REPORT OF THE INDEPENDENT REVIEW OF THE HEALTH PERFORMANCE COUNCIL MEMBERSHIP STRUCTURE

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THE HON JOHN HILL MP, MINISTER FOR HEALTH AND AGEING,
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Government of South Australia
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BACKGROUND

The Review

On 17 January 2012 the Minister for Health and Ageing asked that an independent Review be undertaken of the Health Performance Council Membership structure.

The deadline for the completion of the Review was set at 31 January 2012.

Terms of reference

The terms of reference for the Review are as follows:

- Identify the specific areas of knowledge, expertise, experience, skills or qualifications required of appointees of the Health Performance Council to successfully undertake the functions of the Council;
- Advise the Minister on the composition of the Council having considered the optimal number required to cover the identified areas of knowledge, expertise, experience, skills or qualifications;
- Advise on a process to select suitable appointees consistent with the requirements of the Act and the Health Care (HPC – Appointment of Members) 2008 Regulations; and
- Conduct the Review in accordance with the Department of Premier and Cabinet Circular 22 – Improving the effectiveness of government boards and committees guidelines.

Council outline

The Council was established in 2008 (pursuant to Part 3, Section 9 of the Health Care Act 2008) to provide independent advice to the Minister for Health and Ageing and the Parliament on the operation of the health system, changes in health outcomes for South Australians and the effectiveness of community engagement.

The functions of the Council are set out in Part 3, sections 11, 12 and 13 of the Act and are discussed in more detail in the following section of this Report.

The Governor may, on the recommendation of the Minister appoint up to 15 persons to the Council for a period not exceeding four years and from time to time appoint a suitable person to be a Deputy to the Member.

The Council is supported by a four person Secretariat and, with the Minister's approval, may make use of other public sector staff, services or facilities in undertaking its role.

The Council will complete its first term on 25 June 2012 and the current Chairperson, 14 Members and 5 Deputies are eligible for reappointment.

KNOWLEDGE, EXPERTISE, EXPERIENCE, SKILLS OR QUALIFICATIONS REQUIRED BY COUNCIL MEMBERS

Statutory requirements under the Act

A starting point for a discussion of the knowledge, expertise, experience skills or qualifications[1] required by the Members of the Council must be the statutory requirements specified in the Act. Under the Act the persons appointed as Members must together, in the opinion of the Minister:

- Have a high level of knowledge of, and expertise in, the provision of health care or the administration of health services;
- Be able to represent the diversities of the South Australian community; and
- Have such experience, skills and qualifications to enable the council to carry out its functions effectively.

The only other requirements under the Act relating to the qualifications of members are that the Minister must consult with certain prescribed bodies in accordance with a process set out in the regulations (this is discussed further in the section of this Report dealing with the recruitment process) and, as far as practicable, the Minister must ensure that Members consist of an equal number of men and women.

Functions of the Council

In the context of a discussion of the specific skills required of Members to effectively undertake the work of the Council, the relevant functions under the Act are as follows:

- Provide advice to the Minister about the operation of the health system, health outcomes for South Australians and for particular population groups and the effectiveness of methods used to engage communities and individuals in improving their health outcomes;
- Provide advice to the Minister about any matter referred to it by the Minister or on any matter it sees fit in connection with its responsibilities;
- In providing such advice in respect to the provision of any health services, to take into account:
  - The net benefit provided by the services, the cost effectiveness of services and available resources;
  - The net impact that the adoption of the advice would have on other services or on the community more generally;
  - The value placed on the services by members of the public who use those services; and

[1] For the sake of simplicity the term “skills” will be used in this Report. Wherever this term is used it should be taken to embrace one or more of the above stated competencies.

Functions of the Council *continued*

- On a four yearly basis furnish the Minister with a report that assesses the health of South Australians and changes in health outcomes over the reporting period. The report must:
  - Identify significant trends in the health status of South Australians and consider future priorities for the Health System having regard to trends in health outcomes, including trends that relate to particular illnesses or population groups; and
  - Review the performance of the various health systems established within the State in achieving the objects of the Health Act.

