

Revisit Review of Country Health Advisory Councils Governance Arrangements:

**A Health Performance Council report as
part of the 4-Yearly Review (2015-2018)**

8 August 2017

Health Performance Council



**Government
of South Australia**

Health Performance Council

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Executive Summary

Country Health Advisory Councils (Country HACs) are described in the Health Care Act 2008 (the Act 2008), and are a critical conduit for communication and collaboration between the South Australian country community and regional health services. In March 2016, Health Performance Council (HPC) decided to revisit the 2011 HPC Review of Country HACs Governance Arrangements to analyse how much and what has changed since the first review, now nine years since HACs were established under the Act 2008.

HPC acknowledges the great volume and variety of work that is done by Country HACs across South Australia (SA). HPC commends all Country HAC members for their service, commitment and amazing achievements in contributing to stronger regional health services for all country South Australians, now and in the future. As part of this study, HPC invited Country HACs to submit case examples describing achievements, and these are all published in the report. HPC acknowledges all observations in the review and future expectations for HAC activities should be proportionate with the unpaid part-time role of HAC members.

In 2011, HPC observed:

1. Country HACs promote the general interests of local communities to the health system, although promotion of the interests of specific population groups is limited
2. Country HACs have a low profile in the community and their efforts are not well supported or promoted by the health system
3. The level of satisfaction with the governance arrangements between Country HACs and the local health service staff is low
4. The quality of communication and collaboration processes between Country HACs and the health system is variable across SA country communities

In this new study - a revisit review - HPC observed variation between individual Country HACs and where they focus their efforts. HPC used a mixed methods qualitative approach to describe what is the current activity and experience of Country HACs and Country Health SA Local Health Network (CHSALHN) Governing Council, CHSALHN staff and country community members in relation to findings of the 2011 review. HPC conducted information collection from May 2016 to June 2017 including desktop document review, survey and focus groups. By using multiple review methods HPC has the advantage of being able to triangulate results in making observations. These methods have limitations, and in practice HPC notes that response rates were low compared with full population, making this likely to be less than a representative sample.

As this HPC report reached an advanced stage of finalisation, on 8 August 2017, the Social Development Committee of South Australian Parliament tabled its fortieth report, an inquiry into regional health services, concluding a review of oral and written evidence that commenced in April 2016. The inquiry was conducted as a review of governance arrangements only. The report contains 49 recommendations for the consideration or referral of the Minister for Health, Department for Health and Ageing and CHSALHN: a summary is provided at s2.7. This inquiry was conducted simultaneously with the HPC Revisit Review. HPC recognises these parallel exercises had implications for Country HACs in terms of the burden placed on the HAC members who wished to respond to

both. HPC was concerned about pressures this might put on HAC members who have demands from their many roles in country life and is extremely grateful for the generous and timely contributions of participants through interviews, surveys and focus group data collections. HPC notes the observations and advice in the HPC Revisit Review are consistent on many matters recommended by the Social Development Committee.

HPC found CHSALHN staff and HACs have a shared vision for future collaborative action and engagement across the whole community. However, when HPC measured Country HAC, CHSALHN staff and country community perceptions of how well HACs are performing their legislated functions, there are differences in perception between CHSALHN staff and Country HACs in relation to current performance. CHSALHN staff were significantly less likely to 'strongly agree' where Country HACs did 'strongly agree' on performing well at (i) advocating community interests (ii) providing sound advice on health services and (iii) encouraging community participation.

What is important in the contemporary governance of health services is focusing on increased patient safety, community engagement with the whole population, improved health outcomes for country people and the provision of high quality health services. Country HACs can provide leadership in an advisory capacity and monitoring of regional health services performance. However, HPC noted the CHSALHN governance committee structure is missing clear description of how Country HACs and their activities support Governing Council functions and connect with CHSALHN strategic directions for assuring patient safety and quality health services.

HPC observed that Country HACs report they do not all receive the information from CHSALHN that they need to perform their full functions, and advise that CHSALHN strengthen their information architecture, and work with staff and Country HACs to build greater capacity in performance data provision and health literacy for a system that supports patient safety and service improvement.

In June 2017, CHSALHN released a Partnership Framework describing the aims and actions that will guide collaboration and engagement between CHSALHN, Country HACs and country South Australians. With full implementation, this framework should raise the profile of Country HACs and develop health literacy and health governance literacy, but it does not offer complete coverage of Country HACs functions. HPC notes the CHSALHN Partnership Framework evaluation plan includes an annual review and reporting process. The Partnership Framework *and* work to clarify the description of how HACs connect with CHSALHN strategic directions offers an opportunity to add an assessment of collaboration effectiveness in the performance management framework of Governing Council and Chief Executive (CE) CHSALHN.

HPC analysed observations from the desktop review and survey, and developed a draft governance maturity matrix for the final focus group part of the review. A maturity matrix may help a Country HAC to ask itself a series of questions to understand their own level of governance attainment and what activities might strengthen key functions. The draft matrix was offered to CHSALHN staff and Country HACs as an exploration of findings from earlier phases of the review, and to consider its potential for practical relevance and possible future self-assessment use by Country HACs. HPC did not, and will not, use this maturity matrix to evaluate Country HACs.

Remaining relatively unchanged since the 2011 review, there is room for improvement in the level of HAC engagement with the whole community including vulnerable populations. HPC notes the 2015

CHSALHN Aboriginal Community & Consumer Engagement Strategy goes some way to improving engagement and involvement of Aboriginal people in the health system as a complementary and separate strategy to Country HACs. HPC offers advice to CHSALHN to consider engagement strategies for culturally and linguistically diverse communities and for youth that incorporate HAC membership, activities and expectations.

In conclusion HPC observed in this review:

1. CHSALHN staff and Country HACs have a shared vision for future collaborative action and engagement across the whole community even though there are differences in perception about how well functions are currently delivered. Full implementation of the June 2017 CHSALHN Partnership Framework will help address some issues raised, but it does not offer complete coverage of Country HAC functions.
2. Country HACs have a low profile in the community and their direction is not well described by CHSALHN to ensure efforts support Governing Council functions and the organisation's strategic directions for patient safety and quality health services.
3. There is room for improving CHSALHN performance data provision to HACs and development of health literacy and linkage between staff and HACs so Country HACs can provide leadership in an advisory capacity and monitoring of regional health services performance.
4. Country HACs promote the general interests of local communities to the health system, although promotion of the interests of specific population groups remains limited.

In this report, HPC makes advice on possible improvements in relation to Country HAC governance arrangements, information provision and engagement activities, and invites ongoing dialogue with CHSALHN, Governing Council and Country HACs to support developments.

Information about Country HACs, their locations and membership and Presiding Member contacts is available on the SA Health public website.

1.0 Introduction

1.1 Acknowledgement of country and people

The Health Performance Council (HPC) acknowledges the Aboriginal peoples of South Australia and their participation in the life of South Australia. We acknowledge and respect their spiritual relationship with their respective countries.

We also acknowledge the diversity of Aboriginal people in South Australia. South Australia is estimated to be the area of 50 different language groups at the time of European colonisation and 36 continuing language groups (Reconciliation SA 2012). Aboriginal peoples in their diversity have demonstrated resilience and have made significant contributions to South Australia despite the ongoing effects of colonisation and dispossession.

The health and wellbeing of Aboriginal and Torres Strait Islander Australians are a significant concern for all Australian governments (COAG 2008). HPC is aware of the complexities of the health system's engagement with Aboriginal people in South Australia and the social, environmental and economic factors that affect Aboriginal health. We have identified Aboriginal health as a priority reporting area.

The health and wellbeing of Aboriginal Peoples are improved through respect for Aboriginal knowledges, histories, cultures, kinship relationships and community processes (Beagan 2003). Health services that provide culturally appropriate treatment and draw on the strength and endurance of Aboriginal Australians are better placed to support both individuals and communities to improve wellbeing. Culturally appropriate services not only improve client health, but are also a more efficient investment of health resources due to better returns in health outcomes.

1.2 Use of the term Aboriginal

HPC respectfully uses the term 'Aboriginal', rather than 'Indigenous', to refer to people who identify as Aboriginal, Torres Strait Islander, or both. We recognise Aboriginal Peoples and Torres Strait Islander Peoples as two separate groups. However, this document refers to Aboriginal persons in recognition that Aboriginal people are the original and ongoing inhabitants of the state of South Australia. We recognise there are a number of people with Torres Strait Islander heritage living in South Australia. We acknowledge the complexity and diversity of the Aboriginal communities of South Australia, recognising each has its own beliefs and practice.

1.3 Purpose of the revisit review

The purpose of this HPC revisit review of Country HAC governance arrangements was, in relation to 2011 HPC advice, to:

- Determine whether the areas requiring quality improvements have been addressed
- Determine what quality improvements have been implemented
- Determine whether the quality improvements are likely to have made a difference to quality of care and health outcomes – identify what difference was made and determine whether further quality improvements are required

HPC will include the findings from this Revisit Review in the HPC 4-Yearly Review (2015-2018) Report to advise the Minister for Health by December 2018.

1.4 Previous HPC reviews

The *SA Health Care Act* (2008) (The Act 2008) required the HPC undertake a review of the governance arrangements of the Country HACs. This was delivered to the Minister on 7 December 2011 and tabled in both Houses of Parliament on 4 April 2012. The key findings from the 2011 review were:

1. Country HACs are promoting the general interests of local communities to the health system, although promotion of the interests of specific population groups is limited.
2. Country HACs have a low profile in the community and their efforts are not well supported or promoted by the health system.
3. The level of satisfaction with the governance arrangements between Country HACs and the local health system from the perspective of community members, HACs and the local health system from the perspective of community members, HACs and local health services is low.
4. The quality of communication and collaboration processes between Country HACs and the health system is variable across South Australian country communities.

SA Health's formal response to this report was tabled in both Houses of Parliament on 30 May 2012. SA Health supported the findings and suggestions for quality improvements in principle and committed to working with HACs to address them. SA Health outlined future developments including:

- Engage with Health Consumers Alliance of SA Inc (Health Consumers Alliance) in a partnership approach to ensure consumer engagement strategies are implemented across country SA
- Link with local government community engagement processes to identify effective engagement strategies with hard to reach communities and population groups
- Work with CHSALHN Governing Council and local Health Advisory Councils to establish agreed targets around promoting the interests of specific population groups
- Promote and strengthen the activities of Health Advisory Councils in local communities
- Raise the profile of Health Advisory Councils, including through relevant newsletters and timely release of health service development information
- Support local Health Advisory Councils to work with local government in the development of population health plans, as required under the new *SA Public Health Act (2011)*
- Work with local Health Advisory Councils to focus more on activities that will improve health outcomes in local communities. This will be implemented in a staged approach in partnership with SA Health and the local community
- Work with CHSALHN Governing Council to develop and implement improved pathways and structures for local Health Advisory Councils to engage with Governing Council
- Work with local Health Advisory Councils to improve health literacy skills
- Work with CHSALHN Governing Council to develop a more streamlined structure to facilitate local Health Advisory Councils engagement with Governing Council.

In June 2017 after a twelve month development process, CHSALHN launched a Partnership Framework for HACs and Country Health SA. It is a guide to collaboration and engagement so Country HACs are supported to achieve effective community engagement resulting in improved health care, and by virtue of this it is stated, the framework will support CHSALHN demonstrating

compliance with National Safety and Quality in Health Service Standards (NSQHSS) and achieving CHSALHN strategic directions.

1.5 Scope of the revisit review

At the 24 March 2016 bi-monthly HPC meeting, the council agreed to revisit health system review progress against the previous HPC recommendations and previous audits including the Review of Country HACs Governance Arrangements 2011.

In scope:

1. The 40 Country HACs (39 Country HACs and CHSALHN Governing Council) in South Australia.
2. Proposed review areas are guided by the findings from the 2011 Country HAC Review of Governance Arrangements including but not limited to:
 - a) Extent of promotion of interests of local communities including specific population groups:
 - What are the systems/models of consultation used by Country HACs for listening to Aboriginal people? Culturally and linguistically diverse people? People with a disability? Do Country HACs feel competent providing advice on health issues on behalf of these groups and do the Country HACs provide feedback to those groups?
 - What consumer and community engagement processes are in place and how are they working?
 - b) Profile of the Country HACs within the community and level of support and promotion of Country HACs by the health system:
 - Has the prominence of Country HACs within the community increased?
 - To what extent have the 10 year plans been implemented? What evidence is there that Country HACs have worked with local government on the development of Regional Public Health Plans (under *SA Public Health Act 2011*) and to what extent?
 - c) Governance arrangements of Country HACs:
 - What is the role of Country HACs? Does it include activities to improve health outcomes in local communities?
 - Are Country HACs uniform/diverse in their purpose, structure, method and approach? Is their composition right for their purpose and function? Do Country HACs have the right support?
 - Do Country HACs have access to adequate information to perform their functions? Do they have the right processes to gather information for these functions? What processes does Country Health SA and Regional Health Services have in place to receive, evaluate and respond to the advice they receive from Country HACs?
 - What has been done to improve health literacy of Country HACs? Has health literacy of Country HACs improved?
 - How and to what extent have Country HACs been supported in their role by CHSALHN? What is the expertise of those providing training and support? Does CHSALHN have the right staffing to support the Country HACs?

- To what extent are Country HACs involved in the committees of CHSALHN eg Governing Council and Presiding Member Panel and the recruitment of senior staff?
- d) Communication and collaborations between Country HACs and the local health system
 - What is the new streamlined structure to facilitate Country HACs engagement with the Governing Council? Does it work? Has it been reviewed?

Out of scope:

1. Issues outside of approved terms of reference.
2. Review of any other HACs in local health networks in South Australia or any HAC-like arrangements in other jurisdictions.
3. Systematic review of the literature about HACs and regional health services governance.

1.6 Governance of the revisit review

The 2016-17 revisit review was managed by the HPC Secretariat and HPC member and project sponsor Dr Stephen Duckett. An advisory group was established to provide advice to the review with representatives from Country Health, Presiding Members Panel (PMP), Health Consumers Alliance and Local Government. The advisory group met formally on four occasions to provide guidance to the implementation of the revisit review and provided advice out-of-session throughout the revisit review.

Membership included:

- Dr Stephen Duckett, HPC Member (Chair of Revisit Review)
- Mary Patetsos, Deputy Chair HPC
- Professor Jennene Greenhill, HPC Member
- Barrie Moyle, PMP Representative
- Denis Clark, Local Government Representative
- Jeanette Brown, CHSALHN
- Ellen Kerrins, Health Consumers Alliance of SA Inc
- Jane Austin, HPC Secretariat
- Dr Michelle Jones, HPC Secretariat

HPC would like to formally thank the members for the expertise and advice they have contributed to the Revisit Review.

1.7 Revisit review report structure

Chapter 2 provides an overview of the broader context within which this revisit review is conducted. It includes mention of the particular context of rural life and the vast variation across country South Australia. It also acknowledges the dynamic state within Country Health.

Chapter 3 describes the qualitative mixed method approaches used to collect primary data for the Revisit Review.

Throughout the report you will find the Country HAC achievement case examples from Naracoorte HAC through to Waikerie and Districts HACs. They provide examples of on-the-ground activity conducted by seven Country HACs.

Chapters 4 to 6 present the majority findings from revisit review and reflect the content of the 2011 HPC Review. Given the multiple methods used, the source of the data (pulse-check, desktop review or survey) is identified prior to the presentation of the data. The topics covered include: governance arrangements, health information; and community and consumer engagement.

Chapter 7 outlines the development of the self-assessment maturity matrix for use by HACs to self-monitor their actions and plan future activity.

Chapter 8 describes the strengths and limitations of the revisit review. Concluding comments are made in chapter 9. Finally HPC has prepared advice for the Minister for Health to consider. This is presented in chapter 10.

Country HAC Achievements

Naracoorte Area HAC

Naracoorte Area Health Advisory (NAHAC) together with Local Government and Kinraig Medical Clinic (each represented by 3 members) formed a Committee called the Tri-Committee in approximately 2011 to advocate for secure Anaesthetic Provision plus other services. This eventually morphed into a CT program seeking to have CT services at the Naracoorte Hospital. The Community including the local Service Clubs (Lions 2 clubs), Rotary, Soroptomists Apex CWA embraced the project together with three local donations of \$100,000 each raised over \$850,000 to have the facility up and running with Benson Radiology operating on a share income basis in spring of 2015. A CT Trust was formed for Community ownership of the machine and to hold the surplus funds for ultimate replacement. Plus if feasible to provide other medical infrastructure e.g. replace ultrasound and xray if and when needed (currently owned by Bensons).

- Benefits to the community are to have CT access locally saving a minimum of 100 km travel each way, to support surrounding towns and regions on a radius of 100 km particularly to the north of Naracoorte.
- Challenges to overcome were to convince all including CHSA that it could be achieved and the fund raising which the community absolutely embraced. We would do the same again using the same methods.
- Find a proper need and sell the concept to the community.

While the CT project was in play Naracoorte Area HAC also had two more projects established and completed, fundraising and purchase of a Kia Grand Carnival with special ramp adaption, will cater for two wheelchair patient at a time (\$40,000); and a covered walkway between the Clinic and the Hospital (\$65,000).



Source images: Naracoorte Herald 7 Oct 2015

2.0 Context of the Review

2.1 Country South Australia (SA)

Country SA is vast and diverse in geography and demography. CHSALHN covers 983,776 square kilometres (99.8% of SA) and serves a population of 488,496 people (as of end June 2016). The population of Aboriginal people estimated to be living in country SA is 15,559 (48% of SAs total Aboriginal population). The SA population is ageing and to compound this many young people move to metropolitan centres for study or work. There are also emerging culturally and linguistically diverse communities within country SA, as refugee and new arrival communities are settled in regional areas. For example in Mount Gambier in 2011 2,599 people were born overseas with 21% of this population having arrived in Australia within 5 years prior to 2011.

2.2 Context of living in country SA

There are difficulties in how to define country or rural Australia. Rural communities are not fairly compared with urban areas; arbitrary geographic boundaries are constantly changing; and international comparisons of rural regions deny the scale and scope of the vastness of Australia (Gorman-Murray et al 2008).

Over the years the emphasis in rural communities on primary production has changed (through mechanisation, climate change, consumer and market changes) and once thriving rural industries and communities have seen declines. The rural primary industries that dominated activity since the 1800s - farming, mining and fishing - have been exchanged or supplemented with new industries such as service industries, tourism and leisure (Gorman-Murray et al 2008).

Healthcare is considered a primary industry within country regions, especially with an ageing population. Hospitals and healthcare services provide local employment and bring people to reside in small townships. Such services provide the lifeblood of the community. So when there is silence about improvements and maintenance of health services or announcements about changes or closures seemingly without community consultation, by ripple effect concerns are raised about the continued viability of the township and its ability to survive economically.

2.3 The People – the essence of community

In country Australia there is a culture of both hard work and hardship within rural communities, and perception of high levels of community connectedness and strong family values (Gorman-Murray et al 2008). In rural communities people can know each other well, in smaller numbers, through a variety of transactions (Ife, 2002). In small rural towns one member of the community may play multiple roles (or 'wear many hats'), paid and unpaid. Many Country HAC members wear multiple hats across their communities as well as contributing through membership of a Country HAC in an unpaid, part-time capacity.

Absent from this discussion of rural communities is the struggle of isolation resulting perhaps from distance, or poverty or the invisibility of ethnic diversity within rural towns. HPC recognises that there is great diversity across rural South Australia – diversity within communities; diversity in health needs and diversity within and amongst Country HACs.

2.4 Chronology of activity impacting Country HACs 2008-2017

South Australia has a dynamic public health system with multiple pressures such as demographic change, organisational restructures, new strategic plans, improving clinical standards and increasing demands for services. This requires SA Health organisations, leadership and staff to change, adapt and innovate on a scale that would challenge many corporate bodies.

To understand the context of this HPC review of Country HACs Governance Arrangements, Table 2 offers a high level chronology of change activities impacting Country HACs since 2008.

Table 1: Chronology of activity impacting Country HACs 2008-2017

Month/Year	Activity
2008	SA Health Care Act (2008) – established Health Advisory Councils (HACs)
2008	All incorporated and unincorporated HACs established constitutions and rules respectively in accordance with the SA Health Care Act 2008.
2011	SA Public Health Act (2011) – regional public health planning
July 2011	National Health Reform Agreement 2011 provided for Medicare Locals, local health networks (LHN) and LHN Governing Councils to be established. Governing Councils for each LHN were established by using HAC provisions in the SA Health Care Act 2008.
December 2011	HPC delivered Review of Country Health Advisory Councils Governance Arrangements to the Minister as required under the Act 2008.
4 April 2012	Minister for Health and Ageing tabled the HPC report to both Houses of Parliament as required under The Act
2012	HPC received response to HPC Report on Review of Country Health Advisory Councils Governance Arrangements from Minister for Health and Ageing
2012	National Safety and Quality Standards released
May 2012	CHSALHN Health Advisory Council Inc (known as Governing Council) established constitution.
2012	Country regional boundaries changed from eight to six regions including: Barossa, Hills Fleurieu; Flinders and Upper North; Eyre and Far North; Riverland Murray Coorong; South East; Yorke and Northern.
2012-13	Presiding Members Panel (PMP) introduced to support links between Governing Council and HACs
2014	State Premier's Review of Boards and Committees
2014	Federal budget abolished Medicare Locals and replaced with 'fewer but larger' Primary Health Networks from 1 July 2015
2015	CHSALHN Strategic Plan 2015-2020 released
2015	CHSALHN releases SA Community and Consumer Engagement Strategy 2015-2018
2015	CHSALHN releases the SA Aboriginal Community & Consumer Engagement Strategy including established Aboriginal Experts By Experience register
1 July 2015	Primary Health Networks established including Clinical Councils and local Consumer Advisory Committees
August 2015	CHSALHN Governing Council Health Advisory Councils Presiding Member Panel Terms of Reference released
March 2016	HPC decides to revisit the 2011 Review of Country Health Advisory Councils Governance Arrangements
April 2016	Terms of Reference released for Social Development Committee, SA Parliamentary inquiry into Regional Health Services
June 2017	A Partnership Framework for Country HACs and CHSALHN 2017-2022 released at Combined HAC Conference
August 2017	Social Development Committee of South Australian Parliament tabled its fortieth report, an inquiry into regional health services

2.5 National Safety and Quality Health Service Standards

CHSALHN complies with the ten Australian Commission on Safety and Quality in Health Care (ACSQHC) NSQHSS standards (ACSQH 2011). There are two standards especially relevant to the review of Country HACs Governance Arrangements.

1. The Governance for Safety and Quality in Health Service Organisations Standard:

Health service organisation leaders implement governance systems to set, monitor and improve the performance of the organisation and communicate the importance of the patient experience and quality management to all members of the workforce. Clinicians and other members of the workforce use the governance systems. (ACSQHC, 2012)

2. The Partnering with Consumers Standard:

Leaders of a health service organisation implement systems to support partnering with patients, carers and other consumers to improve the safety and quality of care. Patients, carers, consumers, clinicians and other members of the workforce use the systems for partnering with consumers. (ACSQHC, 2012)

2.6 Country Health South Australia Local Health Network (CHSALHN)

Across South Australia, CHSALHN has six regions (Figure 1); 40 Country HACs (including Governing Council) and there is a network of 64 hospitals and health services (Table 2).

Section 4.1 outlines the CHSALHN strategic directions and governance structure as it relates to this review.

Figure 1: Country Health LHN regions

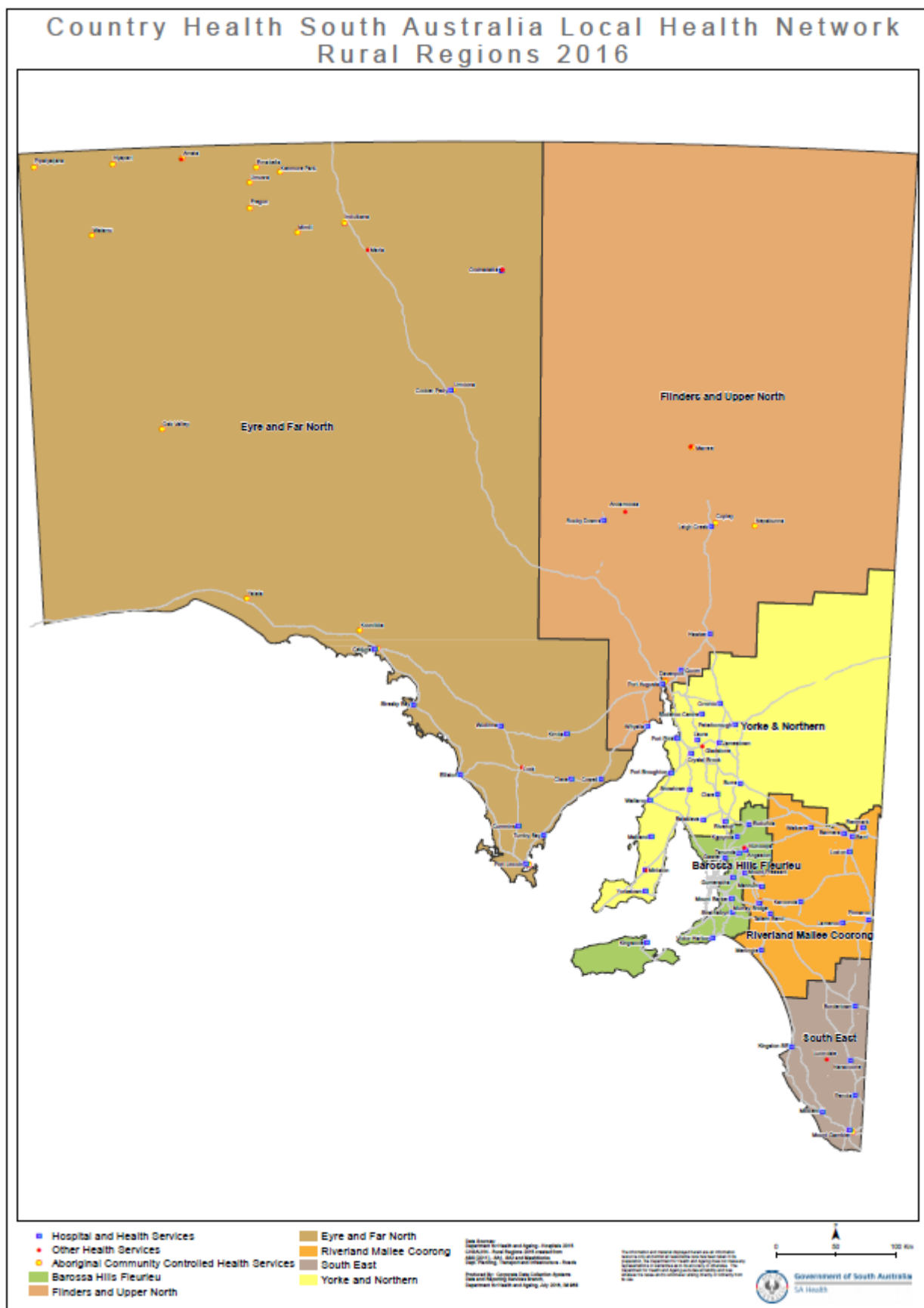


Table 2: CHSALHN Region, Country HACs and corresponding Health Units

Rural Region	Health Advisory Council	Health Units associated with HAC
Barossa Hills Fleurieu	Barossa and Districts Health Advisory Council Inc.	Angaston, Tanunda
	Eudunda Kapunda Health Advisory Council Inc.	Eudunda, Kapunda
	Gawler District Health Advisory Council Inc.	Gawler
	Hills Area Health Advisory Council Inc.	Mount Barker, Strathalbyn, Gumeracha, Mt Pleasant
	Kangaroo Island Health Advisory Council Inc.	Kangaroo Island
	South Coast Health Advisory Council Inc.	Victor Harbor (South Coast)
Eyre & Far North	Ceduna District Health Services Health Advisory Council Inc.	Ceduna
	Eastern Eyre Health Advisory Council Inc.	Kimba, Cowell, Cleve
	Far North Health Advisory Council	Cooper Pedy, Oodnadatta
	Lower Eyre Health Advisory Council Inc.	Cummins, Tumby Bay
	Mid-West Health Advisory Council Inc.	Wudinna, Streaky Bay, Elliston
	Port Lincoln Health Advisory Council	Port Lincoln
Flinders & Upper North	Hawker District Memorial Health Advisory Council	Hawker
	Leigh Creek Health Services Health Advisory Council	Leigh Creek
	Port Augusta, Roxby Downs, Woomera Health Advisory Council	Port Augusta, Roxby Downs
	Quorn Health Services Health Advisory Council	Quorn
	Whyalla Hospital and Health Services Advisory Council	Whyalla
Riverland Mallee Coorong	Berri Barmera District Health Advisory Council Inc.	Berri, Barmera
	Coorong Health Service Health Advisory Council Inc.	Tailem Bend, Meningie
	Loxton and Districts Health Advisory Council Inc.	Loxton
	Mallee Health Service Health Advisory Council Inc.	Karoonda, Lameroo, Pinnaroo
	Mannum District Hospital Health Advisory Council Inc.	Mannum
	The Murray Bridge Soldiers' Memorial Hospital Health Advisory Council Inc.	Murray Bridge
	Renmark Paringa District Health Advisory Council Inc.	Renmark
	Waikerie and Districts Health Advisory Council Inc.	Waikerie
South East	Bordertown and District Health Advisory Council Inc.	Bordertown
	Kingston/Robe Health Advisory Council Inc.	Kingston
	Millicent and Districts Health Advisory Council Inc.	Millicent
	Mount Gambier and Districts Health Advisory Council Inc.	Mt Gambier
	Naracoorte Area Health Advisory Council Inc.	Naracoorte
	Penola and Districts Health Advisory Council Inc.	Penola
Yorke & Northern	Balaklava and Riverton Health Advisory Council Inc.	Balaklava, Riverton
	Lower North Health Advisory Council Inc.	Clare, Burra, Snowtown
	Mid North Health Advisory Council Inc.	Booleroo, Jamestown, Orroroo, Peterborough
	Northern Yorke Peninsula Health Advisory Council Inc.	Wallaroo
	Port Broughton District Hospital and Health Services	Port Broughton

	Health Advisory Council Inc.	
	Port Pirie Health Service Advisory Council	Port Pirie
	Southern Flinders Health Advisory Council	Crystal Brook, Laura
	Yorke Peninsula Health Advisory Council Inc.	Maitland, Yorketown, Minlaton
n/a	Country Health SA LHN Health Advisory Council Inc.	n/a

2.7 Social Development Committee of SA Parliament

On 8 August 2017, the Social Development Committee of South Australian Parliament tabled its fortieth report, an inquiry into regional health services, concluding a review of oral and written evidence that commenced in April 2016. The inquiry was conducted as a review of governance arrangements only. The report contains 49 recommendations for the consideration or referral of the Minister for Health, Department for Health and Ageing and CHSALHN.

