SA HEALTH 2017 HEALTH PERFORMANCE COUNCIL SA

ANNUAL REPORT

WHAT'S WORKING, WHAT'S NOT REVIEW OF THE SOUTH AUSTRALIAN HEALTH SYSTEM PERFORMANCE FOR 2011-2014

BUILDING HEALTHY COMMUNITIES

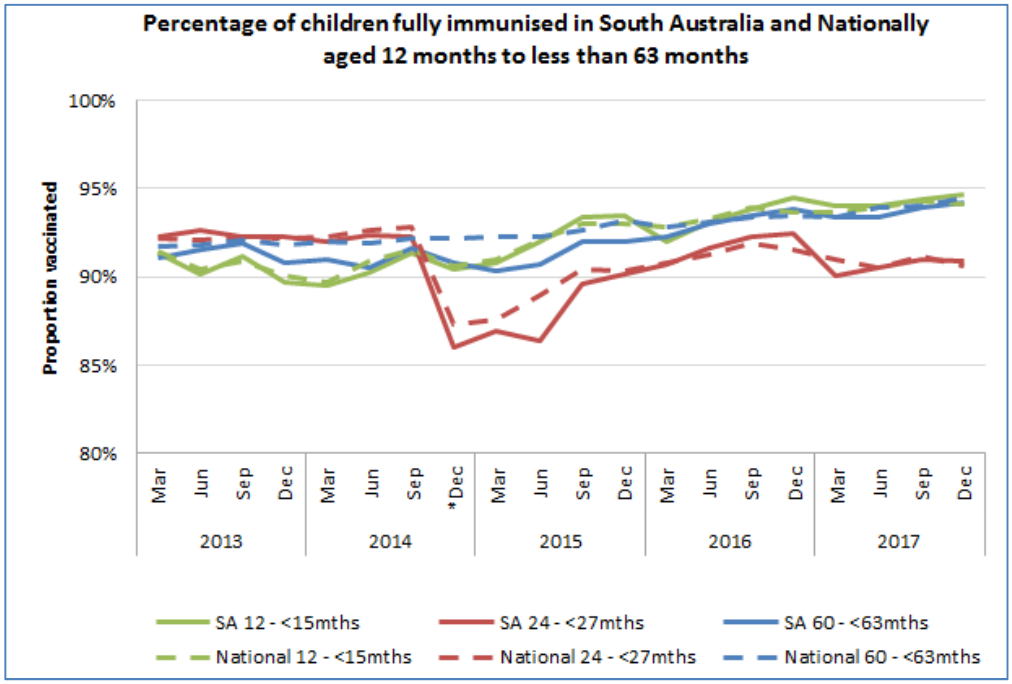
RECOMMENDATION 1
Require SA Health to set a performance outcome that all Local Health Networks increase childhood immunisation rates to 92 per cent or greater by 2018, with a priority focus on Aboriginal rates.

SA Health Performance Indicator
All Local Health Networks increase childhood immunisation rates to 92 per cent or greater by 2018, with a priority focus on Aboriginal rates.

2015 Result for SA	2016 Result for SA	2017 Result for SA	Progress against other Jurisdictions	Strategies
SA annual coverage data for 2015* **12-15 mths 92.4%** **24-27 mths 88.3%** **60-63 mths 91.2%** **SA annual coverage data for Aboriginal children in 2015*** **12-15 mths 89.2%** **24-27 mths 84.5%** **60-63 mths 92.0%** *The data provided are annualised for age groups 12 to less than 15 months, 24 to less than 27 months, and 60 to less than 63 months using the ACIR March, June, September and December 2015 assessment quarters. Where there are less than 10 children in a Local Government Area (LGA) the data are not given. As a result not all LGAs are listed.	**SA annual coverage for 2016*** **12-15 mths 93.4%** **24-27 mths 91.4%** **60-63 mths 93.1%** **SA annual coverage data for Aboriginal children in 2016*** **12-15 mths 89.2%** **24-27 mths 84.5%** **60-63 mths 92.0%**	SA annual coverage data for 2017*. 12-15 mths 94.3% 24-27 mths 90.6% 60 -63 mths 93.8% SA annual Aboriginal children coverage data for 2017*. 12-15 mths 90.3% 24-27 mths 88.3% 60 -63 mths 94.2%	As at December 2017 the national coverage rates for children: 12-15 mths 94.1 % 24-27 mths 90.6% 60 -63 mths 94.5% **See Table 1** As at **December 2017** the **national coverage rate** for Aboriginal children: 12-15 mths **92.3%** 24-27 mths **89.4%** 60-63 mths **96.6%**	**Note:** Approximately 70% of immunisation service delivery occurs through General Practice, 18% via local councils and the residual by government agencies such as Aboriginal Health Services, child and maternal health services and dedicated migrant and refugee services. **LHN impact on SA coverage rates is minimal.** Through the Closing the Gap strategy funding was received to implement projects focussed on improving coverage rates in Aboriginal children. These projects were extremely successful with significant increases in coverage rates across all cohorts (see figure 2). The campaign Help Me Stay Strong continues to target new parents of Aboriginal children. SA Health continues to target the general public through health promotions, and health professionals through education programs. As the 18 month cohort has the lowest coverage in both Aboriginal and non-Aboriginal populations, SA Health is focusing on this age group with data cleaning and stakeholder engagement to continue improving this cohort's coverage. The introduction of the *No Jab No Pay* policy on 1 January 2016 has appeared to have lifted all immunisation coverage Nationally in all cohorts.

