are spot on, and, as this Aboriginal elder’s story shows, together we can make a real impact on renal disease in the Northern Territory. This five-year strategy lays a clear direction to achieve just that.

The Hon Dr Peter Toyne MLA
Minister for Health

May 2005
Chief Executive’s foreword

The Northern Territory Government has identified renal disease as a health priority, reflecting the terrible cost to human lives and its impact on the health system.

The challenge for the Department of Health and Community Services is to ensure we have preventive and awareness strategies, clinical systems and top-class treatment services, and expert people in place to ensure a comprehensive response to chronic kidney disease.

This response must include bringing treatment closer to people to reduce the human and community costs of dislocation. Significant numbers of Aboriginal Territorians – who represent between 80 and 90 per cent of our renal patients – are separated from family and country when they are being treated. As more people are treated close to home, or even in their homes, the confidence of communities in therapies and their awareness of the disease will rise.

At least as important, it must also include an integrated prevention strategy, best described in our Preventable Chronic Disease Strategy. We will focus on improving the management of early disease, doing better with predisposing conditions such as diabetes, and improving the number and effectiveness of primary prevention strategies, particularly in the area of maternal and child health.

A major priority of this strategy is a coordinated approach, a move from single specialities to a team approach and improving community engagement with services and health issues. The establishment of Clinical Reference Groups for all major clinical streams is intended to facilitate this process. The Renal Services Strategy is the first strategy to be released by these Groups and has resulted from significant work and input of the Renal Clinical Reference Group.

My thanks go to the dedicated team from within and outside the Department who have produced this strategy, and for their ongoing commitment to realising our goals.

Robert Griew
Chief Executive Officer,
NT Department of Health and Community Services

May 2005
Our Mission is to improve renal health in the Northern Territory.

We will achieve this through a high quality, client centred, holistic approach to the prevention, early detection and management of renal disease across the continuum of care.

We will provide accessible, accountable and reliable renal services that will reduce the numbers of people with deteriorating renal function.

(Adapted from the Northern Territory Aboriginal Health Forum, Northern Territory Renal Strategic Plan 2003-2007)
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- Paul Rivalland – Western Desert Nganampa Walytja Palyantjaku Tjutaku
- Mark Noonan – Department Education, Employment and Training
We will improve renal health through a high quality, client centred, holistic approach to the prevention, early detection and management of renal disease.
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The Renal Strategy advocates for strong negotiation with clients and organisations.

About this document

The Renal Services Strategy has been developed over a two year period, with the full support of the NT Government. The 2003 Review of the Department Health and Community Services (Bansemer) identified a number of problems with the structural and management systems in renal services and noted the model had difficulty in delivering effective services. The NT Government has subsequently supported and resourced the recommended changes from the review to provide a coordinated and consistent approach to service development and planning.

Renal Services Strategy development

Northern Territory Aboriginal Health Forum NT Renal Strategic Plan 2003-2007

The Renal Services Strategy 2005 - 2009 is drawn from the Northern Territory Aboriginal Health Forum (NTAHF) NT Renal Strategic Plan 2003-2007. The NTAHF is the peak planning body for Aboriginal and Torres Strait Islander health in the Territory.
The membership at the time of the development of the NTAHF Renal Strategic Plan, consisted of the Commonwealth Government (Office for Aboriginal & Torres Strait Islander Health), Northern Territory Government (DHCS), the Aboriginal and Torres Strait Islander Commission, and the Aboriginal Medical Services Alliance of Northern Territory. Representatives from each of these organisations formed the NTAHF Renal Working Party, which was convened in 2003. Following broad consultation, the party developed the NTAHF Renal Strategic Plan, a cross-organisational strategy to improve renal health across the Territory.

This document forms the DHCS response to the NTAHF Renal Strategic Plan. The Renal Services Strategy is not intended to be the only or defining strategy on renal health. It does not describe the full range of activities undertaken by service providers in the Territory nor is it meant to proscribe or limit those activities. The Renal Services Strategy acknowledges the NTAHF Renal Strategic Plan as the reference point for initiatives and identifies those considered attainable by DHCS and necessary to develop and sustain a high quality, holistic and efficient health service. The Renal Services Strategy 2005-2009 has been designed to guide the development and delivery of renal services within the Health Department although it strongly advocates for collaboration, negotiation and the development of partnerships with government and non-government service providers.

DHCS has endeavoured to preserve the philosophy on which the NTAHF Renal Strategic Plan is based, retaining the Mission Statement and Key Result Areas (as Priority Action Areas) within the Renal Services Strategy. Consequently there are many similarities between the two documents, with the intent to promote a coordinated and strategic approach to reduce the impact of renal disease in the Territory. It is expected that during the negotiation process in the implementation phase, other governmental departments may feel it necessary to develop their own strategic responses.

**Related documents**

The Renal Services Strategy is informed by many initiatives. These have included extensive stakeholder input, past service reviews, planning exercises, renal research, and community advocacy as described in the NTAHF Renal Strategic Plan (2004).

In addition to the NTAHF Renal Strategic Plan, other key documents and programs that have provided guidance and direction for the Renal Services Strategy are shown in the column on the right.

| NT Preventable Chronic Disease Strategy (DHCS, 1999) |
| Ottawa Charter (WHO, 1986) |
| National Diabetes Strategy 2000 -2004 |
| Health Promotion Framework for Action (Keleher and Murphy, 2003) |
| CARI – Caring for Australians with Renal Impairment (KHA 2000) |
| Jakarta Declaration (WHO, 1997) |
| Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004-2009 - AHMAC |
| NT Aboriginal Emotional and Social Well-being Strategic Plan 2003 - NTAHF |
| Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework 2002 - AHMAC |
| National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003 -2013 – Framework for Action by Governments - AHMC |
| National Chronic Diseases Strategy (in progress) |
| Improving Indigenous Health: Remote Area Renal Services - AHMC (in progress) |
| National Chronic Kidney Disease Strategy - Kidney Health Australia (in progress) |
**NT Preventable Chronic Disease Strategy**

The Preventable Chronic Disease Strategy (PCDS) is intricately related to the Renal Services Strategy. The PCDS provides a specific framework for the prevention, early detection and best practice management of chronic conditions. The strategy, which has been endorsed by the Department and the Minister for Health, advocates for an integrated, inter-sectoral and whole of life approach, relevant to every Territorian, regardless of ethnicity or location. It has been developed to help communities and health service providers determine the programs of greatest benefit to the community based on the communities specific health needs. This program will be supported by the National Chronic Diseases Strategy and has demonstrated positive outcomes in many areas including the delaying of progression to end stage kidney disease.

**Priority action areas**

The Renal Services Strategy proposes initiatives in six priority areas based on the Key Result Areas described in the NTAHF NT Renal Strategic Plan 2003-2007.

The six priority areas are:

1. **A Coordinated approach**
   Renal health crosses the care continuum and involves far more than renal replacement therapy. Support and assistance are needed for clients and health professionals in a variety of settings and therefore a holistic and whole of government approach to health services is necessary.

2. **Preventing, detecting and managing chronic kidney disease**
   The earlier Chronic Kidney Disease (CKD) is detected, the earlier management of the disease can begin. Earlier detection and management is known to result in better client outcomes.

