Feedback on Draft Health Care (Governance) Amendment Bill: An Act to amend the Health Care Act 2008

The Health Consumers Alliance of South Australia (HCA) is pleased to provide the following comment on this draft legislation. We support the stated intention of the Amendment Bill: to 'better engage communities and clinicians in local health care decisions' (the Minister's Second Reading, 7 June 2018). Devolving decisions to the Boards and their supporting bodies such as Health Advisory Councils may achieve this purpose. HCA has for some time received both consumer and clinician feedback about the absence of purposeful and comprehensive consultation on health policy, services and reform. Consumers tell us they are tired of the political capture of health and its services, the state and national blame game, and the dominant public and media negativity about our health services. HCA remains committed to working with communities, health professionals and policy-makers to enable genuine consumer and community engagement in the health decisions that affect them.

The following comments reflect feedback from our Board, staff, members, consumer advocates and supporters to the degree that the timeline for response has allowed. A number of members and supporters expressed the view that they would have liked more time to respond and for the process to more accessible to all community members (as is the usual case with HCA invitations for comment).

Our comments comprise two major recommendations for changes to the draft legislation, followed by detailed comments about the amendments and information about HCA's role and commitment to supporting the South Australian health system to engage with health consumers to achieve high quality, safe, consumer-centred care for all South Australians.

MAJOR RECOMMENDATIONS

1. **Include consumers on each Board; articulate their required knowledge, skills and contribution as informed by research literature and best-practice health governance**

- The Act is being amended to 'better engage communities and clinicians in local health care decisions' (the Minister's Second Reading, 7 June 2018).
- Engagement of consumers and communities in governance and management is a critical component of this. 'Full and effective involvement' must be with communities as well as with health professionals.
- No longer can consumers – and clinicians – be seen as optional advisers to policy-makers. Services – and the boards that govern them – enter a social contract with their communities to which they must be held to account.
- Nationally and internationally, in health policy, services, research and care, trained and skilled consumer representatives are integral to health governance.
- In Australia, the National Safety and Quality Health Service (NSQHS) Standards clearly articulate the need for this partnership approach, both in their original version and the recently released second version which strengthens this evidence-informed position in Standard 1: Governance and Standard 2: Partnering with Consumers (https://www.safetyandquality.gov.au/our-work/assessment-to-the-nsqhs-standards/nsqhs-standards-second-edition/). Absence of compliance with these standards has been a feature of recent South Australian – and national - health system failures.
  The NSQHS Standards are auspiced by the Australian Commission on Safety and Quality in Health Care and endorsed by all Ministers.
- Determining the health needs of the community is crucial to the sustainability of the Boards and value of the Amendment. Consumer and community perspectives must join clinical perspectives on each board if the commitment to engaging consumers and communities is to be more than words and indeed a matter for (clinical) governance compliance.
- Personal experience by consumers indicates a role on a health advisory committee does not empower them to be involved in decision making and is a poor substitute for Board membership.

2. Enshrine community benefit for all

- The Act is being amended to 'establish a new governance and accountability framework for the public health service system' (the Minister's Second Reading, 7 June 2018). Consumers want to know what will be better as a result of this and to inform and be informed of monitoring and reporting on these promised health outcomes.
- In order to be accountable, services – and their boards – must not only achieve the NSQHS Standards; they must identify with their community's health priorities and health outcome targets and monitor and report on these over time.
- The Amendment Bill does not fully describe how the proposed change to Boards will achieve an effective balance between local decision making in relation to incorporated hospitals and health system planning and management. For example, how would a state-wide Cancer Plan interface with local priority-setting, planning and performance requirements?
- Community benefit must be delivered at local levels and recognise the interests of smaller health units.
- Health outcome targets need to be set on a state-based and local level and monitored over time. Compliance with data collection and reporting must be a high priority with outcomes monitored over time at a local, state and, where possible, national level to identify and resolve unwarranted health variations within and between communities (see ACSQHC Atlases of Health Care Variation: https://www.safetyandquality.gov.au/atlas/atlas-2017/) and interrogate health service performance for equity of access and outcome; cultural and social inclusion; and person-centred approaches to care.
- The Health Performance Council is well positioned to provide independent reporting on the achievement of state-wide health outcome targets and it is good to see their role retained. We note they are constrained by the limitations in the data collected and released for public reporting.