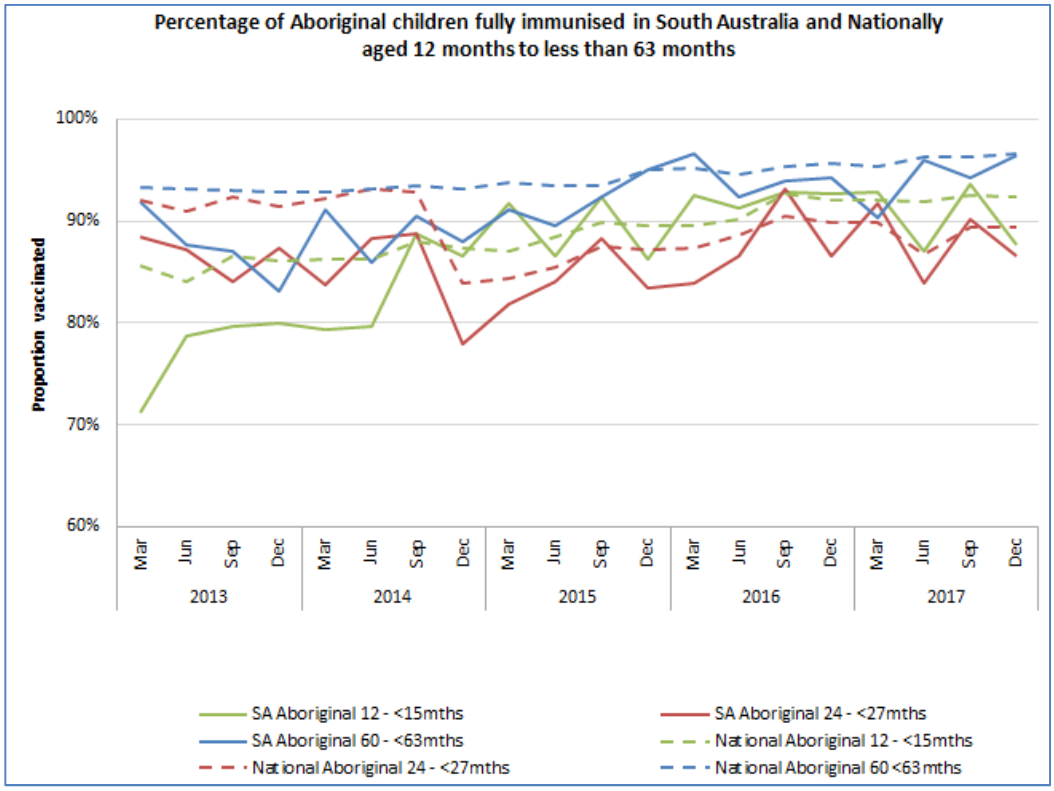
*The data provided are annualised for age groups 12 to less than 15 months, 24 to less than 27 months, and 60 to less than 63 months using the Australian Immunisation Register (AIR) March, June, September and December assessment quarters.

Figure 1:



* From quarter ending 31 December 2014, meningococcal C (given at 12 months), and dose 2 measles, mumps, rubella (MMR) and dose 1 varicella (given as MMRV at 18 months) was included in the definition of fully immunised for the 24-27 month cohort.

Figure 2:



Note:

* From quarter ending 31 December 2014, meningococcal C (given at 12 months), and dose 2 measles, mumps, rubella (MMR) and dose 1 varicella (given as MMRV at 18 months) was included in the definition of fully immunised for the 24-27 month cohort. Source: Australian Immunisation Register.

Further information is published at:
http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+topics/immunisation+for+health+professionals/immunisation+provider+information/south+australian+immunisation+coverage+rates

RECOMMENDATION 2

Take action with the Minister for Ageing to develop a joint plan with the aged care and primary care sector that will increase protection of the older population from vaccine preventable conditions.

SA Health Performance Indicator
Reduce rates of hospitalisation for vaccine preventable conditions such as influenza and pneumonia by 2018.