3. **Increasing Aboriginal and Torres Strait Islander participation**
   Increased understanding and engagement of Aboriginal and Torres Strait Island people in determining health education, resources and services is necessary to improve health.
4. Treatment close to home

People with health needs are entitled to access services when they need them and where they have family support.

5. Developing the workforce

A stable and skilled workforce is integral to promoting health outcomes and depends on recognising, valuing and supporting staff in their efforts.

6. Staying effective

Improved health outcomes rely on clearly defined roles, responsibilities and accountabilities of a multi-disciplinary team within a framework of broad and consultative communication. High-level monitoring, evaluation and reporting mechanisms are essential.

A plan for the future

An Implementation Plan will follow describing how these priority action areas will be achieved, the time frames for the actions and the areas or persons responsible. Reporting, monitoring and evaluation mechanisms are being built into the Implementation Plan to support quality procedural systems rather than people dependence.

The Implementation Plan will be monitored and reported on by the NT Renal Clinical Reference Group. This group consists of senior renal clinicians from across the Territory and DHCS operational representatives. The initial focus of the group has been on the improvement and standardisation of service levels and delivery mechanisms of tertiary renal services. The group intends to become cross-organisational with stakeholder representation to facilitate communication between interested parties and promote a holistic evaluation of the Strategy implementation.

The focus of the Renal Services Strategy is on providing an accessible and timely service for all Territorians. Particular attention is paid to the prevention, early detection and effective management of renal disease through the development of improved support networks for all health workers. The Renal Services Strategy will provide the pathways for the growth, development and improvement of NT Renal Services for the next five years.
Our Vision is to ensure that all Territorians enjoy long and healthy lives and have a health and community services system that is responsive, accountable and effective.

The Renal Services Strategy links with and supports the DHCS *Building Healthier Communities* framework providing direction for Health and Community Services from 2004-2009. The *Building Healthier Communities* framework “lays the foundations to meet the challenges and to make a real difference to the health and wellbeing of all Territorians” (DHCS, 2004).

The *Building Healthier Communities* framework focuses on:

- Giving kids a good start in life
- Strengthening families and communities
- Getting serious about Aboriginal health
- Creating better pathways to health services
- Filling service gaps
- Tackling substance abuse
These strategies are particularly relevant for improving renal health in the Territory. Actions within the Renal Services Strategy include measures to address poor maternal and child health which are strongly linked to renal disease. The Renal Services Strategy aims to provide better support and education for families and communities around disease prevention and management, and develop services closer to home. The Strategy will utilise creative measures to enhance clinical support in remote areas and will endorse priority actions to reduce renal disease in Aboriginal and Torres Strait Island people who are overly represented in the CKD population.

**Building a better system**

- Building quality health and community services
- Creating better pathways of working together
- Valuing and supporting our workforce
- Creating a health information network

The Renal Services Strategy recognises that sustainable improvements are dependent on robust systems that promote a seamless service and provide effective monitoring, evaluating and reporting mechanisms. The focus of the measures will be on promoting procedural based systems rather than people dependant systems, partnerships and collaborations between departments, government and non-government agencies and the development of information technology systems to more effectively manage client data. There is also a strong focus on educating and developing the workforce across the care continuum with particular attention to increasing the Aboriginal and Torres Strait Islander population in the renal workforce.
Renal disease is the progressive loss of kidney function. This condition may lead to end stage kidney disease (ESKD), which is irreversible and permanent. Renal Replacement Therapy (RRT) is necessary to sustain life for ESKD clients and this can be achieved through:

- Transplantation (the most cost effective and efficient form of replacement)
- Haemodialysis (in the hospital, satellite or home)
- Peritoneal dialysis (continuous ambulatory or automated in the hospital or home)

End stage kidney disease in the Territory

The NT has the highest incidence and prevalence of ESKD in Australia. More than 85% of the people with renal disease in the NT are of Aboriginal and Torres Strait Islander descent, are on average 20 years younger when they present for treatment and tend to have shorter treatment survival than their non-Aboriginal and Torres Strait Islander counterparts (NTAHF 2004). This may in part be related to the high level and complexity of co morbidities suffered by Aboriginal and Torres Strait Island people.
Co-morbidities such as anaemia, malnutrition and worsening cardiovascular function are frequently related to the underlying conditions causing renal disease but also increase the consequences of decreasing renal function. Late presentation for identification and treatment together with inadequate dialysis attendance rates only serve to exacerbate the severity of the co-morbidities.

Table 1 demonstrates the higher rate of renal disease in the NT while Table 2 reflects the increased demand for treatments in the NT, which is occurring at more than double the national rate of approximately 8%.

Remote regions of the NT have a high proportion of people with ESKD. Currently more than 70% of Territorians needing dialysis must permanently relocate to regional centres for treatment. Figure I (page 17) demonstrates the higher levels of ESKD in the more remote parts of Australia with the Barkly and coastal regions of the NT registering the highest rates of illness.

Projections

While incidence and prevalence rates of ESKD in the NT are higher than the national average, the exponential projections predicted by some models developed in the mid to late 1990’s have not eventuated. Making an accurate projection of the need for ESKD treatments is a complex and difficult task and a significant degree of uncertainty will exist in all projections. Models used in the Territory have tended to focus on past ESKD activity. It is acknowledged that accurate and useful projections require the inclusion of future activity from the primary to tertiary areas. This necessitates the development of models or tools that consider the success of prevention, intervention and management programs as well as acceptance and success of treatment regimes.

The Renal Services Strategy proposes to improve activity data collection along the care continuum through links and partnerships developed with relevant stakeholders, particularly those in the primary health care sector. Health service planning and evaluation will be supported by the development of appropriate data management tools and systems.

Prevention of renal disease

The causes of renal disease amongst Aboriginal and Torres Strait Island people are complex and not fully understood. Much can be attributed to poor living conditions, unhealthy lifestyles, inadequate maternal and child nutrition and reduced access to health services. Certainly, Aboriginal and Torres Strait Island people suffer from high levels of chronic diseases such as diabetes, renal disease, heart disease and hypertension, which have common developmental pathways.
Diabetes and cardiovascular disease are also the most common co-morbidities for clients with ESKD. It is recognised that good control of just one of these chronic diseases will have positive benefits for the management of the other chronic diseases (Hoy et al 1999).

Strategies to improve renal health involve recognising the underlying determinants of ill-health and acknowledging a community’s own objectives. The development of a culturally appropriate intervention program is also necessary with appropriate education and training and adequate resourcing of both staff and facilities to implement the program. The Renal Services Strategy recognises that prevention education has the potential to offer the best results for the long term and supports the development of appropriate resources and programs surrounding renal health. This will be achieved through promoting and facilitating the links between the primary health care sector and government / non-government organisations such as Kidney Health Australia, Diabetes Australia, Aboriginal Interpreter Service and Batchelor Institute of Indigenous Education.

In addition, guidelines for screening and intervention for renal disease are readily available in the Territory and all communities should have access to at least one of the following:

• Central Australian Rural Practitioners Association (CARPA) Standard Treatment Manual

• Preventable Chronic Disease Strategy (PCDS) protocols including the Standardised Recall System.

