Aboriginal Community & Consumer Engagement Strategy
Our Values:

Customer focus
Collaboration
Care
Creativity
Courage
It is with great pleasure that I submit the Country Health SA Local Health Network (CHSALHN) Aboriginal Community and Consumer Engagement Strategy (ACCE).

The CHSALHN ACCE strategy has been developed to assist CHSALHN implement culturally respectful and meaningful community and consumer engagement strategies. This strategy recognises the excellent work of our Aboriginal Health Advisory Committees and builds a future platform to increase Aboriginal community participation. It surpasses the previous engagement model to reflect the evolutionary process that surrounds improving patient centred care and the future innovative intentions of CHSALHN. The ACCE strategy is part of the overarching CHSALHN Community and Consumer Engagement strategy.

The SA Health Framework for Active Partnership with Consumers and the Community identifies situations where Local Health Networks will inform and engage communities and individuals as patients, carers and consumers of our health services. The Framework ensures there are mechanisms in place to actively engage in order to meet consumer needs and develop appropriate services. It also ensures the methods and practice of consumer engagement are guided by current best practice. The principles and standards recognise the importance of partnering with consumers and the community and maintaining high quality and efficient health services. Importantly by implementing the Aboriginal Community and Consumer Engagement strategy, there will be an increase in Aboriginal participation in health service delivery, design and decision making.

With regard to patient, consumer and carer engagement, the minimum health service standards are prescribed in the National Safety and Quality Health Service Standards - Standard 1 and 2.

Key result areas and deliverables have been assigned to assist CHSALHN's implementation and monitoring of the ACCE. CHSALHN supports self-determination in a practical way by supporting Aboriginal health services to transition to community-control. It advocates that Aboriginal community controlled-health services are the preferred model of primary health care, thereby increasing both access to services and positive health outcomes. CHSALHN will engage individuals, consumers and communities in a range of methods to achieve these outcomes such that we become the best rural health service in Australia.

I look forward to everyone working together to deliver this strategy.

Maree Geraghty
Chief Executive Officer
Country Health SA Local Health Network
We acknowledge and respect the traditional custodians whose ancestral land Country Health SA Local Health Network provides services on. We acknowledge the deep feelings of attachment and relationship of Aboriginal people to country.

The term ‘Aboriginal’ is used respectively in this document as an all-encompassing term for Aboriginal and Torres Strait Islander people and culture.
Background

The development of the CHSALHN Aboriginal Community and Consumer Engagement (ACCE) strategy was facilitated by the CHSALHN Aboriginal Health Directorate with local agencies, organisations, groups and individuals contributing to its development. It took into consideration a range of contributory factors that have impacted on the delivery of Aboriginal health services and the engagement of Aboriginal people over the past few years. It has determined there is a desire by many to increase their level of engagement. To achieve greater engagement and to improve the quality of health service provision, CHSALHN supports the community and key stakeholders in embracing the principles of the National Safety and Quality Health Service (NSQHS) Standards. Overseeing the progress of the strategy, an ACCE strategy Steering Committee provides advice and guidance and makes recommendations on the ongoing development of the strategy.

History of CHSALHN and Aboriginal Health Advisory Committees

Aboriginal communities have always sought good quality health and over the past 20 years the Aboriginal community has been a major contributor towards improving the health and well-being of Aboriginal consumers.

Since 1994 there have been significant developments which have contributed to an overall raised consciousness about the poor status of Aboriginal people’s health in South Australia.

In CHSALHN, Aboriginal Health Advisory Committees (AHACs) have been a central contributor to this positive change. Their contributions have been accompanied by a greater recognition of the rights of Aboriginal people to improved health services, recognition of the important principles of equal participation in the mainstream service system, equity of resource allocation and the rights of Aboriginal people to ‘have a voice’ when critical health priorities of Aboriginal people are being determined.

In 2009, reflecting a period of significant change in the health landscape including the increase in the number of Aboriginal Community Controlled Health Services and the introduction of Medicare Locals, the former Country Health SA Aboriginal Health Forum requested a review into the role and function of AHACs.

The AHACs were surveyed and consulted to determine their aspirations for the future. The members’ perspectives were captured on the biggest issues community members face as consumer participants in CHSALHN. These included new financial and meeting reimbursement procedures, staffing changes, redistribution of resources, different reporting responsibilities and changes to other areas in the department including the SA Health Aboriginal Health Division (AHD), the Office for Aboriginal and Torres Strait Islander Health (OATSIH) in the former Commonwealth Department of Health and Ageing. The report to CHSALHN indicated that changes were necessary. Following a four year period of wide consultation, it is now possible to present the ACCE strategy as the preferred model of engagement.
Involving the community in health service design and delivery

Since 2009 SA Health has developed new policies, plans and services in conjunction with Aboriginal community members and their carers. The mechanism used to formally capture the impact of the policy, plan or service (negative or positive) is an ‘Aboriginal Health Impact Statement’ (AHIS). The ACCE project has been developed according to the submission requirements of the SA Health AHIS guidelines.

As part of the ACCE consultation process, there have been over 19 formal meetings inclusive of more than 104 community members from across country with key stakeholders including all AHACs, Aboriginal Health Council of South Australia (AHCSA), Medicare Locals and individual representation.

The feedback was captured in seven AHISs in which there was general agreement that CHSALHN should aim to:

> Increase Aboriginal community participation across all activities within the organisation
> Develop flexible and dynamic strategies to increase Aboriginal community participation
> Engage directly with Aboriginal staff to increase engagement with community
> Ensure greater attendance by senior CHSALHN executive at local community events
> Ensure that information is appropriate and coordinated, thereby removing / avoiding duplication
> Ensure more integrated service delivery with joint planning of services and programs at state, regional and local levels
> Increase use of local communication strategies to meet the local needs of the community
> Increase use of interactive capabilities and social media tools such as Facebook and Twitter with a focus on engagement inclusive of multi-lingual language groups e.g. Pitjantjatjara
> Place greater emphasis on the importance of governance.