Against this legislative background, in its statement of strategic directions[2] for 2011–14, the Council has given notice that it will review the following:

- Health status of South Australians including specific population groups;
- Health determinants of South Australians;
- Health system's performance in achieving the government's strategic health objectives;
- Competence, commitment and capacity of the health workforce to deliver the government's strategic health objectives; and
- Capability, collaboration and contribution of the health system's community engagement processes.

Sources of skills available to Council

Before addressing the skill issue in some detail, it is necessary to consider the broader context in which the council performs its functions.

Basically, the mix of skills required comes from three sources: the Council Members themselves, the Secretariat and the relationships established with external experts and organisations including the Department where appropriate. Of the three sources the scope and potential of the latter is the most difficult to define. What can be safely said, however, is that it would be impossible for the Council to perform the tasks that have been set for it without access to external sources of knowledge and expertise. In other words, the challenge for this Review is, rather than attempt to identify every conceivable skill that might be required, to define those that are critical for the Council to have in its Membership.

In relation to access to external experts, consideration might be given to inviting external experts (including consumer representatives for example) to Council (or working party) meetings to provide evidence. This would provide a cost and time effective opportunity for Council Members to hear directly from a broader range of views than is currently the case.

[2] Health Performance Council Strategic Plan 2011–2014.

Recommendation	Consideration be given to inviting external experts to attend Council meetings to provide evidence on selected topics

Sources of skills available to Council *continued*

The other contextual consideration is the role performed by the Council's Secretariat. In essence, in addition to the standard range of support services, the role of the Secretariat is to provide strategic advice and to access and analyse relevant epidemiological, health care and health system information and data and provide it to the Council in a form that enables it to perform its high level tasks with maximum efficiency[3]. Thus it would be a mistake, through inattention to this issue, to duplicate the skills already in the Secretariat in the new Council membership. The selection panel should familiarise itself (guided by the Chair of the Council) with the skill base of the Secretariat with the objective of achieving the optimal breadth across the two bodies.

Recommendation	In making its final recommendations to the Minister the selection panel give due consideration to the skills available in the Secretariat and those that it would be preferable to access externally.

Required skills/knowledge

In formulating the list of critical skills set out below, considerable weight was given to the views of the currently serving Members of Council. Most Members have now served for more than three years and individually and collectively have very real on ground experience of what is required. In all 12 of the current Members were interviewed for the purpose of informing this Review. Members were asked to identify the critical skills required by Council Members during the next four year term and to identify any skill gaps in the current membership. A full list of responses is at Attachments A and B. Responses to questions about the other terms of reference for this Review are referred to elsewhere in this Report.

[3] A full list of the current responsibilities of the Secretariat is at Attachment C.

Required skills/knowledge *continued*

In addition to the views of serving Members, the following were taken into account in formulating the skill base for the next term:

- The statutory functions of the Council set out in the Act;
- The Council's own strategic directions for the next four years; and
- The statutory skill requirements set out in the Act.

Against this background the following skill and knowledge attributes are recommended:

Skills

- High level skills in analysing and interpreting epidemiological, health care and health system data;
- High level analytical skills to deal with complex concepts and problems;
- High level skills in evaluation of complex systems, policies and programs including cost benefit analysis;
- Interpersonal skills including team work, collaboration and constructive participation in analytical debate.

Knowledge

- Australian health care system and National and State health reform agenda;
- Health care and health system management. Trends and issues impacting on health systems;
- Broad knowledge of international/national/State health system performance monitoring measures and contemporary approaches to assessing and evaluating system performance;
- Determinants of health and health of specific population groups;
- Community and stakeholder engagement principles and practice;
- Health workforce and research issues, trends and challenges; and
- National health system safety and quality standards.

It is not intended, of course, that each candidate must be able to demonstrate all of these attributes. That would indeed be a challenge. Rather, the task of the selection panel is to ensure that the full range is covered in the totality of the Council membership.