• Kidney Check Australia Task Force (KCAT) Management of Renal Insufficiency in General Practice

• NT Renal Services Management of Chronic Kidney Disease (BEANNS) Guidelines

The Renal Services Strategy promotes and supports local and national campaigns to increase General Practitioners (GP), District Medical Officers (DMO) and community health staff knowledge of the available screening and intervention guidelines. Further the renal team through a variety of communication methods will provide advice and assistance to the primary health area in the management of clients with chronic kidney disease (CKD).
Management of ESKD

When a person has reached ESKD, renal replacement therapy of either transplantation, peritoneal dialysis or haemodialysis must be commenced in order to sustain life. All therapies require either surgical or investigational workup prior to treatment commencement. The earlier a person is identified with CKD the earlier the workup can commence. This facilitates the transition to replacement therapy and eliminates complications from extended hospital visits.

Haemodialysis is the most commonly accepted form of treatment with 30% – 40% of the Australian ESKD population currently receiving it as a form of therapy (ANZDATA 2003). The majority of haemodialysis treatments are carried out in a hospital or satellite facility. Most states have found it difficult to establish home haemodialysis for the majority of Aboriginal and Torres Strait Island people living in remote communities. Inadequate and over crowded housing, unreliable power and water supply and the logistics of delivering supplies via a variety of transport measures hinders processes and increases costs. Only Western Australia has been able to return a few people to remote locations until now. Recently the Queensland and Northern Territory Government’s provided additional funding to facilitate the establishment of self-care dialysis in remote locations.

**FIGURE 1. REGIONAL ESKD INCIDENCE RATE AMONG INDIGENOUS AUSTRALIANS PER MILLION 1993–1998**

Source: MJA 2001, 175:24-27
Peritoneal dialysis (PD) is considered a gentle form of dialysis and recommended for the very young and the elderly. It allows greater freedom and independence as it can be carried out in just about any location. However despite the independence and stability PD might offer people living in remote areas, the practical experience both in the NT and interstate indicates that it is not a form of therapy Aboriginal and Torres Strait Island people actively request despite the benefits it offers.

Kidney transplantation can be difficult to achieve. In Australia there is a growing pool of people waiting for a transplant and waiting times for all people on the transplant list are getting longer. While the transplant rate has remained stable the decreasing cadaveric donor rate has been supplemented by an increase in live donors, which is currently 40% of all kidney transplantations (ANZDATA 2003). Acceptance on to a waiting list is generally determined by age and the absence of medical contraindications to transplantation such as severe co-morbidities. In the Territory this is particularly relevant where the high level of co-morbidities and the very low rate of live donors amongst the Aboriginal and Torres Strait Islander population significantly impacts on transplant rates.

The Renal Services Strategy recognises that client uptake of services and barriers to service delivery are multifactorial and will require whole of government and cross-organisational support to address. The outcomes of a number of studies and strategies currently underway in Australia may provide assistance for the development of appropriate prevention and treatment policies for the Territory. These include the PREVEND IT study, the National Chronic Disease Strategy, Chronic Kidney Disease Strategy - Kidney Health Australia (KHA), Economic Impact of the Burden of Kidney and Urinary Tract Disease in Australia - KHA, Indigenous Remote Areas Renal Strategy and IMPAKT (Improving Access to Kidney Transplantations) Cooperative Research Centre for Aboriginal Health) - Australian Health Ministers Conference.
Challenges for the Department

Demographics

The NT has a very low population of about 200,000 people, dispersed across a large area of 1,346,200 km². It is the most sparsely populated jurisdiction in Australia and access to many areas is seasonal. The population includes a diversity of cultures and languages. Aboriginal and Torres Strait Island people represent almost 30% of the Territory’s population but 71% live in remote or rural areas of the NT while 83% of non-Aboriginal and Torres Strait Island people live in the urban areas of Alice Springs and Darwin (ABS Sept 2004). In addition, the Aboriginal and Torres Strait Islander population is to some extent nomadic with regular movement between communities and across borders.

Consequently health service delivery is challenged by the difficulties in achieving economies of scale, developing health workforce capacity in remote communities and building the necessary relationships with community members and local health staff.
Health services

The NT Government through the DHCS is the major provider of health services to the largely scattered communities in the NT. This includes hospitals in the five main urban centres of Gove, Katherine, Tenant Creek, Darwin and Alice Springs and a widely dispersed network of small community health clinics. Other health service providers include Aboriginal Community Controlled Health Organisations, the Australian Government and non-government agencies and individuals.

It is acknowledged that the lack of GPs and primary health care staff in the bush, the long-term nature of chronic disease and the high costs of acute care negatively impact on the ability to provide primary preventative strategies. However the PCDS, supported by the Renal Services Strategy, promotes the incorporation of brief interventions as part of all health care workers daily practices as a mechanism to address these barriers.

Health status

Unhealthy lifestyles leading to obesity and chronic conditions are an Australian-wide problem. In the NT, chronic diseases affect the whole population but Aboriginal and Torres Strait Island people are particularly affected. In fact Aboriginal and Torres Strait Island people in the Territory exhibit the worst health status of any Australian, with a life expectancy as much as 20 years less than the Australian average (Bansemer 2003).

Furthermore, Aboriginal and Torres Strait Island people are poorer; have lower education and literacy levels; high levels of unemployment; inadequate housing and high levels of substance misuse (NTAHF 2004). In general they suffer lower socio-economic status, which is internationally recognised as an important determinant of health and quality of life.

DHCS recognises that building community capacity is necessary for improving health status and will work with relevant organisations and groups towards this goal. Strategies such as increasing employment opportunities and enhancing community and family education are described in several of the priority areas of the Renal Services Strategy.
The renal health workforce

High levels of transience characterise the NT health workforce. Staff transience, a low skills base and difficulty recruiting into the Territory combine to seriously hinder the ability to develop programs and deliver tangible outcomes. There is a national as well as an international shortage of specialist clinical staff, and the inability to retain staff results in a continuous and expensive cycle of recruitment and training. Rapid turnover in the workforce greatly increases the difficulty of sustaining quality educational programs and maintaining the valuable knowledge base. (NTAHF, 2004)

The Renal Services Strategy promotes innovative approaches to training, education and skill development particularly with the view to increasing Aboriginal and Islander participation in the health workforce. The Strategy recognises that evidenced-based clinical practice is the basis for sound, quality and effective care and staff at all levels will be encouraged to question and evaluate the basis for their practices. Developing partnerships, participation in and promoting links with research organisations, programs and projects is strongly supported and encouraged.

Information management

The DHCS acknowledges that there is difficulty for clinicians and service planners to effectively manage the large amounts of data collected in relation to renal disease. While much of the essential data is present, comprehensive service planning, quality assurance processes and client tracking are hindered by the inability to efficiently manipulate the available data for the required purposes. Further, much of the information necessary for future planning is in the primary health sector in unconnected data sets (Weeramanthri 2002). Strategies to address confidentiality and community ownership in relation to data sharing with the primary health care area will be necessary.

A priority within this Strategy will be to implement an information system that meets the needs of the DHCS in terms of providing accurate, timely and useful data for monitoring, assessing and planning both care and service delivery.
The Home Dialysis Training and Community-based Dialysis Programs are just beginning to see results.