The first item on the committee's terms of reference referred to the 2011 HPC review of Country HAC governance arrangements. The second item referred to specific areas in relations to the current provision and plans for future delivery of health service in regional South Australia.

This inquiry was conducted simultaneously with the HPC Revisit Review. This had implications for Country HACs in terms of the burden placed on the HAC members who were invited to respond to both the HPC review and submit evidence to the committee inquiry. This also guided the choice of methods used by HPC: for example the pulse-check interviews with Country HAC Presiding Members were conducted over a very short period of time. HPC was concerned about time pressures this put on HAC members who have demands from other roles in country life but did not want to miss the opportunity of a quick turn-around of Country HAC views that were able to be directly related in HPC's invited oral evidence to the Social Development Committee on 23 May 2016.

The inquiry report concludes that on balance a great deal of work has been done in the past nine years to successfully address problems initially felt with changes to implement the Act 2008 that restructured the health system and dismantled hospital boards. However, the inquiry found not all HACs have been able to implement the full scope of functions that the Act 2008 provides for, nor have they been confident in their role, as they have understood it. The report highlights how the principles of good governance in action, such as transparency, accountability and consultation, in conjunction with good communication practices and collaborative partnerships should underpin governance and delivery of SA's regional health services.

However, on reviewing progress in 2016 against outcomes of the 2011 HPC review, this inquiry report describes issues identified remain largely consistent concerning functions, role and promotion of HACs and in relation to the role of CHSALHN. This report provides recommendations for ways in which HACs can have a more robust role in the planning and delivery of regional health services, relative to the functions prescribed to them by the Act 2008, and in particular in relation to their role as community advocates within the healthcare system. The report notes there is presently no formal instrument in place that provides for CHSALHN to report to HACs in relation to service planning or clinical services, and observes regional directors are tasked with providing information to HACs including CHSALHN key performance indicators but there is no feature of this in the role description of a regional director. It recommends CHSALHN clarify expectations on key staff for linkage with HACs, and continue to improve communication processes and reporting practices to HACs so that HACs can potentially have a meaningful role in service and activity review, service planning and monitoring quality and safety of health services, hospital budget and workforce planning and meeting the expectations of local communities.

The inquiry report states health outcomes can be influenced by the way in which health services are planned, governed and administered. The Social Development Committee commends the work by

CHSALHN to facilitate Aboriginal participation in the rural health system, and recognises there is still work to do to address lack of engagement between HACs and Aboriginal communities. The inquiry report goes further to recommend CHSALHN address engagement deficits with culturally and linguistically diverse populations and other minority groups in country areas who may be encountering difficulties in accessing services. The committee sees a role for active participation by HACs and continued and appropriate support from CHSALHN in achieving further improvement.

The committee received evidence from some local councils that raised concerns highlighting emerging disparities in local government objectives and CHSALHN service planning, perhaps with new local government responsibilities for regional public health planning, but this is not elaborated upon further.

The report makes recommendations across all the items in the inquiry's terms of reference, as well the roles and responsibilities of HACs summarised above, including trends in local community fundraising for equipment, ownership of property, hiring staff, SA Ambulance Service arrangements, GPs and emergency department care, procurement and management of maintenance and minor works, implementation of Enterprise Patient Administration System (EPAS) in country hospitals, integrated mental health inpatient centres and Patient Assistance Transport Scheme (PATS).

Country HAC Achievements

Loxton and Districts HAC Achievements

The Loxton & Districts Health Advisory Council in 2016 funded the renovation and refurbishment of wards and bathrooms in the West Wing of the hospital. This was a \$300,000 project, funded entirely by the community. The previous bathrooms were so small that wheelchair access was not possible. The project has now transformed the West Wing into large modern rooms, with two beds and a bathroom for each room. The bathrooms are large, and enable carer/nursing support to the patients using them. Loxton and Districts HAC also installed appropriate bariatric fittings for future use. During the build, it became obvious that the existing call bell system would be inadequate, so Loxton and Districts HAC spent a further \$67,000 to install a new call bell system. None of this would have been possible without the generosity and support of the local community, and Loxton and Districts HACs have held an open day to introduce the new facilities.



Source: http://www.kregarbuilding.com.au/loxton_hospital.php

3.0 Review methods

HPC selected a mixed methods, qualitative approach to seek insights about the changes since the 2011 HPC Review. Key informants included Country HAC members, key stakeholder organisations, CHSALHN staff and the community. By combining multiple methods HPC overcame the weaknesses of a small sample and bias of using a single method approach. Multiple methods allowed triangulation in the reporting of the data, such that multiple sources were drawn upon allowing crosschecks of information and providing greater certainty in the data collection and ensuring a 'more detailed and balanced picture of the situation' (Altrichter 2008). HPC is more confident in the findings by the process of crosschecking data from multiple sources (O'Donoghue and Punch 2003).

The five primary approaches to gathering data to inform this report included:

3.1 Brief pulse check – phone interviews

Brief pulse check interviews were conducted by Colmar Brunton Social Research Company in May 2016. All presiding members were invited by the HPC chair to be involved in a phone interview (Appendix 1). A convenience sample of 15 were interviewed, some self-selected others were purposefully selected to ensure coverage across all six CHSALHN regions. The purpose of this pulse-check was for HPC to seek feedback from a small sample of HAC Presiding Members prior to HPC giving evidence at the Social Development Committee inquiry into Regional Health Services.

3.2 Desktop review

A **desktop review** was conducted by Michele Herriot Consulting in November 2016. A stratified sample of Country HACs (n=17) was selected ensuring representation from each country SA region; a mix of incorporated and unincorporated HACs; HACs that service regional country cities as well as small country towns; and the CHSALHN Governing Council. The documents under review included the selected HACs constitutions or rules, annual reports (2011-12 to 2014-15), regional 10 Year Strategic Plan 2011-2020 and implementation plans.

3.3 Surveys

Surveys were conducted by Colmar Brunton Social Research Company. Four slightly different surveys were conducted with:

- a. Country HAC presiding and general members (n=49)
- b. CHSALHN staff Statewide (n=10)
- c. CHSALHN staff regional (n=63) and
- d. Community members (n=44).

The survey questions reflected the functions of HACs outlined within The Act 2008 and the community engagement role outlined within CHSALHN Community and Consumer Engagement Strategy. The surveys were conducted either online, hard copy or over the phone with online data entry. An interpreter service was made available but not accessed. Community members were recruited via an advert in the local newspapers or via articles in HPC prescribed bodies newsletters eg Health Consumers Alliance CE Executive check via email. HAC presiding members were recruited via email (list provided by Country Health) and HAC general members through cascading of emails from presiding members. Response rates and sample demographics from the surveys are appended (Appendix 2).

3.4 HAC achievement case examples

HAC survey responders and all presiding members' were invited to submit **case examples** of their Country HAC achievements to HPC for inclusion in the report. These were drafted by Country HAC members and lightly edited by HPC (without the removal of substantive content) for inclusion within the report.

3.5 HAC focus groups

Focus groups were conducted by Colmar Brunton Social Research Company with HAC members that completed the survey and self-nominated Presiding Members were invited to be involved to ensure coverage across all regions (this was achieved) and Country HACs (this was not achieved). The focus groups were an opportunity to seek feedback on the draft self-assessment governance maturity matrix developed using the findings from the first four methods (Appendix 5). A focus group was also conducted with CHSALHN Regional Directors to provide feedback on the draft Country HAC self-assessment governance maturity matrix.

Country HAC achievements

Port Pirie Health Advisory Council

The helipad built at the Port Pirie Hospital was fully funded by the Port Pirie HAC and the local community.

The Palliative Care unit was 50% local funding and 50% government funding, completed in 2016.

Dialysis Unit was achieved because of consultation between HAC, Community and Country Health.

Port Pirie HAC along with help from local community were responsible for keeping and upgrading our Aged Care facility.

Source images: Port Pirie Regional Health Service, CHSALHN



4.0 Governance Arrangements

Governance is defined by ACSQHC as the set of relationships and responsibilities established by a health service organisation between its executive, workforce and stakeholders (including consumers). Governance incorporates the set of processes, customs, policy directives, laws and conventions affecting the way an organisation is directed, administered or controlled. Governance arrangements provide the structure through which the corporate objectives (social, fiscal, legal, human resources) of the organisation are set and the means by which the objectives are to be achieved. They also specify the mechanisms for monitoring performance.

Effective governance provides a clear statement of individual accountabilities within the organisation to help in aligning the roles, interests and actions of different participants in the organisation to achieve the organisation's objectives.

In the ACSQHC National Safety and Quality Health Standards, *governance* includes both corporate and clinical governance. *Clinical Governance* is defined as a system through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care. This is achieved by creating an environment in which there is transparent responsibility and accountability for maintaining standards and by allowing excellence in clinical care to flourish.

4.1 Governance structures of CHSALHN and strategic directions

The CHSALHN strategic plan 2015-2020 (CHSALHN, 2015a) describes the five strategic directions:

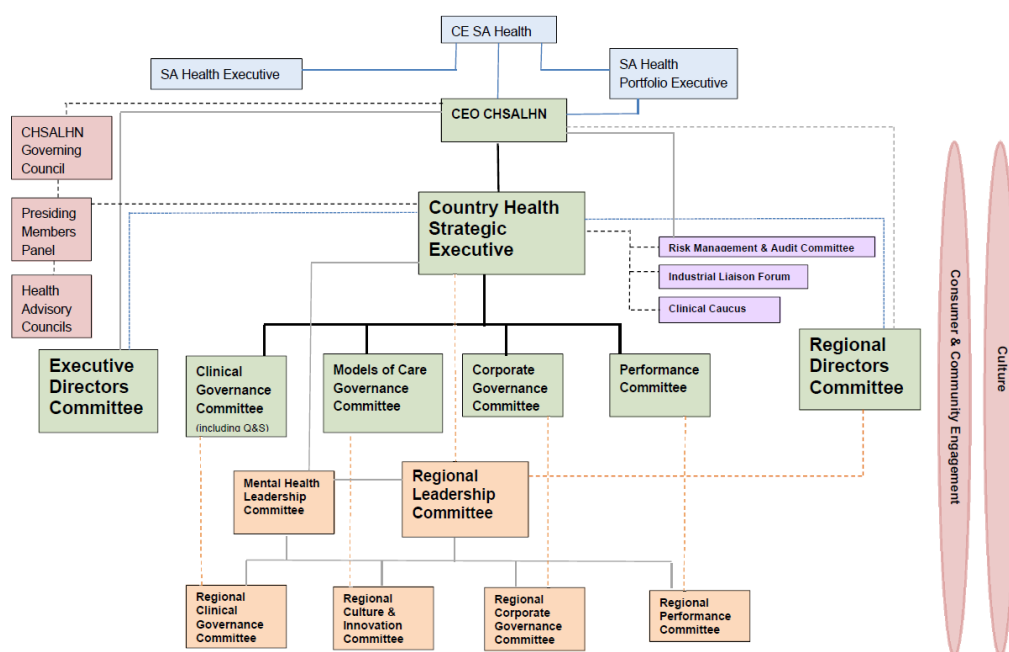
- Person-centred
- Performance
- People
- Partnerships and
- Populations.

These strategic directions are underpinned by their core values of customer focus, collaboration, care, creativity and courage. The plan recognises that achieving excellence in consumer care means creating vibrant, values-based places to work and learn.

The governance committee structure for CHSALHN (Figure 2) identifies the relationships between the Country HACs, PMP, CHSALHN Governing Council and the CE, CHSALHN and CHSALHN Strategic Executive. The nature of the relationships between HACs and PMP; and PMP and Governing Council are shown to be hierarchical in nature. The relationships between Country HACs and their local hospitals/health services do not appear to be included in this figure.

Since the 2011 HPC review there have been several changes within CHSALHN structures. Of particular relevance is the introduction of the PMP.

Figure 2: CHSALHN Governance committee structure (CHSALHN, 2017c)



4.1.1 Functions of CHSALHN Governing Council

CHSALHN Governing Council functions outlined in its constitution (2012) include:

- Advising the LHN on effective clinical and corporate governance frameworks to support the maintenance and improvement of standards of patient care and services by the LHN
- Advise on systems:
 - To support the efficient and economic operation of the Local Health Network and
 - To ensure the Local Health Network manages its budget to ensure performance targets are met and
 - To ensure that the LHN's resources are applied equitably to meet the needs of the community served by the network
- Advise on strategic plans to guide the delivery of services for the LHN
- Provide strategic oversight of and monitor the LHN's financial and operational performance in accordance with any performance measures in the performance agreement for the LHN
- Make recommendations for the appointment of the CE and, where it considers it appropriate to do so, to make recommendations concerning the removal of the CE
- Confer with the CE in connection with the operational performance targets and performance measures to be negotiated pursuant to the service agreement for the LHN
- Advise on the service agreement for the LHN
- Seek the views of providers and consumers of health services, and of other members of the community served by the LHN, as to the network's policies, plans and initiatives for the provision of health services and other members of the community
- Endorse the LHNs annual report
- Liaise with the governing councils of other LHNs in relation to both local and state-wide initiatives for the provision of health services

- Liaise with the health advisory councils which have been established pursuant to section 15 of The Act 2008 in relation to an incorporated hospital established to provide services within the country areas of the State
- Hold assets on trust for nominated Health Advisory Councils and ensure that the funds are administered legally and appropriately
- Perform such other functions as are conferred or imposed on it by the regulations.

Of the 14 Governing Council functions, only two name HACs: financial and liaison role.

However what may be implied from the Governing Council's role to liaise with HACs is how important this connection and communication conduit is to support CHSALHN effectively discharging clinical and corporate governance obligations on standards of patient care and services for every local population and meeting the performance expected in the CHSALHN strategic directions. This relates to both Governing Council's accountability for improvement of standards of patient care and services by the LHN and reciprocally HACs requirement to take account of CHSALHN strategic directions.

The clinical governance role is explicit within the Governing Council functions and this role is also explicit within the Service Level Agreement 2016-2017 between SA Health and CHSALHN. It details: monitoring and providing advice on improving clinical care outcomes within the LHN, with a particular focus on local service integration, performance, the safety and quality of services and risk management (2016:6). This item specifically refers to Governing Council as the HAC, without reference to the liaison role of Governing Council with the 39 Country HACs on clinical governance.

Suggestion B from the 2011 HPC Review was that the CHSA Local Health Network HAC Inc, the Governing Council, clarify its ongoing relationship with HACs. In the desktop review the HAC annual reports did not commonly refer to the Governing Council specifically, although the Governing Council annual reports indicate they sought the view of HACs (Figure 3).

Figure 3: Desktop Review - Seeking the view of HACs

The Governing Council reported that it regularly sought the views of HACs on different issues. During the 2013-14 year Mr Blacker visited a number of country regions with CE allowing the opportunity to hear about issues first hand. He also attended some HAC forums

When Country HAC members were surveyed about engaging with Governing Council members, the largest proportion of responses (20%) related to the need for greater communication, with the next highest proportion suggesting more contact and engagement is necessary (12%). While improvements were suggested, almost a quarter of responses suggested that no improvements were necessary or that they were happy with the current arrangements (24% when combined).

In June 2017, Governing Council with CE, CHSALHN and PMP, launched a Partnership Framework for Health Advisory Councils and CHSALHN 2017-2022 (CHSALHN, 2017a). The framework represents the culmination of a year's work between Country HAC members and CHSALHN. It sets out the following aims:

- Reflect the foundation legislation

- Define the structure of the HAC committees within CHSALHN, their roles and responsibilities, and the lines of communication and accountability of these committees
- Ensure the role of HACs is embedded in CHSALHN governance structures
- Raise the profile of HACs in CHSALHN, in regional and local sites and in relevant communities
- Improve the health literacy and health governance literacy of HAC members
- Support Presiding Members and other members to provide leadership within the HAC structure
- Improve communication and engagement processes between CHSALHN/HAC and local communities
- Empower communities to make decisions about relevant health issues and services.

4.1.2 Functions of Health Advisory Council PMP

The PMP was introduced in 2012-2013, and this review found the introduction of the PMP seems to be a supported change to governance arrangements.

The PMP terms of reference (Aug 2015) describe the purpose of the PMP as a mechanism for effective liaison between local Health Advisory Councils (HAC) and the CHSALHN Governing Council including:

- Facilitate timely and effective communication between HACs and Governing Council
- Provide a forum for effective debate around topical issues that are of significance across country SA
- Provide a conduit between Country HACs and Governing Council
- Provide oversight and work in partnership with local HACs to build their capacity, assets and attributes to identify and mobilise community resources, knowledge and skills to improve the health of and health futures for communities, including a focus on improving health literacy
- Provide a forum to consider and develop partnerships for HACs with other key stakeholders in the context of health reform, most notably Primary Health Network organisations and Local Government
- Monitor and evaluate the CHSALHN Health Advisory Councils PMP.

There are 15 members on this committee representing each of the six regions and two members from the Aboriginal Experts by Experience register (CHSALHN Aboriginal Community & Consumer Engagement Strategy 2015).

The pulse-check found that the quality of communication and collaboration continues to be variable across the regions. There were mixed views on the introduction of PMP – which was established following the 2011 HPC review. In the pulse-check HAC members were asked about the introduction of PMP, while some Country HACs reported improved governance arrangements since the introduction of the PMP, others suggest that it is yet another layer of governance to work through.

The desktop review found that the HACs were initially sceptical of the introduction of yet another committee. As the PMP has matured however the HACs have come to see it as a useful forum for the conduit of communications and information between HACs and Governing Council (Figure 4).

Figure 4: Desktop review – HACs value PMP

The Hawker HAC commented in the 2013-14 Annual Report that the PMP has allowed '*a forum for the advocacy and expedience of issues as they arise and cuts through the levels of bureaucracy.*'

The Yorke Peninsula HAC (2014-15) the PMP is described as '*a useful forum for sharing of ideas amongst like-minded people, in order improve and enhances systems and services.*'

In relation to engagement with the PMP, the survey results were some of the most positive with over a third (36%) of responses suggesting that no improvements are necessary or that they are happy with the current arrangements. The main suggested improvements were for more communication and information (14% and 10% respectively) and improved awareness of their role (8%).

4.1.3 Functions of Country HACs

Key functions and powers of Country HACs are outlined within The Act 2008 and within their respective Country HACs constitutions or rules. The Act 2008 states that the functions of a HAC may include one or all of the following, and note while HAC functions may include one or all, all Country HACs include all of these as HAC functions:

- (a) To act as an advocate to promote the health interests of the community, or a section of the community
- (b) To provide advice about any relevant aspect of the provision of health services from the perspective of consumers of those services, any carers or volunteers or the community more generally
- (c) To provide advice about relevant health issues, goals, priorities, plans and other strategic initiatives
- (d) To provide advice or assistance in undertaking the development or implementation of systems or mechanisms designed to support the delivery of health services or programs
- (e) To provide information to, and to consult broadly with, the consumers of any relevant services, any relevant carers or volunteers, and the community more generally
- (f) To encourage community participation in programs associated with supporting the provision of health services, and to promote the importance of carers and volunteers in assisting in achieving successful outcomes
- (g) To consult with other bodies that are interested in the provision of health services within the community
- (h) To provide advice to the Minister about any matter referred to it by the Minister or Chief Executive
- (i) To participate in the consultation or assessment processes associated with the selection of senior staff of a relevant entity
- (j) In the case of a HAC that is incorporated –
 - (i) To act as a trustee or to assume other fiduciary functions or duties
 - (ii) To participate in budget discussions and financial management or development processes
 - (iii) To undertake fund-raising activities
- (k) In the case of a HAC that is not incorporated -
 - (i) To provide advice in relation to the management of resources available for relevant health services

- (ii) To provide assistance with fund-raising activities in accordance with its rules
- (I) Such other functions -
 - (i) Assigned to the HAC under this or any other Act or
 - (ii) Assigned to the HAC by the Minister or
- (iii) Adopted by the HAC with the approval of the Minister.

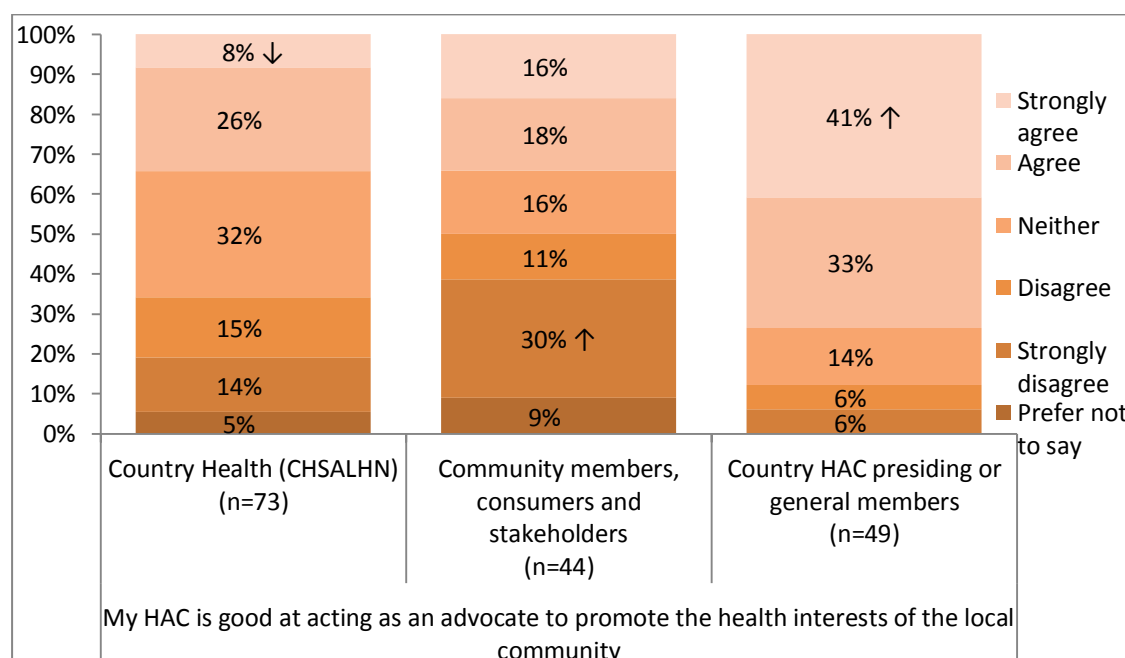
Subject to The Act 2008 a HAC must, in the performance of its functions, take into account the strategic objectives (including any health care plan or plans) that have been set or adopted within the Government's health portfolios. These functions under The Act 2008 remain unchanged.

4.2 Agreement with Country HACs role and functions

The survey sought the level of agreement between CHSALHN (CH) staff (state-wide and regional), community and Country HACs on the HACs' performance of these functions. On the whole, there were disparities between the Country HACs level of agreement compared with those reported by CHSALHN staff and the community, where the Country HACs had greater agreement that they were fulfilling their HAC functions.

When asked about the HACs ability to act as a good advocate to promote the health interests of the local community there was variation in responses between the groups (Figure 5). Both CHSALHN staff (34%) and community members (34%) agreed and strongly agreed that their Country HAC acted as a good advocate to promote the community health interests of the local community. While 74% of Country HAC members agreed or strongly agreed. Community members were most likely to strongly disagree (30%) with this statement.