DETAILED FEEDBACK

3. **Part 2 Amendment of the *Health Care Act 2008***
    - **Definition**: include a definition of clinician and of consumer representative as used in this legislation (see also the notes above regarding board membership). For example, in relation to consumers: 'A consumer representative is a community member who is not a health clinician and who provides a community perspective, based on community knowledge, evidence and consultation'.
    - Consider explicit alignment with the NSQHS Standards and the Australian Health Practitioner Regulation Agency (AHPRA).
    - Consider inclusion of the link between the boards and Health Advisory Councils (HACs), for example: 'Consumer representatives, and other board members, work with Health Advisory Councils and the wider community to inform their community perspectives.' The Health Performance Council review of the governance of HACs identified the lack of clarity regarding respective roles and relationships between HACs, health services, the community and governance structures. There is an opportunity to clarify this.
    - If this functional descriptor were added, something comparable should be articulated for the clinician members of the board.
    - Define governance ie this is about clinical and corporate governance
    - 'Local Health Network Boards' is a less confusing term for the public.
    - There is no mention of collaboration/coordination with the primary health care sector or health promotion: this should be a key role of hospitals and so be included in the functions of the board.
- **(6) Principles** - include 'community' ie 'that achieves an effective balance between local community decision-making …'

4. **Section 33 Governance:**
    - **(2)((b)(i)** – add safety: 'carried out safely, efficiently, effectively and cost-effectively'
    - **(2)(b)(2)** –add health and safety: 'manages its budget so that health, safety and financial targets are met'
    - **(2)(b)(iii)** - add operations: 'hospital operations and resources are applied equitably to meet the needs of all community members served by…'

- **(2)(c)** – add community: '…ensure strategic plans, informed by community health needs and priorities, are developed for the incorporated hospital…'
- **(2)(d)** - add health and safety: '…and monitor the incorporated hospital's financial, health and safety operational performance'
- **(2)(e)(i)** - add outcomes: 'for the provision of health services and achievement of health outcomes by the incorporated hospital'
- **(2)(e)(ii)** - expand health professional engagement and the level of obligation to do this: ´to ensure consultation with health professionals working in and with the incorporated hospital and its patients'.

  Many patients see health professionals outside the geographical area: the focus on which clinicians and other health professionals are consulted should be the community ie all the professionals serving patients in those hospitals and the community covered by the board. Health professional engagement should also explicitly include primary health care/health promotion professionals and services, not just hospital personnel.
- **(2)(e)(iii)** - increase the obligation for consumer engagement: 'Ensure provision of health services and health outcomes is informed by consultation with health consumers and community members'.

  As noted above, this is required by the National Safety and Quality Health Services (NSQHS) Standards, in particular Standard 1: Governance and Standard 2: Partnering with Consumers.
- **(2)(f)** - enshrine co-design as per the NSQHS Standards: 'ensure providers and consumers of health services, and other members of the community served by the incorporated hospital, collaborate in the development, review, monitoring and reporting of the hospital's policies, plans, and initiatives for the provision of health services and health outcomes'
- **(4)(a) -** This does not provide for any scenarios where the Board held view may be in conflict with the Minister/CEO directions - how is this addressed and what autonomy does the Board for decision-making under this obligation?

5. Section 33A – Engagement strategies

- **(1)(a)** – ensure consultation ie doing, not just promoting, clinician engagement is a matter of compliance: 'a strategy to ensure consultations…'
- **(1)(a)** –for the reasons give above re (2)(e)(ii) - expand health professional engagement: ´a strategy to ensure consultation with health professionals working in and with the incorporated hospital and its patients'.