Recommendation	**The above skill and knowledge attributes form the basis for selecting candidates for appointment.**

Member Commitment

There is a further condition that must be satisfied in addition to the acquisition of the skills listed above. In response to interview questions, every current serving Member of the Council interviewed identified capacity (as distinct from skills) as a serious issue with the current performance of the Council. Because of the demands on their time some Members have not been able to contribute to the extent required.

This simply won't work for the future. Optimal operational performance will require the commitment and dedication of every Member of the Council. This is particularly so if the size of the Council is significantly reduced as recommended. In many respects, for those who have a passion about how health services are delivered in this State, it is a privilege to be chosen to serve on this Council. Membership of it should not be regarded as something to be fitted in when other professional commitments allow.

Recommendation	**In making its final recommendations to the Minister, the selection panel satisfy itself that each of the proposed appointees has the capacity and is willing to fully commit to the work of the Council.**

COMPOSITION OF THE COUNCIL

Views from the literature

There is a very extensive literature about the optimum size of a governing board. Although now almost 9 years old the most authoritative work on public sector corporate governance in Australia probably remains the Review of Corporate Governance by John Urig. According to Urig:

> "…it is not possible, nor is it appropriate, to recommend a one size fits all approach when looking at Boards in the public sector. It should also be noted that over time the optimal Board size for an entity may vary in line with a change in its functions or the needs of the board. Based on current thinking on best practice in the private sector a board of between 6 and 9 members represents a reasonable size. Boards with members within this range seem to be more easily able to create an environment for the active participation in meetings by all Directors. Boards with less (sic) than six members may have difficulty in meeting their statutory responsibilities due to workload pressures and the potential lack of breadth of views."[4]

Although opinions vary according to the nature of the organisation to be governed – public corporation or private company, not for profit organisation or philanthropic foundation for example – the views expressed by Urig are more or less representative of those to be found in the wider international literature on this topic and are useful as a starting point for a discussion of the optimum size of the Council. The point needs to be made of course that, self evidently, the Council is not a governing board in the sense that its primary purpose is the corporate governance of a (usually large) public organisation. Its purpose, rather, is to perform the functions set out for it in the legislation (none of which relate to governance). There is much less guidance to be found in the literature on the optimum size of a functional board of this kind. Nevertheless, there are factors common to both types of board which are useful to draw upon.

Alternative models

Basically there are three of ways of viewing the membership structure of a board:

- A functional approach where the emphasis is on the skills, knowledge and expertise required to achieve the purpose for which the board was established; or
- A representative approach where members of the board are chosen to represent major constituents or stakeholders; or
- A diversification approach where members of the board represent a variety of cultures, values, opinions and perspectives.

[4] Urig, John, *Review of the Corporate Governance of Statutory Authorities and Office Holders*, p96. Published by the Australian Government, 2003.

Alternative models *continued*

Of course these approaches are not mutually exclusive and it is often the case that appointing authorities strive to include all three in their membership structure. I do not think that is an appropriate approach for the Health Performance Council. There are several reasons for this view:

- First, the functions of the Council as set out in the Act are stunningly ambitious. They will not be achieved unless the members of Council are first and foremost highly skilled and organisationally competent;
- Secondly, if the Council is to have influence – in the sense that it brings about a change in health policy as distinct from simply reporting ex post on the operation of the system – it must be possessed of one characteristic above all others: credibility. A Council made up of representative Members or Members appointed from a diversity perspective is much less likely to achieve this objective than a Council made up of Members widely seen by stakeholders as experts in their field; and
- Thirdly, the Council is not there to represent constituents and stakeholders[5]. It is there to provide an expert and robust evaluation of the performance of the health system and to suggest changes. Trying to achieve representation – and with so many interests it would be impossible to cover the field in any event – will only serve to detract from this objective.

Thus in seeking to reach a view about what constitutes an optimum number of Members, there are only two factors which warrant serious consideration:

- The range of skills needed to do the job (refer to the discussion in the previous section); and
- What number will maximise the Council's functionality – that is to say maximise its operational performance
  – taking into account group dynamics and other factors discussed in this Report.