2015 Result for SA	2016 Result for SA	2017 Result for SA	Progress against other Jurisdictions	Strategies
In the absence of an adult vaccination register the coverage of influenza vaccination is loosely based on distribution doses. The last National Adult Vaccination Survey was conducted in 2009 and estimated that, for the population aged ≥65 years, 74.6% were vaccinated against seasonal influenza and 54.4% against pneumococcal disease.	Influenza vaccine coverage of residents in aged care facilities is not collected at a state level. The number of influenza vaccines distributed in SA for the National Immunisation Program in 2016 was approximately 385,000 as at August 2016. The total number of influenza vaccine doses distributed during 2015 was 396,363 which is slightly more than in 2016. In 2015-16, the age-standardised hospital separation rate for vaccine preventable conditions was 2.3 per 1,000 people.	The total number of influenza vaccine doses distributed during 2017 was 418,743. In 2016-17, the age-standardised hospital separation rate for vaccine preventable conditions was 2.2 per 1,000 people. This was a slight improvement from the rate of 2.3 percent reported in 2015-16.	Previous CATI surveys used to measure the uptake of influenza vaccination in the elderly routinely showed SA to have the highest uptake nationally with the last survey demonstrating SA with uptake in excess of 83% compared to the national average of 74.6%.Adults with chronic conditions such as diabetes, chronic lung disease and renal failure, and those taking immuno-suppressive medications are also under-immunised.	The Commonwealth has responsibility for the aged care and primary care sectors. Implementation of and promotion of vaccines for adults including Influenza, Pneumococcal and Zoster vaccines. Expansion of Australian Childhood Immunisation Register (ACIR) to become a whole of life register in September 2016 (Australian Immunisation Register (AIR) will include adult vaccination records and capture more accurate data. Implementation of a Zoster vaccination program commencing November 2016 will provide free vaccine to those aged 70 years up to 79 years and provide a degree of protection from shingles. The department will promote the use of the vaccines through GPs and aged care facilities. Education programs and the promotion of an annual influenza vaccination program for residents and health care workers in aged care facilities are ongoing. In 2016, a new influenza vaccination educational program for health care workers will be released, and an initiative to allow pharmacists to directly administer the influenza vaccine. It is also noted that engagement with the primary care sector requires some input from the Commonwealth.

GETTING INTO THE SYSTEM

RECOMMENDATION 5
Require SA Health to manage a reduction to 15 per cent or less by 2018 of people living in country South Australia reporting delaying or not seeing a dental professional.

SA Health Performance Indicator
SA Health to reduce the number of people living in country South Australia reporting delaying or not seeing a dental professional due to cost by up to 15% by 2018.

2015 Result for SA	2016 Result for SA	2017 Result for SA	Progress against other Jurisdictions	Strategies
Whilst the number of people waiting for care increased in the 12 months to 30 June 2015, the gap between the country and metropolitan waiting times reduced from 5.7 months to 3.30 months by 30 June 2015.	In the 12 months to 30 June 2016 the country waiting list improved from 13,046 people waiting 15.5 months as at 30 June 2015) to 11,082 people waiting 13.7 months by 30 June 2016. Importantly in the same timeframe the gap between metropolitan and country areas further reduced from 3.3 months to just 0.6 months. Due to a change in data source, waiting time data are not comparable with survey data published previously. Public dentistry waiting times is defined as the median time waited between being placed on a public dentistry waiting list and receiving an offer of a course of public dental care from a waitlist. In 2015-16, the median waiting time for an offer of public general dental care for people living in country SA was an average of 358 days, an increase from 338 days in 2014-15. The median waiting time for people living in the Metro area was also 358 days, an increase from 268 days in 2014-15. In 2015-16, the median waiting time for an offer of public denture care for people living in country SA was an average of 502 days, an increase from 411 days in 2014-15. The median waiting time for people	In the 12 months to 30 June 2017 country public dental waiting lists deteriorated slightly from 11,082 people waiting 13.7 months (as at 30 June 2016) to 14,101 people waiting 15.3 months by 30 June 2017. The gap between metropolitan and country waiting times remained relatively stable, improving slightly from 0.6 months longer in country areas to 0.2 months longer in the same timeframe. In 2016-17, the median waiting time for an offer of public general dental care for people living in country SA was an average of 492 days (outer regional) and 405 days (remote), an increase from 399 days (outer regional) and 340 days (remote in 2015-16. The median waiting time for people living in the Metro area was 406 days, an increase from 358 days in 2015-16. People in remote areas waited a similar time to metro area. In 2016-17, the median waiting time for an offer of public denture care for people living in country SA was an average of 588 days (outer regional) and		The National Oral Health Plan (2015-2024 Healthy Mouths – Healthy Lives) includes people living in regional and remote areas as a priority group and calls for specific actions for this population group including access to care. SA Dental Service and SA Health continue to focus on improving access to affordable timely oral health for people in rural and remote locations. The use of overseas qualified dental practitioners via the National Public Sector Dental Workforce Scheme (PSDWS) has been a major source of the dentist workforce in SA public dental clinics in country locations over the past several years. Recent changes to the scheme indicate access to the use of the PSDWS dentists is likely to decrease in future and lead to a reduction in the availability of dentists in country areas and increasing waiting lists. SA Dental Service will continue to explore strategies to assist meeting the workforce requirements for public dental clinics in country areas. In South Australia the majority (around 85%) of dental services are provided in the private dental sector. The level of any out of pocket costs charged by the private sector are largely outside the scope of the Minister for Health, SA Health and/or Local Health Networks to manage. Modest patient co-payment fees are applied within the SA public dental system. However, strategies implemented in the public dental system to reduce cost barriers include: • Financial hardship arrangement for patients who are assessed by an accredited Financial Counsellor as being unable to pay the usual fees have care provided free of charge; • Patients requiring urgent care are not refused care if they are unable to pay the emergency patient fee on the day; • Targeted programs for specific client cohorts are fee free, for example clients who are Aboriginal, homeless or live in Supported Residential Facilities; • Continuing to work with private dental providers to maintain the viability of private dental practice in some small country areas.

	living in the Metro area was 408 days, an increase from the 301 days in 2014-15. (RoGS 2017)	610 days (remote), an increase from 498 days and 516 days in 2015-16. The median waiting time for people living in the Metro area was 566 days, an increase from the 408 days in 2015-16. People in outer regional and remote areas waited about three to six weeks longer for dentures than people in the metro area. (RoGS 2018)		In recent years, this has included initiatives in Peterborough, Kingscote and Kingston SE. .