**NT Renal Service profile**

DHCS is supported by individuals, government, non-government and Aboriginal Community Controlled Health Organisations (ACCHO) in the delivery of renal services across the care continuum in the NT. Tertiary renal services are delivered predominantly from the two major referral centres of Alice Springs for Central Australia and Darwin for the Top End. Smaller satellite centres offering haemodialysis have opened and DHCS has commenced home dialysis in some remote areas (see Figure 2).

**Types of service**

In addition to tertiary renal services DHCS also provides advice, support and education for the primary health sector and clients with CKD. This includes support for clients who have been transplanted as well as those undertaking peritoneal dialysis in their communities. All known renal clients will attend one of the major referral centres for assessment, investigation, education and preparation for treatment.

The majority of haemodialysis treatments and peritoneal dialysis training and support are based at the larger centres at Nightcliff and Flynn Drive Renal Units (see Figures 3 and 4). Clients undertaking haemodialysis maybe able to dialyse at a satellite centre closer to their home after a stabilisation period. These are currently located at Palmerston, Katherine, Bathurst Island, and Tennant Creek.
Home dialysis is also available for those people able to attain independence in their treatment or have assistance from a buddy or carer. This therapy covers the modalities of peritoneal dialysis (continuous ambulatory or automated) and haemodialysis.

Pre-transplant education and client workup are directed from the main referral centres in the NT. The visiting nephrologists from The Queen Elizabeth Hospital (TQEH) in South Australia, who have responsibility for transplant operations and immediate post operation care, undertake client assessment and approval for transplantation. Post-transplant care is usually returned to the main referral centres of Darwin and Alice Springs after six to eight weeks. Clients are often able to return to their communities once they have been stabilised on their medications.

Private dialysis services are currently not available in the Territory, nor are they likely to be in the foreseeable future due to the very low rate of private health cover amongst renal clients.

Although DHCS is seen as the only provider of tertiary renal services in the NT, partnerships with other organisations are encouraged and promoted. Currently the Department is working with the Western Desert Ngarampa, Walytja Palyantja Tjuṯaku (WDNWPT) to support the trial of a unique reverse respite dialysis program. ATSIC provided funding to assist with the establishment of self-care dialysis in the East Arnhem region and in the past both the Jawoyn Association and the Tiwi Land Council provided assistance to help establish dialysis services in their communities.

Table 3 identifies the percent of renal clients undertaking each modality and the location by state. It highlights a lower percentage of hospital dialysis treatments, home haemodialysis and transplant clients in the Territory in comparison to other states. This graph reflects the difficulties the largely Aboriginal and Torres Strait Islander ESKD population have in attaining transplant status and the inadequate number of hospital dialysis stations necessitating unwell people to be frequently and inappropriately dialysed in satellite facilities.

The Renal Services Strategy has a strong focus on providing treatment closer to home and developing the necessary support mechanisms to ensure clients and communities, particularly the primary health care area, are assisted where and as needed. Further, implementation of the strategy will see service development occur in areas to ensure national benchmarks are met. Activity in this area is already underway as evidenced by the development of plans for an incentre renal facility within Alice Springs Hospital.
Remote Services

The DHCS’s policy for remote dialysis requires that client’s requesting home or community based dialysis must meet self-care criteria and have support of a buddy based in their home community. Peritoneal dialysis (PD) has always been available for people able to meet the necessary criteria or have a support person able to carry out the treatment for them. Both regional centres manage PD clients in remote communities through collaboration with and support of the local health staff.

However, the Home and Community-based Haemodialysis Training Program is a relatively new initiative and is only just beginning to see results with four clients now dialysing at home or in their communities (Figure 2). These clients have attained a level of self-care and independence in their haemodialysis treatments allowing them to dialyse in their own communities unaided by clinical staff.

The Renal Services Strategy recognises that a remote home and community based dialysis program requires flexibility in the way services are established and delivered in addition to significant resources to support clients, family and community members. The strategy sees a number of mechanisms employed for this process with emphasis placed on the development of partnerships with community organisations to ensure clients are able to safely and securely reintegrate with community life.

Impact of treatment options

Aboriginal and Torres Strait Island people are over represented among renal clients in the Northern Territory. While not all are from a remote community, many are and have been relocated from their home communities in order to access life saving treatment. Although there are now service points (Figure 2) in Katherine, Bathurst Island and Tennant Creek, there is still a requirement for clients to commence treatment in the main centres in order to be appropriately and thoroughly assessed. In addition these service centres may be at capacity as is the current case with Katherine.

Trialing new concepts

WDNWPT Pilot

Currently DHCS is in a unique, twelve-month partnership with the Western Desert Nganampa Walytja Palyantjaku Tjutaku (WDNWPT) to support the delivery of dialysis services to the remote community of Kintore.

WDNWPT has established a program Going Home (aka Reverse Respite), enabling a number of members to receive short bursts of peritoneal and haemodialysis support and training in a facility WDNWPT has established in the Alice Springs area. This is followed by a 2–3 week stay in Kintore community where they are clinically assisted with their treatment within the local Primary Health Care Service (PHCS).

The program is rotational and transport is funded by WDNWPT. The aims are to re-establish family networks and relationships; focus on current treatment issues and offer dialysis support; develop opportunities for training with members, families and PHCS staff, whilst gradually developing confidence and independence.

The DHCS is supportive of this trial and has provided one-off funding for the two nursing staff and part funding for a research officer.

As per other communities, DHCS has contributed to the establishment and will continue to cover the recurrent treatment costs incurred at both the training facility and Kintore community. The implications of Going Home to members, families and health services are being assessed within a broader evaluation of WDNWPT 5/04 – 5/05.
Figure 2. Main service delivery points and catchment areas

Catchment areas include W.A. and S.A. borders.

- **Main referral centre with nephrologist**
- **Staffed satellite facilities**
- **Self-care dialysis sites**
- **Reverse respite dialysis**
FIGURE 3. NT RENAL SERVICES – TOP END

ROYAL DARWIN HOSPITAL (RDH)

RENAL WARD: 10 BEDS
Caters for:
1. Renal Investigations
2. Acute admissions
3. Access and other renal surgery
4. Pre and post transplant care

DIALYSIS STATIONS: 5
Caters for:
1. Acute dialysis
2. HDU and plasmapheresis
3. Dialysis during admissions
4. Overflow dialysis

KATHERINE DISTRICT HOSPITAL (KDH)

DIALYSIS STATIONS: 4
Caters for:
1. Maintenance dialysis
2. No acute dialysis - transferred to RDH
3. Developing PD and Transplant client support

NIGHTCLIFF RENAL UNIT

DIALYSIS STATIONS: 5
Caters for:
1. Peritoneal Dialysis Training and Client Support
2. Staff training - RN, EN, AHW
3. Allied Health Support base for top end - Social Worker, Aboriginal Liaison Officer, Dietitian
4. Anaemia/Access, CKD RN and Renal Educator base for top end.
5. Management of Tiwi Dialysis Centre and Palmerston Dialysis Unit

THE QUEEN ELIZABETH HOSPITAL

PROVIDES EVALUATION AND SUPPORT FOR:
1. Client acceptance for transplantation
2. Transplantation operation and immediate post-op care

TIWI DIALYSIS CENTRE (TDC)

DIALYSIS STATIONS: 5
Caters for:
1. Self-care haemodialysis clients
2. Some dependant clients
3. Short respite for dependant clients
4. Support/monitoring for returned peritoneal and transplanted clients

PALMERSTON DIALYSIS UNIT (PDU)

DIALYSIS STATIONS: 8
Caters for:
1. Maintenance Dialysis

HOME-DIALYSIS TRAINING STATIONS: 2
Caters for:
1. Client and buddy training
2. Support for home clients

Source: Author
ALICE SPRINGS HOSPITAL (ASH)
NO DEDICATED RENAL WARD
MEDICAL WARD CATERS FOR:
1. Acute admissions
2. Renal Investigations and surgery
DIALYSIS STATIONS: 2
Caters for:
1. Acute dialysis
2. Admissions too unwell to travel to Flynn Drive Renal Unit.