Whilst there has been significant support and compliance with the AHIS process, a small portion of AHAC Chair members expressed frustration and cynicism regarding the ACCE project methodology. There is a perception that the proposed strategies recommended to supersede the AHAC structure and improve Aboriginal participation will diminish, as opposed to increase Aboriginal community participation and input into mainstream health services designing and decision making.

In accordance with the AHIS Guidelines, the Key Result Areas that have been determined aim to equalise or negate these concerns. This strategy moves to surpass the previous engagement model by reflecting the evolutionary process and will encourage confident participation.

To achieve the Key Result Areas and Strategic Priorities, CHSALHN will partner with external organisations including the Aboriginal Health Council of South Australia (AHCSA).
Purpose, Methodology and Governance of the ACCE Strategy

The ACCE strategy provides instruments to enable CHSALHN to better plan, design, deliver and respond to the needs of Aboriginal people who use CHSALHN services.

To move forward CHSALHN has taken the existing model and developed it into a more flexible and dynamic process that is responsive to the input of community and consumers. To ensure effective Aboriginal community engagement CHSALHN sought input from key stakeholders to devise principles that underpin the strategy.

The Aboriginal Health Directorate within CHSALHN is responsible for ensuring stakeholders are kept informed of the implementation of the strategy.

Methodology

CHSALHN conducted a series of initial AHAC consultations across country in the first half of 2014 to:

> inform each AHAC that CHSALHN will be conducting new business that falls in line with National Safety and Quality Health Services Standard – Standard 2
> consult with AHAC in identifying other engagement models that are more inclusive of all Aboriginal people living in Country SA

CHSALHN ACCE Steering Committee

To support and oversee the development of the CHSALHN ACCE strategy, a Steering Committee was established. The ACCE strategy Steering Committee provides advice and guidance and makes recommendations on the ongoing development of the strategy. It also feeds information and recommendations via its representatives into the overarching CHSALHN Community and Consumer Engagement Steering Group.

Membership for the ACCE Steering Group has been sourced from the following:

> Aboriginal Health Council of SA
> SA Health
> Medicare Local Representation from Country North and Country South
> South Australian Medical Health Research Institute - Aboriginal Programs representative
> South Australian Aboriginal Elders Council representative
> CHSALHN Governing Council representative
> CHSALHN members who provide advice and input on specific topics

CHSALHN commitment to communication

A key message throughout the consultation and development process has been the importance of communication. CHSALHN understands that partnering requires working with partners and groups to address the needs and preferences of consumers, patients and carers. Effective partnering can only be achieved through seeking out, listening, understanding and responding to concerns and aspirations.

To support and assist partners and groups to be more informed, CHSALHN will provide information that is accessible, easily understood, meaningful and takes into consideration the general health knowledge of the audience.

ACCE Community and Consumer Engagement regions

While there are numerous identified Aboriginal communities of different language groups CHSALHN will drive the ACCE strategy through the established regional network. Refer Appendix 4.
Key Strategic, Legislative and Policy frameworks

As with the Country Health South Australia Community and Consumer Engagement strategy, the development and implementation of the Aboriginal Community and Consumer Engagement strategy is informed by International National and State legislation, policies, service standards and frameworks. It also draws on key CHSALHN mission statements, strategic plans and the cultural respect model.

Key frameworks

The two key frameworks underpinning this strategy are the International Association for Public Participation Framework (IAP2) and the National Safety & Quality Health Services Standards (NSQHS).

In developing the ACCE Strategic framework CHSALHN considers:

- The philosophy that Aboriginal Health is ‘Everybody’s Business’
- Complementing work already established by Aboriginal people, communities and organisations
- Respecting cultural knowledge and diversity and cultural sensitivity
- Recognising and respecting the worldviews of Aboriginal people in relation to health and wellbeing
- Aboriginal self-determination
- Recognition that Aboriginal people have diverse cultures, histories and life experiences and that ‘no size fits all’ in regards to delivery of health care and support
- Shared learning and responsibility
- Establishing a continual improvement philosophy
- Effective communication and dissemination of information

International Association for Public Participation framework (IAP2)

The International Association for Public Participation (IAP2) is the leading international organisation advancing the practice of public participation (P2). IAP2’s core values, code of ethics, and public participation spectrum are foundational elements of this initiative. IAP2 provides a spectrum that actively engages with consumers and the community based on the level of influence and contribution that stakeholders can make. In CHSALHN the stakeholders are the Aboriginal Community and Consumers; there are four levels of engagement as illustrated below. How the principles of engagement can be applied at the various levels is outlined in Appendix 5: Definitions of Engagement.
Under the IAP2 the Spectrum of Participation has five options from informing through to empowering. Refer diagram below.

- **Inform**: CHSALHN provides information about the project or problem to be addressed and shares information about something that is going to happen or has happened.
- **Consult**: CHSALHN seeks an opinion or input to inform a decision. A two way communication process aimed at obtaining a public feedback about ideas.
- **Involve**: CHSALHN and Aboriginal community & consumers engage with stakeholders in order to understand and consider their input and feedback.
- **Collaborate**: CHSALHN and Aboriginal community & consumers work in partnership to come to a decision.
- **Empower**: Aboriginal consumers enable self determination to participate in own health outcomes.

**CHSALHN Strategic Plan 2014-2019**

This ACCE strategy builds on the people centred concept of CHSALHN Strategic Plan 2014-2019 by introducing an innovative and high performing health service model that delivers outstanding consumer and community health outcomes.