Figure 5: Agreement with HACs role as advocate to promote health interests of local community

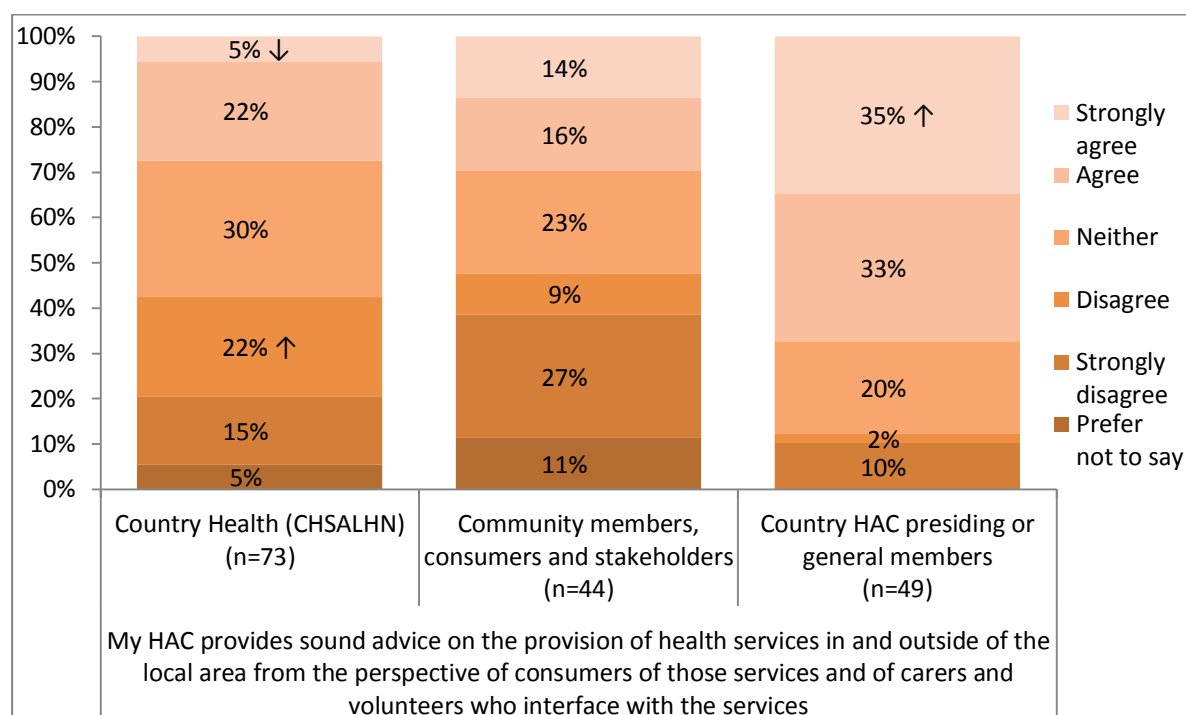


Q60: On a scale of 0 to 10 where 0 is strongly disagree and 10 is strongly agree, to what extent do you agree with the following statements in relation to your local Country HAC (SR)

Base: All respondents (n=166)

When asked about whether their Country HAC provides sound advice on the provision of health services in and outside of the local area from the perspective of consumers of those services and carers and volunteers who interface with the services, CHSALHN staff were significantly less likely to strongly agree (5%) while Country HAC members were more likely to strongly agree (35%) with this statement (Figure 6).

Figure 6: Agreement with HACs provision of sound advice on health services from perspective of consumers, carers and volunteers by group

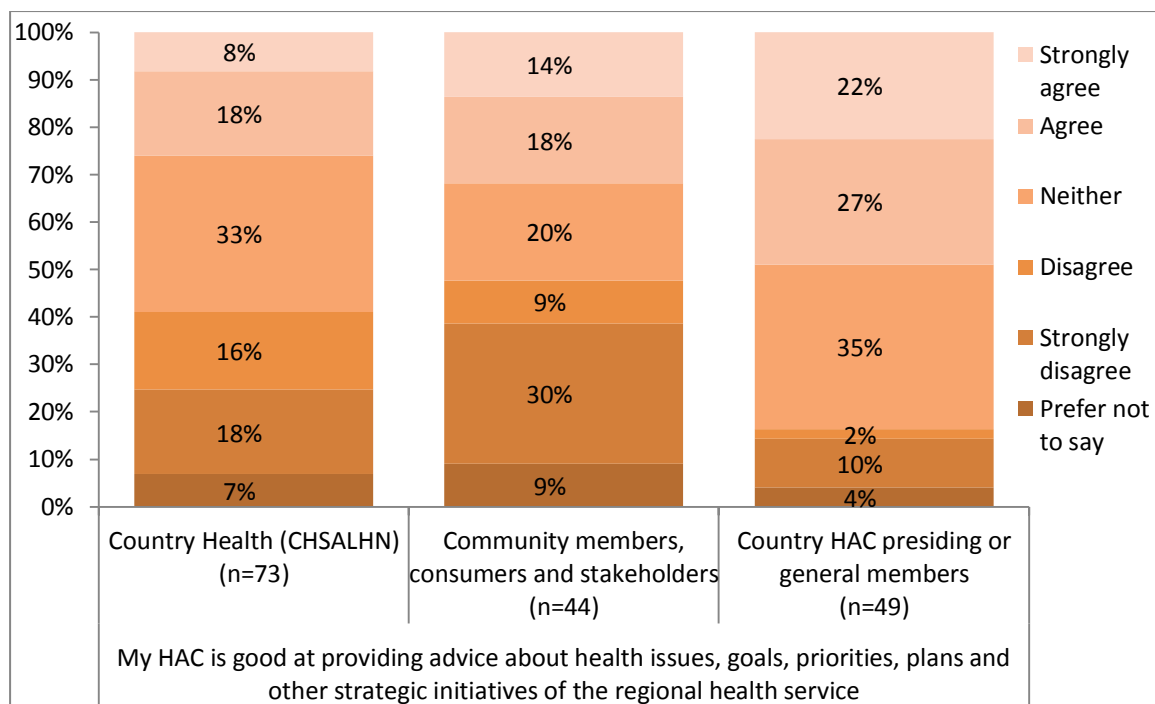


Q60: On a scale of 0 to 10 where 0 is strongly disagree and 10 is strongly agree, to what extent do you agree with the following statements in relation to your local Country HAC (SR)

Base: All respondents (n=166)

More HACs agreed or strongly agreed (49%) with their ability to provide good advice about health issues, goals, priorities and plans compared with CHSALHN staff (26%) and community members (32%). Thirty percent of community members strongly disagreed (Figure 7).

Figure 7: Agreement with HACs provision of sound advice about health issues, goals, priorities, plans and other strategic initiatives of the regional health service by group

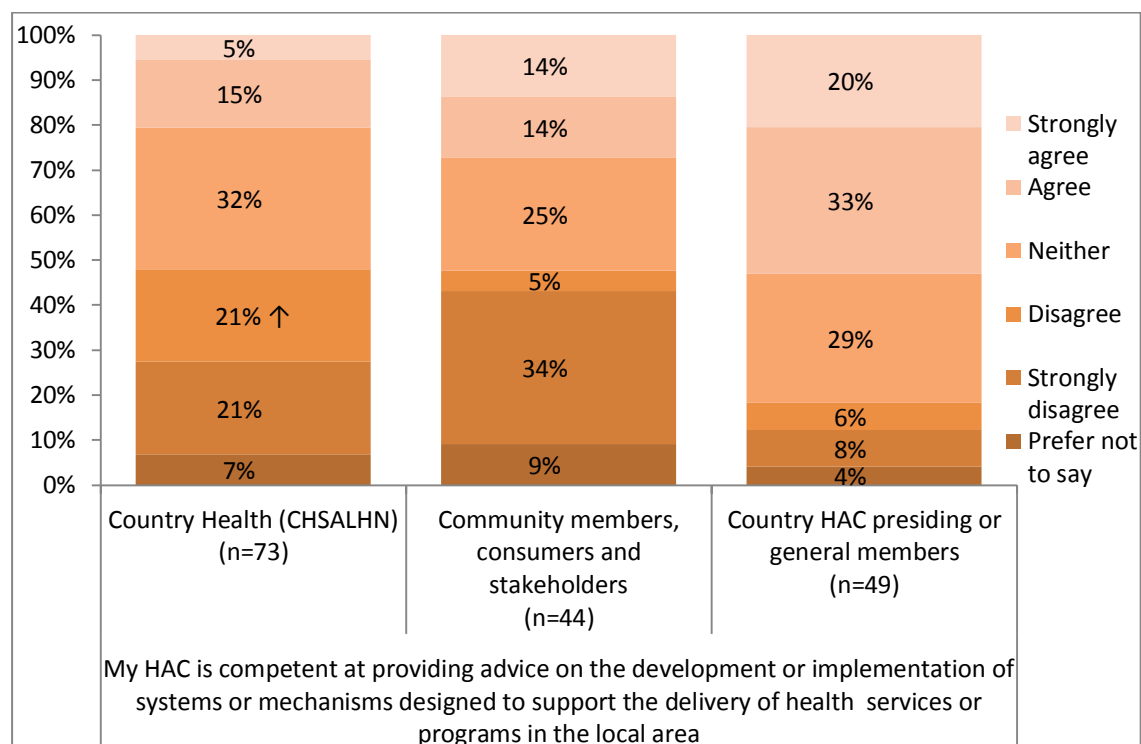


Q60: On a scale of 0 to 10 where **0 is strongly disagree** and **10 is strongly agree**, to what extent do you agree with the following statements in relation to your local Country HAC (SR)

Base: All respondents (n=166)

When asked about the extent of agreement with Country HACs provision of sound advice on the development or implementation of systems or mechanisms designed to support the delivery of health services or programs in the local area, CHSALHN staff were more likely to disagree (21%) with this statement (Figure 8).

Figure 8: Agreement with HACs competency to provide advice to support delivery of local health services by group

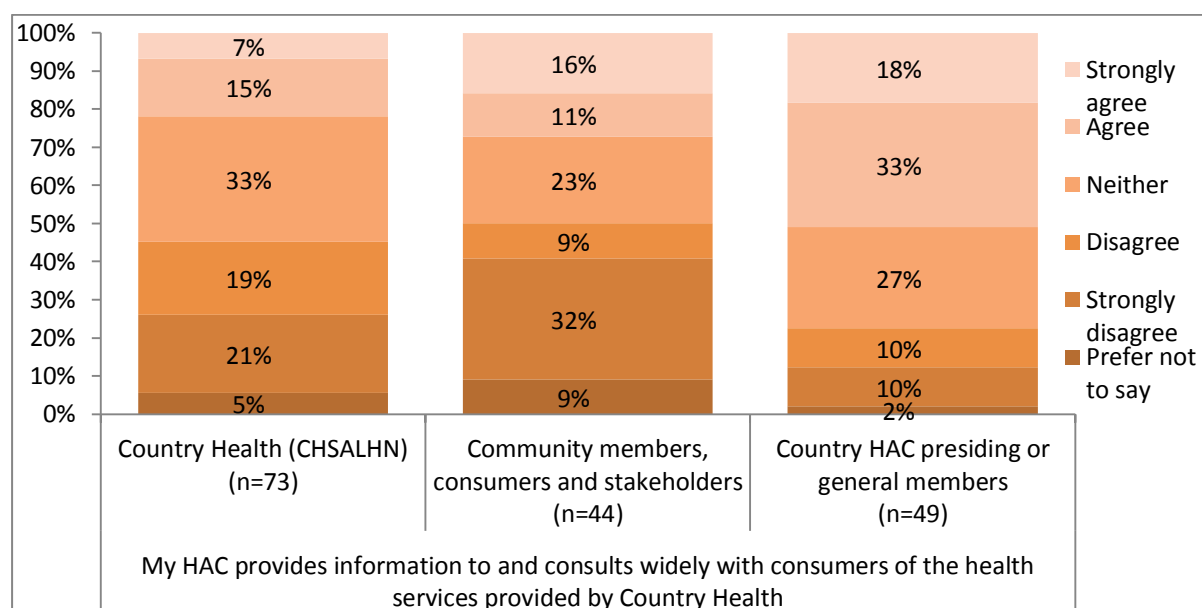


Q60: On a scale of 0 to 10 where **0 is strongly disagree** and **10 is strongly agree**, to what extent do you agree with the following statements in relation to your local Country HAC (SR)

Base: All respondents (n=166)

No differences were observed between groups when comparing results in response to Country HACs provision of information to and consulting widely with consumers of health services provided by CHSALHN (Figure 9). The level of agreement was higher amongst HACs (51%) than CHSALHN staff (22%) and community (27%).

Figure 9: Agreement with HAC's provision of information and consulting widely by group

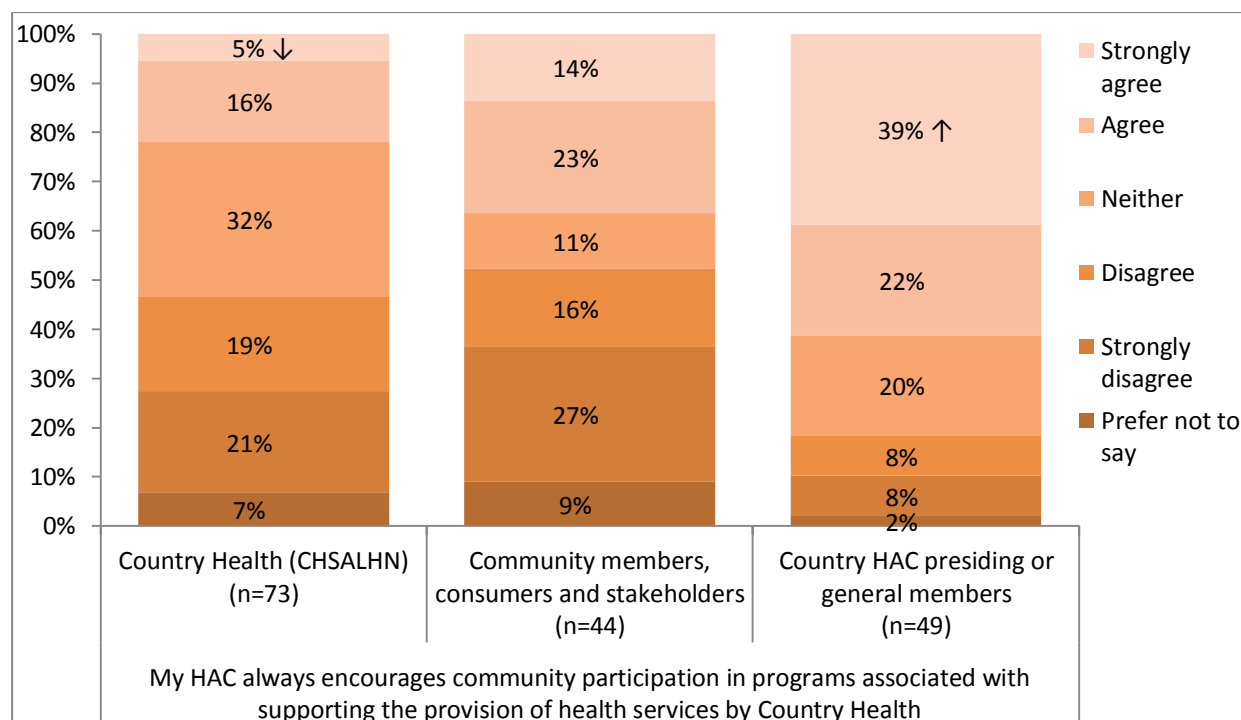


Q60: On a scale of 0 to 10 where **0 is strongly disagree** and **10 is strongly agree**, to what extent do you agree with the following statements in relation to your local Country HAC (SR)

Base: All respondents (n=166)

When asked about agreement with Country HACs encouragement of community participation, CHSALHN staff were significantly less likely to strongly agree (5%) while Country HAC members were more likely to strongly agree (39%) with this statement (Figure 10).

Figure 10: Agreement with Country HAC's encouragement of community participation by group



Q60: On a scale of 0 to 10 where **0 is strongly disagree** and **10 is strongly agree**, to what extent do you agree with the following statements in relation to your local Country HAC (SR)

In summary, HPC found CHSALHN staff significantly less likely to 'strongly agree' where Country HACs did 'strongly agree' on performing well at (i) advocating community interests (ii) providing sound advice on health services and (iii) encouraging community participation. In general CHSALHN staff responses were most frequently 'neither', with a rating of 5 on a scale of 0 to 10 for each question about function, and community member responses were most frequently in the 'disagree' range, with a rating between 0 and 4 on a scale of 0 to 10 for each function. Consistent with 2011 findings, while Country HACs are clear about their functions, it may be that a sustained low profile of HAC work leads CHSALHN staff and community members to have less awareness of HAC functions.

4.2.1 HAC infrastructure and projects

The desktop review found that 11 of the 17 HACs reviewed included a significant focus on fundraising and supporting the facilities of the local health services. This included both incorporated and unincorporated HACs. Annual reports from large and small HACs included examples of equipment purchased, identification of maintenance or service improvements required or equipment needed, celebrations of the opening of new or upgraded facilities or gardens funded through the HACs, improved access to services through things such as ramps and so on (Figure 11). Not all HACs were involved in fundraising events. When they were HACs achieved community and volunteer engagement and often partnerships with local businesses, other organisations such as Red Cross and frequently with the Hospital Auxiliary. Some needs such as lighting, disability access, parking were addressed in collaboration with local councils.

Figure 11: Example of HAC infrastructure and projects

Examples of supports include:

- Upgrades to the nurses station
- Funding of IT upgrades and a data base of donors
- Kegel chairs
- Upgrades to residential facilities for staff in places such as Ceduna and Yorketown
- Stillborn baby memorial at Pinnaroo.
- Digital X-ray machines were a priority for a number of HACs.
- scholarships for local students or workers or
- funds for local projects such as the Good Sports program and a SHINE program on sexual health.

4.3 Country HAC membership and meetings

4.3.1 Country HAC membership

The requirements for membership of the Country HAC is specified in their constitution/rules (Table 3). Recruiting HAC members can be difficult. In the desktop review HPC found that one HAC did not always have membership from certain areas or townships. While another HAC in the sample appeared to have viability issues though they noted two other HACs were having similar problems.

Table 3: Country HAC member key requirements as identified within their constitutions/rules

HAC membership requirements as identified within the constitutions/rules include:

- Not fewer than 6 and not more than 15 members
- Appropriate balance of skills, qualifications or experience. Examples include:
 - * Health services
 - * Management
 - * Finance
 - * Community participation
 - * Knowledge of the needs of people from Aboriginal or Torres Strait Islander descent
- No more than two medical practitioners at any one time
- The manager responsible for the Area Health Service sites or his or her nominee shall attend but is not entitled to vote
- One member as a nominee from local government
- One member who is a member of Parliament or nominee
- One medical practitioners as a nominee of medical practitioners providing services site
- One Health Unit Employee Member (not a medical practitioner)
- The Minister may appoint 3 members.

Around 59% of HACs surveyed within the desktop review had the same Presiding Member over the four years as shown in Table 4. Note there has been no change in the Chair of the Governing Council over the four years examined.

Table 4: Presiding member turnover

Changes in Presiding Members 2011-12 to 2014-15 inclusive	No. of HACs	%
No change four years	10	59
One change in four years	4	23
Two changes in four years	1	6
Three or more changes in four years	2	12
TOTAL	17	100

It is not always clear from the desktop review whether there are active local government or local member representatives on the HAC as they are not always specifically noted. Certainly the information on the SA Health website (included in the excel sheet) indicates vacancies. General practitioners were sometimes hard to recruit to HACs and it is not clear from the document review who the health service representative is on the HAC and whether that position is filled.

In summary Country HAC membership is skill-based (health, management, finance, community participation, knowledge or experience of the needs of Aboriginal communities) and positional (local government representative, Member of Parliament, medical practitioner, health unit employee, resident of community) as outlined in the constitution and rules. There is no length of term outlined for Country HAC members, so some Country HACs have long-term memberships while other Country HACs struggled to recruit and retain consistent membership on their Country HACs. Few Country HACs have representation from Aboriginal communities.

4.3.2 Regional Country HAC meetings

In the desktop review there was generally support from HACs for the formal regional meetings. In 2012-13 Berri noted the move to a wider Riverland, Mallee, Coorong region was designed to better manage duplication, identify gaps and improve reporting. They commented it is *'yet to prove itself'* but were pleased to be talking to others in the region. Region meetings allowed updates on information and discussion such as clarifying the interface between (the then) Medicare Locals and CHSALHN service delivery to clients (Mallee 2011-12) and Gawler reported (2011-12) that it allowed more *'strategic positioning'* around role and function by engaging with other HACs in the region.

Ceduna expressed concern that the time of the meetings made attendance difficult. Another three HACs (Balaklava Riverton, Whyalla and Port Lincoln) made little or no mention of the regional meetings. Where they occur the regional meetings appear to be a supported change to governance arrangements.

4.4 HAC relationships with Country Health

4.4.1 HAC relationships with Regional Health Services

In the pulse-check most HAC members reported the relationship between their HAC and their Executive Officer/Director of Nursing (EODON) from local health services and Regional Directors is improved. HAC members' reported that their attendance at Country HAC meetings helps to facilitate good communication and collaboration.

The desktop review found that:

- HAC reports frequently included appreciation for the role and involvement of local health staff and Regional Directors as illustrated by the following:
 - Thanks to X for *'her ongoing involvement and attendance at our meetings, providing that conduit between us and the bureaucracy'* (Yorke HAC 14-15).
 - The Regional Director has implemented a meeting schedule for the whole RMC region. *'Reporting across the whole region has allowed better understanding and co-operation across the sites'* (Mallee 14-15).
- Only two of 17 HACs did not refer to support provided by the local health service and senior regional CHSALHN staff.
- In terms of HAC involvement in employing CHSALHN staff three of 17 HACs from the sample reported sitting on the interview panel for a regional director.

Regional Directors were often acknowledged for attending all meetings face to face or via video or phone link up, often travelling some distances. Country HACs find the contact with regional staff valuable. Local health service staff provide essential administrative support to the Country HACs.

When Country HAC members were surveyed about suggested improvements on how they engage with regional directors, the results were also quite positive with the largest proportion of responses stating that they were happy with the current arrangements (18%) or suggesting that no improvements were required (14%). Where suggestions were made, they related to more contact and engagement, listening and acting on community concerns and more communication (12%, 10% and 8% respectively).

When surveyed the Country HAC members commented that the main opportunities for improvement with CHSALHN regional executives and staff related to more contact with staff (14%), a greater focus on community engagement and understanding of community needs (12%), more communication (10%) and more information (10%). Supporting these comments, Social Development Committee (2017) observed regional directors are tasked with providing information to HACs including CHSALHN key performance indicators but found no feature of this in the role description of a regional director. It recommends CHSALHN clarify expectations on key staff for linkage with HACs, and continue to improve communication processes and reporting practices to HACs so that HACs can potentially have a meaningful role in service and activity review, service planning and monitoring quality and safety of health services, hospital budget and workforce planning and meeting the expectations of local communities.

4.4.2 Relationships with State-wide Country Health

In the desktop review of HAC annual reports a number of HACs expressed great appreciation for the visits by CE, CHSALHN and acknowledged in particular Maree Geraghty, CE, CHSALHN, who travelled extensively to regional areas. Visits by the Minister were also recorded with appreciation.

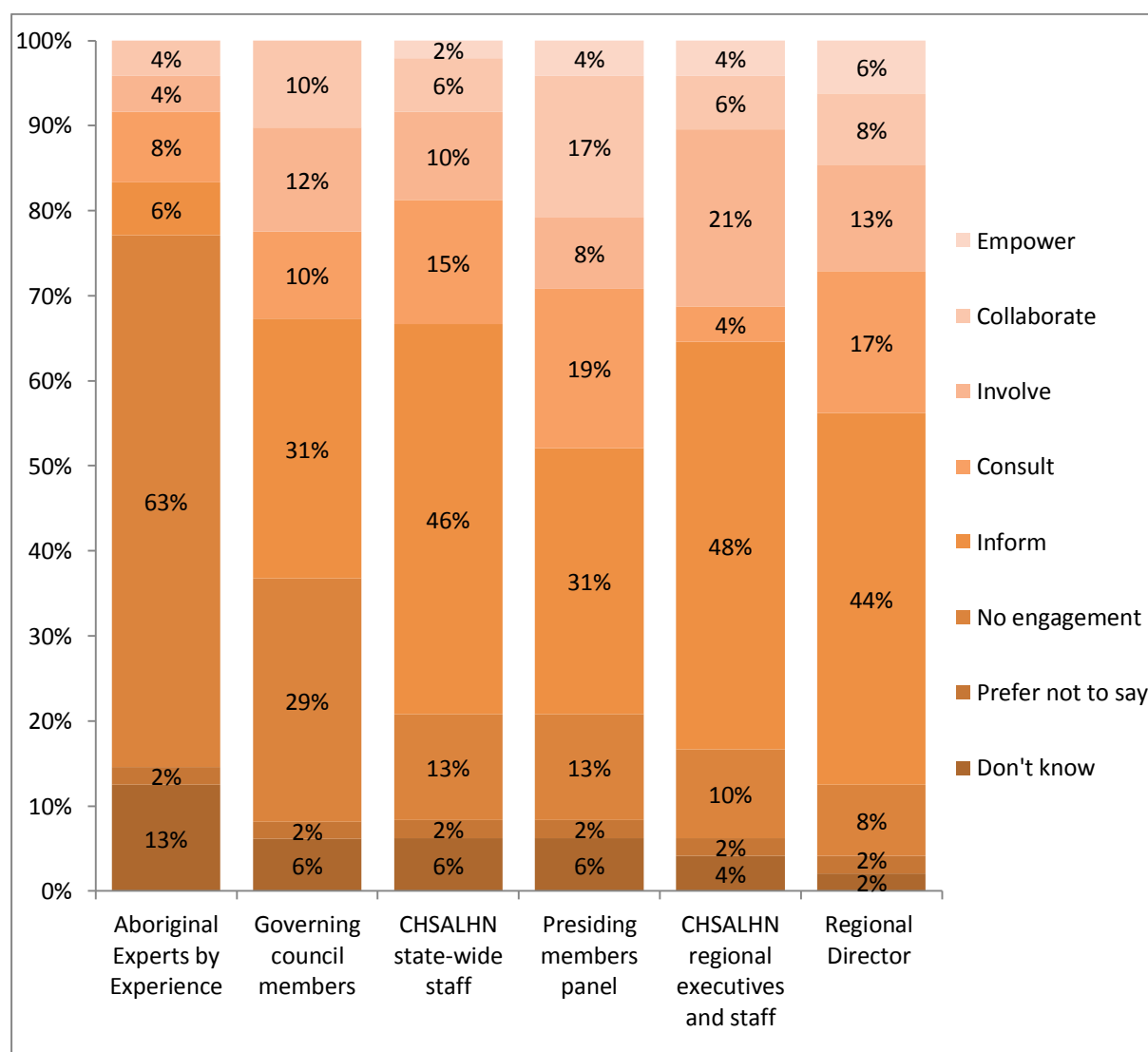
In the survey from CHSALHN's perspective, most staff respondents stated that there was 'no engagement' between them and Country HACs. Further most had no engagement with Governing Council members or the PMP. The survey asked Country HACs their level of satisfaction with the timeliness of CHSALHN state-wide staff's response. Only 30% of HACs were very satisfied or satisfied. While 34% were either very dissatisfied or dissatisfied and 31% of HACs were neither satisfied or dissatisfied.

4.5 CHSALHN engagement with HACs

4.5.1 Country HAC perceptions of Health's engagement with them

Country HACs were asked about the level of engagement that CHSALHN has had with them over the past year. Just over a fifth of HAC members described the Governing Council and PMP's engagement with them as either at the empower or collaborate level (22% and 21% respectively). While 14% of HACs stated their regional directors engage at these levels. The majority of engagement with HACs is at the inform level (Governing Council 31%, CHSALHN Statewide – 46%, PMP – 31%, CHSALHN regional staff – 48% and Regional Directors – 44%).

Figure 12: Country HACs perception of how the health system engaged with their HAC over the past year



Q12: Using the following scale, please insert the number that coincides with the primary type of engagement that these groups had with your Country HAC over the past year? (SR)

Base: Country HAC presiding or general members, missing cases excluded (n=48) to (n=49)

When Country HAC members were asked about suggested improvements on how they engage with CHSALHN state-wide staff, the results generally focused on offering more information (10%), basing decisions on need and being less bureaucratic (10%), and consulting more (10%).