Channels for representative, consumer and community participation

In making this observation I do not mean to dismiss either the representative or diversity dimensions as irrelevant (indeed the latter is a requirement of the Act as discussed earlier). Community and stakeholder participation in decisions about the operation of the health system is of vital importance. It is just that membership of the Council is not the most effective way to achieve it or the appropriate place to give it expression. A superior way to achieve community/consumer input to the work of the Council is the readymade mechanism already provided for in the Act – through the Health Advisory Councils, the special purpose advisory committees appointed by the Minister or the committees or subcommittees established by the Council to assist in the performance of its functions.

Indeed, the Council is already moving in this direction in its planning for the 2014 review of the performance of the health system. The proposed review process involves the hosting of a number of forums for the specific purpose of listening to the views of the community, clinicians and system managers.

[5] This viewpoint was strongly supported by all serving Members of Council interviewed – except one who argued that both representation and expertise should be accommodated.

Moreover, the National Health Reform Agreement 2011 specifically provides for Governing Councils to be established for each Local Health Network within South Australia. These were all established in July 2011 under the Health Care Act 2008 utilising the Health Advisory Council provisions. These Governing Councils give effect to the representative and diversification principles described above further reducing the need for the Health Performance Council to undertake this role. The membership of these councils comprises hospital/health management, business and/or financial management skills, clinical experience, health consumer representation, knowledge or experience of the needs of people of Aboriginal or Torres Strait islander descent and cross membership with Medicare Locals. In addition, the Aboriginal Advisory Council provides independent advice to Government on Aboriginal matters.

If committees are established under the Act as recommended, it is important that they be established for a specific consultative purpose and then disbanded. Standing consultative bodies would require the support of an already stretched Secretariat and tend to lack focus – often going in search of a role.

Recommendation	**In recruiting members of Council the emphasis should be on expertise and knowledge rather than representation and diversity;** **Greater use should be made of existing provisions in the Act to appoint committees and sub committees to provide an effective channel for community/consumer input; and** **Where such bodies are established, they should be for a discrete, time limited purpose rather than standing.**

Optimal number of Members

The current Council consists of 15 members (including the Chair) and 5 Deputies. A Council of this size may have been appropriate during the establishment and consolidation phase of the Council's life cycle when a greater emphasis on representation and diversity could be justified. For the next phase, however, the emphasis must shift to optimising performance. As noted above, performance will be determined by two critical variables: the skill set of its Members and the operational dynamics of Council proceedings.

The range of skills required for the Council to effectively carry out its functions is discussed in the previous section of this report. Self evidently, the greater the number of Members the Council has, the greater will be the opportunity to expand its skill base – providing there is an effective process for selecting and appointing Members. There is a limit to how far this hypothesis can be taken, however. To take an absurd example, a Council with 50 Members could accommodate every conceivable skill that might be required in the course of the Council's work including those called upon only once during a four year term. But a Council of that size would be unmanageable and its output close to zero. The point is that somewhere along the continuum there must be a trade off between the breadth (depth is another matter) of the skill base and operational efficiency. Where that occurs is a matter for judgment but it is significantly fewer than 15[6].

[6] It should be noted also that although opinions varied as to optimal size, in interviews with current Members, a large majority supported a smaller Council – "way too big" was a common response – with only two supporting continuing with 15 members.

Optimal number of Members *continued*

In considering how to optimise operational performance, experience suggests that a large number of Members represents a challenge in terms of using them effectively and/or having any kind of individual participation and interactive discussion or engagement. Communication and the melding of minds is more difficult with a larger Council. A critical point too is that this is a working Council in the true sense of that word. Although supported by a small (and competent) Secretariat, the Council is where the grunt is. It is not there to pontificate on broad corporate strategy or to immerse itself in the minutiae of governance. It is there to crunch the numbers. Its Members must have a focus and a strong task orientation – a tight-knittedness that is difficult to achieve with a larger group.

In conclusion, because there are so many variables and as it is an imperfect science, it would be disingenuous to attempt to specify a precise size and convincingly demonstrate its advantage over a Council with say one fewer Member or one more. Therefore, a more defensible approach would be to specify a range. Based on the above analysis, I recommend that the Council consist of between 8 and 10 Members (including the Chair). One approach would be to start with eight and have the option of adding up to two more if experience demonstrated a need. It would be the responsibility of the Chair to keep this under review and to raise it with the Minister if this were the case. There could be a list of up to five people identified in the recruitment process discussed in the next section of this Report who could be approached thus avoiding the need for a new process every time a new appointment was made.