- **Person Centred**: Build innovative and high performing health service models that deliver outstanding consumer experience and health outcomes.
- **Performance**: Pursue excellence in all that we do.
- **People**: Create a vibrant, values based place to work and learn.
- **Partnerships**: Harness the power of partnerships to improve the effectiveness of services.
- **Populations**: Elevate and enhance the level of health in country communities.

**Our Values:** Customer focus, Collaboration, Care, Creativity, Courage
Cultural Respect

CHSALHN Cultural Respect is the recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander Peoples. It is achieved through ensuring focused effort on four critical underpinning elements:

- increasing the knowledge and awareness of the history, experience, culture and rights of Aboriginal and Torres Strait Islander Peoples;
- ensuring strategies focus on good practice and culturally appropriate behaviour;
- pursuing strong customer and community relationships, and
- having systems and practices in place that support a positive outcome.

The Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004-2009 and the Aboriginal Cultural Respect Framework have been used as the basis for CHSALHN to create its model for driving cultural change. The proposed model provides clarity, enables focused effort by staff across the organisation on each of the key elements and has been designed to be easily understood.

CHSALHN seeks to demonstrate its commitment to improving Aboriginal Peoples’ access to culturally safe and competent health services and programs by developing, engaging and improving relationships between staff and the customer and staff and the Community.
Key Result Areas and Priority Strategies

Four Key Result Areas that align with the requirements under NSQHS Standards 1 and 2 (refer to Appendix 1 for NSQHS detail) have been identified for this ACCE Strategy. CHSALHN can create a health service that is responsive to patient, carer and consumer input and needs by driving strategies around the Key Result Areas including:

> Individual Community and Consumer Engagement
> Directorates, Programs and Services
> Network Aboriginal Community and Consumer Engagement
> Systems Aboriginal Community and Consumer Engagement

The Key Result Areas are relevant to the overall governance and structure of CHSALHN as well as to the communities and consumers across country. As this is a new initiative responsive to meet stakeholder needs, it is important to approach the development of strategies and actions with flexibility. It is expected that local content and context will be identified by those taking the lead and partnering in the actions that produce the required outcomes. Time frames around deliverables are to be determined subject to operational requirements, priorities and stakeholder engagement.

CHSALHN will monitor and report progress. Given the flexibility of the document, any reassessment of the appropriateness and effectiveness of strategies chosen is the responsibility of CHSALHN Executive.

Several priority strategies under each key result area have been identified as bringing about significant change and or demonstrating a major commitment to patient centred care. These strategies seek to deliver:

> Improvements to systems and practices with consistent application across CHSALHN
> Formalised Aboriginal consumer and community engagement approaches
> An increase in the number of Aboriginal people currently engaged
> The appointment of a Senior Aboriginal Health Lead for each region
> An increase in the engagement of CHSALHN staff, at all levels, in events and activities of significance
PRIORITY STRATEGIES
ABORIGINAL COMMUNITY AND CONSUMER ENGAGEMENT

**Individual**

> Establish an Aboriginal Health Experts by Experience Register (the Register) that promotes and encourages Aboriginal participation in the planning and delivery of health services and programs.

> Create local opportunities and pathways for Aboriginal communities, carers, patients and consumers to be orientated, and informed on CHSALHN business.

> Target the engagement of Youth and Elders.

**Directorates, Programs & Services**

> Promote and encourage genuine and meaningful engagement in primary and acute health settings.

> Implement the Cultural Respect and Awareness training programs across CHSALHN.

> Implement the CHSALHN Reconciliation Action Plan.

> Implement a community engagement and customer satisfaction staff training program to improve the level of service.

> Schedule quarterly meetings between regional directorates and key Aboriginal Health stakeholders.

**Network**

> Establish a discrete council of Aboriginal leaders to provide advice to the CEO on hospital and local health service delivery across CHSALHN.

> Introduce regional CHSALHN Aboriginal Community, Consumers and Carers Sounding Board to explore and keep abreast of community issues and concerns.

> Establish a CHSALHN Aboriginal Health Services and Strategy group, representative from all Directorates and Regions to assist in the advancement of Aboriginal health priorities in CHSALHN.

> Increase Aboriginal Consumer participation on all CHSALHN committees.

**Systems**

> Implement the roll out of the Aboriginal Health Impact Statement (AHIS) process.

> Develop and implement a culturally respectful consumer/patient/carer centred approach to care.
### Individual Community and Consumer Engagement

**Goal:** Build and maintain relationships and strong partnerships with Aboriginal community members across all CHSALHN regions

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Possible actions to achieve strategy</th>
<th>Inform</th>
<th>Consult</th>
<th>Involve</th>
<th>Collaborate</th>
<th>Empower</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.1</strong></td>
<td>Establish an Aboriginal Health Experts by Experience Register (the Register) that promotes and encourages Aboriginal participation in the planning and delivery of health services and programs.</td>
<td>Establish and maintain a register of Aboriginal people to contribute in their areas of preferred interest, expertise and training requirements. Implement the Register. Develop and implement an orientation and induction process for Experts nominated on the Register. Ensure Register participants nominating as Experts have the opportunity to engage in individual development plans. Develop, in consultation with Register participants, an Exit interview process.</td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td><strong>1.2</strong></td>
<td>Create local opportunities and pathways for Aboriginal communities, carers, patients and consumers to be orientated, and informed on CHSALHN business.</td>
<td>Engage communities, consumers and carers in CHSALHN at the local rural region level. Develop a marketing strategy specifically aimed at engaging the 52% Aboriginal youth population across Country SA. Develop a marketing strategy to attract Aboriginal people to; and be engaged with CHSALHN.</td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td><strong>1.3</strong></td>
<td>Target the engagement of Youth and Elders.</td>
<td>Encourage identified Youth and Elders to participate on the Register.</td>
<td></td>
<td></td>
<td></td>
<td>✔</td>
</tr>
</tbody>
</table>
### Directorates, Programs and Services