- **(1)(b)** - Within what time frame of the implementation of the enactment of this act and the implementation of the Board? The Act could/should provide for a date/time period for compliance with this – to ensure priority and all Local health Networks have a current Consumer Engagement Strategy within a required timeframe. This enables Boards, Minister and Chief Executive to monitor and measure**.**
- **(1)(b)** as for (2)(e)(iii) above - increase the obligation for consumer engagement: 'a strategy to ensure provision of health services and health outcomes is informed by consultation with health consumers and community members'.
- **Note:**
  - Health professionals and consumers should be consulted together as well as separately to achieve a whole of community perspective in governance; health professionals and consumers are partners, and should be working together to ensure decisions reflect the needs and perspectives of all parties.
  - Boards should be required to demonstrate genuine engagement with Aboriginal and other community and cultural leaders.
- **(2)(a)** – as above; expand to 'health professionals working in and with the incorporated hospital and its patients'.
- **(2)(b) –** include community and cultural leaders: 'health consumers and community and cultural leaders'. NB members of the community are health consumers.
- **(3)(b)** – add a requirement for accessibility, for example, 'published in plain language, in English and other community languages, and accessible to the public including those with sensory and other special access needs'.

  Reiterate the requirement for the board to 'develop, publish and oversee implementation of…': documents are not an end in themselves.

6. **Section 33B – Composition of governing boards for incorporated hospitals**
   - **(2)** – add 'consumer and community engagement'. This should be a competency required of all – or at least the majority – of board members.
   - **After (2)** – add 'at least 2 members of a governing board must be consumer representatives'.
   - **(4)** Consider additional not eligible criteria: 'a person has been found guilty of an offence (and define what offence would be considered under the Act)' and 'a person has conditions or restrictions on their registration as a health practitioner' (this could address concerns under (8)

- **(8)** This definition does not exclude health professionals against whom AHPRA or their relevant Board has rescinded registration, has been found guilty of an offence under the Act or who has conditions or restrictions on their practice.
  Therefore, a person who previously held registration but had their registration rescinded or conditions put on their registration for unprofessional conduct or misconduct etc could fit into this category. This could be addressed in (4) above as a criterion by which a person was not eligible for appointment to a board.

7. **Division 10 - Inspectors**
   - The scope and limits of the role of inspectors is not clear. We would support this being directly related to lack of compliance with the NSQHS Standards and the delivery of safe and high-quality health care, and health outcomes, for South Australians. Compliance, and investigation of noncompliance, should be clearly linked to both community and clinical governance frameworks which are driven by three central principles: Consumer Centred Care: Quality Care driven by Information and Organising Services for Safety.
   - Additional levels of monitoring through investigators - and advisors - will require careful and considered implementation if South Australia is to retain its current health workforce and attract a contemporary high-quality health care workforce in the future.
   - Compliance requirements should not apply to patients in the hospital; patients, carers and consumers must inform any investigation but people, while in hospital, should not be subjected to any coercion to answer questions while they are a patient – other measures must be in place to seek their views as relevant and ensure these views inform and influence an investigation.
8. **Schedule 3 – governing boards for incorporated hospitals**
   - Board members/directors must comply at all times with the requirements of high quality clinical and corporate governance.
   - **(2)** – does the term of office apply to the chair and deputy chair as well?
   - Boards can become closed to new ways of thinking. Membership/terms should be staggered to allow for refreshing of the board and/or consideration given to limiting the term to six years.
   - **(2)(3)** – reword: 'may continue in office' to allow for choice on the part of the Minister and the board director.

- **Add** (a) clause(s) regarding management of complaints/ grievance including community complaints regarding the behaviour of the board
- **4 (b)** What constitutes misconduct under the Act? ie is it related to misconduct within the role or more broadly misconduct outside of the role (eg as found by another regulatory body, workplace, court)?
- **(8)** Given the small membership (6-8) this could see a decision being made by as little as 2 members- is this rigorous enough?
- **(8)(6) –** add a requirement to accurately record, in the same manner as minutes of meetings, resolutions and the process of out-of-session decision-making
- **(9)(4)** – we expect consumers and community members will be adequately remunerated along with other committee members; that remuneration rates will be set via a transparent process such as via Tribunal; and that there will be capacity to reimburse costs.