THE QUEEN ELIZABETH HOSPITAL
PROVIDES SUPPORT FOR:
1. Client acceptance for transplantation list
2. Transplantation operation and immediate post-op care

FLYNN DRIVE RENAL UNIT
• Peritoneal Dialysis Training and Client Support
• Pre and post transplant care
• Staff training – RN, EN, AHW
• Allied Health Support base for central region - Social Worker, Aboriginal Liaison Officer, Dietitian.
• Anaemia/Access, CKD RN and Renal Educator base for central region
• Management of acute services at ASH
DIALYSIS STATIONS: 26
Caters for:
1. Maintenance Dialysis
2. Client Haemodialysis Training

TENNANT CREEK HOSPITAL (TCH)
DIALYSIS STATIONS: 8
Caters for:
1. Maintenance dialysis
2. No acute dialysis - transferred to ASH
3. Developing PD and Transplant client support.

PROPOSED 12 BED RENAL WARD AND 8 DIALYSIS STATIONS

PROPOSED HOME HAEMODIALYSIS TRAINING STATIONS: - 2

WESTERN DESERT NGANAMPA WALYTJA PALLYANTJAKU TJUTJAKU
• Partnership arrangement to support reverse respite dialysis at Kintore Community.

FIGURE 4. NT RENAL SERVICES – CENTRAL AUSTRALIA

Source: Author
Relocation

The consequences of relocation and its impact on family and community are well documented. Forced relocation fractures communities, families and support networks and increases the burden on community resources and services. Renal clients themselves suffer reduced disposable income, decreased quality of life and decreased life expectancy.

Furthermore, the majority of Aboriginal and Torres Strait Islander renal clients speak English as a second, rather than first, language. This presents new and complex problems for service providers as health professionals try to encourage frightened and lonely people (in a foreign language), to accept a highly technical and demanding treatment without the benefit of their usual support systems.

It is evident that many clients are unable to reconcile treatment requirements (variously estimated between 15-30%) with their need to be with family and community. This inability can be manifested in a number of ways such as choosing not to start treatment, to stop treatment after commencing or to regularly miss treatments in order to maximise on community visits. This phenomenon continues to be poorly identified and documented, often being labelled as non-compliance or rejection of treatment when a more accurate description might be rejection of treatment location.

Renal clients suffer an unusually high and sustained level of anxiety, loneliness and depression, which further serves to negatively affect their health. The full impact of relocation and the acceptance that one has a life-long and life-threatening illness on the mental and emotional well-being of renal clients, goes largely unrecognised. Cultural and language differences inhibit communication between clients and carers while counselling is not routinely offered to new clients. The Renal Services Strategy promotes the use of Interpreters all along the care continuum and the role of counsellors to ensure the social, emotional and mental well-being of renal clients is adequately addressed.

Greater emphasis has been placed on assisting pending renal clients to make a smooth transition to the urban area and in understanding treatment choices that would facilitate their return to the community.

Providing support and services as close to home as possible is a key objective of the Renal Services Strategy and is strongly supported within the ‘Building Healthier Communities Framework’.

Table 4 identifies the number of renal clients who remain relocated for treatment in the Territory at the end of 2004. Clients dialysing at Katherine, Tennant Creek and on Tiwi Islands are excluded.
NT Renal Team

NT Renal Services promotes a multi-disciplinary team approach to renal care. Recent initiatives have seen a number of new clinical and support positions established in each referral area to address identified service gaps.

The Multi-disciplinary team consists of:

Clinicians
Nephrologists, Advanced Trainee Renal Registrars, Registered Medical Officers, Clinical Nurse Managers, Enrolled Nurses and Aboriginal Health Workers.

Support Clinicians
Renal Educator CN, Chronic Kidney Disease CN, Peritoneal Dialysis CN, Transplant CN, Home Haemodialysis CN, Anaemia/Access CN, Renal Dietitian, Pharmacy technician.

Allied Health Staff
Social Worker, Aboriginal Liaison Officers, Clerical Staff, Dialysis Patient Care Assistants and Patient Support Assistants.

NT Renal Services intends to develop the skills and knowledge of the renal team so that they may offer greater assistance and support to DMOs, community health staff, GPs and clients and their family in the management of early renal disease and the chosen treatment modality.

Stakeholders and interested parties

The impact of the high rates of renal disease and the necessity to relocate for treatment has had a significant impact not only on clients, families and communities but also on governmental and non-government organisations across the NT. The importance of the Renal Services Strategy and the NT Marilyn Gayle Health Strategic Plan to stakeholders is reflected in the broad consultation undertaken.

Key stakeholders outside of DHCS Acute care are shown in the column on the right.

Key Stakeholders

Aboriginal Interpreter Services
Aboriginal Medical Services Alliance NT
Aboriginal Resource Development
Anglicare
Anyinginyi Congress Tennant Creek
Australian Medical Association
Australian Nurses Federation
Batchelor Institute Indigenous Training and Education
Centrelink – Commonwealth Government
Charles Darwin University
Chief Medical Officer DHCS
Community Physicians
Congress Alice Springs
Danila Dilba
Department Employment Education and Training
Diabetes Australia
General Practice and Primary Health Care NT
Heart Foundation
Jukalikari Council
Katherine West Health Board
Kidney Health Australia
Miwatj Regional Council
Ngaanyatjarra Health Services
Nganampa Health Council
Principal Nursing Advisor DHCS
Remote Health Services
Rural District Medical Officers
Sunrise Health Services
Tangentyere Council
Territory Housing and Indigenous Housing Australia NT
Western Desert Nganampa Walytja Palyantjaku Tjuṯaku
Wurlu Wurulinjang Health Service
Yillireung Housing
Considerable work has already been undertaken and positive results are now evident.


Present position

While the picture of Renal Services in the Territory is challenging, considerable work has already been undertaken to improve the situation and positive results are now evident. A number of reviews and renal consultation groups have provided the NT Government with sufficient information and impetus to commence the planning and implementation process. This has resulted in a substantial financial commitment by the Government to Renal Services, including an additional $1 million in 2003-2004, $2 million in 2004-2005 and a further $2 million in 2005-2006 financial years.