In the survey Country HACs were asked what would support them to undertake their functions:

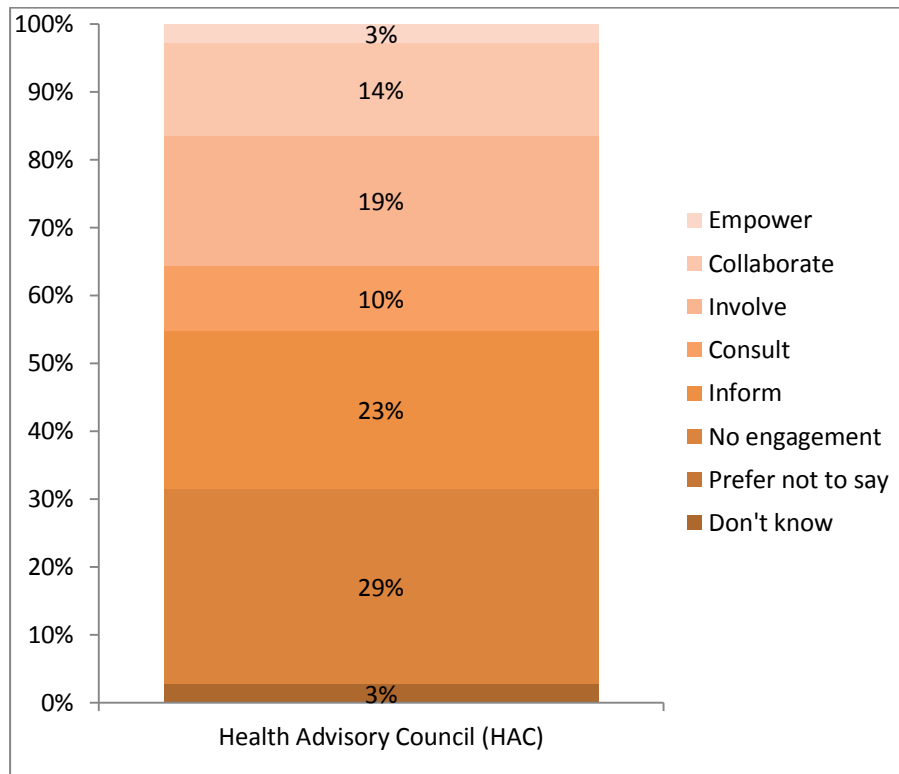
- 24% reported more information on the community and its needs and more specific statistics and relevant to our area
- 20% reported more understanding of the role and value of HACs within the health system
- 20% reported more training on governance, engagement processes and skills
- 16% reported more involvement and input into decision-making
- 12% reported the need for more communication
- 12% more community engagement

- 12% more financial support for maintenance
- 12% greater understanding of plans and their implementation

4.5.2 CHSALHN perceptions of their engagement with HACs

In relation to Country HAC members, the largest proportion of CHSALHN respondents reported that they had no engagement with HACs, while 23% reported engaging with HACs at the inform level.

Figure 13: CHSALHN's perception of how they engage with Country HACs over the past year



Q12: Using the following scale, please insert the number that coincides with the primary type of engagement that you had with the following groups over the past year? (SR)

Base: Country Health (CHSALHN) respondents (n=73)

*Please note: small sample size, please interpret results with caution

When asked about suggested improvements as to how CHSALHN respondents engage with Country HAC members, the most common responses included more communication (15%), more contact or engagement via site visits and discussions (14%) and further promotion of Country HAC members to the community. It is worth mentioning that 11% of responses communicated that no improvements were necessary.

CHSALHN staff were asked what would help them to provide more support to Country HACs:

- 55% needed to better understand the responsibilities associated with governance and roles
- 36% suggested using a coordinated regional model
- 33% reported having country-wide resources eg communications planning for key message for HACs
- 29% reported being able to trust that confidentiality will be maintained

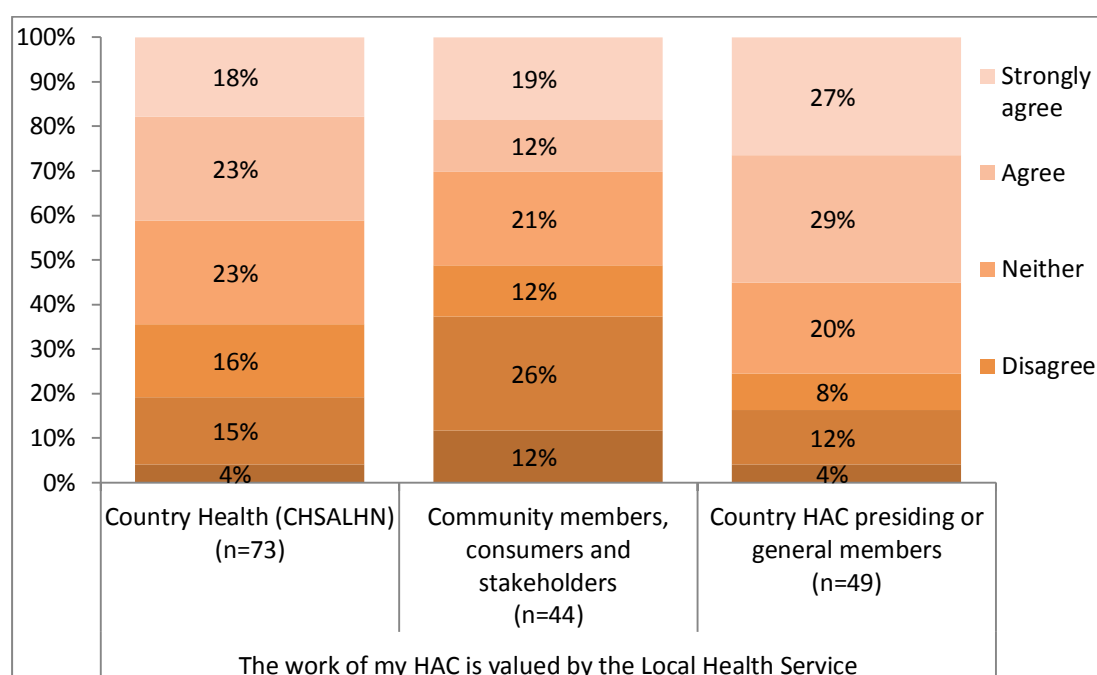
- 22% the use of innovative IT solutions to improve frequency and efficiency of communications

In terms of differences between Country HAC and CHSALHN perceptions, more CHSALHN staff were unsure of the level of engagement Country HACs had with all stakeholder and community groups.

4.6 Value of HAC work

Over half of the surveyed Country HAC members agreed or strongly agreed that their work is valued by the local health service (Figure 14) and the local community (Figure 15). There were no differences observed when comparing results between groups to the work of Country HACs being valued by the local health service.

Figure 14: Valuing HAC work by Local Health Service

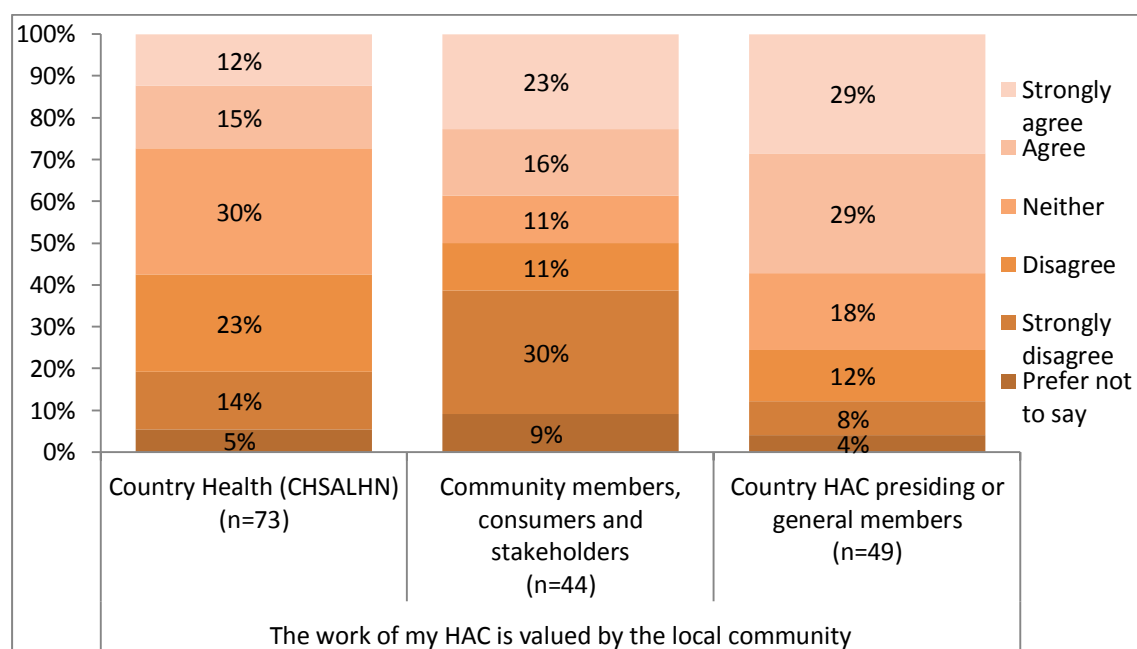


Q60: On a scale of 0 to 10 where 0 is strongly disagree and 10 is strongly agree, to what extent do you agree with the following statements in relation to your local Country HAC (SR)

Base: All respondents, missing cases excluded (n=165)

Over half (58%) of Country HACs agreed or strongly agreed that their HAC work is valued by the local community (Figure 15). While 31% of community members and 41% of CHSALHN staff agreed or strongly agreed that the work of the local HAC was valued by the community. No differences were observed when comparing results in response to the work of Country HACs being valued by the local community.

Figure 15: Value of HAC work by local community



Q60: On a scale of 0 to 10 where **0 is strongly disagree** and **10 is strongly agree**, to what extent do you agree with the following statements in relation to your local Country HAC (SR)

Base: Country Health (CHSALHN) & Country HAC members (n=166)

Country HAC achievements

Renmark Paringa Districts Inc HAC

Renmark Paringa submitted their Annual Report detailing their achievements from the past year (this has been abridged).

Current Priorities:

- Facilities retaining visiting specialists and supporting Renmark Paringa District Hospital (RPDH) to maintain its high standards in acute services and in aged care.

Facilities:

- Upgrade of the outdoor area at Shiralee House - a new shelter is to be erected.

Donations:

- Developed a donations form
- Implemented a new process for receiving money donated to the RPDH at funeral services.

Advocacy:

- Renmark Paringa District Hospital Funding Model
- Geriatric Evaluation and Management (GEM) Funding at the Riverland General Hospital
- Building Workforce Capacity in the Renmark Paringa Community
- Submission to Social Development Committee regarding Regional Health Services
- HAC representations on the Riverland Ageing and Disability Taskforce

Guest Speakers:

We have guest speakers before our monthly HAC meetings to better inform us about the current situation in relation to health initiatives. We have looked at a number of areas:

- Aged Care
- Out of Hospital Care
- Mental Health
- Cancer Support for Women
- Drug and Alcohol Support Services

Emerging Priorities:

- Mental health services- prevention of suicide
- Expansion of services to address drug and alcohol addiction
- Music and Dementia Program in the Aged Care

Quality and Safety:

We receive regular hospital and regional statistics on quality, risk and safety. This allows HAC members to find out what sorts of incidents are common across the health sector and how Renmark Paringa stands in comparison. For example injuries from falls within hospital and medication errors.

Community Interaction:

- Facebook Presence
- Renmark Rose Festival Opening – held stall
- Stakeholder Meetings eg Primary Health Network (PHN)
- Dinner for GPs

Services:

- Music and Dementia Program

5.0 Health Information

5.1 CHSALHN information reporting and dissemination to HACs

The pulse check interviews (n=15) found inconsistency in the types of reports (for corporate and clinical governance) provided across HAC regions and how the information is reported. The reports from regional director and EODONs ranged from quality and safety, complaints and compliments, activity reports to occupancy rates, two HAC members would like to receive budgets and financial reports. HAC members stated the most useful reports provided comparisons – between other hospitals and regions (R6R1) and/or trends over time (R4R2). There was variation within and between regions as to use and value of the reports received – some found them very useful and easy to understand ‘they are normally filled with lots of information that is useful for us’ (R2R3), while others commented ‘we look at them but don’t use any of the information in practice’ (R2R4) and ‘regional director provides reports but we don’t usually look at them’ (R6R2).

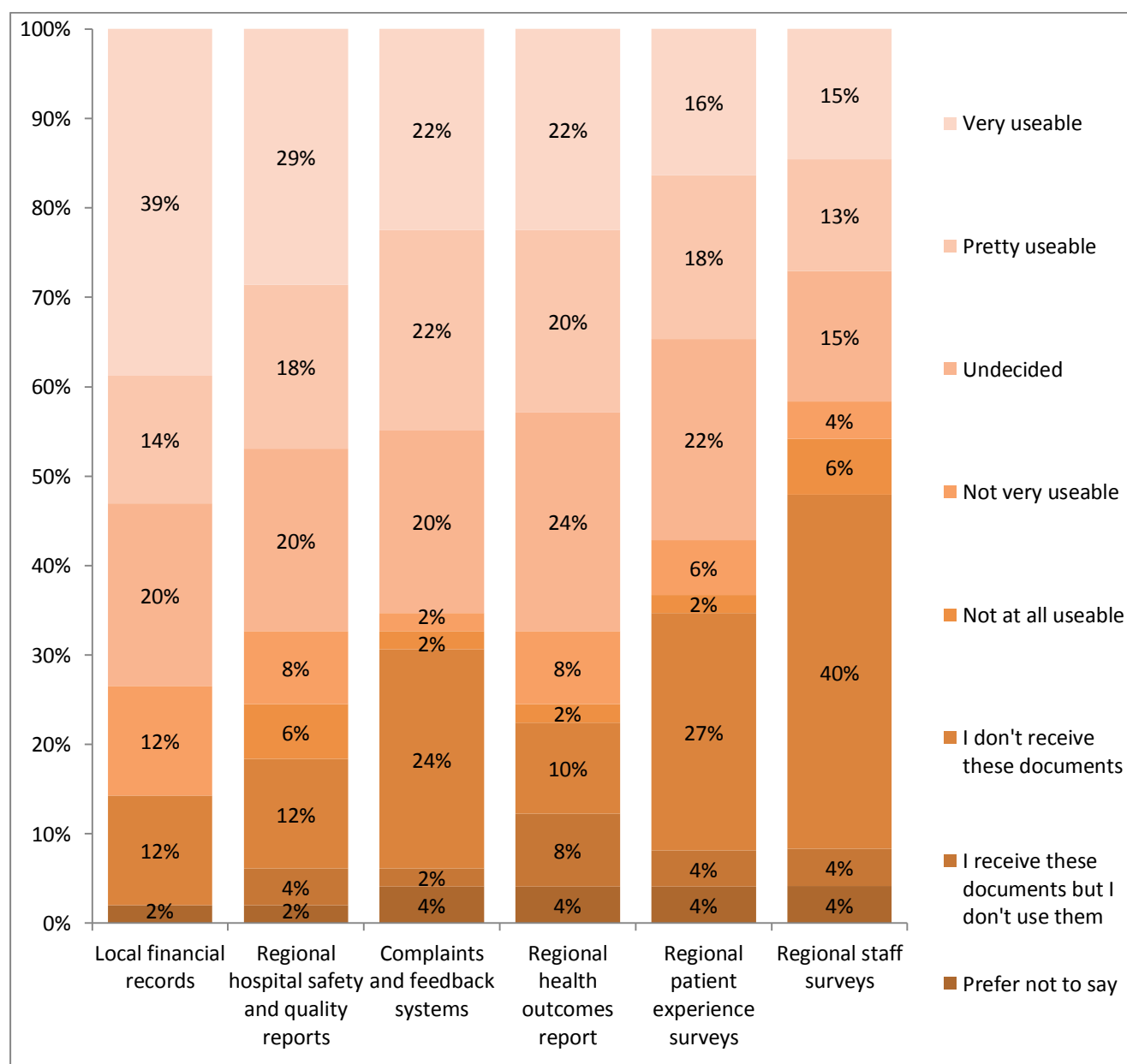
In the survey Country HAC members reported (Figure 16) that the local financial records (39%) and regional hospital safety and quality reports (29%) were the most likely to be very useful. Not all respondents agreed with this, with regional hospital safety and quality reports also seen as being the most likely to be not at all useable by some (6%). Nearly a quarter (24%) of HAC members were undecided about the useability of the health outcomes reports they received. Responses suggest that just under half of respondents don’t actually receive the regional staff surveys and just over a quarter of respondents don’t receive the regional patient experience surveys.

HPC recognises the June 2017 CHSALHN Partnership Framework introduces a new information template for HACs that will be rolled out by regions aiming to improve consistency of information provision. This is a promising development. However this HPC review has not assessed the fitness for purpose of the template, nor how well it has worked in pilot phase or in practise.

Recent research on interpretation of performance data by governing bodies of health organisations has emphasised the importance of meaningful representation of data (Mountford and Wakefield 2017). This requires knowing priority topics on which to focus when producing and reading performance data; having the information architecture within organisations; and developing skills and knowledge of governing body members to understand effective data use.

The review findings suggest that HACs are potentially constrained in discharging their obligations under The Act 2008, in particular ‘give advice to the Minister and CE on the development and management of health services and on the resources made available for those services and in so doing reflect the view of the community’. And as identified in 4.1 Governance, these observations raise questions about how consistently data-informed advice is reaching Governing Council and CHSALHN on clinical and corporate governance for every local population as part of fulfilling the performance expected in the CHSALHN strategic directions.

Figure 16: Country HACs usability of reports and documents provided by CHSALHN



Q41: On a scale of 0 to 10 where 0 is not at all useable and 10 is very useable, how useable are the following documents for your Country HAC? E.g. they help you in your day to day work. (SR)

Base: Country HAC presiding or general members, missing cases excluded (n=48) to (n=49)

Just under half (45%) of CHSALHN staff agreed that once they provide reports to Country HAC members they confirm that HAC members understand the information, while just under a third (31%) disagreed and 23% preferred not to say. When the reverse question was asked to Country HAC members, 45% agreed that CHSALHN staff confirm HAC members' understanding of the report. A higher proportion of Country HAC members (43% compared with 31% CHSALHN) reported that CHSALHN staff do not confirm their understanding of the report.

Compared with CHSALHN staff, Country HAC members were more likely to agree that they provided feedback to CHSALHN staff on the reports they received (32% and 53% respectively). The top three types of feedback provided by Country HACs on these reports included: raising questions, identifying health issues raised by the community, finance related. When asked what further information they require, the top three responses from Country HAC members (n=23) were:

1. Receiving more relevant and timely information (48%)
2. Consultation and having a say before decisions are made (26%) and
3. Accurate financial reporting and more meaningful and locally relevant data (22%).

These findings suggest a need for transparent communication processes between Country HACs and CHSALHN staff in particular establishing procedures to confirm HAC members' receipt and understanding of the information within the reports provided.

Since the pulse-check interviews and surveys, when fully implemented the CHSALHN Partnership Framework (June 2017) lists specific actions with aims to improve communication processes and improve health literacy of HAC members as well as the new regional information template.

5.2 Clinical governance

The desktop review found that in reference to the 2011 HPC suggestion to *'equip HACs to participate in the monitoring of impacts of implemented local action and statewide clinical network plans'* that there was no reference to these plans nor to anything clinical. The Governing Council reported a range of key performance indicators (KPIs) including indicators such as elective surgery waiting lists and patients treated within clinically recommended time and participated on the SA Health Consumer and Community Advisory Committee which examined issues such as clinical handover and communication but there was no found mention of the clinical network plans.

The HAC annual reports mention health outcomes and quality of care primarily in terms of greater access to health professionals e.g. allied health visiting remote locations like Ceduna and Hawker; or improved access to facilities such as digital X-ray machines and readers as occurred in a several locations over the four years. In annual reports references to patients were few, covering things such as developing a maintenance list for the benefit of staff and patients; occupancy rates on Kangaroo Island; and the need to pay for more security for dementia patients at Ceduna.

The quality of care provided by health services was regularly acknowledged in HAC annual reports. HACs did not report any information on broader health outcomes such as the rate of diabetes or clinical outcomes such as the rate of infections.

In the desktop review, Governing Council's 2013-24 annual report advised that 'consistent and comprehensive regional reports were now being provided to all HACs' with the Governing Council receiving a sample at each meeting. This was not evident in any of the pulse-check interview, review of Country HACs annual reports nor the Country HAC survey (Figure 16).

This lack of evidence of CHSALHN sharing clinical safety and quality performance information with Country HACs raises questions about how consistently HACs are able to provide advice to Governing

Council and CHSALHN on clinical and corporate governance for every local population as part of fulfilling the performance expected in the CHSALHN strategic directions.

Figure 17: Desktop Review - HAC involvement in safety and quality

In relation to safety and quality there were minimal mentions from the HAC annual reports:

- One HAC member is on the SA Health Quality Risk and Safety Committee (Port Augusta 2013-14)
- Common issues discussed at the combined HAC meetings of Pt Augusta, Quorn, Roxby, Leigh Creek included '*...concern for the ongoing maintenance and upkeep of facilities and guarantee of funding for quality and safety requirements.*' (Hawker 2011-12)
- The Kingston Robe HAC participated in the South-East regional accreditation alignment survey. This included assessment against the National Safety and Quality Service Standards and all were met. (Kingston Robe 2013-14).
- CHSALHN Governing Council – in 2013-14 three governing council members participated in the CHSALHN Corporate Accreditation Periodic Review including Standard 2 on Partnering with Consumers.

Correspondence from HACs, brought two Coroner's inquests to the attention of HPC as part of the revisit review. The Coroner makes recommendations to improve the health system and in these cases the CHSALHN (Appendix 4). The recommendations have direct relevance to SA Health, CHSALHN, country hospitals and health services and the relevant Country HAC. The findings and recommendations from the Coroner's reports provide HACs with additional evidence in support of improving patient safety and the delivery of quality health services in country regions.

5.3 Understanding and accessing health information

A commitment from SA Health in their response to the 2011 HPC review was to improve the health literacy of Country HACs. In addition, a function of Country HACs is the provide advice on health issues, which requires sound health literacy skills.

The National Statement on Health Literacy by ACSQHC states the complexity of the health system is challenging for everyone who uses it and works in it. ACSQHC states about 40% of adults have the level of individual health literacy needed to meet the complex demands of everyday life. This isn't a reason to blame individuals. Rather it's a challenge and imperative for CHSALHN and HACs in strengthening governance and partnership to establish methods by which HACs can access the information they need and want, when and how it is relevant to them.

The desktop review found that many of the HACs report having speakers to learn more about local or statewide health and other issues. The involvement of Regional Directors in the meetings also provides a conduit for building health knowledge as does the annual Combined HAC Conference and the Governing Council communiqués. Those HAC members involved in the needs assessment informing the development of the Implementation Plans received a lot of information about community needs but there have been membership changes since this time and it is not clear how much further information has been provided. Also, there is attention paid to the expressed needs in

terms of access to accident and emergency, GPs, hospitals and allied health but little mention of the determinants of health, inequalities in health, community health issues such as alcohol misuse or sexual health and similar.

As identified in 5.1 CHSALHN information reporting, the survey found many HAC members do not perceive they receive the reports required to undertake their role, and while more than half of the CHSALHN staff reported that they do routinely check-back with HAC members about their understanding of the information presented, many are not.

5.3.1 Measures of health literacy

To appreciate Country HAC members understanding of and access to health information two dimensions of a health literacy tool were used within the survey – ‘appraisal of health information’ and ‘ability to find good health information’. These items were taken from a validated tool – Deakin University’s Health Literacy Questionnaire (HLQ) (Osborne et al 2013). Only two of nine dimensions were selected from the tool as they were of relevance to health literacy as part of the HAC role and function, rather than individual health literacy. Therefore, the responses are only indicative of ‘appraisal of health information’ and ‘ability to find good health information’ not a complete measure of health literacy.

5.3.2 Appraisal of health information

A high scorer of this measure is able to identify good information and reliable sources of information. They can resolve conflicting information by themselves or with help from others. In contrast, a low scorer, no matter how hard they try, cannot understand most health information and confusion when there is conflicting information. This score is made up of five individual questions. At an overall level, the mean score for the appraisal of health information (n=48) was 2.82 (sd 0.40).

5.3.3 Ability to find good health information

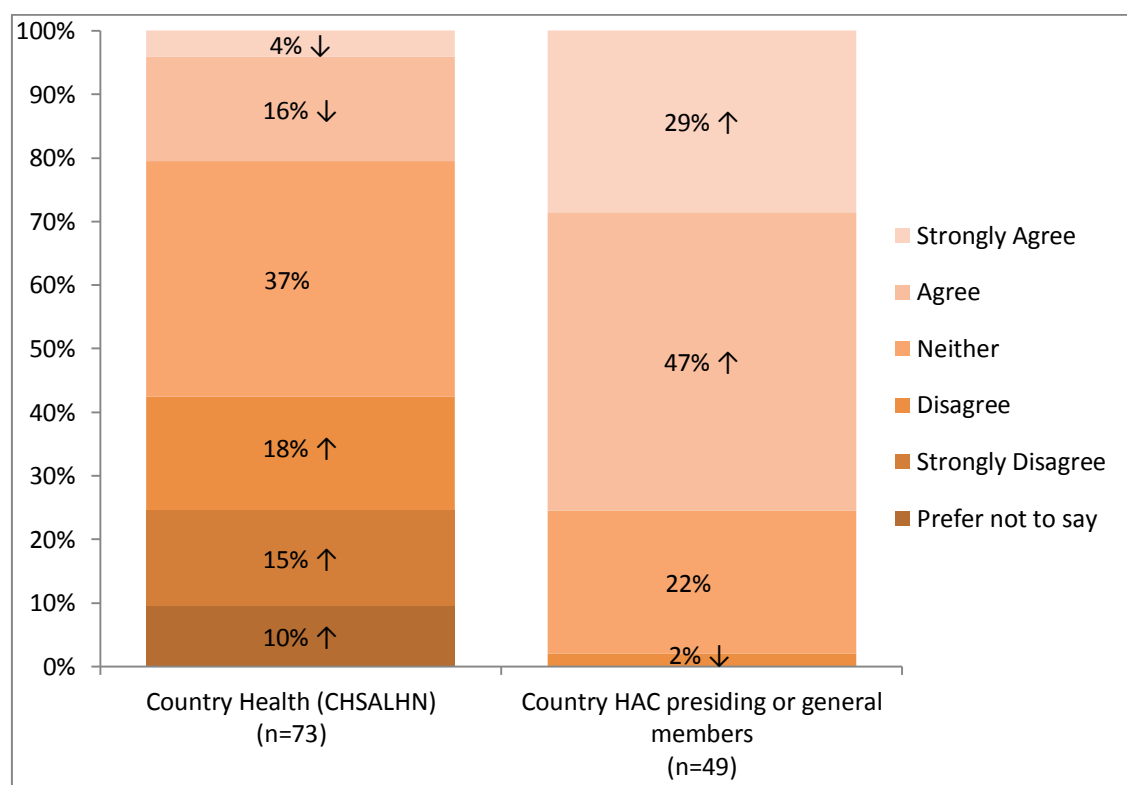
For this scale, a high scorer is an ‘information explorer’. This person actively uses a diverse range of sources to find information and is up to date. In contrast, someone who scores low cannot access health information when required. They are also dependent on others to offer information. This score is made-up of five individual questions. The mean score for the ability to find good health information (FHI) was 3.41 (n=48) with a standard deviation of .35.

A cluster analysis of appraisal of health information and ability to find good health information linked with the HAC members demographic information can be found in Appendix 3.

5.4 Perceptions of Country HACs’ skill-base

Country HAC members were more likely to strongly agree (29%) or agree (47%), that they had the right skill-base to undertake their functions (Figure 18). This was greater than the proportion of CHSALHN staff who agreed (4% strongly agree and 16% agree).

Figure 18: Country HAC's skill-base



Q23: On a scale of 0 to 10 where 0 is strongly disagree and 10 is strongly agree, to what extent do you agree that... (SR)
 IF 1 AT Q1 = your Country HAC members have the right skill-base to allow you to do your job?
 IF 2 AT Q1 = Country HAC members have the skill-base to do their job?
 IF 4 AT Q1 = your Country HAC members have the right skill-base to do their job?