**Goal:** Embed a philosophy and create practices in CHSALHN that values Aboriginal Community and Consumer participation and supports genuine and meaningful engagement

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Possible actions to achieve strategy</th>
<th>Inform</th>
<th>Consult</th>
<th>Involve</th>
<th>Collaborate</th>
<th>Empower</th>
</tr>
</thead>
</table>
| 2.1 Promote and encourage genuine and meaningful engagement in primary and acute health settings. | Engage with local Aboriginal communities and consumers through strategies such as:  
> Expand on existing CHSALHN Nunga luncheon model across all regions  
> Consumer participation in the development and delivery of local programs for example; Keeping It Corka, Renal Dialysis Mobile Unit, AMIC, Mental Health Units.  
> Participation in CHSALHN Aboriginal Health Services and Strategy group.  
Report on activities regularly to share good practice and contribute to CHSALHN planning. | | | | ✓ | |
| 2.2 Implement the Cultural Respect and Awareness training programs across CHSALHN. | Implement the CHSALHN Cultural Competency Learning and Development program.  
Monitor through Workforce Services and the PDR process the uptake of the mandatory on-line cultural orientation training.  
Monitor the development of stages 2 and 3 of the Cultural Competency Learning and Development Program. | | | | ✓ | |
| 2.3 Implement the CHSALHN Reconciliation Action Plan. | Establish RAP reference/focus groups across directorates and regions and set targets that meet the three outcome areas of the CHSALHN Reconciliation Action Plan. | | | | ✓ | |
| 2.4 Implement a community engagement and customer satisfaction staff training program to improve the level of service. | Create and modify training sessions and resources for staff on consumer centred care and customer satisfaction.  
Invite community, patients and carers to speak to staff about their experience of healthcare service provision. | | | | ✓ | |
| 2.5 Schedule quarterly meetings between regional directorates and key Aboriginal Health stakeholders. | Implement meeting schedule, including:  
Country Health Executive  
> AHCSA  
> SA Health Policy and Intergovernmental Relations  
Clinical Planning  
> SAMHRI  
> Lowitja O’Donoghue Institute  
> Public Health–AHCSA  
Operations  
> Regional Aboriginal Community Controlled Health Organisations  
> Relevant local regional Aboriginal community groups. | | | | ✓ | |
### Network Aboriginal Community and Consumer Engagement

**Goal:** CHSALHN to lead systemic reform in the area of Aboriginal Community engagement and meet the NS&QHS

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Possible actions to achieve strategy</th>
<th>Collaborate</th>
<th>Empower</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Establish a discrete council of Aboriginal leaders to provide advice to the CEO on hospital and local health service delivery across CHSALHN.</td>
<td>Identify effective spokespeople to provide input on consumer patient care. Develop Terms Of Reference to include strategies to meet legislative and accreditation standards. Undertake orientation, induction and training on health consumer advocacy for the council.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>3.2 Introduce regional CHSALHN Aboriginal Community, Consumers and Carer’s Sounding Board to explore and keep abreast of community issues and concerns.</td>
<td>Establish regular Sounding Board Schedule in each operational region. Engage with local communities to develop local strategies from the issues raised.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>3.3 Establish a CHSALHN Aboriginal Health Services and Strategy group, representatives from all Directorates and Regions to assist in the advancement of Aboriginal health priorities in CHSALHN.</td>
<td>All Directorates and Regions to nominate a participant from their leadership team to the Aboriginal Health Services and Strategy group to monitor and report on Aboriginal health activities/business.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>3.4 Increase Aboriginal consumer participation on all CHSALHN committees.</td>
<td>Review all existing committees and examine Aboriginal community/consumer participation and compliance in relation to AHIS processes and NHS&amp;QS-Standard.</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>
### Our Values:

- Customer focus
- Collaboration
- Care
- Creativity
- Courage

### Goal: Implement effective processes and practices that support a culturally safe environment for delivering quality services

#### Strategy

<table>
<thead>
<tr>
<th>Possible actions to achieve strategy</th>
<th>4.1</th>
<th>4.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement the roll out of the Aboriginal Health Impact Statement (AHIS) process.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify and train relevant staff on AHIS process, including QPPS users.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establish and implement a CHSALHN AHIS triage and assessment process.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop a clinician engagement strategy, including the use of Aboriginal Health Practitioners, Aboriginal Health Workers and Aboriginal consumers, carers, patients.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop a communication strategy describing the process for disseminating information on patient centred care to the community.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Input from the Experts on the Register is actively sought to ensure Aboriginal consumer input is obtained in the development of policy and procedures.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendices

Appendix 1: National Safety and Quality Health Standards

Under the NSQHS Standard 1: Governance for Safety and Quality in Health Service Organisations, and Standard 2: Partnering with Consumers set the overarching requirements for the effective application of the other eight NSQHS Standards which address specific clinical areas of patient care.

Standard 1 refers to the performance of the organisation and how it communicates 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.

Standard 2 ensures 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.

By applying criteria under Standard 2, CHSALHN can create a health service that is responsive to patient, carer and consumer input and needs.