Furthermore an additional $900,000 was allocated in 2003-2004 and 2004-2005 for remote renal capital works to facilitate the expansion of community based dialysis. In 2005/06 the total budgeted spending for renal services will be $19.06 million.
Although the Renal Strategy has had a long gestation period, activity towards improving the service has continued to progress. This has included:

- Implementation of a coordination and advisory structure through the establishment of a Director of Renal Services and the Renal Clinical Reference Group
- Employment of 2 Nephrologists for the Central Australian area after an absence of 2 years
- The assessment of satellite work load and functions resulting in additional positions in both the Top End and Central Australian regions for nursing and Allied Health
- Securing an additional Advanced Renal Trainee Registrar position for the Alice Springs Hospital through the Commonwealth Advanced Specialist Trainee Program for Rural Areas (ASTPRA)
- Review and standardisation of all the renal procedures and protocols utilised in Renal Services
- The establishment of a senior project position to facilitate the implementation of the Renal Strategy including the development of new services
- Territory-wide tenders for machinery and a variety of consumables to capitalise on economies of scale and standardise quality
- The establishment of dialysis services in Tennant Creek
- The establishment of dialysis services in Palmerston
- The establishment of the Home Training program with dedicated staff
- The development of a prototype relocatable facility for community based dialysis
- The establishment of a twelve month partnership with WDNWPT to support a pilot reverse respite dialysis program at Kintore Community Clinic
- The commencement of the remote community-based home dialysis program with clients at Umbakumba, Galiwinku and Maningrida
- The assessment of service needs in Alice Springs with plans developed for the expansion of incentre dialysis stations, establishment of a future renal ward as well as a satellite dialysis facility within Alice Springs Hospital
- Working with Housing Business Services to address accommodation issues for renal clients in the Territory
- The implementation of the Primary Care information System for client management in Alice Springs
Priority action areas

The following pages outline the strategies in each of six priority areas identified under the Renal Services Strategy: These strategies reflect the Key Result Areas identified in the NTAHF Renal Strategic Plan 2003-2007. The initiatives from these priority areas provide clear strategic direction for renal services to advance into 2005 – 2009.

1. A coordinated approach

Territory-wide coordination of health services across the continuum of care is needed to improve renal health and deliver renal services effectively across the NT.

2. Preventing, detecting and managing chronic kidney disease

The Renal Services Strategy proposes closer working relationships between renal services and communities, along with the expansion of the Preventable Chronic Disease Strategy, to improve communication, education and support of health staff in the prevention, early identification and management of people with chronic kidney disease (CKD).
3. Increasing Aboriginal and Torres Strait Islander participation

This strategy recognises the social, cultural and linguistic diversity of the NT and promotes the development of culturally appropriate resources to support increased Aboriginal and Torres Strait Islander involvement in the delivery of services and programs.

4. Treatment close to home

Delivering high quality renal treatment services as close as possible to people’s homes requires collaboration and negotiation with community services. It includes access to transplantation, home haemodialysis and peritoneal dialysis. The focus is on patient education and appropriate resourcing particularly in the areas of transplantation and self-care training.

5. Developing the workforce

Addressing workforce requirements is crucial to providing and maintaining a quality and effective renal services system. The priority actions here recognise the low number of Aboriginal and Torres Strait Island people employed in health, the shortfall in specialist clinical renal staff and the need to work more closely with departments that can help with training and skill development.

Creative strategies are needed to recruit and retain staff across the primary and tertiary sectors and into a variety of service delivery areas including clinical, management, educational, social support and research.

6. Staying effective

Information management in relation to the management of renal clients is problematic. The establishment of a coordinated NT-wide information system that allows tracking of clients across the continuum of care will improve client management, service planning and delivery and address issues of confidentiality and community ownership. The system will facilitate evaluation of service delivery through the reporting of clinical and performance indicators.

Under each priority action area, strategies are identified, along with some examples of what has been done and what the next steps should be. Each objective under “Where we are going” within the Priority Areas, is identified as it relates to the Key Result Areas in the NTAHF NT Renal Strategic Plan 2003 – 2007.
"For too long the quality of the service has been dependant on the skill and ability of individuals. A structure that supports monitoring and evaluation to deliver an accountable and transparent service is necessary."

**A coordinated approach**

Territory-wide coordination of health services across the continuum of care is needed to improve renal health and deliver renal services effectively across the NT.

**Strategies**

1.1 Establish a suitable coordination structure that addresses service planning, decision-making, implementation and an accountability framework for renal health services across the NT.

1.2 Resource tertiary areas including in-centre facilities, surgery and radiology to an agreed regional standard.

1.3 Develop and strengthen partnerships and policy that relate to implementing the Renal Services Strategy.

1.4 Develop comprehensive communication strategies.
What we have done

• Implemented a coordination structure through the Renal Clinical Reference Group to promote reporting and accountability of service standards.
• Standardised renal procedures and protocols across the Territory.
• Developed performance indicators for NT Renal Services under Building Healthier Communities Framework and commenced the development of indicators for individual areas.

Where we are going

a. Facilitating the establishment of multidisciplinary, cross agency participation to promote informed, collaborative and consultative decision-making. See KRA 1.1. a)
b. Establishing annual service planning cycles based on sound activity data and projections. See KRA 1.1. b)
c. Standardising audit mechanisms governing the delivery of clinical practice across the Territory. See KRA 1.1. c) and d)
d. Linking clinical and other renal services to National Best Practice guidelines. See KRA 1.1 e)
e. Establishing clear and agreed lines of accountability and responsibility for service standards at all levels. See KRA 1.1. f)
f. Identifying areas that require structural changes, operational changes, resource support and incorporate these actions into the implementation plan. See KRA 4.1. a)
g. Working with hospital departments to set benchmarks for timely access to radiology, surgeons and theatre lists to prevent or reduce co-morbidities and extended hospital admissions. See KRA 4.1. b) and c)
h. Identifying stakeholders to support the development of partnerships and provide mechanisms for them to advise, consult, negotiate and monitor service delivery. See KRA 1.3. a), b) and 1.4. a), b) and c)
i. Identifying gaps in service delivery in order to share resources and prevent duplication of programs between partners and stakeholders. See KRA 1.3. c) and 2.2. a)
j. Developing inter-agency and Governmental agreements to ensure support services such as accommodation and disability payments are in place when needed. See KRA 1.3. d)
k. Developing comprehensive and robust communication plans across health care sectors, organisations and regions. See KRA 1.4. a), b) and 6.4. d)
Preventing, detecting and managing chronic kidney disease

The Renal Services Strategy proposes closer working relationships between renal services and communities, along with the expansion of the Preventable Chronic Disease Strategy, to improve communication, education and support of health staff in the prevention, early identification and management of people with chronic kidney disease (CKD).

Strategies

2.1 Assist primary health care services in their core roles and within a multi-disciplinary approach to prevention, early detection and management of renal disease.

2.2 Manage chronic kidney disease (CKD) through accountable partnerships between all levels of care: primary, secondary and tertiary.

2.3 Promote and support the expansion of the Preventable Chronic Disease Strategy into the primary health care sector.

2.4 Establish partnerships and support local community networks to raise awareness of renal disease.
**What we have done**

- Established guidelines for the early intervention, management and timely referral of people with CKD for PHC staff including the development of relevant CARPA guidelines.

- Established care plans and case conferencing to assist DMOs and GPs manage known clients with CKD.

- Contribute regularly to the Preventable Chronic Diseases regional workshops.

- Contributed to the training of GPs in screening, early intervention and management of renal disease through the Division of GPs.