Base: Country Health (CHSALHN) & Country HAC presiding or general members (n=122)

While HAC members are appointed based on their skill and position, the differences in perception between staff and HACs suggest that the skills CHSALHN staff think are required to fulfil the functions are different to the skill-mix that Country HAC members bring.

5.5 HAC training and development

In the 2016 pulse-check interviews Country HACs reported inconsistent training of new Country HAC members. Some mentioned attending the Health Consumers Alliance training program on consumer advocacy. Two members stated that 'HACs do not receive adequate training' and 'there has been very poor training of new members'.

When surveyed about completed training and other opportunities the HAC members (n=49). The most common form of training undertaken by Country HAC members was new member orientation and responsibilities (61%) followed by community engagement and council membership and responsibilities (both 43%) and understanding health data and reports (16%). Eight percent reported having completed no training sessions. When asked what sort of training would better support work on the Country HAC, members were most likely to suggest access to clear information (52%), followed by engagement in ongoing planning and implementation (45%), community engagement processes (36%), orientation (27%) and advice on how to interpret quality and safety reports (25%).

In summary, for those who receive reports HACs find the local financial reports the most useful followed by safety and quality and complaints reports. However many HAC members do not receive

the reports required to undertake their role. More than half of the CHSALHN staff reported that they routinely check-back with HAC members about their understanding of the information presented.

Country HAC Achievements

Mid North HAC

Mid North HAC has worked to increase their communication and visibility with the local community through the following actions:

1. All minutes are made available at local pharmacies for community members to read (for privacy reasons some names or content blocked out on occasions - though rarely)
2. When needed HAC activity updates are included in community papers and local rural press
3. A "pull up banner" has been developed for each community, they are positioned either at the entrance to the hospital or in the local doctors surgery
4. Similar A3 posters have also been printed for display on community notice boards
5. A tri fold DL brochure has been created and is added to every patients admission pack introducing HAC, role, function etc. A DL insert is added to the brochure with the current HAC contact details and is updated annually after the AGM
6. Fridge magnets have been printed with the contact number for the HAC hospitals and promoting HAC, these will be distributed in the New Year
7. Attended a community services day recently at Peterborough
8. Peterborough members have attended community service club meetings to promote and explain HAC to counter ill-informed information re HAC that was gaining momentum.
9. HAC has asked for the email address midnorthhac@sa.gov.au so as create to a single contact point, with all emails being forwarded to the current Presiding Member - CHSA is struggling with this concept at present.
10. Public meetings called when needed to discuss major issues
11. AGM's with CHSA or other relevant speakers

Figure 19: Mid North HAC communications materials including brochure, magnet and banner

Source image: Mid North HAC

Health Advisory Councils

You are a vital partner in your own health, the health of your community, and in designing and delivering better healthcare in our region.

Health services in our region recognise the value of consumer and carer engagement and participation.

Involving consumers and carers in health decision-making provides an important balance to the views of health professionals.

The Health Advisory Council in our region provides members of the community with the opportunity to comment on the way in which health services provide for our health-care needs.

It is also about making community members more aware of current trends in health care provision and the impact that any proposed changes may have on the delivery of health care.

If you or a group you belong to want to discuss a current health service issue, we encourage you to contact us.

If you are interested in joining the Mid North Health Advisory Council, please contact us for further details.

Visit www.countryhealthsa.gov.au then follow the 'Health Advisory Councils'.

Mid North Health Advisory Council Members

Community Elected Representatives

- 2 x Booleroo Centre Community Members
- 2 x Jamestown Community Members
- 2 x Orroroo Community Members
- 2 x Peterborough Community Members

Appointed Community Members

- 1 x Country Health SA staff member (necesse)
- 1 x Local Government representative
- 1 x Local Member of State Parliament representative
- 1 x Medical Officer Representative

Country Health SA Advisors

- BOICOs for Booleroo Centre, Jamestown, Orroroo Centre and Peterborough Hospitals
- Regional Director, Yorke and Northern Ranges Region

For more information

Mid North Health Advisory Council Inc.
PO Box 646
Post Office 646
Telephone: 8651 4001
www.countryhealthsa.gov.au

Linking Mid North communities and consumers with health services for the Mid North Region

Booleroo Centre, Jamestown, Orroroo and Peterborough

The Mid North Health Advisory Council is established to work with the Mid North Community to:

- Advise on the health needs, priorities and issues within our communities
- Understand the health needs and priorities of all the communities we represent and the view point of these communities in the development of health services
- Advocate on behalf of the communities with local health services and Country Health SA to support the planning and provision of health services as part of a whole state-wide health system

Types of information we want to share/receive

- Service changes, service improvement and feedback on what communities want
- Linkages with other services available within the communities and the region
- Quality and safety within our health services and improving safety for consumers
- Rights and responsibilities of consumers and carers

Who we want to connect with

All interested health care consumers and their carers and families in the communities of the Mid North of South Australia, including:

- Mental health consumers and carers
- People with chronic disease
- Aboriginal people
- Culturally and linguistically diverse groups
- Aged people
- Youth
- Children and families
- People with a disability

Contacting your Mid North Hospitals

Booleroo Centre: 8667 2211
Jamestown: 8664 1406
Orroroo: 8658 1200
Peterborough: 8651 0400

Mid North Health Advisory Council
(Booleroo Centre, Jamestown, Orroroo and Peterborough)

Local people advocating for Local health services

Become involved
Visit www.sahealth.sa.gov.au/healthadvisorycouncils

Local people advocating for Local health services

www.sahealth.sa.gov.au

6.0 Community and Consumer Engagement

6.1 Partnering with consumers

CHSALHN's Community and Consumer Engagement Strategy 2015-2018 (CCES) outlines their approach to meeting NSQHS standard 2 (Table 5) and provides direction to Country HACs in engagement practices with consumers and the community. Country HACs are one part of CHSALHN's overall approach to community and consumer engagement. The goals of the CCES are to:

1. increase the consistency of engagement strategies
2. enable more involvement, collaboration and empowerment
3. broaden the range of communities and consumers involved.

The strategy is guided by SA Health's A Framework for Consumer and Community Engagement and the International Association for Public Participation (IAP2) Framework. The IAP2 framework demonstrates the range of levels of public participation from inform through to empower (Figure 20). The IAP2 spectrum helps us recognise that there are different levels of engagement. While it is part of a spectrum, one level is not more important than other level. The spectrum is used to identify the appropriate level of engagement required to meet the desired aim of the engagement.

The CCES identifies four different areas of influence (individual, service, network and system) and sets out objectives and strategies across the IAP2 framework (inform, consult, involve, collaborate, empower) (Figure 20).

In 2011 HPC found that 'Country HACs were promoting the interests of local communities to the health system, although promotion of the interests of specific population groups is limited'. In the revisit review HPC once again inquired on HAC engagement with the community and specific population groups the findings are reported below. In the survey HPC asked about the level of engagement using the IAP2 spectrum.

The CHSALHN Framework for Community and Consumer Engagement is supported by the Partnership Framework for Health Advisory Councils and CHSALHN 2017-2022 (CHSALHN, 2017a) launched at the Combined HAC conference June 2017.

Figure 20: International Association for Public Participations' (IAP2) spectrum of public participation
(Source CHSALHN, 2015b)


Increasing Level of Public Impact 					
	Inform	Consult	Involve	Collaborate	Empower
Public Participation Goal	To provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions.	To obtain public feedback on analysis, alternatives and/or decisions.	To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered.	To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution.	To place final decision-making in the hands of the public.
Promise to the Public	We will keep you informed.	We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how public input influenced the decision.	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision.	We will look to you for advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible.	We will implement what you decide.
Example Techniques	<ul style="list-style-type: none"> > Fact sheets > Web Sites > Open houses 	<ul style="list-style-type: none"> > Public comment > Focus groups > Surveys > Public meetings 	<ul style="list-style-type: none"> > Workshops > Deliberate polling 	<ul style="list-style-type: none"> > Citizen Advisory Committees > Consensus-building > Participatory decision-making 	<ul style="list-style-type: none"> > Citizen juries > Ballots > Delegated decisions

Table 5: CHSALHN's Community and Consumer Engagement Objectives for 2015-2018 (as they relate specifically to Country HACs)

IAP2 Spectrum	Objective	Strategy	NSQHS Standard
Inform	Raise the profile of HACs as the voice of the community and their role in community engagement	Work with Presiding Members Panel to develop an annual advertising campaign to promote the role of HACs and benefits of being a member	2.2.1 The health service organisation establishes mechanisms for engaging consumers and/or carers in the strategic and/or operational planning for the organisation
Consult	Ensure implementation of the SA Health Policy 'A Framework for Active Partnerships with Consumers and Community' is in place and effective	Report our performance regularly to local HACs and Governing Council, demonstrating compliance with the SA Health Framework	2.1.1 Consumers and/or carers are involved in the governance of the health service organisation 2.5.1 Consumers and/or carers participate in the design and redesign of health services
	Increase opportunities for consumers and communities to provide feedback on government level health policy	Actively distribute relevant government level draft policies for consultations with CHSA consumer groups, HACs and CHSA communities	2.1.1 Consumers and/or carers are involved in the governance of the health service organisation
	Increase breadth of community and consumer participation in consultation strategies	Work closely with HACs to identify targeted incentives which will promote increased participation in engagement strategies	2.2.1 The health service organisation establishes mechanisms for engaging consumers and/or carers in the strategic and/or operational planning for the organisation
Involve	Build the capacity of HACs to provide a voice for the community	Further develop the role and promotion of HACs using an existing training and development framework, such as the Making Connections health reform workforce program	2.3 Facilitating access to relevant orientation and training for consumers and/or carers partnering with the organisation
Collaborate	Collaborate with the Governing Council and HACs to achieve common goals	Refine and implement this CCES strategy in partnership with the Governing Council and HACs .	2.1.1 Consumers and/or carers are involved in the governance of the health service organisation
Empower	N/A to HACs	N/A to HACs	N/A

6.2 Country HACs engagement with community and consumers

The pulse-check found that most (n=10 of 15) of the HAC members interviewed were aware of CHSALHN's Community and Consumer Engagement Strategy, however some found it confusing and were unsure how to implement it locally. In terms of promoting the interests of the local community the HAC reported that it is easier if the community members come to them and that their HAC is reactive not proactive. There was variation between regions where some felt they are a 'keen HAC and hope to get everyone involved in activities' while another reported that he 'didn't feel as though the HAC's responsibility is to engage anymore. They are essentially fundraisers' and that 'they don't seek out issues to be addressed as they don't have the avenues to make changes'. When asked about specific strategies used to engage with particular population groups within the community the following summary comments were made:

Table 6: Pulse-check interview responses HAC engagement

Population group	HACs Engagement
Aboriginal people	Low or no population of Aboriginal people in the community (n=6 of 15) Tried to get or have an Aboriginal HAC member (n=7 of 15) Aboriginal people do not want to work with HAC (n=2 of 15) Equality approach rather than equity (2 of 15)
Culturally and Linguistically Diverse people	Low or no population in the area (4 of 15) There is a need or emerging need / population but not addressed (3 of 15) Translated materials to highest language groups for region (1 of 15) No knowledge of specific strategies to engage with this group (6 of 15)
People with a disability	No knowledge of specific strategies to engage with this group (11 of 15) Need addressed eg transport to increase access to health services, access ramps installed in facilities Work with advocacy group in community (1 of 15)
Low income families	Centrelink assistance offered No knowledge of specific strategies to engage with this group (13 of 15)
Lesbian, Gay, Bisexual, Intersex, Trans-sexual, Intersex and Queer (LGBTIQ)	No knowledge of specific strategies to engage with this group (14 of 15) Awareness of a support group – but no longer in existence (1 of 15)
Other groups	Mental Health and youth are groups that need attention

The desktop review found a few references made to engagement with specific population groups within the local community by HACs (8 of 17). These included mentions of HAC expertise in Aboriginal or multicultural issues; service needs for people with a disability and HAC involvement in NAIDOC week celebrations.

In the survey review HPC asked about the levels of HAC engagement with specific population groups using the IAP2 scale as a measure. Country HACs self-reported engagement was highest with local community members, health service consumers/patients and stakeholder organisations (Figure 21). With these groups engagement was reported to be primarily at the: inform, consult and involve levels of the IAP2 spectrum.

Consistent with responses from the pulse-check Country HACs reported in the survey (Figure 21) that they largely had 'no engagement' with Aboriginal Experts by Experience (73%), local Aboriginal and Torres Strait Islander People (67%) and local culturally and linguistically diverse people (54%). Country HACs engagement was reported to be at the inform level with Aboriginal people (6%), culturally and linguistically diverse populations (21%), low income families (23%), people with a disability (17%) and young people (29%).

How do Country HACs engage?

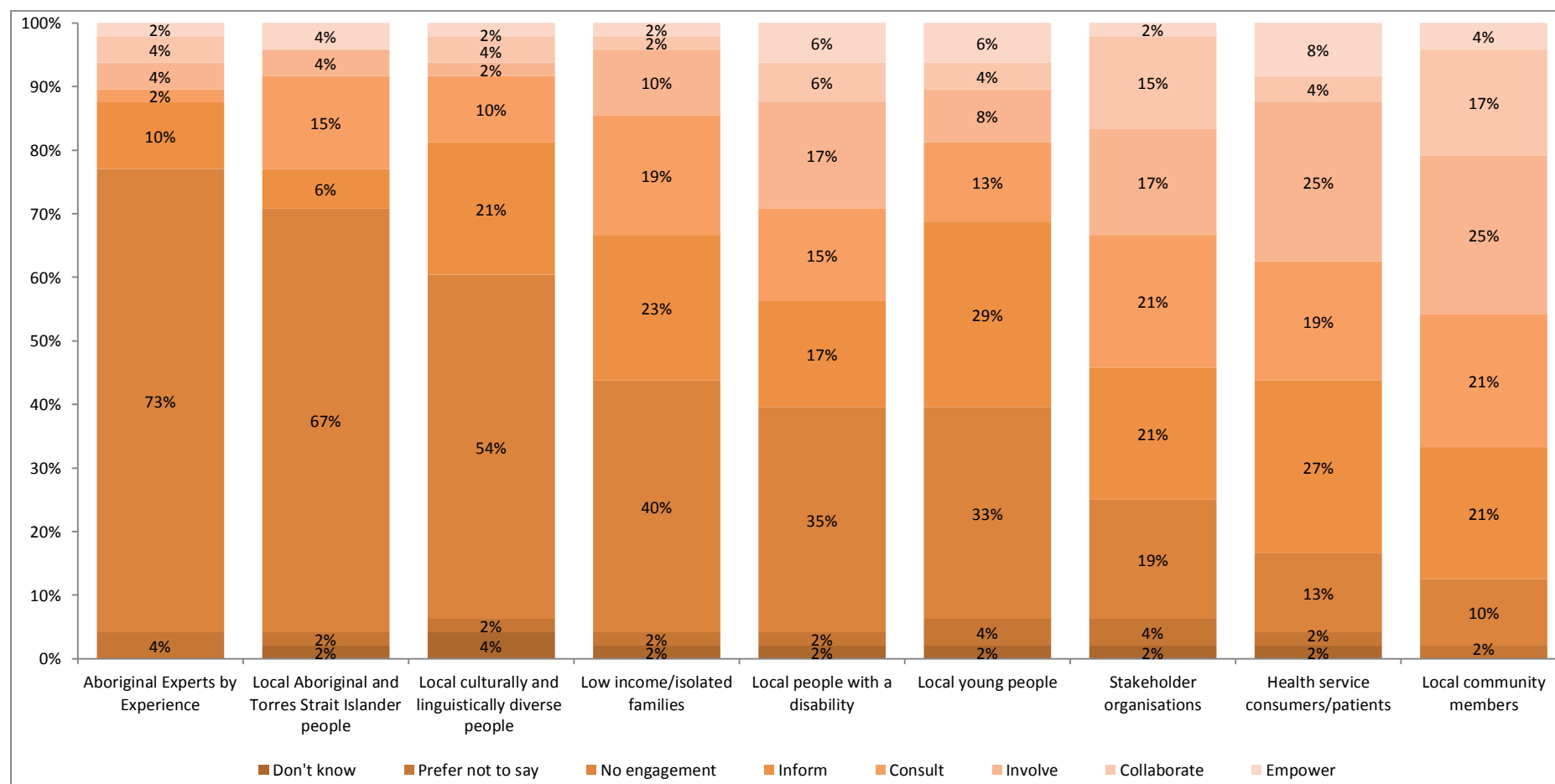
There is great variation between HACs in the types of strategies used to engage with their local community. The following strategies were reported in the pulse-check:

- Through outreach and community health
- Local doctor
- Community consultation and surveys
- Community meetings and attendance at community events
- Newsletter
- Talk to our community
- Host health information evenings and
- Host fundraising events

6.3 CHSALHN's perception of Country HAC's engagement with others

When CHSALHN staff were asked about Country HAC's engagement with the community, there was a greater level of uncertainty about Country HACs engagement with others (Figure 22). For many groups, CHSALHN staff stated they were unsure or 'didn't know' what the engagement was in the past year. Similar to Country HACs perceptions, engagement was largely at the 'inform' level for health consumers/patients (22%) and local community members (24%). 'No Engagement' was largely reported for Aboriginal Experts by Experience (46%), local Aboriginal and Torres Strait Islander people (49%), low income/isolated families (46%), local culturally and linguistically diverse people (48%), local people with a disability (43%), and local young people (41%).

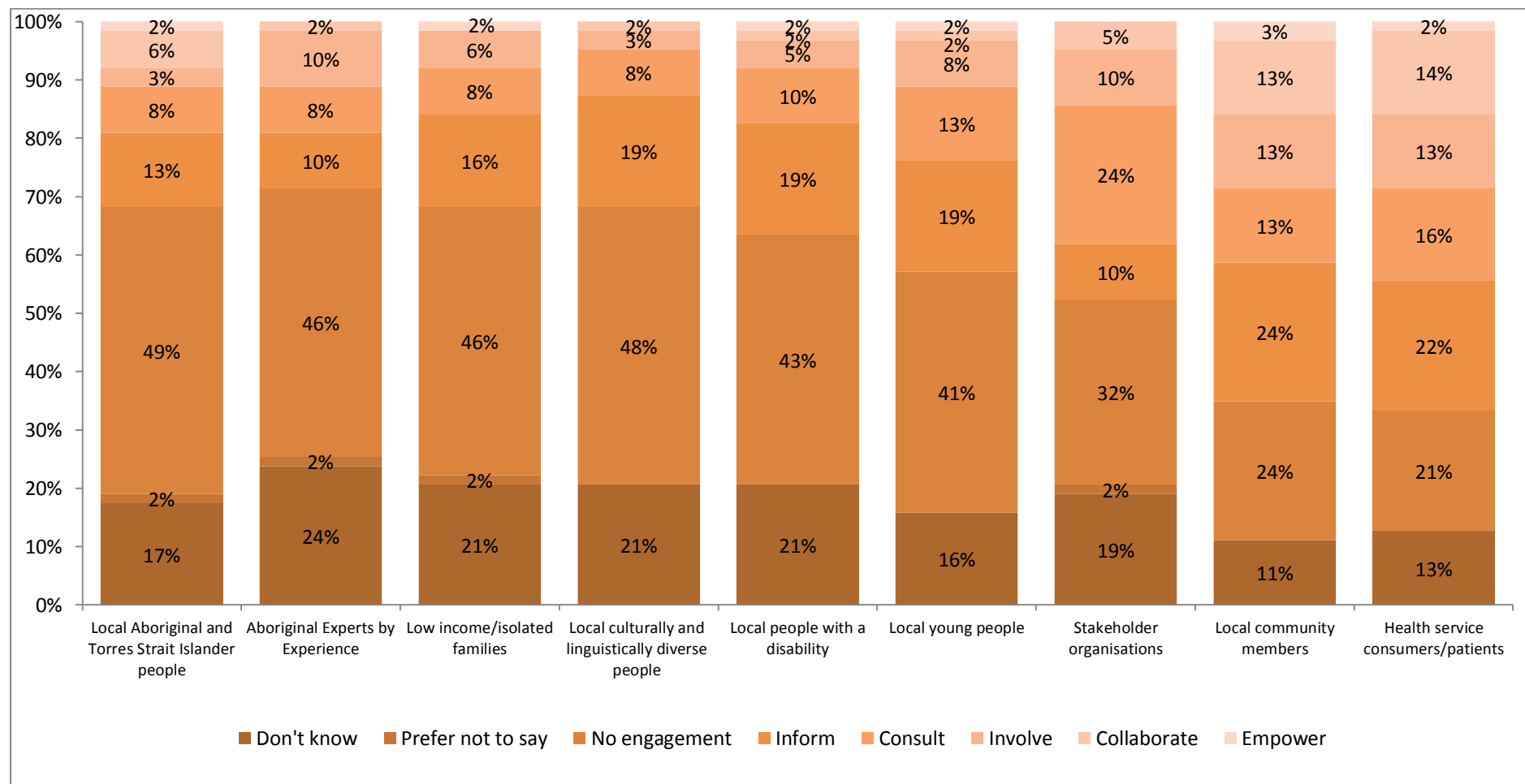
Figure 21: Country HAC's self-reported engagement levels with vulnerable population groups in the past year



Q17a: Using the following scale, please insert the number that coincides with the primary type of engagement <IF 1 AND 4 AT Q1 = your Health Advisory Council (Country HAC) has had over the past year with the following groups?>/ <IF 3 AT Q1 = your Health Advisory Council (Country HAC) has had over the past year with you?>

Base: Country HAC members (n=48), missing cases excluded

Figure 22: CHSALHN's staff perception of Country HAC's engagement with vulnerable population groups in the past year



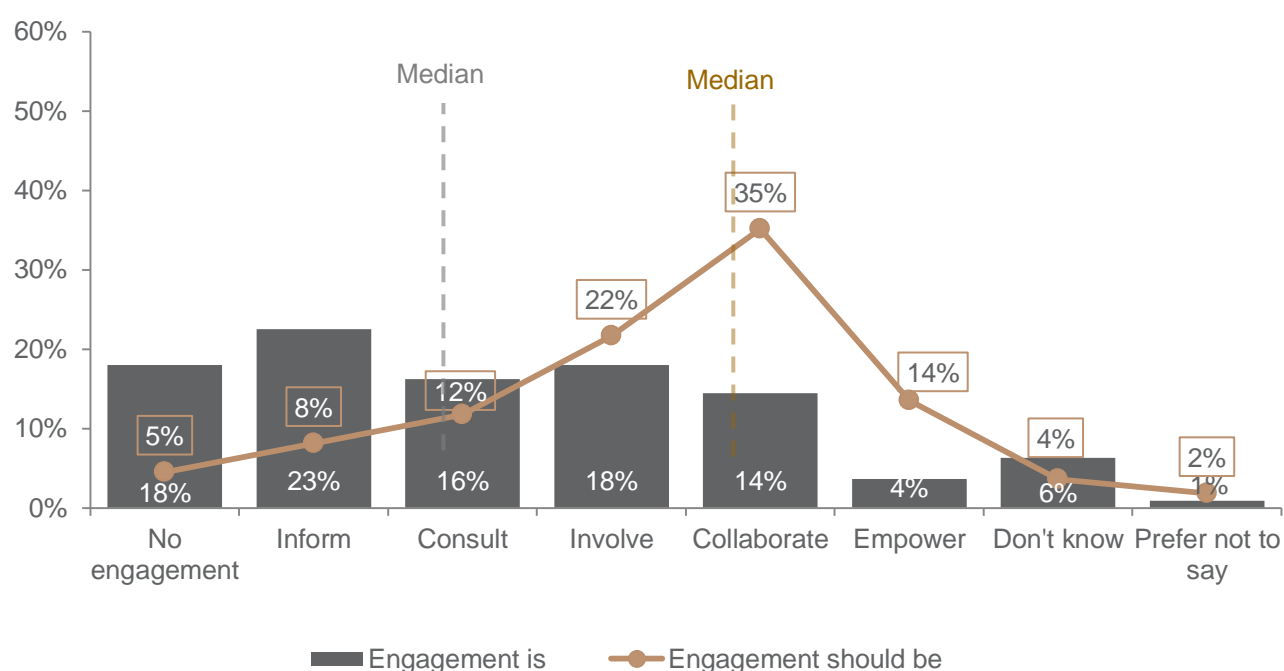
Q17a: Using the following scale, please insert the number that coincides with the primary type of engagement <IF 1 AND 4 AT Q1 = your Health Advisory Council (Country HAC) has had over the past year with the following groups?>/ <IF 3 AT Q1 = your Health Advisory Council (Country HAC) has had over the past year with you?>

Base: Country Health (CHSALHN) (n=63), missing cases excluded

6.4 Country HAC future engagement

In the survey HAC members and CHSALHN staff were asked the level they thought their engagement 'should be'. Both CHSALHN staff and HACs suggested that engagement should be at the 'involve or collaborate' levels of the IAP2 spectrum with all population groups, rather than the no engagement or inform levels identified in the past year. Below for each population group the bar graph illustrates the combined Country HAC and CHSALHN staff views on the current level of engagement, while the line graph overlaid illustrates the combined Country HAC and CHSALHN staff view of what the level of engagement should be (Figure 23 to Figure 31).