Improving access to affordable basic public dental care for people living in country areas continues to be a major focus for SA Dental Service.

State public dental waiting lists have fluctuated over the past four-six years in line with the availability of additional Commonwealth National Partnership Agreement funding.

RECOMMENDATION 9
Require SA Health to set a performance outcome that all Local Health Networks increase the rate that Aboriginal people attending hospital emergency departments are seen on time (treated within national benchmarks) to 75 per cent or above by 2018.

SA Health Performance Indicator
SA Health to undertake analysis of Aboriginal people rate seen on time in emergency department – targeted at metro EDs to establish baseline.

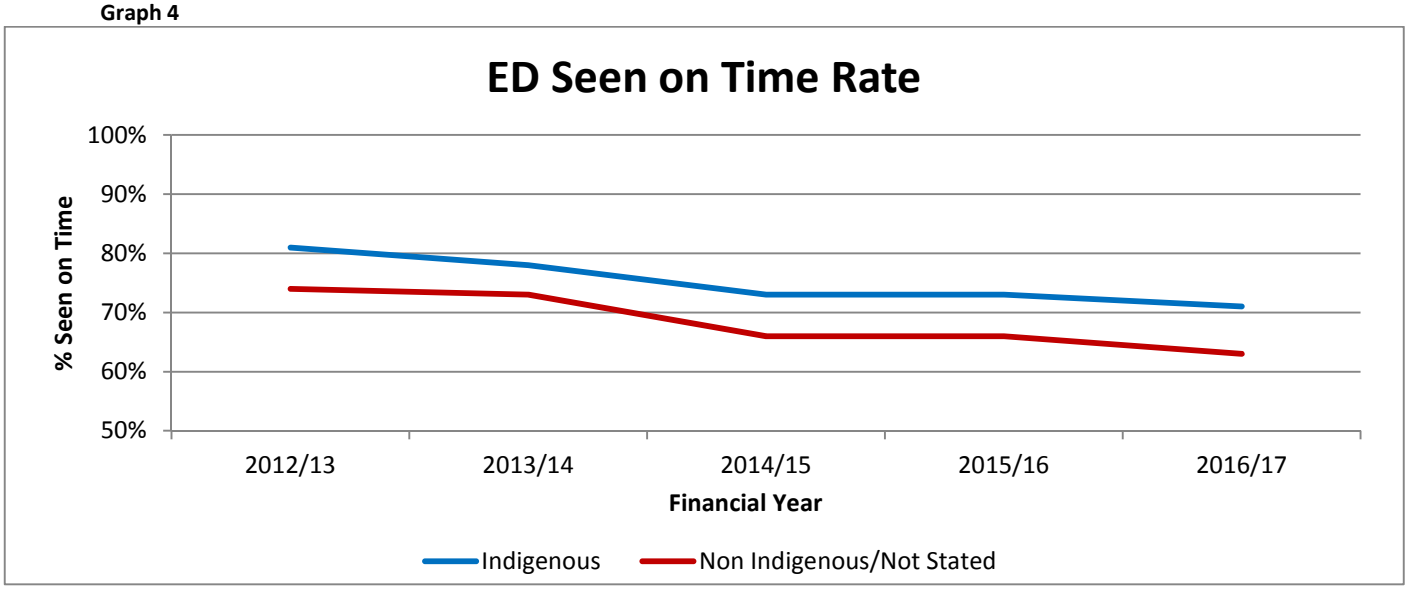
2015 Result for SA	2016 Result for SA	2017 Result for SA	Progress against other Jurisdictions	Strategies
Prioritisation of patients seen is based on clinical needs, regardless of cultural background or gender. In 2014-15, 73 percent of Aboriginal patients presenting at a South Australian ED were seen on time.	In 2015-16, 73 percent of Aboriginal patients presenting at a South Australian ED were seen on time, compared to 66 percent of Other Australians These figures have remained stable compared to 2014-15.	In 2016-17, 71 percent of Aboriginal patients presenting at a South Australian ED were seen on time, a decline when compared to 73 percent in 2015-16 In comparison, 63 percent of Other Australians presenting at a South Australian ED were seen on time. This is a decline of 3 percent when compared to 2015-16 figures.	In 2016-17 SA performance was 71 percent compared to the national rate of 74 percent for indigenous presentations to an ED. For other Australians 63 percent in SA were seen on time as compared with the national average of 73 percent. The percentage of patients with ED visits completed within 4 hours declined for South Australia between	Through the state investment in Closing the Gap, an Aboriginal Cultural Learning Framework was developed to provide Aboriginal Cultural awareness training for all staff within SA Health in preparation for the new Aboriginal specific Quality and Safety health standards in 2017. AHMAC Hospital Principal Committee has commenced the "Take Own Leave" project to address rates of Aboriginal people discharging from Emergency Departments (ED's) against medical advice and increase the rates of Aboriginal people being seen on time. Key component of Transforming Health (TH) is to ensure the design and structure of metropolitan hospitals, including Emergency Departments improve care and waiting times