Recommendation	**The Council consist of eight Members but there be the capacity to appoint a further two Members should the need arise.**

Short term and discrete appointments

A smaller Council of the kind recommended has all the advantages of focus, nimbleness and agility. Flexibility might also be added if consideration is given to making short term and discrete appointments for a particular task. Continuity is required for the Council's core function – its four yearly report – but if there are any special assignments – either through referral by the Minister or on the Council's own volition – then there could be considerable benefit to be derived from the capacity to appoint a Member with particular skills for a defined task. Any such discrete appointments would be in addition to the maximum of 10 Members recommended above and would be made by the Minister in consultation with the Chair of the Council without the need to consult further with the prescribed bodies (that condition having been satisfied – to the extent it is required – by the earlier process).

Recommendation	**Consideration be given to providing the capacity to appoint additional Members with particular skills for a discrete period and for a defined task. Any such appointments to be in addition to the maximum of 10 Members recommended above.**

Deputies

The final issue to be dealt with under this section is the question of Deputies. Under the Act, the Governor may, from time to time, appoint a suitable person to be a Deputy of a Member. There are presently 5 Deputies.

Upon examination it is difficult to see a continuing need for this role. As discussed above, the core function of the Council – the four yearly report – requires continuity of participation; Deputies cannot jump in and out of the process (when members are absent) and expect to be effective. Moreover, as discussed earlier, a high level of operational performance by the Council will require a strong commitment from and regular attendance by Members. A system of Deputies weakens this obligation. Supporting Deputies also adds to the work of a busy Secretariat. During interviews, none of the current Members of Council supported a continuation of Deputy appointments. In making this recommendation, it should not be taken as an adverse comment of the performance of the Deputies. I am advised by the Chair of the Council that all of the Deputies made a significant contribution to the achievements of the Council over the past four years. This should be acknowledged in a letter from the Minister thanking them for their service.

Recommendation	**The current practice of appointing Deputies be discontinued.**

PROCESS FOR SELECTING SUITABLE APPOINTEES

Proposed approach

The first section of this Report considered the range of skills required to enable the Council to perform its functions.

This section proposes a process for ensuring that the most skilled people available are appointed to the Council for its second term. In designing the process two important objectives were borne in mind:

- First and foremost, and self evidently, the process must result in the appointment of the best qualified people to do the job; and
- Of equal weight, however, is the critical requirement that the process must be, in both perception and in reality, transparent and merit based. This is especially important because a significant number of the current Members (representing various stakeholders) may not be re-appointed – particularly if the recommendation to reduce the size of the Council to eight is accepted and the opportunity is taken to introduce new skills to the membership.

Under the Act, Members hold office for such period (not exceeding four years) as may be specified in the instrument of appointment and are eligible for reappointment at the expiration of a term of office. However, Members may not hold office for consecutive terms that exceed eight years in total. The terms of the current Members of Council expire on 25 June 2012 and the effect of the Act is that each is eligible for reappointment.

One option would be to simply reappoint the current Members (or such numbers of them as are required if the overall size of the Council is reduced) without contest. This approach is not recommended. As discussed elsewhere in this Report the Council is about to enter a new phase in its life cycle; a phase where its credibility will be determined by the expertise and performance of its Members. It is not an exaggeration to say that whatever long term impact the Council has on the health system in this State will be determined, by and large, by what it is able to achieve over the next four years. If it does not have an impact in this time frame it is never likely to. It is critical, therefore, that the Council begins its next term with the very best people it can lay its hands on.

Again, in making this observation, it is not the intention to suggest there are performance issues with the current membership. The Review was not asked to evaluate the past performance of the Council or any of its current Members and there has been no attempt to do so. However, the opportunity exists to test the market and, because of the critical importance of this next phase, it is essential that full advantage is taken of this opportunity. If it turns out that the current membership cannot be improved upon after rigorous market testing, then so be it.