Standard 2:

**Consumer partnership in service planning:** Governance structures are in place to form partnerships with consumers and/or carers.

| 2.1 Establishing governance structures to facilitate partnerships with consumers and/or carers | 2.1.1 Consumers and/or carers are involved in the governance of the health service organisation |
| 2.1.2 Governance partnerships are reflective of the diverse range of backgrounds in the population served by the health service organisation, including those people who do not usually provide feedback |

| 2.2 Implementing policies, procedures and/or protocols for partnering with patients, carers and consumers in: | 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 |
| > Strategic and operational services planning | 2.2.2 Consumers and/or carers are actively involved in decision making about safety and quality |
| > Decision making about safety and quality initiatives | |
| > Quality improvement activities | |

| 2.3 Facilitating access to relevant orientation and training for consumers and/or carers partnering with the organisation | 2.3.1 Health service organisation’s provide orientation and on-going training for consumers and/or carers to enable them to fulfil their partnership role. |

| 2.4 Consulting consumers on patient information distributed by the organisation | 2.4.1 Consumers and/or carers provide feedback on patient information publications prepared by the health service organisation (for distribution to patients) |
| 2.4.2 Action is taken to incorporate consumer and/or carers feedback into publications prepared by the health service organisation for distribution to patients |
### Consumer partnership in designing care
*Consumers and/or carers are supported by the health service organisation to actively participate in the improvement of the patient experience and patient health outcomes*

<table>
<thead>
<tr>
<th>2.5 Partnering with consumers and/or carers to design the way care is delivered to better meet patient needs and preferences</th>
<th>2.5.1 Consumers and/or carers participate in the design and redesign of health services.</th>
</tr>
</thead>
</table>
| 2.6 Implementing training for clinical leaders, senior management and the workforce on the value of and ways to facilitate consumer engagement and how to create and sustain partnerships | 2.6.1 Clinical leaders, senior managers and the workforce access training on patient-centred care and the engagement of individuals in their care.  
2.6.2 Consumers and/or carers are involved in training the clinical workforce. |

### Consumer partnership in service measurement and evaluation
*Consumers and/or carers receive information on the health service organisation’s performance and contribute to the on-going monitoring, measurement and evaluation of performance for continuous quality improvement.*

| 2.7 Informing consumer and/or carers about the organisation’s safety and quality performance in a format that can be understood and interpreted independently. | 2.7.1 The community and consumers are provided with information that is meaningful and relevant on the organisation’s safety and quality performance. |
| 2.8 Consumers and/or carers participating in the analysis of safety and quality performance information and data, and the development and implementation of action plans. | 2.8.1 Consumers and/or carers participate in the analysis of organisational safety and quality performance  
2.8.2 Consumers and/or carers participate in the planning and implementation of quality improvements. |
| 2.9 Consumers and/or carers participating in the evaluation of patient feedback data and development of action plans | 2.9.1 Consumers and/or carers participate in the evaluation of patient feedback data  
2.9.2 Consumers and/or carers participate in the implementation of quality activities relating to patient feedback data. |
Appendix 2: Monitoring and Evaluation

To assess and improve the implementation of the ACCE strategy, it is important to monitor and evaluate progress. A monitoring and evaluation process requires identifying those elements that need to be measured, the methods that look at the frequency of monitoring, the methods used to gain and evaluate the information and how the information is to be used.

For the purposes of reviewing and evaluating, CHSALHN refers to two national frameworks. These are the National Standards for Community Engagement and the National Safety and Quality Health Standards (NSQHS). Both frameworks provide tools to conduct in-house audits and assessments.

Elements to be measured

Under the CHSALHN ACCE strategy there are four Key Result Areas with a number of priorities. The progress of all strategies will be monitored and evaluated. There are various recognised methods for obtaining information for monitoring and evaluation purposes.

**Informal feedback**

Leads, Partners, CHSALHN, staff and nominated others will talk to stakeholders to ask how they perceive the process and its outcomes.

**Interviews**

More formal settings are used when information needs to be gathered from a number of sources and/or where there is a lot of feedback to be recorded.

**Questionnaires/Formal surveys**

These are to be used as required; they are useful if statistical information is required.

**Peer evaluations**

Other parties within CHSALHN may review progress against the overall CHSALHN CCE strategy.

**Debriefs**

A debrief is encouraged after an event where there has been public participation. The team is to look at outcomes and identify possible improvements for future activities.

**Formal third party evaluation**

An independent party is engaged to conduct an evaluation of the program design and implementation.

Frequency of monitoring and evaluation

The frequency of monitoring and evaluation of the implementation of strategies is to be determined by the Lead in consultation with the Partners designated to effect the strategy. In the case of the priority strategies, progress is to be reported in already established regular reporting mechanisms.

Use of information

Information obtained through a monitoring and evaluation process can be used for a number of purposes. For example, changes can be effected immediately, improvements can be introduced, priorities and focus areas revisited or amended, other parties can be invited to participate.

Assessment criteria

Progress of the CHSALHN ACCE strategy will be reported against a three point rating scale as identified in the NSQHS. This scale is:

- **Not Met (NM)**: The actions required have not been achieved.
- **Satisfactorily Met (SM)**: The actions required have been achieved.
- **Met with Merit (MM)**: In addition to achieving the actions required, measures of good quality and a higher level of achievement are evident. At this level it means that a culture of safety, evaluation and improvement is evident throughout the organisation.

Our Values:  
**Customer focus**  **Collaboration**  **Care**  **Creativity**  **Courage**
### Appendix 3: Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
</tr>
<tr>
<td>ACCE</td>
<td>Aboriginal Community and Consumer Engagement</td>
</tr>
<tr>
<td>ACCHO</td>
<td>Aboriginal Community Controlled Health Organisation</td>
</tr>
<tr>
<td>AHAC</td>
<td>Aboriginal Health Advisory Committee</td>
</tr>
<tr>
<td>AHCSA</td>
<td>Aboriginal Health Council of South Australia</td>
</tr>
<tr>
<td>AHD</td>
<td>Aboriginal Health Directorate</td>
</tr>
<tr>
<td>AHIS</td>
<td>Aboriginal Health Impact Statement</td>
</tr>
<tr>
<td>APY Lands</td>
<td>Anangu Pitjantjatjara Yankunytjatjara Lands</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>CHE</td>
<td>Country Health Executive</td>
</tr>
<tr>
<td>CHSALHN</td>
<td>Country Health South Australia Local Health Network</td>
</tr>
<tr>
<td>EbyE</td>
<td>Experts by Experience</td>
</tr>
<tr>
<td>HAC</td>
<td>Health Advisory Council</td>
</tr>
<tr>
<td>HCSCC</td>
<td>Health and Community Services Complaints Commission</td>
</tr>
<tr>
<td>IAP2</td>
<td>International Association for Public Participation</td>
</tr>
<tr>
<td>LHN</td>
<td>Local Health Network</td>
</tr>
<tr>
<td>NSQHS</td>
<td>National Safety and Quality Health Services</td>
</tr>
<tr>
<td>OCEO</td>
<td>Office of the Chief Executive Officer</td>
</tr>
</tbody>
</table>
Appendix 4: Profile