**Where we are going**

a. Promoting initiatives, which strengthen the primary health care sector. See KRA 2.1. a)

b. Working towards raising the profile of renal disease in the community. See KRA 2.1. b)

c. Improving primary health care staff awareness of and education about CKD. See KRA 2.1. c)

d. Promoting the importance of continuity of client care through establishing and maintaining links (referral systems and care plans), between levels of care. See KRA 2.1. e) and 2.2. e)

e. Encouraging greater involvement of specialist outreach services in primary health practice. See KRA 2.2. b) and 2.3. c)

f. Reviewing the linkages to epidemiological data, client recall systems and chronic disease registers to assist with the identification of people with CKD. See KRA 2.2. c), d) and 2.3. b)

g. Exploring options and strategies to develop a flagging system for predetermined identifiers (eg raised creatinines) from multiple sources to feed into a single database. (New)

h. Supporting locally determined health promotion strategies and the development of appropriate and useful resources. See KRA 2.4. a) and 2.1. f)

i. Supporting Indigenous and non-Indigenous schools and colleges in the inclusion of renal disease and renal unit visits as part of health sciences curriculum. See KRA 2.4. d)
Increasing Aboriginal & Torres Strait Islander participation

This strategy recognises the social, cultural and linguistic diversity of the NT and promotes the development of culturally appropriate resources to support increased Aboriginal and Torres Strait Islander involvement in the delivery of services and programs.

**Strategies**

3.1 Increase levels of local community engagement, decision-making capacity and advocacy opportunities.

3.2 Enhance client, family and community education to maximise client independence and minimise family dislocation.

3.3 Improve quality of communication between service providers and Aboriginal and Torres Strait Islander clients, families, communities and organisations.
What we have done

• Raised the profile of interpreters within DHCS Renal Services, through collaboration with Aboriginal Interpreter Service and research projects such as “Sharing the True Stories” in Darwin.

• Raised awareness of renal staff in how and when to use Interpreters through regular in-services and development of check lists in Darwin.

• Organised for Interpreters from various language groups to be present at client clinics and promoted telephone conferencing with community interpreters.

• Investigated available health educational resources in particular those appropriate for Aboriginal and Torres Strait Islander groups.

• Collaborated with “Sharing the True Stories” to develop appropriate and translated health information including that on renal disease for dissemination to Aboriginal and Torres Strait Islander communities.

Where we are going

a. Establishing communication pathways with regional and local community organisations and renal services. See KRA 3.1. a), b) and c).

b. Supporting mechanisms to increase community ownership of programs through collaboration and negotiation with service providers. See KRA 3.1. d) and e)

c. Assisting with strategies for service providers (primary and tertiary), communities and language centres to develop culturally appropriate health resources applicable to the continuum of care. See KRA 3.2. a), b),c) and 3.3. a) and b)

d. Advocating for organisations and institutions to collaborate in the development of renal disease education particularly medical concepts, terms and phrases in local languages. See KRA 3.2. d) and 3.3 f)

e. Promoting regular Territory-wide renal health campaigns such as Kidney Week and assist with appropriate evaluation. See KRA 3.3. b)

f. Advocating for ongoing staff training in cultural safety and the effective use of interpreters. See KRA 3.3. c) and e)
Treatment close to home

Delivering high quality renal treatment services as close as possible to people’s homes requires collaboration and negotiation with community services. It includes access to transplantation, home haemodialysis and peritoneal dialysis. The focus is on patient education and appropriate resourcing particularly in the areas of transplantation and self-care training.

Strategies

4.1 Through interagency cooperation and coordination, provide greater support for clients relocating to regional centres as well as those returning home.

4.2 Offer all renal replacement therapy including haemodialysis, peritoneal dialysis, transplantation and training at recognised national standards.

4.3 Develop a supportive environment for home and community-based dialysis.

What we have done

• Established a dedicated area for home-dialysis training in the Top End and redesigned the Flynn Drive facility in Central Australia to accommodate an appropriate training space.

• Established an appropriate education and training program, including dedicated staff with suitable physical and financial resources.

“I am so happy to be home – people can’t believe that we do the machine by ourselves”

(Claude Mamarika - on returning to Groote Eylandt on haemodialysis)
• Developed a format for rights and responsibilities between clients and service provider relating to training, respite and retaining independence.

• Community consultation has been undertaken in several communities with the view to establish community-based dialysis.

• Through community negotiation we have developed a template Memorandum of Understanding, outlining the relative roles and responsibilities of the service provider, community, council, primary health care area and client.

• Gained support from Community Development Employment Programs in relevant communities to register dialysis buddies as employees.

• Established a protocol for respite care for self-care clients.

• Established community-based self-care dialysis on Groote Eylandt and Elcho Island.

• Established satellite services in Tennant Creek.

• Established satellite services in Palmerston.

• Developed a partnership with Western Desert Nganampa Walytja Palyantjaku Tjutaku to support reverse-respite dialysis services at Kintore Community.

**Where we are going**

a. Developing client assessment tools for pre-dialysis clients that address clinical as well as psychosocial issues. See KRA 4.2. a) and d)

b. Establishing orientation programs to the new environment to cover transport, local; support services, shopping in urban centres and introductions to schools if necessary. See KRA 4.2. e)

c. Developing community level cross-agency protocols between Health Services, Housing and Centrelink to facilitate transition and ensure clients and their families are not penalised as a result of transfer. See KRA 4.2. b), f) and 4.3. g)

d. Providing greater access to interpreter, counselling and psychological services for new and established clients and their families. (New)

e. Negotiating to amend Patient Assisted Travel (PATS) guidelines to enable family members to be with clients in times of crisis and decision making periods. See KRA 4.2. a)

f. Identifying and addressing barriers to accepting peritoneal dialysis and attaining active transplant status. See KRA 4.3. c)

g. Establishing appropriate education and training programs, including dedicated facilities with suitable resources. See KRA 4.3. d)

h. Developing a dependency assessment tool for all modalities and in-centre and satellite centres to determine appropriate staffing levels. See KRA 4.3 b) and 4.4. a)

i. Establishing criteria for models of care across all modalities and locations. See KRA 4.4. b)

j. Investigating creative and innovative strategies to support decentralised services. See KRA 4.3. f),g) and 4.4. c), d), e) and f).
Addressing workforce requirements is crucial to providing and maintaining a quality and effective renal health system. The priority actions here recognise the low number of Aboriginal and Torres Strait Islander people employed in health, the shortfall in specialist clinical renal staff and the need to work more closely with departments that can help with training and skill development.

Creative strategies are needed to recruit and retain staff across the primary and tertiary sectors and into a variety of service delivery areas including clinical, management, educational, social support and research.

Strategies

5.1 Increase levels of Aboriginal and Torres Strait Islander employment in renal services.

5.2 Develop strategies to recruit and retain skilled renal clinical staff.

5.3 Monitor and review renal staff recruitment training and retention.
What we have done

• Negotiated to include the renal competencies from the Territory produced Aboriginal Health Worker (AHW) Renal Training Manual in the nationally accredited AHW competencies.

• Identified non-clinical duties to be carried out by non-renal trained staff in the dialysis area.

• Assessed staffing levels across the multidisciplinary team and service areas, resulting in the establishment of new positions and additional staffing levels.

• Collaborated with Charles Darwin University to establish a Renal Diploma Course.