Consultation with prescribed bodies

Under the Act and Regulations, before the Minister makes a recommendation to the Governor on people to be appointed to the Council, the Minister must consult with the following impressive array of prescribed bodies:

- Aboriginal Health Council
- Australian Medical Association
- Carers SA
- Consultative Council of Ex-Service Organisations
- Council of the Ageing
- Health Consumers Alliance
- Multicultural Communities Council
- Regional Communities Consultative Council
- Rural Doctors Association
- Divisions of General Practice
- Flinders University
- Returned Services League
- Country Women's Association
- University of Adelaide
- University of South Australia
- Volunteering Association of South Australia

The process that is required to be followed in consulting these bodies is as follows:

- An invitation is to be extended to each to recommend suitable candidates within a specific period;
- The invitation is to specify the number of people to be appointed and invite each body to recommend a specified number of suitable candidates consisting, as far as practicable, of equal numbers of men and women; and
- The invitation may specify areas of knowledge, expertise, experience, skills or qualifications required of appointees and, if it does so, a recommendation of a candidate is to be accompanied by relevant information about the candidate's credentials.

No doubt the statutory requirement to consult with the specified bodies was decided at the time when it was felt necessary to encourage broad sector ownership of the Council in order to gain support for what was then a new and somewhat bold initiative.

Consultation with prescribed bodies *continued*

As we have observed, the Council has now been in operation for approaching four years and any initial apprehension about its role is likely to have receded. This, together with the objective of moving beyond any perceptions that the Council is a representative, rather than an expert body, would suggest that the requirement to consult in the manner prescribed is an anachronism. One option would be to revoke the Regulation. This is not recommended for two reasons:

- Even with a serious attempt to explain the reasoning (which would be a labour intensive exercise), it would be difficult to do this without causing a negative reaction from at least some parts of the sector. Thus the net benefit of avoiding this aspect of the process is unlikely to be worth the cost; and
- Notwithstanding the desire to move beyond representation, the prescribed bodies are likely to be a useful source of information on quality candidates – providing the invitation to them is clear about the qualifications required and any nominations are subject to rigorous evaluation in the context of a competitive process.

The upshot of this is that the recruitment process will need to be built around the requirement to consult with the prescribed bodies.

Panel

To achieve the two objectives of first best outcome and transparency mentioned above, careful consideration will need to be given to the composition of the selection panel. Apart from the Chair of the Council, I do not propose to recommend actual names – the process will benefit from seeking a range of views on this point – but rather identify categories which will need to be represented on the panel.

First, the Chair of the panel should be independent of the Government and the Department and should be widely respected in the sector as a person of eminence and standing. A senior health professional would be ideal for the role. In addition to the Chair, it is proposed that there be three members of the panel chosen as follows:

- If the Council is to achieve a high level of performance, a critical factor will be a productive working relationship between the Chair of the Council and its Members. To achieve this objective and consistent with standard governance practice, it is important that the Chair have the opportunity to have some input to the appointment process and this is best achieved, in this case, through membership of the selection panel. The Minister has indicated that, in recognition of her outstanding work so far and to provide continuity in leadership of the Council, he intends to recommend that the current Chair be reappointed for a further four year term. In the interests of transparency, and to legitimise the Chair's inclusion on the panel, it is proposed that the reappointment be given effect immediately. The Cabinet submission should foreshadow that a further submission recommending the appointment of Members will be brought forward in due course;
- The second member of the panel should have a detailed knowledge of how the health system works – both at a national and State level and including both the private and public components of the system; and
- The third person should be an expert in analysis and evaluation. This is the sharp end of the Council's work and it is vital that the selection panel is able to say with confidence that this capacity exists within the group of eight it recommends.

Recommendation	The selection panel consist of an independent Chair, the Chair of the Council and two additional members with expertise in the health system and analysis and evaluation: and The intention to reappoint the current Chair of the Council be given effect immediately.