Figure 23: Country HAC's engagement with local community members

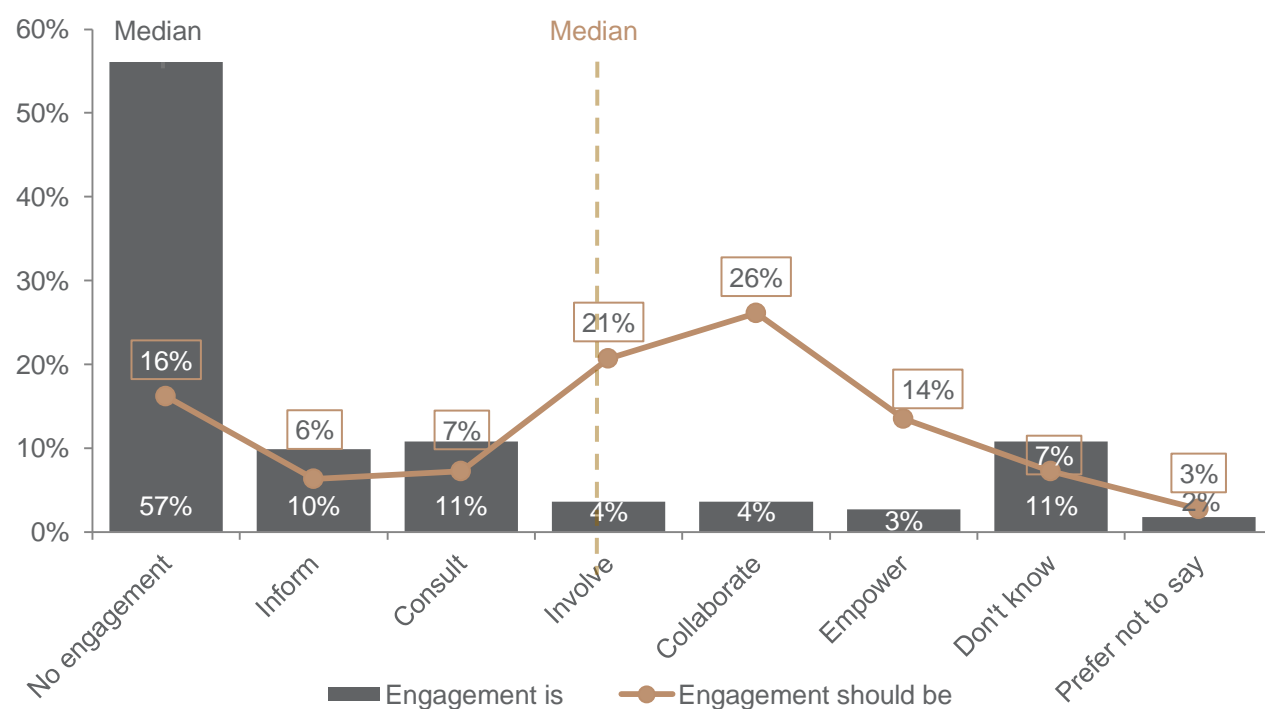


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Q17b: Using the following scale, please insert the number that coincides with the primary type of engagement < IF 1 AND 4 AT Q1 = your Health Advisory Council (Country HAC) should have with the following groups? >/<IF 2 AT Q1 = Health Advisory Councils (Country HACs) should have with the following groups?>/<IF 3 AT Q1 = your Health Advisory Council (Country HAC) should have with you?>

Base: Country Health (CHSALHN) & Country HAC members (n=111), missing cases excluded

Figure 24: Country HAC member engagement with local Aboriginal and Torres Strait Islander people

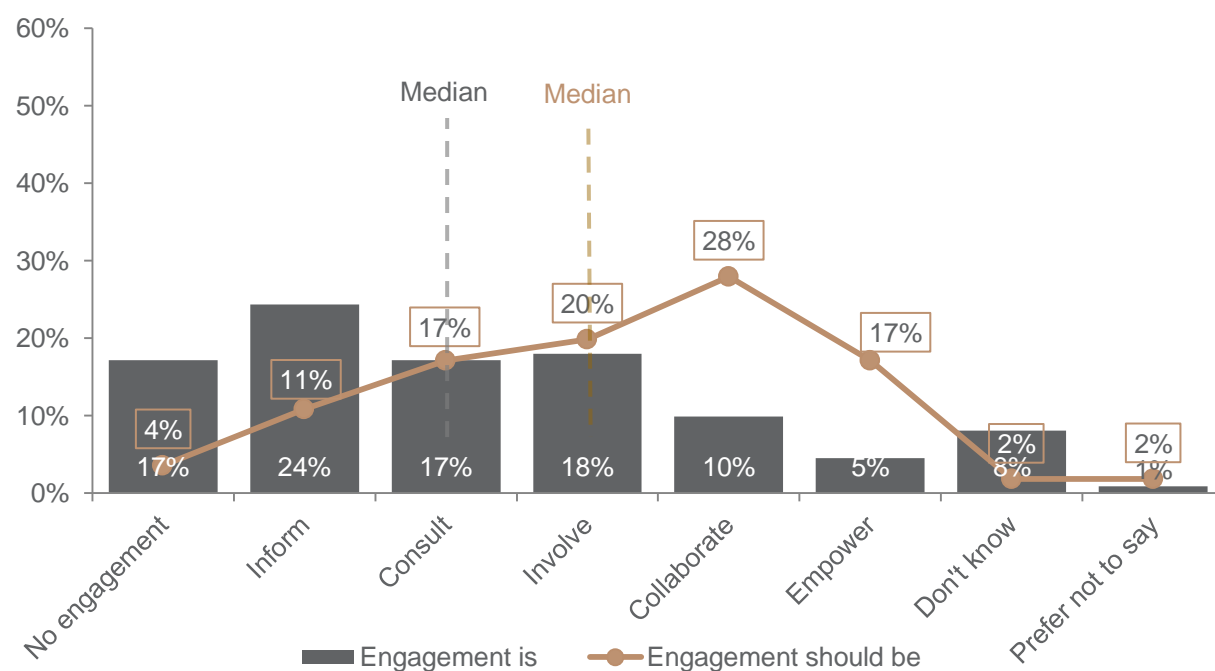


Q17a: Using the following scale, please insert the number that coincides with the primary type of engagement <IF 1 AND 4 AT Q1 = your Health Advisory Council (Country HAC) has had over the past year with the following groups?>/ <IF 3 AT Q1 = your Health Advisory Council (Country HAC) has had over the past year with you?>

Q17b: Using the following scale, please insert the number that coincides with the primary type of engagement < IF 1 AND 4 AT Q1 = your Health Advisory Council (Country HAC) should have with the following groups? >/<IF 2 AT Q1 = Health Advisory Councils (Country HACs) should have with the following groups?>/<IF 3 AT Q1 = your Health Advisory Council (Country HAC) should have with you?>

Base: Country Health (CHSALHN) & Country HAC members (n=111), missing cases excluded

Figure 25: Country HAC's engagement with health service consumers/patients

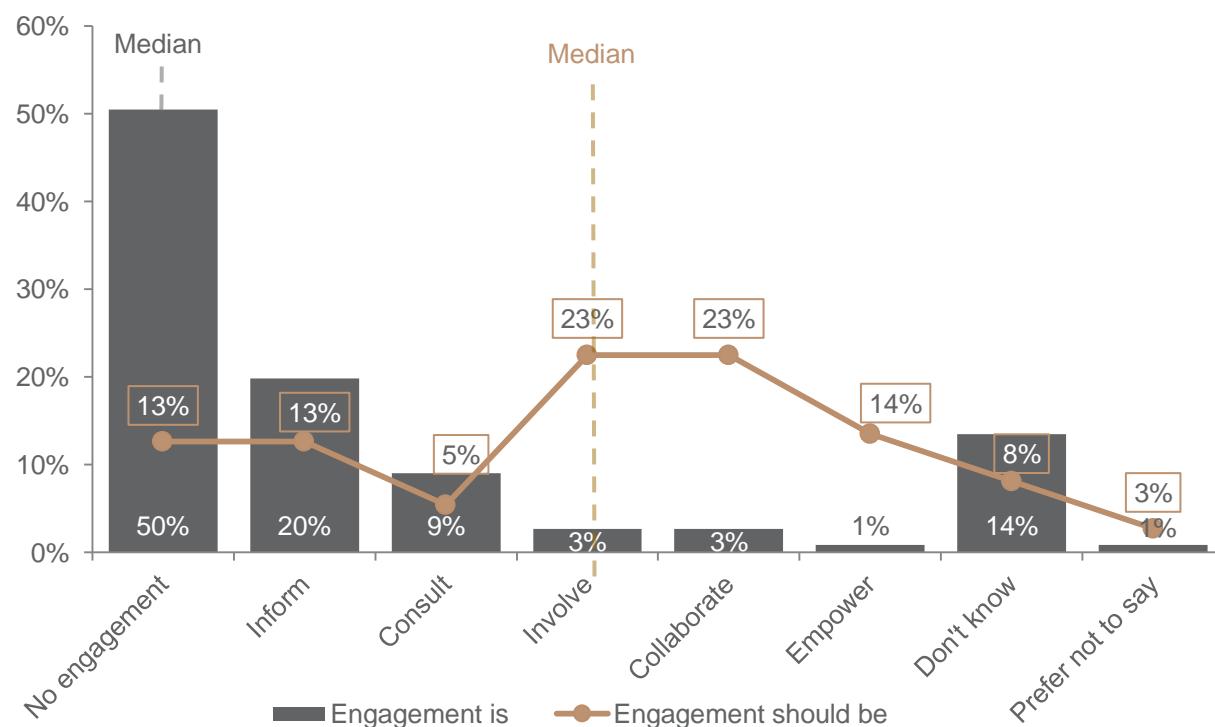


Q17a: Using the following scale, please insert the number that coincides with the primary type of engagement <IF 1 AND 4 AT Q1 = your Health Advisory Council (Country HAC) has had over the past year with the following groups?>/<IF 3 AT Q1 = your Health Advisory Council (Country HAC) has had over the past year with you?>

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Base: Country Health (CHSALHN) & Country HAC members (n=111), missing cases excluded

Figure 26: Country HAC member engagement with local culturally linguistically diverse people

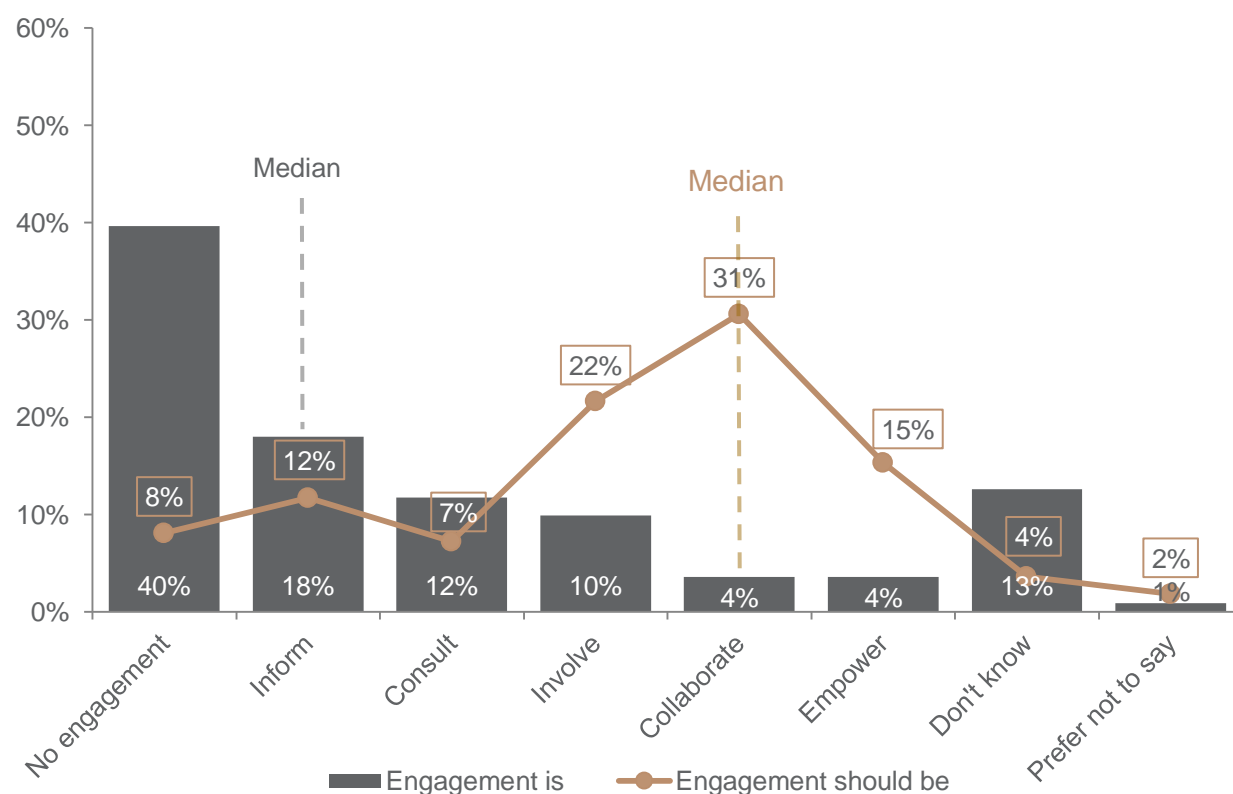


Q17a: Using the following scale, please insert the number that coincides with the primary type of engagement <IF 1 AND 4 AT Q1 = your Health Advisory Council (Country HAC) has had over the past year with the following groups?>/<IF 3 AT Q1 = your Health Advisory Council (Country HAC) has had over the past year with you?>

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Base: Country Health (CHSALHN) & Country HAC members (n=111), missing cases excluded

Figure 27: Country HAC member engagement with local people with a disability

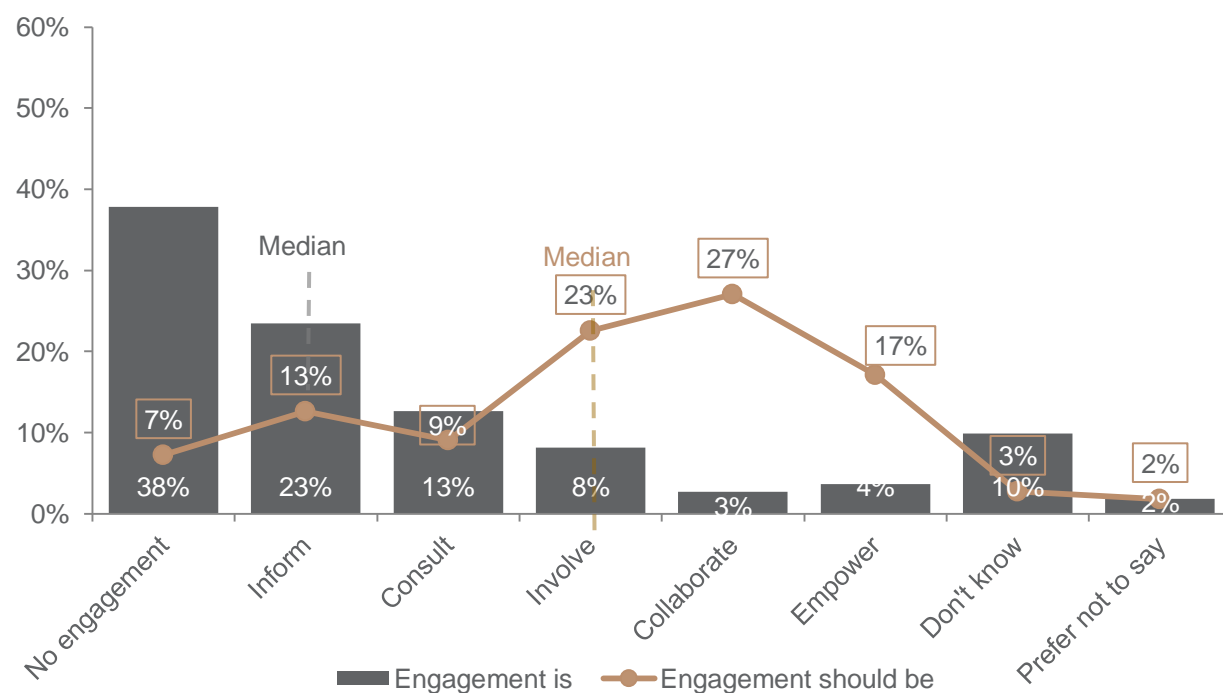


Q17a: Using the following scale, please insert the number that coincides with the primary type of engagement <IF 1 AND 4 AT Q1 = your Health Advisory Council (Country HAC) has had over the past year with the following groups?>/ <IF 3 AT Q1 = your Health Advisory Council (Country HAC) has had over the past year with you?>

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Base: Country Health (CHSALHN) & Country HAC members (n=111), missing cases excluded

Figure 28: Country HAC member engagement with local young people

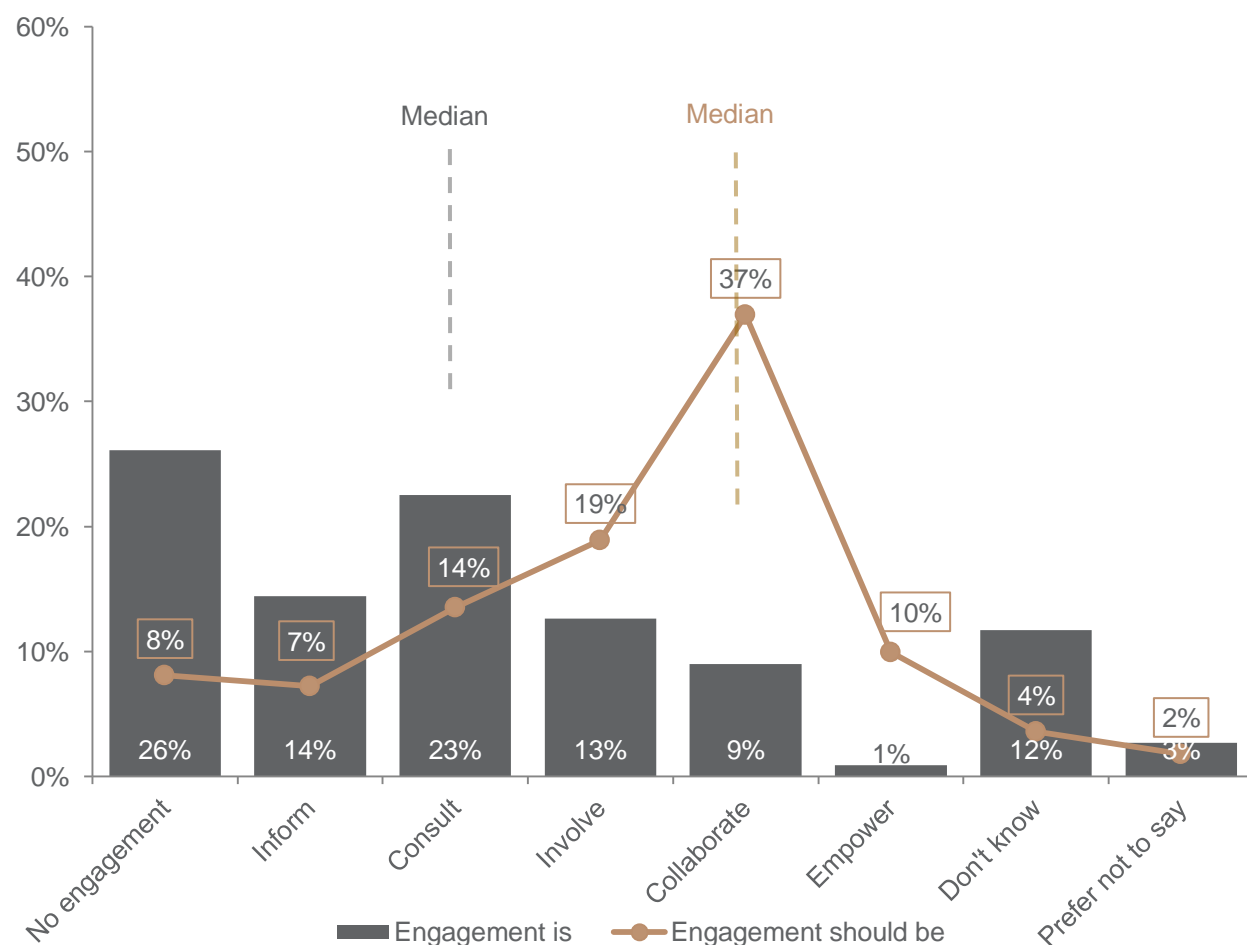


Q17a: Using the following scale, please insert the number that coincides with the primary type of engagement <IF 1 AND 4 AT Q1 = your Health Advisory Council (Country HAC) has had over the past year with the following groups?>/ <IF 3 AT Q1 = your Health Advisory Council (Country HAC) has had over the past year with you?>

Q17b: Using the following scale, please insert the number that coincides with the primary type of engagement < IF 1 AND 4 AT Q1 = your Health Advisory Council (Country HAC) should have with the following groups? >/<IF 2 AT Q1 = Health Advisory Councils (Country HACs) should have with the following groups?>/<IF 3 AT Q1 = your Health Advisory Council (Country HAC) should have with you?>

Base: Country Health (CHSALHN) & Country HAC members (n=111), missing cases excluded

Figure 29: Country HAC member engagement with stakeholder organisations

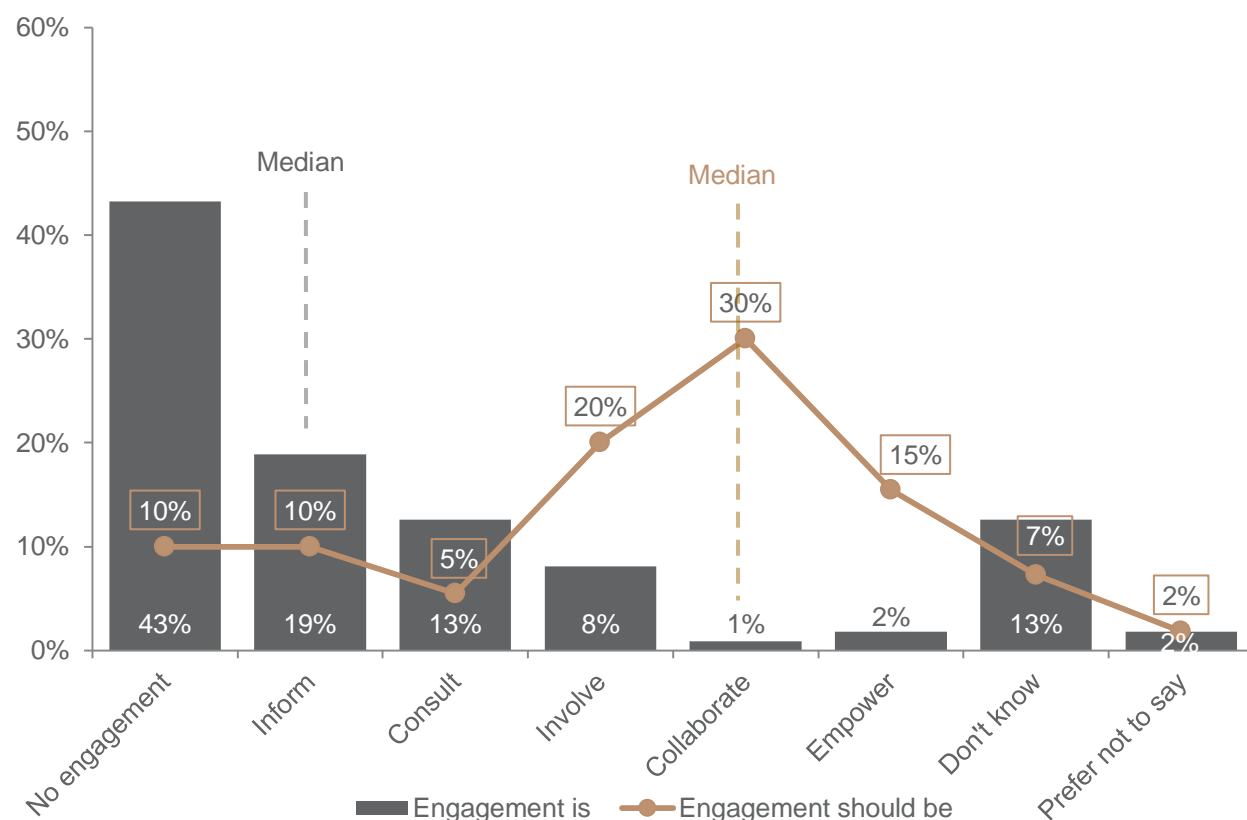


Q17: Using the following scale, please insert the number that coincides with the primary type of engagement <IF 1 AND 4 AT Q1 = your Health Advisory Council (Country HAC) has had over the past year with the following groups?>/ <IF 3 AT Q1 = your Health Advisory Council (Country HAC) has had over the past year with you?>

Q17b: Using the following scale, please insert the number that coincides with the primary type of engagement < IF 1 AND 4 AT Q1 = your Health Advisory Council (Country HAC) should have with the following groups? >/<IF 2 AT Q1 = Health Advisory Councils (Country HACs) should have with the following groups?>/<IF 3 AT Q1 = your Health Advisory Council (Country HAC) should have with you?>

Base: Country Health (CHSALHN) & Country HAC members (n=111), missing cases excluded

Figure 30: Country HAC member engagement with low income/isolated families

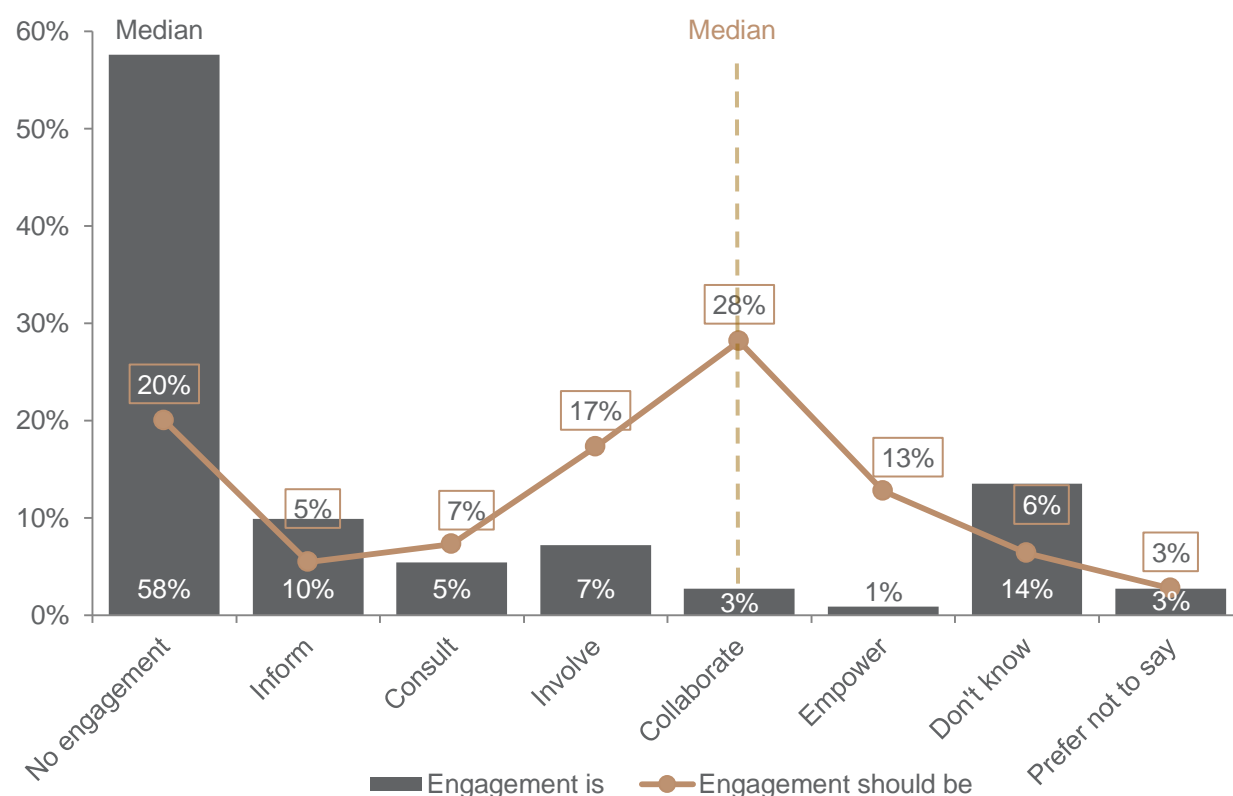


Q17a: Using the following scale, please insert the number that coincides with the primary type of engagement <IF 1 AND 4 AT Q1 = your Health Advisory Council (Country HAC) has had over the past year with the following groups?>/ <IF 3 AT Q1 = your Health Advisory Council (Country HAC) has had over the past year with you?>

Q17b: Using the following scale, please insert the number that coincides with the primary type of engagement < IF 1 AND 4 AT Q1 = your Health Advisory Council (Country HAC) should have with the following groups? >/<IF 2 AT Q1 = Health Advisory Councils (Country HACs) should have with the following groups?>/<IF 3 AT Q1 = your Health Advisory Council (Country HAC) should have with you?>

Base: Country Health (CHSALHN) & Country HAC members (n=111), missing cases excluded

Figure 31: Country HAC's engagement with Aboriginal Experts by Experience



Q17a: Using the following scale, please insert the number that coincides with the primary type of engagement <IF 1 AND 4 AT Q1 = your Health Advisory Council (Country HAC) has had over the past year with the following groups?>/ <IF 3 AT Q1 = your Health Advisory Council (Country HAC) has had over the past year with you?>

Q17b: Using the following scale, please insert the number that coincides with the primary type of engagement < IF 1 AND 4 AT Q1 = your Health Advisory Council (Country HAC) should have with the following groups? >/<IF 2 AT Q1 = Health Advisory Councils (Country HACs) should have with the following groups?>/<IF 3 AT Q1 = your Health Advisory Council (Country HAC) should have with you?>

Base: Country Health (CHSALHN) & Country HAC members (n=111), missing cases excluded

Whilst most responses to survey questions found disparities in responses between CHSALHN staff and HACs, responses to the question about asking 'what Country HACs engagement 'should be'?' found a shared opinion. CHSALHN staff and Country HAC members had similar perceptions about what Country HAC's engagement 'should be'. For example:

- 33% Country HACs and 38% CHSALHN staff reported they should collaborate with local community members
- 29% Country HACs and 23% CHSALHN staff reported they should collaborate with Aboriginal and Torres Strait Islander people
- 32% Country HACs and 23% CHSALHN staff reported they should collaborate with health service consumers/patients
- 24% Country HACs and 21% CHSALHN staff reported they should collaborate with local culturally and linguistically diverse people
- 30% Country HACs and 31% CHSALHN staff reported they should collaborate with local people with a disability

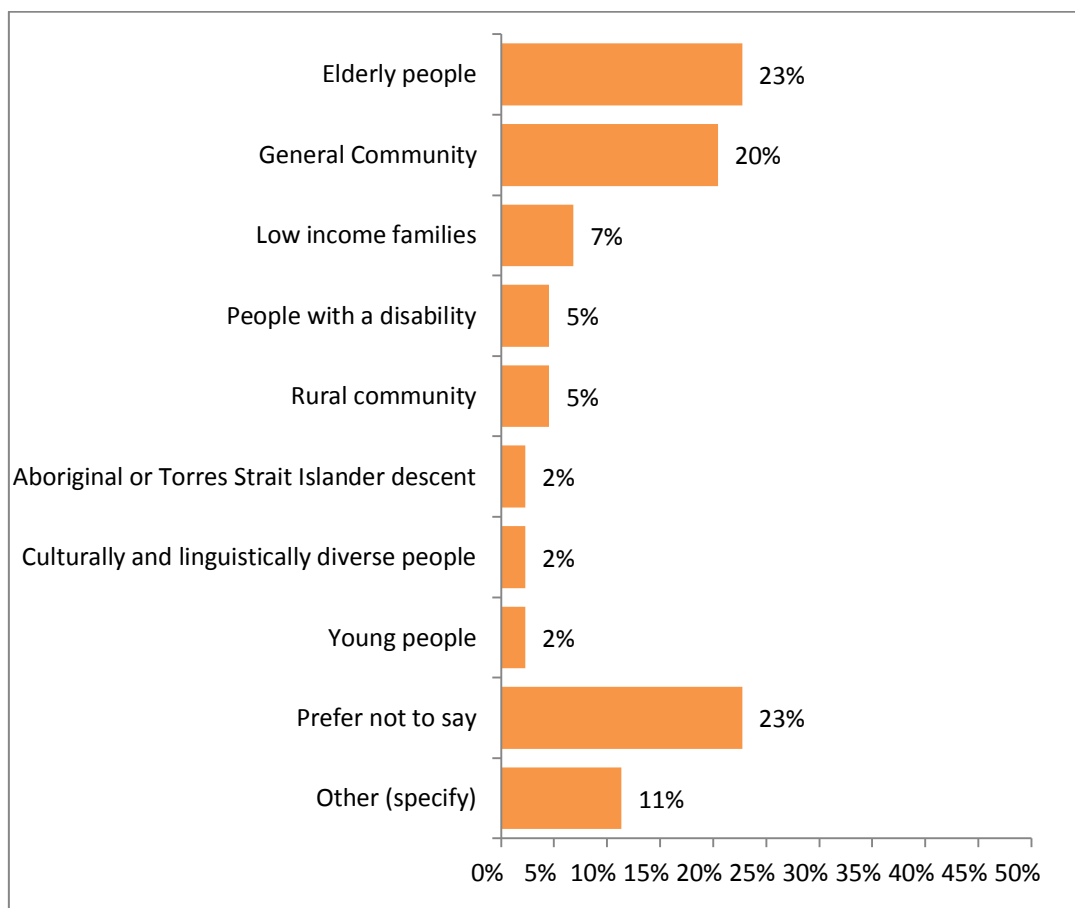
- 27% Country HACs and 27% CHSALHN staff reported they should collaborate with local young people
- 37% Country HACs and 38% CHSALHN staff reported they should collaborate with stakeholder organisations
- 32% Country HACs and 28% CHSALHN staff reported they should collaborate with low income families
- 30% Country HACs and 26% CHSALHN staff reported they should collaborate with Aboriginal Experts by Experience

This shared vision for future engagement identifies opportunities to build on current engagement and interactions and enable further collaboration.

6.5 Community perception of Country HAC's engagement

As part of the survey community members and stakeholders were asked the population group that best described them or they represented (Figure 32). Most respondents (23%) either identified with the aged population or preferred not to say, while one fifth of community and stakeholder respondents identified as representing the general community.

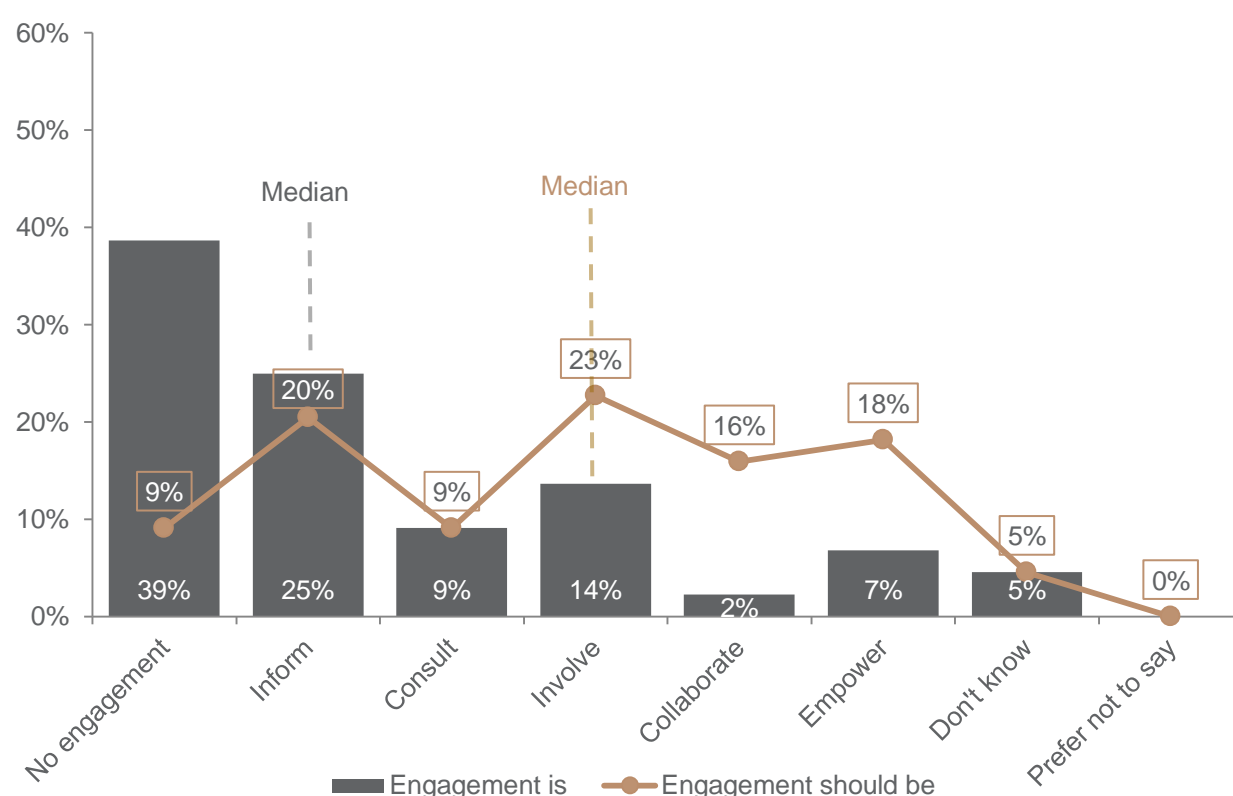
Figure 32: Vulnerable populations surveyed community members represent



Q11: Which of the following best describes you or (if stakeholder) who your organisation represents? (SR)
 Base: Community members, consumers and stakeholders (n=44)

Community members and stakeholders were asked to report the primary level of engagement their local HAC had with them over the past year (Figure 33). The largest proportion of respondents reported that no engagement had taken place with them by Country HAC members (39%) in the past year. However, a fifth (20%) stated that the engagement was at an inform level. In comparison, when asked what level of engagement should be taking place almost a quarter (23%) of respondents felt that the Country HAC's engagement with them should be at involve level, along with more inform (20%) and empower (18%) levels. The communities expectation of the level of engagement is different to CHSALHN staff and HACs perception that engagement should be at collaborate or involve levels.

Figure 33: Community members' and stakeholder's perceptions of Country HAC member engagement with them



Q17a: Using the following scale, please insert the number that coincides with the primary type of engagement <IF 1 AND 4 AT Q1 = your Health Advisory Council (Country HAC) has had over the past year with the following groups?>/ <IF 3 AT Q1 = your Health Advisory Council (Country HAC) has had over the past year with you?>

Q17b: Using the following scale, please insert the number that coincides with the primary type of engagement < IF 1 AND 4 AT Q1 = your Health Advisory Council (Country HAC) should have with the following groups? >/<IF 2 AT Q1 = Health Advisory Councils (Country HACs) should have with the following groups?>/<IF 3 AT Q1 = your Health Advisory Council (Country HAC) should have with you?>

Base: Community Members and stakeholders (n=44)

6.6 Profile of HACs in the community

In 2011 HPC found that Country HACs have a low profile in the community and their efforts are not well supported or promoted by the health system. In 2016 the pulse-check phone interviews found that HAC members (n=15) agreed that HACs continue to not be well known in the community as the boards were. It appears the governance in regional health services offered by HACs has been difficult to explain in plain language without using the terminology of 'boards'. Country HAC members

agreed that their efforts as a HAC are inconsistently supported across the regions by the health system and that HACs are not well promoted by the health system.

In the pulse-check phone interviews when asked about how the HAC could be better promoted HAC Presiding Members commented:

- Ensure they have the authority to make changes suggested by the community
- SA Health promote HACs by dual training of HAC and CHSALHN staff on functions of HACs; presence of profile and photos in hospital
- Communication materials eg local newspaper/media; talks to local community groups/associations/organisations; Mail-out to the whole community; Pamphlets with photos of HAC members

In the desktop review eight of the 17 HACs mentioned concern about their profile in the community and the following types of strategies were implemented to redress this:

- Development of banners and promotional brochures on the work of the HAC (e.g. Yorke, Berri, Gawler, Port Augusta, Whyalla). As an example, the Whyalla HAC banner has the message *'Assisting, Advising and Advocating on your behalf'*.
- Developing a HAC Face book page for the Whyalla HAC.
- Print media promotions e.g. a newspaper article on the Kingston HAC.
- Undertaking activities that improve the profile of the HAC e.g. consultations by the Berri HAC using social, electronic and print media; undertaking a media workshop and developing a strategy by the Mt Gambier HAC and producing a bi-monthly newsletter with news from Leigh Creek HAC meetings amongst many other things.

In addition, whilst not done necessarily to raise the profile of the HAC, the following events activities were mentioned: fundraising and events, attendance at country shows and Anzac Day events, travel around region sharing information on the HAC and funding projects such as the foreshore exercise equipment at Port Lincoln, all seem likely to promote HACs.

The CHSALHN Community and Consumer Engagement Strategy includes a specific strategy: *Work with the Presiding Member Panel to develop an annual advertising campaign to promote the role of HACs and benefits of being a member.* This should assist in raising awareness of the HACs as will the support from the CHSALHN Communications Officer, together with the employment of a HAC Community Engagement Officer (CHSALHN, 2017).

Country HAC achievements

Mid West HAC

Mid West HAC meets monthly by video-conference to reduce travelling time between towns, while maintaining a strong agenda of promoting country hospitals, staffing needs and regional community priorities.

As well as supporting country doctors and nurses to provide care for the community Mid West HAC has been involved in improving facilities such as centralisation with the hospital kitchen providing meals to Elmhaven residents, including a choice of meals

7.0 Self-assessment good governance maturity matrix tool

7.1 Tools for continuing to improve health governance and health governance literacy in Country HACs

This review has revisited the 2011 HPC findings on HAC governance arrangements to acknowledge changes. This revisit review has also been aware of growing international and domestic attention on publically accounting for clinical and corporate governance and the role of community based advisory groups in supporting high quality care in health services.

In Australia in little over the past decade, a number of case examples have been published that indicate room to monitor and improve the effectiveness of governance arrangements of health services (Queensland's Forster Review 2005, Victoria's Targeting Zero 2016, and two Coroners Reports in the past five years in SA (Appendix 4)).

To help understand this review's observations and provide potential ongoing value, HPC combined findings from the interviews, desktop review and surveys to test one type of governance self-assessment instrument with a view that it might offer some practical relevance for a HAC's formative development. HPC tested this draft instrument, a maturity matrix, in the focus groups (Appendix 5). HPC did not and will not apply this instrument to any HACs.

7.2 Background self-assessment good governance maturity matrix tool

Using the work of Healthcare Quality Improvement Partnership (HQIP) UK development of the good governance handbook – maturity matrix, HPC developed a draft instrument for self-assessment of HAC governance (Appendix 5).

The draft instrument is derived using the HQIP framework populated with findings from the HPC Revisit Review and the HAC legislative mandate (Table 7). Each cell of the matrix is populated with a proposed set of outcomes of good governance that can be described and measured. Examples used within the matrix were drawn from identified Country HACs activities.

The self-assessment maturity matrix instrument could be used by Country HACs in a variety of ways:

- It can be used as a simple self-assessment tool by individual HAC members and as a group
- This tool can be used within a HAC to start a local discussions about the function, role and activity of the HAC and future directions of the HAC
- It could be used over time to identify HAC processes that are more effective approaches to deliver HAC requirements
- It could be used to test how different stakeholders understand the governance arrangements, and to identify any communication or other developmental issues
- The matrix could also be compared by several HACs as a benchmarking tool to identify examples of good practice that other HACs could learn from
- The matrix could be used to establish the supports needed by the HACs to move from promising practice to exemplar.

The maturity matrix was selected by HPC to modify for HACs as it recognises that all HACs are different and have differing capacity. Also that there is a range of activity occurring across HACs and

performing at 'exemplar' is not an expectation for all HACs, but demonstrates what a HAC performing at that level would look like (at any given time).

The aim of the focus groups was to engage Country HAC members (representatives from all regions) and CHSALHN staff separately to provide feedback on the draft self-governance rubric specific to the role and functions of Country HACs for their continued self-assessment, ongoing improvement and management of their own performance.

Seven focus groups were held in total with the following demographics:

- 6 with Country HACs, 1 with CHSALHN Regional Directors
- 4 video conference focus groups, 3 face-to-face focus groups held in regional locations including Port Pirie, Renmark and Gawler
- 27 HAC members attended, 6 Regional Managers attended
- All Country HAC regions were represented, not all HACs were represented.

Table 7: Development of Country HAC self-assessment maturity matrix: Alignment with HACs legislative functions

Governance Maturity Matrix items	HAC Functions in The Act 2008/Constitution/Rules
Understanding the role of Country HACs	
Effective external relationships with stakeholders and community members	Encourage community participation in programs associated with supporting the provision of health services by CHSALHN and to promote the importance of carers and volunteers in assisting to achieve successful outcomes for health services by CHSALHN
	Consult with other bodies that are interested in the provision of health services within the community
Effective internal relationships with the Minister, Chief Executive (CE), other HAC staff, hospital staff and CHSALHN staff	Assist the Minister and CE in the provision of information to and to consult broadly with, the consumers of health services provided by CHSALHN in the community and with carers and volunteers who interface with the services
	Provide advice to the Minister and CE about any matter referred to it by the Minister or CE
Knowledge and promotion of health/health issues within the community	Advocate to promote the health interests of the community
	Provide advice to the Minister & CE about any aspect of the provision of health services in the local area by CHSALHN from the perspective of consumers of those services and of carers and volunteers who interface with services
	Provide advice to the Minister and CE about any aspect of the provision to the Community of health services outside of the local area, from the perspective of consumers of those services and of carers and volunteers who interface with services
	Provide advice to the Minister and CE about health issues, goals, priorities, plans and other strategic initiatives of the health services in the region
Accountability and transparency of local health Services	Participate in the consultation or assessment processes associated with the selection of senior staff of the regional CHSALHN
	Give advice to the Minister and CE on the development and management of health services and on the resources made available for those services and in so doing reflect the views of the community

	Provide advice to the Minister and CE in relation to the development or implementation of systems or mechanisms designed to support the delivery of health services or programs in the local area
Fundraising or fiduciary responsibilities	Act as a trustee or assume fiduciary functions or duties in relation to property that may be used or in connection with the provision of health services ¹
	Ensure any property held by the HAC is available for use of a hospital or ambulance service
	Where the CHSA would obtain the benefit of testamentary disposition or trust, assume the benefit in substitution for those hospitals
	Establish a gift fund and solicit gifts to the Fund from members of the public
	Undertake, if the HAC chooses, fund-raising activities in compliance with policies of the minister as may be adopted from time to time

7.3 Feedback on the draft maturity matrix from Country HAC focus groups

HACs commented on the potential value and use of the self-assessment maturity matrix instrument commenting:

- Could be included in the orientation pack for new HAC members
- Could be used to consider adding a measure to capture support from CHSALHN
- Tool could be used to start discussions
- HACs could use this tool to identify which level they would like to be operating at and plan out their goals for the year and then identify what support they need from CHSALHN

The following concerns were raised about using the self-assessment maturity matrix:

- That CHSALHN would use it to evaluate HACs and this is not their purpose
- It would be used as a benchmarking tool to assess HACs performance
- Concerned it would be used to 'check-up' on HACs and that HACs success should be determined by the community
- There is a need to link the matrix to the Partnership Framework
- HACs are the driving force behind their engagement role, which is through their existing community relationships.
- There is a concern about the increasing professionalisation of the volunteer HAC role.

More specific feedback on the content of the matrix was provided by HAC members, which has informed edits to the maturity matrix. Other findings from the focus group:

There needs to be greater articulation of the functions and expectations of HACs. The functions and reporting lines need to be clear, measureable and achievable including clear guidance as to who to contact for help.

Many HACs were unaware of the activities of their equivalent HACs elsewhere across South Australia. Some HAC members were surprised to hear of the activities of HACs. Opportunities for sharing activity between HACs in addition to the Combined HAC Conference might create greater cohesion across HACs and support for each other in their respective roles.

¹ Red font denotes items of relevance to incorporated HACs only

7.4 Feedback from CHSALHN Regional Directors focus group

CHSALHN staff commented on the potential value and use of the self-assessment maturity matrix, commenting:

- the tool is not a test that will be graded/assessed by CHSALHN or by HPC
- the tool could add value to the HAC role and be useful to help them track their progress in their community
- an implementation plan including clear communication for the tool is required to ensure that there is a shared understanding and agreement about the tool across all regions.

The following concerns were raised about using the self-assessment maturity matrix:

- staff were unsure that HACs would use it
- that HACs would take it negatively as in CHSALHN were patrolling their work
- and potential confusion with the Partnership Framework

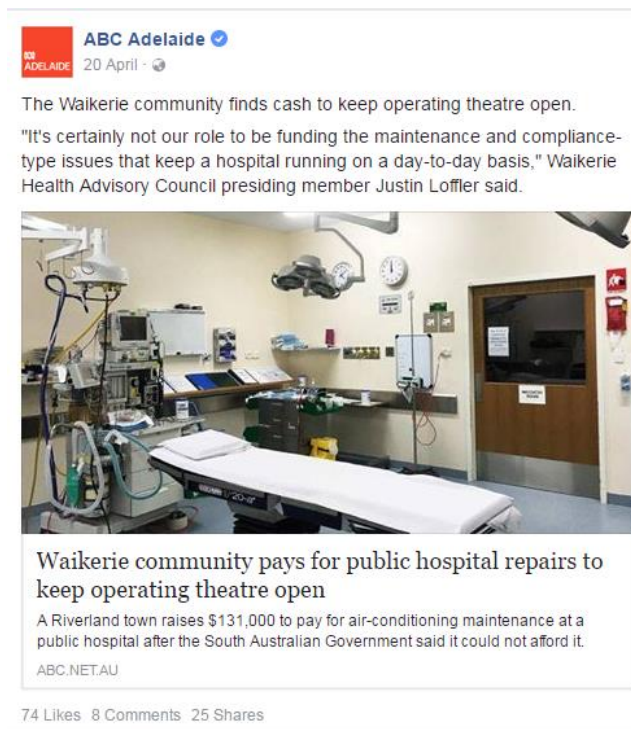
This was accurately described by CHSALHN staff as an ‘inward looking tool’, while the Partnership Framework was described as an outward looking set of strategic commitments and may be best used together.

Country HAC Achievements

Waikerie and Districts HAC

Waikerie and Districts HAC reported the following achievements:

1. Waikerie and Districts HAC has a long history of community financial support to support local health services.
2. The HAC has funded the works out of the community funds to keep the operating theatre running (\$141,000), but are still looking at ways to try and get CHSA to fund it while working with statutory services for longer term commitments to resources.
3. This work has enabled the operating theatre to remain open and available to the community for minor surgical procedures, for accidents/emergencies and allow birthing theatre needed for caesarean emergencies to continue at Waikerie.
4. Compliance/maintenance issue therefore is CHSA responsibility. However despite numerous requests and ongoing conversations CHSA has refused to fund the required work.



Source image: ABC Facebook

8.0 Study strengths and limitations

The purpose of this study was to gain insights from HACs within the scope outlined earlier. As with all studies there are strengths of limitations of the methodology used. This revisit review study was a qualitative study revisiting the experiences of HACs since the previous 2011 review. A strength of the review was the use of multiple methods with multiple data sources to triangulate responses to verify responses. It was not conducted as a quantitative randomised controlled trial and so will not withstand the scrutiny is assessed by these standards in terms of methods and sampling.

There were limitations in this review. The low response rates to the survey mean that the responses are not representative of the whole community, whole CHSALHN staff nor all the HAC Presiding and general members.

The survey tools were not tested for reliability and validity as required in quantitative studies with the notable exception of the health literacy items taken from a tool (Batterham et al 2016) that has been found to be valid and reliable.

Feedback from HAC presiding and general members on the HPC revisit review included:

- Survey was open for short timelines over the busy Christmas period making it difficult for HAC members to respond

HPC mitigation strategy:

- Survey opening time extended and telephone calls made to HAC Presiding Members to seek feedback, offer paper copies and encourage response
- The online survey was difficult to use and navigate through and many respondents dropped out as a result

HPC mitigation strategy:

- Hard copies were posted with return postage
- Survey could be completed over the phone with HPC Secretariat
- In-situ review of the online survey to examine patterns in points of drop-out to improve survey.
- Modifications were made to the survey.
- HPC requested the provider supply the details post-survey but the provider was unable to provide exact details of the number of repeated survey attempts.
- The questions within the survey were not the right questions

HPC mitigation strategy:

- Involvement of Review Advisory Group (ref s1.6 Governance of the Review) in the design and selection of questions
- Survey piloted with HAC members from Review Advisory Group
- Quick response required for the pulse-check phone interviews was unrealistic and disrespectful

HPC mitigation strategy:

- Thank the HAC members for their contributions and apologise to the HAC members for the short notice.
- The money should not have been spent on the contracting the social research company

HPC mitigation strategy:

- Given the capacity of the HPC and secretariat , and the desire to honour the contributions of HACs, external providers were required to undertake the review. HPC resources were used for the Advisory Group, liaison with key informants including CHSALHN, Governing Council meetings and PMP, project management and drafting the final report.

9.0 Conclusion

HPC commends all Country HAC members for their service, commitment and amazing achievements in contributing to stronger regional health services for all country South Australians, now and in the future. HPC acknowledges all observations in the review and future expectations for HAC activities should be proportionate with the unpaid, part-time role of Country HAC members.

What is important in the governance of regional health services is that the focus is on increased patient safety, community engagement with the whole population, improved health outcomes for country people and the provision of high quality health services. This is reinforced in the functions of the Governing Council and supports the CHSALHN strategic directions.

HPC acknowledges that there is great variation in the functions adopted by HACs across South Australian country regions. The variation between HACs is their strength and also their weakness. For example, some undertake community engagement, others fundraise, some are involved in the employment of CHSALHN staff, others are not.

In conclusion HPC observed in this review:

1. CHSALHN staff and Country HACs have a shared vision for future collaborative action and engagement across the whole community even though there are differences in perception about how well functions are currently delivered. Full implementation of the June 2017 CHSALHN Partnership Framework will help address some issues raised, but it does not offer complete coverage of Country HAC functions.
2. Country HACs have a low profile in the community and their direction is not well described by CHSALHN to ensure efforts support Governing Council functions and the organisation's strategic directions for patient safety and quality health services.
3. There is room for improving CHSALHN performance data provision to HACs and development of health literacy and linkage between staff and HACs so Country HACs can provide leadership in an advisory capacity and monitoring of regional health services performance.
4. Country HACs promote the general interests of local communities to the health system, although promotion of the interests of specific population groups remains limited.

As this HPC report reached an advanced stage of finalisation, on 8 August 2017, the Social Development Committee of South Australian Parliament tabled its fortieth report, an inquiry into regional health services, concluding a review of oral and written evidence that commenced in April 2016. The inquiry was conducted as a review of governance arrangements only. The report contains 49 recommendations for the consideration or referral of the Minister for Health, Department for Health and Ageing and CHSALHN. HPC notes the observations and advice made in this HPC Revisit Review are consistent with Social Development Committee evidence and recommendations on many matters relating to governance arrangements and ways forward.

Governance Arrangements

There remain discrepancies in the perception of the functions of HACs. The Act 2008 outlines functions that HACs *may* adopt, yet within the HAC constitutions and rules all HACs have adopted the full range of functions described within the HAC. There is also evidence that some CHSALHN staff are not fully aware of the functions of HACs as described within The Act 2008, constitutions and

rules. However, at the regional level most Country HAC members reported good relationships with their local and regional CHSALHN staff (EODON, hospital CE, Regional Director).

Many Country HAC members reflected improvements to governance structures including the introduction of PMP and involvement of regional directors and regional Country HAC meetings. There remains discrepancies between reports of levels of communication between CHSALHN statewide staff and Country HACs: some HACs report good communication and others less so.

There is an inconsistent focus by Country HACs on health system performance elements that now feature highly in CHSALHN strategic directions such as patient safety. Country HACs attention on clinical governance could be emphasised more to support Governing Council in its functions.

There is some variation between the HACs. The greatest variation being between constitutions and rules, where incorporated Country HACs hold assets which varied their functions (eg fiduciary regarding property, fundraising trusts) and powers (banking, investment and property improvement).

Health Information and Performance Data

Data systems need to be put in place within CHSALHN to provide Country HACs with the reports and information needed to support their work and inform their community. As part of the Partnership Framework 2017 development, CHSALHN produced a standard regional template for information provision to HACs that is, at best, in the very early stages of implementation, and in this review, the template is untested for adequacy of covering governance information elements identified.

This review identified HAC information reports need to include:

- Quality and safety (with support from Department for Health and Ageing(DHA))
- Staff surveys and feedback
- Patient compliments and complaints (including items from SACCESS)
- Health outcomes at the regional level comparing regions (with support from DHA Public Health and Clinical Systems and potentially HPC)
- Financial reports for hospital and HAC

Together with these reports is the training required to support the HACs to understand and interpret this information to share with their community. It is evident that CHSALHN is inconsistent in equipping Country HAC members with the training, skills or support needed to undertake the all the functions of HACs within their constitutions or rules. There are gaps in the delivery of the training to HACs and some training can only be accessed through use of local HAC budgets, reducing funds available to the community. While CHSALHN has developed an orientation package (including PowerPoint presentation) for Country HACs the local implementation requires local capacity to deliver. A flexible training framework would allow the building of skills across a diverse HAC membership and give something back to the volunteer community members. Reciprocally, CHSALHN staff may find it useful to have induction material on getting the most out of working with Country HACs.