			2012-13 and 2016-17 by 2.2 percentage points (from 65.9 percent to 63.7 percent). Nationally there was an 5.1 percentage point improvement (from 67.3 percent to 72.4 percent) for the same period. South Australia declined by 2.3 percentage points (from 66.0 percent to 63.7 percent) between 2015-16 and 2016-17 whilst nationally performance declined by 0.9 percentage points (73.3 percent to 72.4 percent). For South Australia the median ED visit time increased by 16 minutes between 2012-13 and 2016-17 (from 2 hours and 52 minutes to 3 hours and 8 minutes) and this was an increase by 8 minutes compared to the 2015-16 results. Nationally the reverse occurred with an improvement in median ED visit time of 11 minutes to 2 hours and 48 minutes in 2016-17) compared with 2012-13 but increased by 4 minutes compared to 2015-16.	and Aboriginal Hospital Liaison Officers continue to support Aboriginal patients. In addition a new Aboriginal Expert Advisory Group (AEAG) is being established under the governance of the TH Ministerial Clinical Advisory Group to identify: • How to ensure the needs of Aboriginal and Torres Strait Islanders peoples (including those who are SA Health staff) are addressed under TH • Opportunities to strengthen TH programs to focus on Aboriginal health and achieving improved health outcomes as well as assessing potential impact on staff • Approaches to existing evaluations of TH programs to ensure their effect on Aboriginal people and Aboriginal SA Health staff is measured • Work with MCAG and the TH decision-making bodies to disseminate and help translate information about TH programs improve the way they connect with South Australian Aboriginal communities.

Table 3
ED Seen On Time Rate (Excludes Did Not Wait)

Indigenous Status	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Indigenous	81%	81%	78%	73%	73%	71%
Non Indigenous/Not Stated	76%	74%	73%	66%	66%	63%
Sum:	**76%**	**75%**	**73%**	**66%**	**66%**	**64%**

Graph 4



BEING TREATED WELL

RECOMMENDATION 12
Require SA Health to direct local health networks to investigate, in collaboration with Aboriginal leaders, the causes of each hospital's discharge against medical advice rates and develop appropriate implementation and monitoring strategies to achieve the SA Health target by July 2016.

SA Health Performance Indicator
N/A

2015 Result for SA	2016 Result for SA	2017 Result for SA	Progress against other Jurisdictions	Strategies
ED and inpatient measure included in tables 3,4,5 and 6. SA generated figures include dialysis and mental health and are therefore slightly higher than national rates.		In South Australia, the percentage of indigenous patients who discharged against medical advice was 5.2% in 2016-17. This is an improvement from the 2015-16 rate of 5.4% and 5.7% for 2014-15. NOTE: this is Public	http://www.aihw.gov.au/indigenous-data/health-performance-framework Refer to table 5 - after excluding dialysis, mental and behavioural disorders for 2013-14 and 2014-15 in SA 5.7 percent of indigenous person treated as inpatient	Refer to Recommendation 9. LHNs continue to monitor discharge rates. The Aboriginal Health Care plan implementation committees also monitor discharge rates and support the development and of strategies that support decreasing discharge rates for example: • Cancer Care Coordinators and Aboriginal Liaison Officers provide support, cultural brokerage with linkages to interpreter services, social work services including referrals to Step Down Units and other services provided external to the Hospital.

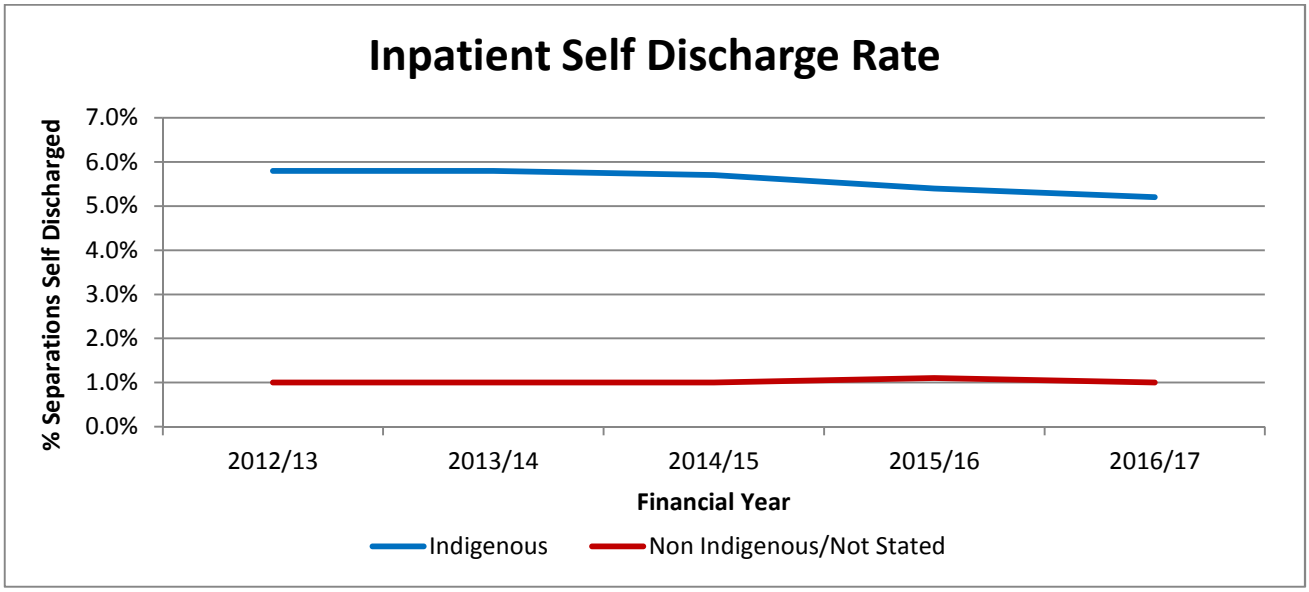
		and private hospitals.	left against medical advice. Compared with the national average of 4.3 percent. Age-adjusted these rates were 4.2 and 3.4 respectively.	• Self-discharge mechanisms implemented under the new Aboriginal Consumer Engagement Strategy support making hospitals culturally safe and inclusive • Each of the LHN Health Advisory Councils have an Aboriginal community representative to ensure the health needs of Aboriginal people are considered including clear discharge strategies and patient feedback