CHSALHN covers 983,776 square kilometres or 99.8% of South Australia and is one of the largest Local Health Networks in Australia. Engagement occurs on a daily basis across country South Australia. CHSALHN has 63 hospital sites and incorporates over 240 health unit sites, employing over 8000 people. It provides provide acute health services to over 94,000 people and a further 175, 000 people access country emergency services.

The Aboriginal population comprised 3.3% of the CHSALHN resident population at the 2011 Census (Source: Australian Bureau of Statistics (ABS)). Over half of the Aboriginal population resides in country South Australia with a large proportion living in very remote regions.

Aboriginal South Australians have a higher prevalence of many chronic diseases, biomedical risk factors, such as high cholesterol, diabetes, renal, obesity and high blood pressure, and behavioural risk factors, such as smoking, high-risk alcohol consumption, lack of physical activity and psychological distress, compared with the non-Aboriginal population. Other potentially preventable and manageable conditions are also more prevalent in Aboriginal communities, including oral, ear and eye health conditions. The majority of care required for chronic diseases is ongoing and requires management through the primary health care sector as the underlying condition itself is permanent and not episodic.

Aboriginal population in South Australia

The Aboriginal population in South Australia in 2011 was 32,000. By 2021, it is predicted to be approximately 38,500. The population by region is shown in the table below.

<table>
<thead>
<tr>
<th>Country Health SA Rural Region</th>
<th>Non-Aboriginal</th>
<th>Aboriginal</th>
<th>Not stated</th>
<th>Total</th>
<th>% Aboriginal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyre, Flinders &amp; Far North - West</td>
<td>32,366</td>
<td>4,682</td>
<td>1,491</td>
<td>38,539</td>
<td>12.1%</td>
</tr>
<tr>
<td>Eyre, Flinders &amp; Far North - East</td>
<td>38,816</td>
<td>3,992</td>
<td>3,271</td>
<td>46,079</td>
<td>8.7%</td>
</tr>
<tr>
<td>Riverland Mallee Coorong</td>
<td>61,989</td>
<td>2,398</td>
<td>3,299</td>
<td>67,686</td>
<td>3.5%</td>
</tr>
<tr>
<td>Yorke &amp; Northern</td>
<td>69,015</td>
<td>1,664</td>
<td>2,647</td>
<td>73,326</td>
<td>2.3%</td>
</tr>
<tr>
<td>South East</td>
<td>60,060</td>
<td>1,092</td>
<td>1,919</td>
<td>63,071</td>
<td>1.7%</td>
</tr>
<tr>
<td>Barossa Hills Fleurieu</td>
<td>171,498</td>
<td>1,729</td>
<td>6,026</td>
<td>179,253</td>
<td>1.0%</td>
</tr>
<tr>
<td>Total CHSALHN</td>
<td>433,744</td>
<td>15,557</td>
<td>18,653</td>
<td>467,954</td>
<td>3.3%</td>
</tr>
</tbody>
</table>

Table: Aboriginal population in South Australia 2011
Aboriginal Communities in South Australia

There are numerous identified Aboriginal communities across South Australia of different language groups. These communities are easy recognisable as the following:

- Amata
- Davenport (Port Augusta)
- Dunjiba (Oodnadatta)
- Gerard (Riverland)
- Ivantja (Indulkana)
- Kalka
- Kalparrin (Murray Bridge)
- Kaltjiti (Fregon)
- Koonibba (West Coast)
- Maralinga Tjarutja Lands (Oak Valley)
- Mimili
- Nepabunna (Flinders Ranges)
- Pipalyatjara
- Point Pearce (Port Victoria)
- Port Lincoln Aboriginal Community Council
- Pukatja (Ernabella)
- Raukkan (near Meningie)
- Umoona (Coober Pedy)
- Umuwa
- Watarru
- Yalata (West Coast)
- Yunyarini
In addition to the main communities, over the last 30 years there has been an emergence of the homelands. Most of the communities are self-contained providing an environment that retains the rich tradition and culture.
Age profile

The Aboriginal population is getting younger and is also growing at twice the rate of the non-Aboriginal population. The median age is 23 compared with 43 in the non-Aboriginal population. Conversely the Standardised Death Rate for Aboriginal people in inner and outer regional SA is 25% higher than non-Aboriginal people in the same area. This means there is a great variation on the range of health needs being sought in different areas of the state.

Aboriginal mobility

The Aboriginal population is highly mobile with frequent changes in usual place of residence for reasons such as access to health and social services, cultural and family obligations, or leisure and recreation. Short term mobility challenges health and social service providers not only to deliver services to remote communities but to make sure that adequate services are available in places Aboriginal people visit.

Source: Kainz, T., Carson, D.A., Carson, D.B. Temporary Indigenous Mobility in Remote South Australia: Understanding the Challenges for Urban Based Health and Social Service Delivery

Aboriginal health morbidity and mortality

A combination of Aboriginal Health surveys, Australian Bureau of Statistics census and other State and National surveys provide South Australian statistics relating to key health issues and outcomes of those living in rural or remote regions.