Steps and timing

Following as a guide are some of the more important steps that will be required to be taken in the course of the appointment process with an indicative timeline assigned to each. Note that the timelines are meant as a guide only and not all of the steps have been identified. As the schedule shows, if the appointed Members are to be in place ready to start work on 26 June 2012, the process must start now.

Steps		Indicative deadline for completion
1.	Canvas selected views on suitable appointees to the selection panel	17 February
2.	Selection of recruiting firm (involves specification brief, 3 quotes, and evaluation of bids)	24 February
3.	Decide on and appoint selection panel	24 February
4.	Minister to write to prescribed bodies inviting nomination of suitable candidates (allow 6 weeks for response to enable the bodies in turn to canvass their constituents)	27 February
5.	Panel agrees position description and content of ads (involves input from recruitment firm) and information kit for applicants on the role and functions of the Council.	9 March
6.	Panel identifies potential candidates to be directly approached (requires input from the recruitment firm and each of the panel members)	9 March
7.	Obtain necessary approvals and place ads inviting applications in Advertiser, the Australian, relevant websites and selected health journals, newsletters etc (requires liaison with prescribed bodies)	23 March
8.	Receive nominations from prescribed bodies	13 April
9.	Receive applications in response to advertisements	13 April
10.	Recruitment firm collates and evaluates nominations from prescribed bodies, applications received and any candidates identified for direct approach	20 April

Steps and timing *continued*

Steps		Indicative deadline for completion
11.	Panel meets for initial debate on short listing of candidates	27 April
12.	Recruitment firm undertakes any further work or inquiry as a result of the initial debate	2 May
13.	Panel settles shortlist	9 May
14.	Shortlisted candidates asked to attend interview	10 May
15.	Panel interviews short listed candidates (may require more than one session)	18 May
16.	Panel agrees a list of candidates to be taken to the next stage	18 May
17.	Recruitment firm undertakes referee checks and any other avenue of inquiry identified by the panel and prepares a written report for the panel	23 May
18.	Panel meets to debate final list of candidates to be recommended for appointment	30 May
19.	Chair of the panel and Chair of the Council meet with the Minister to brief him on recommended candidates	4 June
20.	Preparation of a Cabinet Submission recommending appointments	5 June
21.	Submission signed by Minister and lodged	7 June
22.	Submission considered by Cabinet	18 June
23.	Successful candidates notified	20 June
24.	Unsuccessful candidates notified	20 June
25.	Minister writes to current Members who sought reappointment and were unsuccessful and to the current Deputies thanking them for their service	20 June
26.	Appointments approved by Governor in Council	21 June
27.	Gazettal of appointments	21 June
28.	Orientation of new Members	25 June
29.	Process complete and new Council in place	26 June

Planning for the third term

An important factor to be borne in mind when making the final selection of candidates is the need to plan for the Council's third term. As discussed above, Council Members, including the Chair, may not hold office for more than eight years. Suppose that all of the eight Members appointed for this coming four year term were selected from the pool of existing Members. The effect of this, by and large (recognising that some serving Members were appointed during this term), would be the Council in its third term would be made up entirely of new Members – an unsatisfactory situation. Thus, in addition to bringing new skills onto the Council regard should be had to the objective of continuity beyond this next term – which means in effect that some Members will be appointed with the expectation that they will serve for eight years.

An option would be to appoint some of the Members for two years in the next round and then make some four year appointments two years from now. There are some issues with this that would need to be thought through. Nevertheless the option should be taken into account by the selection panel in making its final recommendations to the Minister.

Recommendation	**The need to plan for the Council's third term be taken into account by the selection panel in making its final recommendations to the Minister.**

SUMMARY OF RECOMMENDATIONS

Consideration be given to inviting external experts to attend Council meetings to provide evidence on selected topics. (Page 5)

In making its final recommendations to the Minister the selection panel give due consideration to the skills available in the Secretariat and those that it would be preferable to access externally. (Page 5)

The skill and knowledge attributes listed on page 6 of this Report form the basis for selecting candidates for appointment. (Page 6)

In making its final recommendations to the Minister, the selection panel satisfy itself that each of the proposed appointees has the capacity and is willing to fully commit to the work of the Council. (Page 7)