Table 5

Inpatient Self Discharge Rate (Overnight Stay Only)

Indigenous Status	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Indigenous	5.6%	5.8%	5.8%	5.7%	5.4%	5.2%
Non Indigenous/Not Stated	0.8%	0.8%	0.8%	0.8%	0.9%	0.9%
Total:	**1.0%**	**1.0%**	**1.0%**	**1.0%**	**1.1%**	**1.0%**

Graph 5



GETTING GOOD OUTCOMES

RECOMMENDATION 16

The Department to assess rates of patient incidents, and develop strategies to reduce the rate to less than 10 per 100 overnight separations by 2018.

SA HEALTH PERFORMANCE INDICATOR
10% reduction on actual harm (number not proportion, actual SAC 1 and 2 incidents) from 2015-16 to 2017-18.

2015 Result for SA	2016 Result for SA	2017 Result for SA	Progress against other Jurisdictions	Strategies
The total number of SAC 1&2 incidents was 536.	The total number of SAC 1&2 incidents was 567. There has been a 3% increase in the number of incidents reported for 2016. The percentage of actual harm has reduced from 2.9% in 2011 to 1% in 2016. Refer table 7	The total number of SAC 1&2 incidents was 506. There has been a 9.5% increase in the number of incidents reported for 2017. There has been a 11% reduction in harm reported for 2017. The percentage of actual harm has reduced from 2.9% in 2011 to 0.84% in 2017. Refer table 7		Per last year's response SA Health continues to implement and modify: • a focused patient safety program targeting areas of patient harm which may result in an adverse consumer outcome aligned to the National Safety and Quality Priorities and National Safety and Quality Health Service Standards • a suite of safety and quality metrics in LARS (LHN Analytics and Reporting Service) to support continuous monitoring and improvement which include volume of incidents and near misses reported and the actual level of harm.

Table 7
SAC 1&2Incidents

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
Total Incidents	27860	32698	37691	44113	53830	55330	60559
SAC 1&2	818	904	606	588	551	568	506
Harm (SAC 1&2) as % of total	2.9%	2.8%	1.6%	1.3%	1.0%	1.0%	0.84%

RECOMMENDATION 17
SA Health through its Infection Control Service (ICS) continues implementation of quality programs aimed at improving infection control in hospitals, and monitoring the effectiveness of new interventions.

SA Health Performance Indicator
Monitoring of key infection control indicators:

- Rate of healthcare associated *Staphylococcus aureus* bacteraemia (SAB) per 10,000 patient days (National target: 2.0) – includes all SA public hospitals
- Hospital vancomycin resistant enterococci (VRE) infections per 10,000 bed days (no national target) – includes all public metropolitan hospitals and 6 larger country hospitals
- Healthcare associated methicillin resistant *Staphylococcus aureus* (MRSA) infections per 10,000 bed days (no national target) – includes all public metropolitan hospitals and 6 larger country hospitals

2015 Result for SA	2016 Result for SA	2017 Result for SA	Progress against other Jurisdictions	Strategies
2014/15 Rate of SAB for public hospitals: 0.56 per 10,000 bed-days 2014/15 Hospital VRE infections 0.50 per 10,000 bed days 2014/15 MRSA infections 1.33 per 10,000 bed days	2015/16 Rate of SAB for public hospitals: 0.67 per 10,000 bed-days 2015/16 Hospital VRE infections 0.68 per 10,000 bed days 2015/16 MRSA infections 1.24 per 10,000 bed days	2016/17 Rate of SAB for public hospitals: 0.77 per 10,000 bed-days 2016/17 Hospital VRE infections 0.92 per 10,000 bed days 2016/17 MRSA infections 1.08 per 10,000 bed days	The national SAB rate for 2016/17 was 0.76 per 10,000 patient bed-days. SA compares favourably to other states (range 0.72 – 1.04). Hospital VRE infections: there is no comparator rate available. MRSA infections: there is no comparator rate available.	ICS monitors and reports on the incidence of key healthcare associated infections for public acute hospitals. Surveillance data are reported to the Department and Hospital Executives on a monthly basis. • ICS develops and maintains policies, guidelines and resources on the prevention of infection. Documents are reviewed as required, including at the request of LHN CEOs.