Diabetes

Respondents with doctor diagnosed diabetes were statistically significantly more likely to be from remote areas of SA, when compared to those reporting no diabetes.

> Respondents with doctor diagnosed diabetes were statistically significantly more likely to be from remote areas of SA, when compared to those reporting no diabetes

> 40% of the remote residents reported having diabetes

> 2002/04 survey of over 16 years olds found Northern & Far Western region had the highest prevalence of diabetes in 10.3% of the population; the second highest region was Mid North with 9.2%

High blood pressure

> Respondents with current high blood pressure and/or on medication for high blood pressure were statistically significantly more likely to be living in remote parts of SA and statistically significantly less likely to be from rural area of SA, when compared to those without current high blood pressure

> 40% remote residents reported having high blood pressure

25% said health was fair or poor

32% rated their psychological distress as high or very high

33% had sight problems

40% were current smokers

20% had asthma

Over 70% reported one or more chronic health conditions

Source: SA Health Report based on ABS National Aboriginal and Torres Strait Islander Health Survey, 2004-05
Kidney disease
> Respondents with doctor diagnosed kidney disease were statistically significantly more likely to be from remote areas of SA and statistically significantly less likely to be from rural SA, when compared to those reporting no kidney disease
> 19% of remote residents reported having kidney disease
> 7% of SA Health mobile dialysis population are Aboriginal, majority from remote communities

Cancer
> In 2006-2010, lung cancer, cancer of ‘unknown primary site’, breast cancer (for women), and bowel cancer was the second most common cause of death for Aboriginal people

Tobacco
> Smoking is the number one cause of chronic conditions and diseases among Aboriginal Australians responsible for 12% of the total burden of disease
> 56% of Aboriginal people in South Australia are current smokers, compared to 23% of the non-Aboriginal Australian population

Mental health
> 21% of those from remote areas reported feeling nervous some of the time in the past 4 weeks (statistically significant)
> 26% of those from remote areas reported feeling so sad that nothing could cheer them up some of the time in the past four weeks (statistically significant)
> In 2001 and 2010 Aboriginal South Australians committed suicide at a rate of more than twice that of non-Aboriginal South Australians, ie 26.7 deaths per 100,000 Aboriginal people as opposed to 11.2 per 100,000 non-Aboriginal South Australians

Oral health
> Aboriginal children experience approximately 70% more dental caries than non-Aboriginal people and they have more teeth with untreated dental decay
> Rate of decay is the major cause for hospital admissions
> Aboriginal adults have a higher prevalence of severe periodontal disease than non-Aboriginal adults

Substance use
> Substance use is a contributing factor to ill health, accidents, violence, crime, family and social disruption, and workplace problems. Whilst petrol sniffing has reduced with the introduction of Opal fuel, marijuana use has become more common in the APY Lands

Eye and/or sight problems
> Uncorrected refractive error, cataracts, diabetic retinopathy and trachoma, are the four main causes of visual loss and blindness in Aboriginal adults and occur more frequently in rural and remote locations
> 3% of Aboriginal adults suffered vision loss caused by cataracts, but only 1 in 3 of those who needed cataract surgery received it
> In 2013, Aboriginal children in 22 rural and remote communities were screened for trachoma. Trachoma was identified in 12 communities, the prevalence of trachoma in children aged 5-9 years screened was 4%. The prevalence ranged from 0.3% in the Far North region to 11% in the APY Lands.

Our Values: Customer focus  Collaboration  Care  Creativity  Courage
Aboriginal Community & Consumer Engagement Strategy page 23
Ear health
> Respondents with a doctor diagnosed hearing problem were statistically significantly more likely to be from remote areas of SA when compared to those reporting no hearing problem
> Ear problems are particularly problematic for children
> 26% of remote residents reported a hearing problem

Pregnancy
> The median age of Aboriginal mothers giving birth was 24.5 years while the non-Aboriginal was 30.6 years
> 20% of Aboriginal women giving birth were teenagers compared to only 4% of non-Aboriginal women
> South Australian babies born to Aboriginal mothers are more than twice as likely to be low birth weight as babies born to non-Aboriginal mothers
> In 2008, 16.3% of Aboriginal live births were low birth weight

Early childhood
> Children under 5 years of age were 1.4 times more likely to be hospitalised with respiratory disease the most common reason for hospitalisation
> Aboriginal children aged less than four years, suffer from nutritional anaemia and malnutrition at 29.6 times the rate for non-Aboriginal children

Youth health
> 30-50% of gonococci infections and approximately 10% of syphilis infections notified in South Australia arise from Aboriginal people in the 15-29 year old age group

Women's health
> Around 50% of Aboriginal women aged 15-44 years live in country regions, but account for 62% of all Aboriginal obstetrics-related hospitalisations due to higher birth rates
> Aboriginal women living in remote or very remote areas of South Australia account for 43% of obstetrics hospitalisations

Men's health
> Around 45% of Aboriginal men die before the age of 45; only 29% Aboriginal males reach the age of 65.
> Aboriginal men under 45 are up to three times more likely to commit suicide than non-Aboriginal men of the same age
Aged care
> Limited statistics are available regarding Aged Care specifically directed at older Aboriginal People.

Food
> Remote residents were more likely than rural residents to consume a piece of fruit daily and only 19% rural residents and 30% remote residents said they ate vegetables daily
> 39% remote residents and 10% rural residents reported having run out of food at least once in the last twelve months

Physical activity
> Remote residents were significantly less likely to undertake sufficient physical activity

Road safety
> Road deaths and injuries rank second highest for Aboriginal people life expectancy but the eighth highest impact on non-Aboriginal life expectancy

CHSALHN Aboriginal workforce data
As at 2014/15 there were 151 Aboriginal staff working across CHSALHN. This represents 1.69% of CHSALHN total workforce. The South Australian Strategic Plan has a target of 2%.