In recruiting Members of Council the emphasis should be on expertise and knowledge rather than representation and diversity;

Greater use should be made of existing provisions in the Act to appoint committees and sub committees to provide an effective channel for community/consumer input; and

Where such bodies are established, they should be for a discrete, time limited purpose rather than standing. (Page 10)

The Council consist of eight Members but there be the capacity to appoint a further two Members should the need arise. (Page 11)

Consideration be given to providing the capacity to appoint additional Members with particular skills for a discrete period and for a defined task. Any such appointments to be in addition to the maximum of 10 Members recommended above. (Page 12)

The current practice of appointing Deputies be discontinued. (Page 12)

The selection panel consist of an independent Chair, the Chair of the Council and two additional members with expertise in the health system and analysis and evaluation; and

The intention to reappoint the current Chair of the Council be given effect immediately. (Page 16)

The need to plan for the Council's third term be taken into account by the selection panel in making its final recommendations to the Minister. (Page 18)

ATTACHMENT A – CRITICAL SKILLS REQUIRED BY THE COUNCIL FOR ITS NEXT FOUR YEAR TERM – VIEWS OF SERVING MEMBERS

The following were identified by Members in response to the question: what do you think are the critical skills required by Council Members during the next four year term? The list is not compiled in any particular order of priority. The highlighted entries represent skills which were nominated by more than three Members.

- data skills and analytical skills generally
- understanding how the health system works
- ability to work as a team
- ability to consider a wider perspective
- corporate skills – how to work on a Board
- policy experience
- experience in the health sector
- regulatory experience
- quantitative as well as qualitative skills
- auditing
- finance
- strategic thinkers
- strong academic cohort
- strong clinical/medical cohort
- consumer/community participation
- communication and education
- indigenous health
- mental health
- scientific research skills
- quality assurance
- understanding education system for clinicians
- experience at life

ATTACHMENT B – GAPS IN THE CURRENT SKILL BASE – VIEWS OF SERVING MEMBERS

In general, Members of Council felt that there are few significant gaps in the current skills base. The following list includes both those skills which, in the view of the Members, are present to some degree but not in sufficient depth and those skills where there is no capacity at all.

- data analysis
- knowledge of the health system generally
- knowledge of the private system in particular
- financial expertise
- academic rigour
- youth perspective
- multi-cultural viewpoint
- allied health
- business skills and auditing
- indigenous health
- epidemiological input
- mental health

ATTACHMENT C – HEALTH PERFORMANCE COUNCIL SECRETARIAT RESPONSIBILITIES

Initial functions

- Map existing health status/outcomes and health system performance measures
- Establish effective qualitative and quantitative data collection and analysis processes with all sectors of the health system
- Establish effective networks and community/stakeholder engagement processes

Ongoing functions

- Provide high level strategic and expert advisory and business support services to the Council in achieving their objectives under the Health Care Act 2008.
- Provide specialised advice in the identification of significant trends in the health status of South Australians and the development of future priorities for the health system.
- Provide high quality strategic advice to the Council in relation to the operation of the health system and population health outcomes for South Australia.
- Identify performance indicators and national and international benchmarks that are useful for comparing performance and identifying areas and issues requiring improvement.
- Model and predict the diversity of factors and complex interrelationships between determinants and components of health services and trends, as well as their impact on health and wellbeing.
- Undertake advanced statistical analyses of individual and population based health and health system data and support high level interpretation of those analyses by the Council, in order to (a) evaluate the performance of the health system in SA; (b) identify important trends, opportunities for service improvement and impact of reforms; and (c) benchmark the performance of the system.
- Produce high quality public reports on the performance of the health system in SA in priority areas identified by the Council.
- Provide specialised advice to the Council about best practice stakeholder engagement practice, and lead the development, implementation and evaluation of engagement strategies.
- Produce the four yearly report that includes comprehensive population health information and an extensive array of other health and demographic data that portrays the current state of the health of South Australians, including the illustration of how risk factors associated with lifestyle choices, socioeconomic circumstances and environmental conditions can lead to ill health.