RECOMMENDATION 18

SA Health to develop strategies that will close the gap in the rates of potentially avoidable deaths between Aboriginal and non-Aboriginal people in South Australia by 2018.

SA Health Performance Indicator

Close the gap in the rates of potentially avoidable deaths between Aboriginal and non-Aboriginal people in South Australia by 2018

2015 Result for SA	2016 Result for SA	2017 Result for SA	Progress against other Jurisdictions	Strategies
There has been a reduction in potentially avoidable deaths from 1.6 per 1,000 persons in 2008 to 1.5 in 2011 However, the 5-year average for Aboriginal people from 2007-2011 was almost four times as high at 5.4 per 1,000 population.	There has been a 16% decline in mortality rates between 1998 and 2013, and a 39% decline in deaths due to circulatory disease. A narrowing of the gap in low birth weight babies from 10.4% in 2001 to 8.5% in 2011. (per Aboriginal and Torres Strait Islander Health Performance Framework Report 2014)	In 2011–2015 in South Australia, there were 403 deaths of Indigenous Australians aged 0-74 from avoidable causes. The age-standardised avoidable death rate for Indigenous Australians was 3.3 times the rate for non-Indigenous Australians (346 compared with 106 per 100,000).	Data not available	Since 2009 the State investment into Closing the Gap programs has seen some 29 programs and initiatives implemented to contribute to Close the Gap in life expectancy in a generation by 2031 & halve the gap in mortality rates for children under 5 by 2018.

WORKING EFFICIENTLY AND REMAINING STABLE

RECOMMENDATION 23

Develop strategies and implement efficiencies that will reduce growth in cost per case mix to a nominated target (eg. Consumer Price Index) to bring down the South Australian average to the national average over a five year period.

SA Health Performance Indicator
Reduce growth in cost per case mix to bring down the South Australian average to the national average over a five year period.

2015 Result for SA	2016 Result for SA	2017 Result for SA	Progress against other Jurisdictions	Strategies
			The recurrent cost per casemix-adjusted separation in 2013-14 was $5,402, higher than the national average of $4,836 and higher than the 2012-13 average cost of $5,113. (RoGS 2017) Costing Report for 2015-16 is not available. Note: It is anticipated that costing's and trend data against national costing's will be available in 2017.	Per last year's response, spending on health care will always increase, however, SA Health continues to identify, implement and monitor strategies so we spend our money wisely including efficient ward configurations, product standardization, the negotiation of improved procurement terms, optimized pathology and pharmacy costs, and voluntary redundancies. Many of these programs will continue to deliver benefits across the forward estimates. Recommendations 21, 22 and 23 fall under the state governments commitment to TH and the six principles underpinning TH which include: a health system that is: Patient centred 1. Safe 2. Effective 3. Accessible 4. Efficient, and 5. Equitable. TH health aims to provide the right care, minimises waste and optimises value and productivity. The Transforming Health Ministerial Clinical Advisory Group (MCAG) continues to provide clinical leadership and guides the way Transforming Health is implemented. The MCAG provides input into and leadership of: • Service delivery changes required for the new metropolitan wide configuration of services • New models of care and new hospital models • Capital re-design to deliver quality

				• Quality principles, standards of care and productivity improvements identified in TH.

ENGAGING WITH THE COMMUNITY

RECOMMENDATION 24
Build on its Framework for Active Participation by establishing a single point of contact to support units across SA Health to conduct quality engagement by:

- providing engagement tools and advice
- contributing to continuous improvement in engagement practices and delivery of health care by monitoring and making public engagement processes and their outcomes
- implementing a strategic approach to relationships with community organisations, businesses, universities, consumers and the community
- linking in with whole of government efforts to improve engagement practice through the Better Together Principles.

SA Health Performance Indicator
N/A

2015 Result for SA	2016 Result for SA	2017 Result for SA	Progress against other Jurisdictions	Strategies
The SA Health Consumer and Community Advisory Committee Policy Guideline and Toolkit were released in October 2015, as a practical tool to assist health care services to implement the Framework. The SA Health Sitting Fees and Reimbursement for External Individuals Policy Directive was released in October 2015. The SA Health Partnering with Consumers and Community Advisory Group was set up in March 2013. The group is established under the governance structure of the SA Health Safety and Quality Strategic Governance	See Strategies	**Partnering with Consumers and the Community** The SA Health Partnering with Consumers and Community Advisory Group continued to meet in 2017, to progress the Strategic Action Plan. In 2017, the SA Health Consumer and Community Engagement Governance Model – Consumer and Community Advisory Groups was established. The governance model outlines the Consumer and Community Advisory Groups involved in service planning, designing care, measuring and evaluating health care services at a local level. In 2017, SA Health continues to	N/A	Safety and Quality Branch coordinates the state's 'Partnering with Consumers and the Community' program and provides advice and assists health services in planning for assessment against the National Safety and Quality Health Standard 2 – Partnering with Consumers. The SA Health Partnering with Consumers and the Community Strategic Action Plan is the strategic framework which underpins the National Safety and Quality Health Service Standards 1 and 2. Standard 1 includes consumer feedback and complaints management, open disclosure, patient rights and engagement, informed consent, and measuring consumer experience. National Standard 2 includes consumer partnerships in service planning, designing care and service measurement and evaluation. The SA Health Framework for Active Partnership with Consumers and the Community and Guide for Engaging with Consumers and the Community were released in 2013 are due to review in December 2018. The Better Together Principles and best practice are embedded within the Framework.