A key initiative under the CHSALHN commitment to providing a culturally safe and respectful health service to Aboriginal consumers will be the employment of Aboriginal Health Practitioners. To increase the skill level of current staff the new national qualification is currently being explored as an option for CHSALHN.
### Appendix 5: Definitions of Engagement

For the purposes of the ACCE strategy, the following definitions apply.

<table>
<thead>
<tr>
<th>Engagement</th>
<th>is the practice of actively bringing community voices into decisions that affect or interest them</th>
</tr>
</thead>
<tbody>
<tr>
<td>The community</td>
<td>is a general term for individuals and groups of people not part of an organised structure or group</td>
</tr>
<tr>
<td>Stakeholders</td>
<td>are people organised under the banner of a defined group or organisation, often providing representation to a broader group, e.g. AHCSA</td>
</tr>
<tr>
<td>Community and Stakeholder Engagement</td>
<td>Refers to the connections between government, communities and people in the development and implementation of policies, programs, services and projects. It encompasses a wide variety of government-community interactions ranging from information sharing to community consultation and, in some instances, active participation in government decision making. It incorporates public participation, with people being empowered to contribute to decisions affecting their lives, through the gaining of skills, knowledge and experience.</td>
</tr>
<tr>
<td>Levels of engagement</td>
<td>CHSALHN has elected to have four key levels of engagement ie</td>
</tr>
<tr>
<td></td>
<td>&gt; Individual Community and Consumer Engagement</td>
</tr>
<tr>
<td></td>
<td>&gt; Directorates, Programs and Services.</td>
</tr>
<tr>
<td></td>
<td>&gt; Network Aboriginal Community and Consumer Engagement</td>
</tr>
<tr>
<td></td>
<td>&gt; Systems Aboriginal Community and Consumer Engagement</td>
</tr>
</tbody>
</table>
The table below provides a summary of how the levels of engagement can be applied in CHSALHN.

<table>
<thead>
<tr>
<th>Level of engagement</th>
<th>Principle relationship</th>
<th>Principle in practice</th>
<th>Examples of potential stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INDIVIDUAL</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; Individuals with their respective health care arrangements.</td>
<td>This level focuses on engaging with the individual consumer and/or their family/carer as partners in their own health care, support and treatment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; Individuals and health care planners/designers/clinicians</td>
<td>Individuals with a specific health interest</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **DIRECTORATES, PROGRAMS AND SERVICES** | > Program delivery  
> Service delivery  
> Hospital/Health unit  
> AHCSA  
> ACCHOs  
> Medicare Locals  
> Primary Health Networks  
> Non-government & Community organisations  
> Key stakeholders | This level focuses on engaging with consumers and the community to have input into how programs, services or facilitates are delivered, structured, evaluated and improved. | Short/medium term focus group for hospital redevelopments  
Aboriginal Birthing program focus group  
Renal Bus service Advisory group |
| **NETWORK**         | > Hospital/Health Unit  
> AHCSA  
> ACCHOs  
> Medicare Locals  
> Primary Health Networks  
> Non-government & Community organisations  
> Key stakeholders | This level focuses on how the rural region or respective Directorates can partner with Medicare Locals, ACCHOs and other key stakeholders to work with community and consumers at the local level | Aboriginal participation at regional HAC  
Support of programs, for example “Nunga lunches”  
Regular scheduled forums  
Involvement at whole of government meetings |
| **SYSTEMS**         | > Local government  
> State government  
> AHCSA  
> Commonwealth government  
> CHSALHN  
> Other LHNs | This level focuses on the governance and the strategic input from invited spokespeople to deliver the required outcomes | High level strategic Aboriginal Advisory spokespeople providing the CEO with feedback, advice and monitoring the business and Aboriginal impacts |
References and reading material


Australian Human Rights Commission 2011, *Social Justice Report Chapter 4*


Australian Institute of Health and Welfare, 2001


Edwards, W.H. 1998 *An Introduction to Aboriginal Societies*, Cengage Learning, Melbourne


Our Values:
Customer focus  
Collaboration  
Care  
Creativity  
Courage

Aboriginal Community & Consumer Engagement Strategy


Human Rights and Equal Opportunity Commission 1997, Bringing them Home: report of the national inquiry into the separation of Aboriginal and Torres Strait Islander children from their families, Human Rights and Equal Opportunity Commission, Sydney. International Association for Public Participation (IAP2)

Lavrie, W., Guerrera, D. 2013, Imposed Shame lecture notes, SHINE SA, Woodville, South Australia.

Lowell, A. 1998, Communication and Cultural Knowledge in Aboriginal Health Care, Cooperative Research Centre for Aboriginal and Tropical Health, Northern Territory.


Maddison, S. 2009, Black Politics: Inside the Complexity of Aboriginal Political Culture, Allen and Unwin, NSW


National Indigenous Eye Health Survey (NIEHS) 2008


Population Research & Outcome Studies (PROS) Unit, University of Adelaide 2012, SA Aboriginal Health Survey 2012

South Australian Centre for Rural and Remote Health 2001, Working with Aboriginal people in Rural and Remote South Australia, South Australian Centre for Rural and Remote Health, Whyalla, South Australia.

Taylor, A.W., Marin, T., Avery, J. and Dal Grande. 2012 South Australian Aboriginal Health Survey, Population Research and Outcome Studies, Adelaide, South Australia.

South Australian Native Title Services 2012,Native Title in SA, viewed 18 October 2012, www.nativetitlesa.org


For more information

Country Health SA Local Health Network
SA Health
Telephone: 08 8226 8409
Email: healthAHDAdmin@sa.gov.au
www.sahealth.sa.gov.au

Public – I1 – A1