There is scope to improve the health literacy of some Country HAC members – this was identified as an action in response to the 2011 HPC review, is identified as a role of PMP and

listed as an action in the CHSALHN Partnership Framework 2017. This is a challenge and imperative for CHSALHN and HACs in strengthening governance and partnership to establish methods by which HACs can access the information they need and want, when and how it is relevant to them.

Community Engagement

Moving from the 2011 review findings to this report, HPC has found that some Country HACs continue to have a low profile within the community, while others have gone to great lengths to improve both their visibility and their activity within the community. Engagement over the past year with community (and across population groups) was reported as either '*no engagement*' or '*inform*', the future vision is for '*collaboration*' with the community.

There is scope for improvement in the breadth of community engagement across the community including population groups such as Aboriginal people, culturally and linguistically diverse people, people with a disability. This is not an easy task, even paid professionals struggle to ensure the whole community is engaged. CHSALHN has a scaffolding of structures in place in their Community and Consumer Engagement and Aboriginal Community & Consumer Engagement strategies to ensure engagement is sufficient for quality and safety purposes.

Sometimes Country HACs report they are in a 'no win' situation. They are trusted members of the community and seek advice from their community on their health needs, maintenance and service requests to provide to CHSALHN. The tension is that HACs then rely on CHSALHN to respond (positively or otherwise) in a timely manner, and to date there may not have been an explicit compact between HACs and CHSALHN on how collaboration, communication and participatory decision-making would work. Quite understandably, a HAC will feel their community needs outcomes in response to what they say to their HACs and HACs need outcomes to know CHSALHN hears them.

During the course of this review, HPC was encouraged to see the Partnership Framework develop that offers a shared future vision for Country HACs engagement from CHSALHN and Country HACs. With full implementation, this framework should raise the profile of Country HACs and develop health literacy and health governance literacy, but it is as yet untested for how comprehensively it will cover development of all HAC functions. HPC notes the CHSALHN Partnership Framework evaluation plan includes an annual review and reporting process. HPC considered whether evaluation might also include KPIs for Governing Council to CE, CHSALHN performance that invite HACs to make an assessment of collaboration effectiveness.

10.0 Advice

Governance

As part of the CHSALHN governing mechanisms, HACs should be considered critical in their provision of locally-grounded advice and support through Governing Council to CHSALHN to ensure safe and high quality patient care as well as service improvement. This should be more explicitly described in the organisation's governance structure so it is clearer how Country HACs, and their relationship with local health facilities, effectively contribute to CHSALHN strategic directions, national safety and quality standards compliance and Governing Council functions on corporate and clinical governance.

Country HACs capacity to advise on clinical and corporate governance should be resourced and developed, and reciprocally CHSALHN should work with staff to level up their understanding of Country HACs functions and working with Country HACs on reporting and advice.

As part of this review, HPC developed a draft governance maturity matrix for consideration by CHSALHN and Country HACs. HPC hopes CHSALHN and Country HACs may reflect on how they might apply this in their own work locally and over time. A maturity matrix can offer insights into processes adopted by HACs with higher levels of maturity in their approach to legislative function and contributions to Governing Council and governing for quality and safety and CHSALHN strategic directions.

Health Information

HPC endorses the full implementation of actions listed to support the aims of the Partnership Framework, noting particularly support for CHSALHN staff and HACs to build health literacy and health governance literacy.

This review noted patchy provision of performance information and data to Country HACs, and patchy take up and use. Given the imperative to support clinical and corporate governance, CHSALHN should prioritise implementing and testing of the new regional template for a routine reporting schedule between the LHN and HACs. This should include delivery of performance data relevant to local Country HACs. It might mean investing in CHSALHN information architecture to support this, and supporting HAC members to build skills and knowledge to understand effective data use.

This information could include, and may not be limited to:

- regional health outcomes reports
- financial reports
- reports on quality and safety
- complaints and compliments
- staff surveys

Importantly, knowing there are new ACSQHC safety and quality standards coming in 2018, CHSALHN and Country HACs should work together to be prepared to understand current performance and comply with standards that will have greater emphasis on ensuring delivery of culturally competent health services with an emphasis on Aboriginal Australians.

Community and Consumer Engagement

Relatively unchanged since the 2011 HPC review, specific population groups in country SA remain disengaged from Country HACs including Aboriginal people, culturally and linguistically diverse communities and youth. HPC appreciates it can be hard work to build diversity into each Country HAC, but the evidence tells us that the benefits are well worth the effort. A diversity of contributors to a HAC adds to its ability to monitor and improve the quality of care for everyone in the community. It makes each HAC stronger and more representative, and collectively demonstrates the respect and support CHSALHN has for the country community it serves.

HPC endorses the CHSALHN Aboriginal Community & Consumer Engagement Strategy 2015, and has noted in its implementation how CHSALHN is supporting greater involvement of Aboriginal people in health service design, planning and delivery as a new and complementary approach to the community engagement mechanisms of Country HACs. CHSALHN should consider the development and implementation of a CHSALHN Culturally and Linguistically Diverse Communities and Consumers Engagement Strategy and Youth Strategy that incorporate HAC activities and expectations.

HPC endorses the full implementation of actions listed to support the aims of the Partnership Framework, noting particularly support for the need for training and support to conduct community and consumer engagement. Based on findings of this review, the Partnership Framework's description of adding a community engagement officer for Country HACs and CHSALHN is encouraging. It is vital this role should adopt community development theory and practices as described in the framework; be engaged at a level to influence strategic directions of country health; and be highly skilled in community development, community capacity building and community engagement.

The Partnership Framework and work to clarify the description of how HACs connect with CHSALHN strategic directions may be an opportunity to add an assessment by Country HACs on collaboration effectiveness in the performance management framework of Governing Council and CE CHSALHN.

In this report, HPC makes advice on possible improvements in relation to Country HAC governance arrangements, information provision and engagement activities, and invites ongoing dialogue with CHSALHN, Governing Council and Country HACs to support developments.

Information about Country HACs, their locations and membership and Presiding Member contacts is available on the SA Health public website.

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12.0 Appendices

Appendix 1: Pulse-check Phone Interview Schedule

1. In what region is your HAC?
2. How long have you been involved in the HAC?
3. Are you aware of the HPC report on the Review of Country HACs governance arrangements that was conducted by the HPC in 2011?
4. And, what about SA Health's response to the report?
5. On a scale of 0 to 10 where 0 is not at all effective and 10 is very effective, how effective is your HAC in promoting the interests of the local community?
6. We understand that Country Health SA has released a Community and Consumer Engagement Strategy and an Aboriginal Community and Consumer Engagement Strategy. How has your HAC used these strategies to guide your local engagement?
7. What steps has your HAC taken to promote the interests of specific population groups within your community? (PROBE)
 - a. Aboriginal people?
 - b. Culturally and Linguistically Diverse people?
 - c. People with a disability?
 - d. Low income families?
 - e. LGBTI (lesbian, gay, bisexual, transsexual and intersex) people?
8. How have you obtained information about health and health service needs of these previously mentioned groups within your community? (PROBE)
9. What have been the most effective sources for collecting information about the health and health service needs of the previously mentioned groups within your community? (PROBE)
10. On a scale of 0 to 10 where 0 is not at all effective and 10 is very effective, how effective do you believe your HAC has been in promoting the interests of these previously mentioned groups within your community?
11. Has the Health Consumers' Alliance been involved in your engagement processes?
12. On a scale of 0 to 10 where 0 strongly disagree and 10 is strongly agree, how much do you agree or disagree with the following statements...
 - a. My HAC is well known within the community
 - b. Our efforts as a HAC are *supported* by the health system
 - c. Our efforts as a HAC are *promoted* by the health system
13. What effort has been made (if any) by the Country Health and local health system to increase the profile of the HACs in your community? (PROBE)
 - a. Local Newsletters?
 - b. Article in Country Connect newsletter?
 - c. Media – have you got any local media? What type of stories?
 - d. Availability of health service development information?
 - e. Promotional material of HAC activities?
 - f. Working with local government?
 - g. Other? Please specify...
14. How could your HAC be better supported?
15. How could your HAC be further promoted?
16. How have the governance arrangements for your HAC changed in the past five years? We understand that CHSA has introduced the panel of presiding members. What have been the implications of these changes?
17. What have been the implications for your HAC as a result of these changes?
18. We understand that you receive quarterly performance reports for your region. How understandable are these reports? How useful are they for your HAC?
19. What has been done to improve the quality of communication and collaboration between your HAC and the local health service?

20. How has your HAC collaborated with the health service to develop ideas on how to improve health outcomes within the local community?
21. Is there anything else that could be improved? How?
22. How has the level of satisfaction changed over time?
 - a. Is it better than it was?
 - b. Is it worse?
 - c. Is it the same?
23. Are there any other comments on your current governance arrangements that you would like me to feed back to HPC?
24. Did you have any final comments?

Appendix 2: Response rates and demographics of survey respondents

Response rates (Table 8) and demographics of the sample:

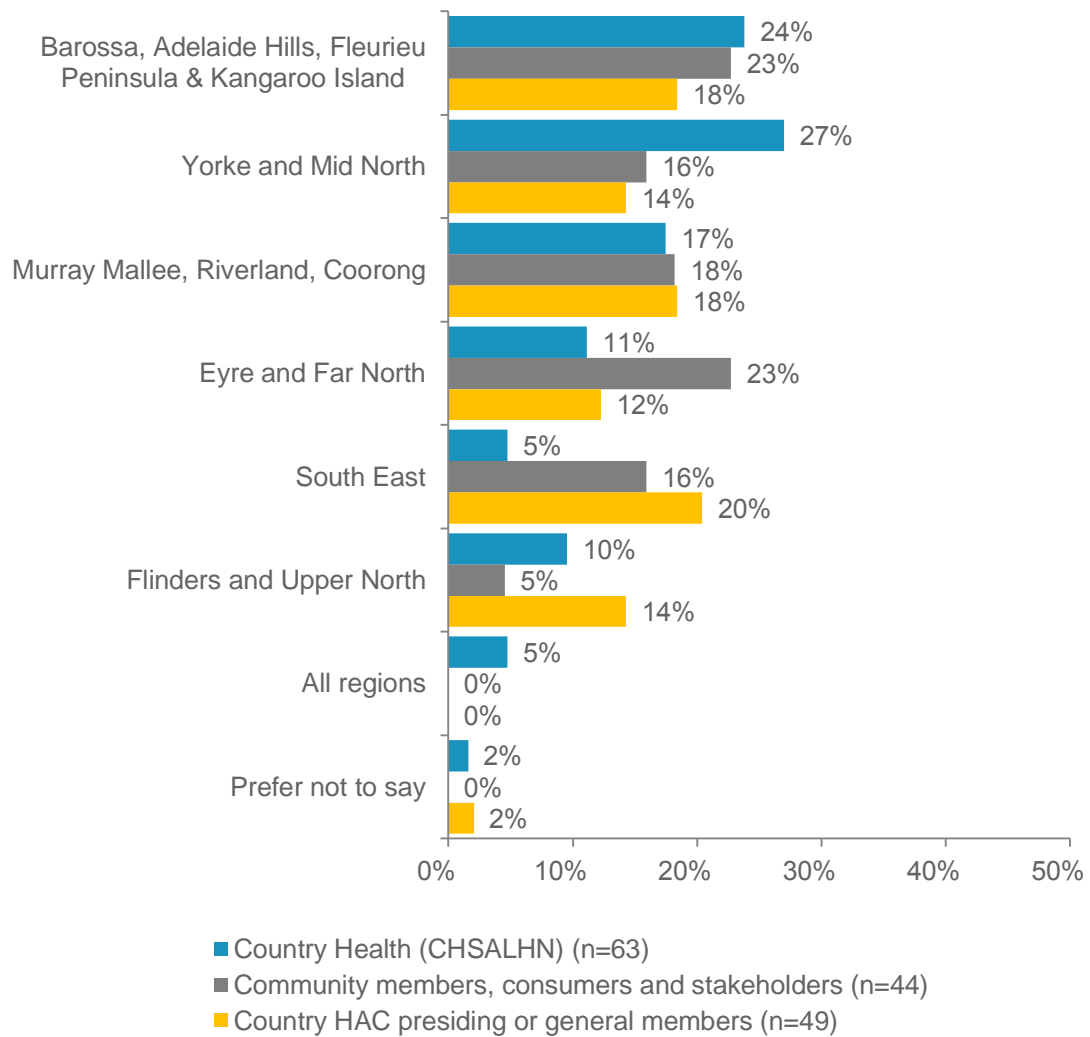
- 68% female.
- 3% identified as Aboriginal or Torres Strait Islander
- 87% born in Australia, 8% born in United Kingdom 1% born in Italy, New Zealand, India, Ireland, Philippines, South Africa and United States of America.

Table 8: Survey response rates

Classification of respondent	Approached (n=)	Achieved (n=)	Response rate (%)
Country Health (CHSALHN) regional staff	7730	63	0.82%
Country Health (CHSALHN) state-wide staff and Governing council members	270	10	3.70%
Community members, consumers and stakeholders	488,496	44	0.01%
Country HAC presiding member or general members	385	49	12.73%
TOTAL		166	

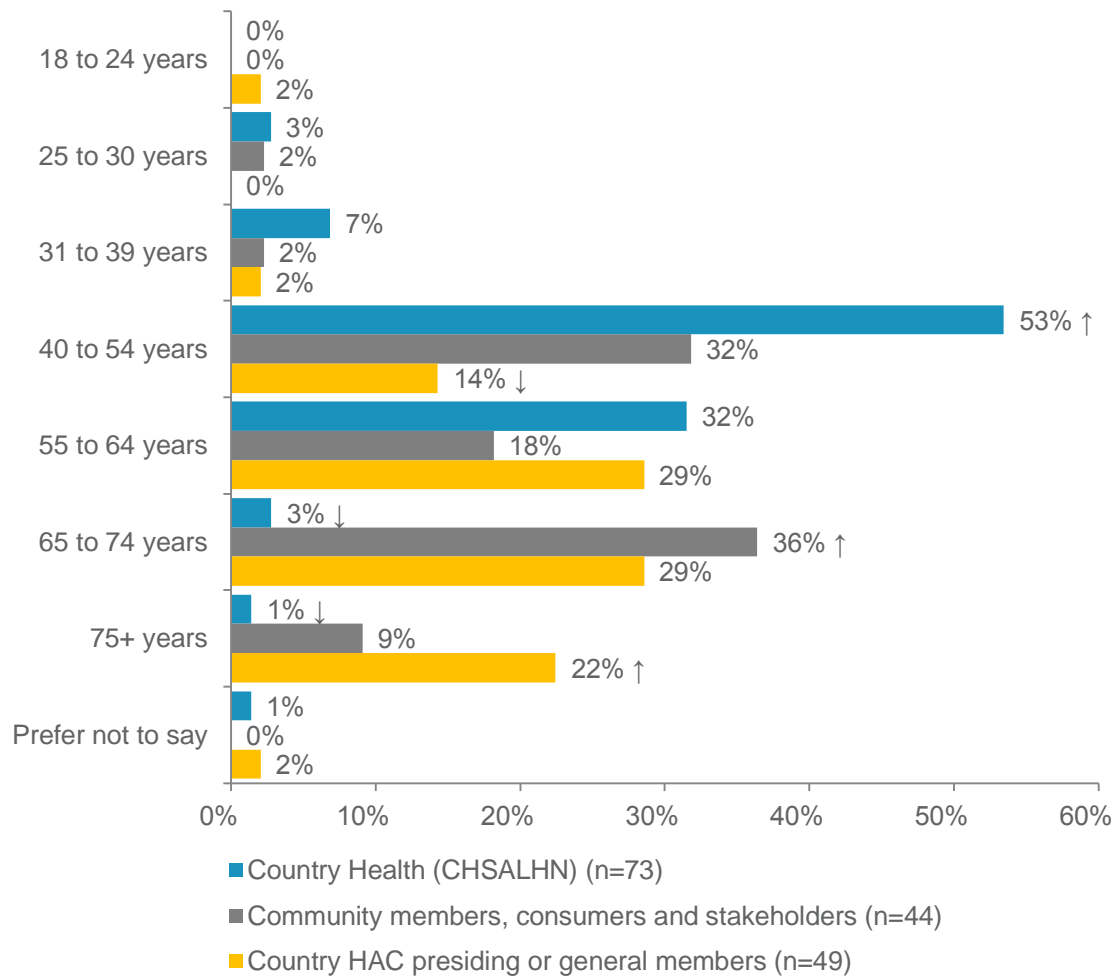
*These values are an estimation

Figure 34: Survey responders - region by group



Q2: Firstly, could you please indicate which region your local community is in? (SR)
 Base: All respondents excluding Country Health (CHSALHN) state-wide staff (n=156)

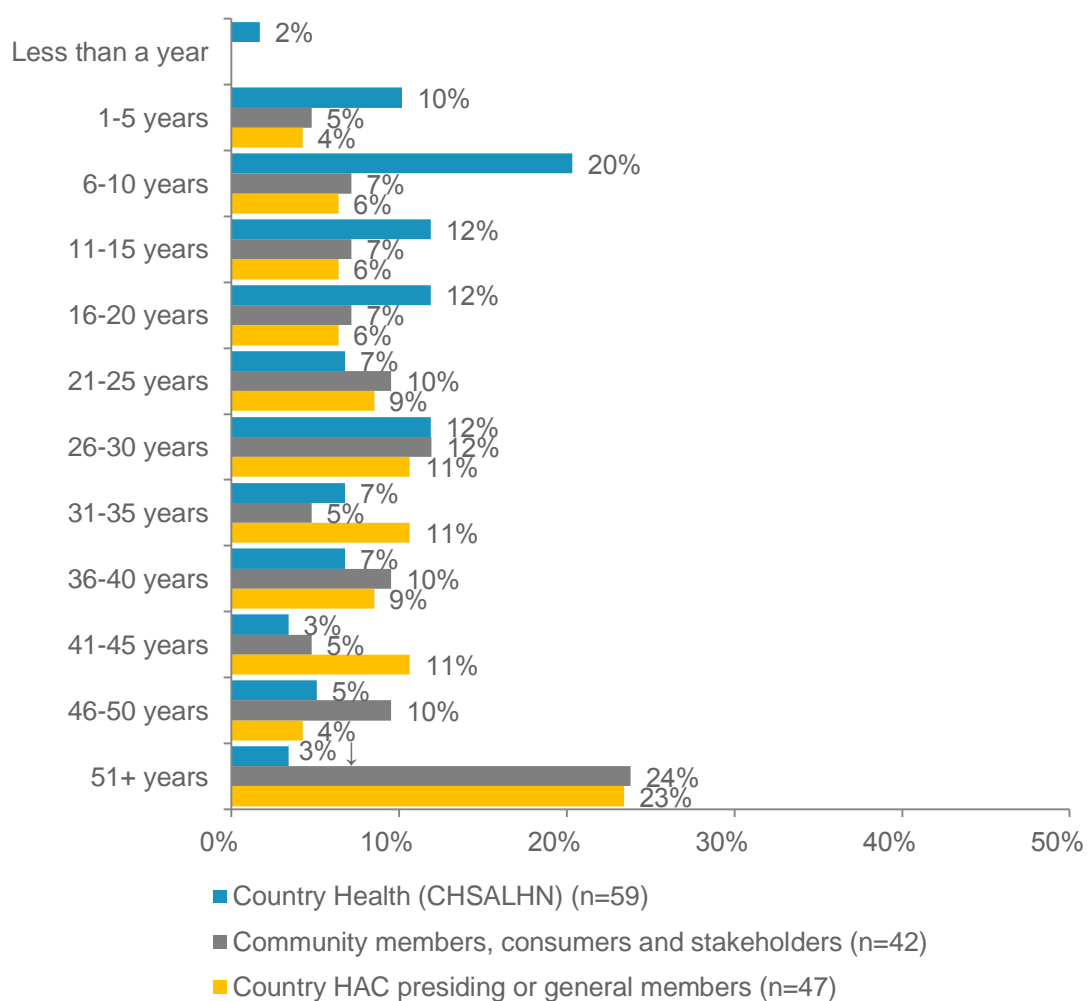
Figure 35: Survey responders - age by group



Q3: In which of these age groups do you fall? (SR)

Base: All respondents (n=166)

Figure 36: Survey responders - duration of living within the community by group



Q5: How long have you lived within your community? (SR)

Base: All respondents excluding Country Health (CHSALHN) state-wide staff, missing cases excluded (n=148)

Appendix 3: Cluster analysis of appraisal of health information and ability to find good health information

Cluster analysis tries to identify homogenous groups of cases that display similar characteristics. Cluster analysis was undertaken with the health literacy items.

Table 9: Cluster analysis of appraisal of health information and ability to find good health information

Cluster	Appraisal of health information	Ability to find good health information
1	1.7	3.4
2	2.92	3.85
3	3.18	3.33
4	2.47	1.8

Table 10: Basic demographics of clusters 1 - 4

	Cluster 1	Cluster 2	Cluster 3	Cluster 4
Number of people in this cluster	8	18	17	6
Age category	38% 65-74 years 33% 55-64 years 33% 75+	28% 55-64 years 28% 75+ 22% 40-54 years	47% 65-74 years 18% 55-64 years 18% 75+	66% 55-64 years
% Region	38% from Yorke Peninsula 33% from South East	22% from South East 22% Murray 17% Barossa 17% Eyre	29% Barossa 24% Flinders 24% Murray	33% Flinders 33% South East
% Male	87.5%	39%	64%	50%
Aboriginal	0%	0%	0%	17%
Born Australia	87.5%	89%	82%	100%
Presiding Member	62.5%	33%	53%	33%

The cluster analysis highlights groupings and demographics of HAC members that could be better supported to appraise health information (cluster 1) and find good health information (cluster 4).

Appendix 4: Coroner's inquest findings of relevance to CHSALHN

During the course of this review, correspondence from HACs brought two Coroner's inquests to the attention of HPC. The Coroner makes recommendations to improve the health system and in these cases the CHSALHN. The recommendations have direct relevance to SA Health, CHSALHN, country hospitals and health services and the relevant Country HAC. The findings and recommendations from the Coroner's reports provide HACs with additional evidence in support of improving patient safety and the delivery of quality health services in country regions.

The Coroner's report recommendations include:

From 2013 inquest into the death of Angela Catherine Fensom:

- Ensure that country hospitals in SA are staffed with appropriate medical expertise and to ensure that patients admitted to such hospitals are properly and regularly reviewed by a medical practitioner of appropriate and relevant experience.
- That the Minister for Health ensure the promulgation within public hospitals in both metropolitan and country SA of systems and protocols designed to enable medical practitioners and nurses to recognise and appropriately respond to the deteriorating patient.

From 2017 inquest into the death of Edward John Mayell:

- Clear and mutual understanding with regard to the appropriate hospital to which a patient in the South East of SA should be transferred having regard to the patient's clinical circumstances.
- That Millicent hospital ensure there are appropriate procedures in place in respect of:
 - Identification of a deteriorating patient
 - Carrying out regular clinical observations and the recording of the same
 - Appropriate and accurate triaging processes
 - That radiological and pathological results be drawn to the attention of the medical practitioner immediately
 - Colour coded observation charts be used routinely
 - Robust processes available that enable rapid and appropriate response in the case of patients whose vital signs are outside the normal range
- That a state-wide project be run in SA regarding sepsis identification and treatment.
- That Picture Archival Communications System (PAC) be immediately installed at the Millicent hospital

Appendix 5: Country HAC Good Governance Self-Assessment Maturity Matrix

The purpose of the Country HAC self-governance maturity matrix is for Country HAC members to self-assess your HACs progress against agreed standards and examples from practice. The matrix acknowledges that variations will occur between and within country SA regions. This is not for evaluation purposes.

To use the matrix: Identify with a circle the level you believe your Country HAC has reached then draw a line and arrow to the right to the level you intend to reach in the next 12 months. Eg **1→?**

Progress level 1-3 Country HAC Functions	1 Basic level	2 Promising practice	3 Exemplar
Clarity of purpose, function and behaviours of country HACs	Country HACs activities are detailed in the annual report tabled in Parliament (Mandatory). All members have undertaken orientation/induction with Country Health to be familiar with functions of country HACs.	Evidenced annual discussion of purpose and function on country HAC agenda. Evidence of progress in the HACs Action Plan.	Description of country HAC activity in annual report highlighting achievements by HAC functions eg communications planning - pamphlets, newsletters, poster (pull-up banner), Facebook page describing what the country HAC is about, how it does it's work and how to get in contact.
Effective external relationships with stakeholders and community members	Country HAC has a regularly updated list of stakeholders and contact people within the community.	Country HAC has a regular discussion item on their agenda to consider their stakeholder list and plans for all local population groups eg culturally and linguistically diverse people, Aboriginal people, young people and relevant organisations. HAC engages with all local population groups at the information sharing level. Country HAC collects feedback and discusses this at country HAC meetings. Invites relevant guest speakers to HAC meetings.	Country HAC has a plan for local community and consumer engagement, and awareness of opportunities for community engagement at the 'consult', 'involve' and 'collaborate' levels with Culturally and Linguistically Diverse people, Aboriginal people, young people and relevant organisations in line with the Partnership Framework. Country HAC arranges and/or has members available for regular community meetings. Country HAC periodically conducts community surveys.
Effective internal relationships with the Minister, Chief Executive, other country HACs, Country Health	Annual reports provided to the Minister. Attendance by HAC members at regional HAC meetings and/or the annual Combined HAC Conference.	Country HAC regularly engages with Regional Director, Presiding Members Panel and Governing Council, and reports this at HAC meetings.	Processes built in to monitor country HAC actions and evidence from Country Health that action has been addressed eg meeting minutes and feedback from interactions with internal stakeholders in line with the Partnership Framework. Information flows frequently in

Progress level 1-3 Country HAC Functions	1 Basic level	2 Promising practice	3 Exemplar
			both directions.
Knowledge and promotion of health and health issues within the community	Country HAC has a regular discussion item on their agenda to consider observations of local health issues.	Country HAC uses Country Health localised demographic information with feedback from community engagement and considers this in country HAC meetings, promoting health and health issues and informing Country Health.	Country HAC works with Country Health to understand and influence progress on health issues and gaps in health service delivery eg Country Health attending country HAC meetings, Country Health reporting back progress, joint projects. In line with the Partnership Framework
Accountability and transparency of local health services	Country HAC receives and discusses at HAC meetings the Country Health provided regular reports on health service delivery including safety and quality reports, financial reports; patient and staff surveys.	Country HAC reviews and asks questions of Country Health about the provided reports on health service delivery, and makes itself available to assist Country Health in health service management such as being involved in employment of Country Health staff and policy review. These activities are reported in country HAC meetings and minutes.	Information flows frequently in both directions in line with Partnership Framework on topics raised in Country Health reports on health service delivery and country HAC involvement in health service management eg employment of staff, development of plans. Country HAC records show how this collaboration informs practice and work-plan of country HAC.
Fiduciary responsibilities (if incorporated)	Country HAC review and approve a compliant financial report within the annual report in line with specifications outlined annually by Department of Premier and Cabinet. Asset management and ownership.	HACs meet minimum distribution requirement of \$8,000 per year.	HACs are involved in budget investigation with Country Health.
Fundraising (if incorporated and if applicable)	Country HAC review and approve a compliant financial report within the annual report in line with specifications outlined annually by Department of Premier and Cabinet.	Country HAC has a regular discussion item on fundraising actions, and asks Country Health for advice on targeting local needs so local funds raised are invested in local health service priorities.	Country HAC has a fundraising strategy with plans to address needs identified from the community and consumer engagement strategy activities and from working with Country Health reports to assess gaps.