Committee. The SA Health Culturally and Linguistically Diverse (CALD) Consumer Experience Group was established in December 2012. The group works collaboratively with Safety and Quality Branch to understand the CALD communities' needs in health care. Representatives include Multicultural Communities Council SA (MCCSA).		collaborate with HCA, HCSCC, AHCSA, Carers SA, COTA and MCCSA. **Partnering with Carers** The SA Health Partnering with Carers Strategic Action Plan 2017-2020 and key priorities was launched at the International Carers Conference in Adelaide in October 2017. National Carers Week is celebrated every October with care information displayed at health sites and carer stories shared via social media. Lyell McEwin Hospital piloted the first Partnering with Carers Education and Training Forum – a collaboration with SA Health and Carers SA. With positive feedback, the Partnering with Carers Education and Training Forum will be implemented statewide in 2018. Partnering with Carers webpage was established at www.sahealth.sa.gov.au/carers In 2017, Safety and Quality continued to work with Culturally and Linguistically Diverse (CALD) Experience Group, and details are provided in recommendation 25.		SA Health continues to fund the Health Consumers' Alliance (HCA) as the peak agency in South Australia for consumer engagement. SA Health is collaborating with the HCA to co-create consumer and community engagement strategies. The Safety and Quality Branch works collaboratively with HCA, Health and Community Services Complaints Commissioner (HCSCC), Aboriginal Health Council SA, Carers SA, Council on the Ageing (COTA), and Multicultural Communities Council SA (MCCSA) to provide quality community engagement. Safety and Quality Branch works collaboratively with Carers SA. The Partnering with Carers Strategic Action Plan 2017 – 2020 and key priorities was launched at the International Carers Conference in Adelaide in October 2017. The SA Health Culturally and Linguistically Diverse (CALD) Consumer Experience Group was established in December 2012. The group works collaboratively with Safety and Quality Branch to understand the CALD communities' needs in health care. Representatives include Multicultural Communities Council SA (MCCSA).

RECOMMENDATION 25
Commission a Consumer Experience Survey of Aboriginal and culturally and linguistically diverse South Australians to complement its existing mainstream survey.

SA Health Performance Indicator
N/A

2015 Result for SA	2016 Result for SA	2017 Result for SA	Progress against other Jurisdictions	Strategies
The SA Consumer Experience Surveillance System (SACESS) is a telephone survey where consumers are interviewed soon after an overnight stay in a metropolitan or country hospital using a set of internationally validated questions. In 2015, 2340 South Australians were interviewed, and since 2010, over 13,000 patients have participated in SACESS.	See Strategies	The Australian Hospital Patient Experience Question Set (AHPEQS) by the Australian Commission on Safety and Quality in Health Care and endorsed by Australian Health Ministers Advisory Council (AHMAC) in late 2017. In early 2018, discussions commenced with the Aboriginal and Torres Strait community and Multicultural Communities Council SA (MCCSA) to review the AHPEQS and consider survey questions to be implemented for community surveys.		SA Health continues to identify where gaps exist for Aboriginal people to share their experience with SA Health. In February 2016, a MCE CAPI Aboriginal and Torres Strait Islander Work Group was convened with members from NALHN, DASSA, SALHN, Aboriginal Health Branch, Wardliparingga Aboriginal Research Unit at SAHMRI, Safety and Quality, and is working in collaboration with Northern Territory Department of Health. Discussions included review of the national core patient experience questions and top ATSI languages to translate surveys. A background image has been developed specifically targeted to Aboriginal and Torres Strait Islander people, and a statewide ATSI survey is planned for early 2017. In mid-2016, Watto Purrunna Aboriginal Private Health Care Service commenced surveying consumers. Consumers from Lyell McEwin Hospital and Wonggangga Turtpandi, were asked about being treated with respect and dignity, their involvement in decision making, information, pain and follow up care. In 2015/16 the Measuring Consumer Experience Computer-Assisted Personal Interview (MCE CAPI) pilot commenced. The pilot enables SA Health to better understand the consumer and community needs in health care for all consumers including Aboriginal and Torres Strait Islander (ATSI), Culturally and Linguistically Diverse (CALD), patients aged 16 years and under, maternity, mental health / lived experience, substance abuse, chemotherapy or renal dialysis episodes of care. The MCE CAPI will enable all consumers the opportunity to share their experiences and provide us with their perspective on health care services, which is currently excluded from the SA Consumer Experience Surveillance System (SACESS).