• Employed an additional Nephrologist for Central Australia.

• Secured an Advanced Trainee Renal Registrar for the Central Australian region.

• Established quarterly, industry funded Territory wide renal workshops to promote and facilitate networking, standardisation and quality improvement of services.

Where we are going

a. Assisting with the identifying and describing of existing and potential Aboriginal and Torres Strait Islander employment opportunities in the renal services sector. See KRA 5.1. a)

b. Supporting training and educational opportunities to develop required skills particularly those along managerial pathways. See KRA 5.1. b), c), d), e), g) and h)

c. Developing recruitment strategies that promote uniqueness of Renal Services in the Territory and provide opportunities to experience new and different environments. See KRA 5.1. f) and 5.2. a)

d. Accessing a variety of professional, promotional and advertising materials for recruitment in order to reach the widest market. (New)

e. Providing support for Allied Health staff and clinicians to enable effective service delivery across the care continuum. See KRA 5.2. b) and c)

f. Developing a sustainable skill and knowledge base in renal care across the Territory. See KRA 5.2. d), e), f) and 5.3. c)

g. Establishing systems to document renal staff recruitment and retention patterns including reasons for exits. See KRA 5.3 a) and b)
Staying effective

Information management in relation to the management of renal clients is problematic. The establishment of a coordinated NT-wide information system that allows tracking of clients across the continuum of care will improve client management, service planning and delivery and address issues of confidentiality and community ownership. The system will facilitate evaluation of service delivery through the reporting of clinical and performance indicators.

Strategies


6.2 Develop appropriate performance indicators, monitoring, evaluation and planning cycles.

6.3 Identify and develop the main data components and IT functions necessary for effective clinical care delivery and service planning.

6.4 Promote and sponsor research, including evaluation, to provide evidence-based decision making for service delivery across the continuum care.

“The current situation of relying on RRT trends only, has been described as always projecting forwards by looking backwards”

Tarun Weeramanthri on evaluating renal data information systems for NTAHF.
What we have done

• Established closer links with Menzies School of Health Research, Charles Darwin University and Cooperative Centre for Aboriginal Health regarding established and proposed research. Several renal staff are involved with research projects through in-kind support.

• Assessed current data management capabilities and systems with the view to develop useful and appropriate reporting mechanisms to provide service performance and clinical indicators.

• The needs of the service in terms of data collection, management and reporting mechanisms have been determined.

• Implemented stage one of the Primary Care Information System in Alice Springs.

• Established whole of Territory tenders for dialysis hardware and consumables to capitalise on economies of scale and ensure equity and quality of services.

• Established whole of Territory tender for dispensing of medication aids to reduce staff workload and improve quality of service.

Where we are going

a. Determining relevant data sets and describing their current status. See KRA 6.1. a)

b. Negotiating and developing agreements with relevant groups regarding data flow, ownership and issues such as client consent.

c. Developing performance indicators that are meaningful to the Territory. See KRA 6.2. a), b), c), d) and e)

d. Establishing monitoring, evaluation and reporting cycles that promote early intervention if targets are not being met. See KRA 6.4. b)

e. Establishing an audit, review, action-planning cycle to assist multidisciplinary advisory group to plan for current and future service delivery. See KRA 6.4. c), e) and f) and Priority Area 1 c), d) and e).

f. Establishing a communication plan for stakeholders. See KRA 6.4. d) and Priority Area 1 k)

g. Determining the needs of the service in terms of data collection, management and reporting mechanisms. See KRA 6.3. a)

h. Developing a comprehensive renal management database that is integrated across the care continuum to assist service providers with client management. See KRA 6.3. b)

i. Promoting and supporting research into renal service delivery issues and renal economics.

j. Negotiating to establish a senior analyst research position within Renal Services.
**Glossary**

**Access**: refers to the creation of a fistula, insertion of a Tenckhoff catheter or subclavian catheter to enable dialysis to take place.

**Buddy**: Person who provides assistance to the client in delivering their dialysis treatment. Usually spouse or family member but can be anyone committed to the client.

**Centre**: interchangeable with Facility or Unit and refers to the building the service is run from.

**Chronic Kidney Disease**: a condition involving deterioration of renal function which may occur acutely or progressively.

**Community-based Dialysis**: refers to self-care haemodialysis undertaken in any space within a remote community, including home, clinic, dedicated facility or other allocated space. It usually refers to single client set-ups but may include a group of people undertaking self-care dialysis and sharing machines.

**Dialysis**: the process of removing the body’s metabolic wastes and excess fluid that would normally be carried out by the kidneys. The two forms of dialysis are haemodialysis and peritoneal dialysis.
**Donor**: Refers to the person donating an organ. Cadaver donor is from someone who has died but had consented previously to donating his or her organs. Live or living related donor is from someone with a compatible blood group to the receiver who has consented to donating a kidney. Although it is usually a family member, live donors are no longer restricted to blood relations.

**End Stage Kidney Disease**: the final stage of renal disease where remaining kidney function is less than 5% and renal replacement therapy is required to sustain life.

**Fistula**: the surgical joining of an artery and a vein usually in the lower arm, to increase circulation through the superficial venous veins to make them larger and stronger. This allows easier access for needles in order to perform haemodialysis.

**Haemodialysis**: involves pumping the blood through an external circuit and artificial kidney in order to filter out the waste products before the blood is returned to the body. People on dialysis usually attend treatment three times a week for a minimum of four hours per treatment.

**Home-based Dialysis**: refers to a client undertaking dialysis in their home with the partial or complete assistance of a buddy or carer. Home based dialysis can be either peritoneal or haemo-dialysis.

**In-centre Dialysis**: Refers to a unit within a hospital and implies greater input from the renal team and access to tertiary referral services.

**Incidence**: the number of new cases per year.

**Peritoneal Dialysis**: a form of dialysis that uses the peritoneal membrane in the abdomen as the filter to remove the wastes and excess fluid that would normally be removed by healthy kidneys.

**Continuous Ambulatory Peritoneal Dialysis**: involves the regular exchange of 2-3L of fluid via a surgically inserted abdominal tube, four to five times a day.

**Automated Peritoneal Dialysis**: the use of an automated machine to warm, deliver and drain the necessary fluid volume over a set number of hours.

**Prevalence**: total number of cases each year.

**Relocation**: refers to a patient transferring from their normal place of residence to a regional centre for an indefinite period in order to access treatment.

**Renal Unit**: refers to a facility, which offers a range of renal services other than dialysis. These may include investigations and management of renal disease, surgical intervention and preparation for treatment and transplantation.
Renal Replacement Therapy: a form of treatment that replaces the functions of the kidneys and can be haemodialysis, peritoneal dialysis or transplantation.

Satellite Service/Centre/Unit/Facility: refers to a facility managed by a parent hospital where people come as outpatients to access dialysis services. Satellite services in the Territory usually accommodate more than 4 clients and are staffed. A satellite service can either stand alone or be within an established facility such as a hospital.

Self-care: refers to the ability of a client to attend his or her own dialysis treatment without specialist supervision or intervention.

Transplantation: the process of removing a functioning kidney from a donor (live or dead person) and placing it in the abdomen of an appropriate recipient. Transplantation is a treatment and not a cure and involves taking medications for the rest of the recipient’s life.

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