INSTITUTIONAL RACISM MATRIX AUDIT OF SOUTH AUSTRALIA’S TEN LOCAL HEALTH NETWORKS

Report to the Health Performance Council, South Australia

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Acknowledgement of Country

The authors wish to pay our respects to and acknowledge the First Peoples of South Australia and their deep feelings of attachment and relationship to their country.

Adrian Marrie and Chris Bourke
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- The interviewees who participated in the validation process for the SA Health Matrix Template.
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LANGUAGE POLICY

The term “Aboriginal” is used in this document as an all-encompassing term for Aboriginal and Torres Strait Islander peoples and their cultures in South Australia.

ACRONYMS

1) South Australia’s Local Health Networks

- BHFLHN Barossa Hills Fleurieu Local Health Network
- CALHN Central Adelaide Local Health Network
- CHSALHN Country Health SA Local Health Network
- EFNLHN Eyre & Far North Local Health Network
- FUNLHN Flinders & Upper North Local Health Network
- LCLHN Limestone Coast Local Health Network
- NALHN Northern Adelaide Local Health Network
- RMCLHN Riverland Mallee Coorong Local Health Network
- SALHN Southern Adelaide Local Health Network
- WCHN Women’s and Children’s Health Network
- YNLHN Yorke & Northern Local Health Network

2) General

- ACCHO Aboriginal Community Controlled Health Organisation
- ACLO Aboriginal Clinical Liaison Officer
- ACSQHC Australian Commission on Safety and Quality in Health Care
- ADCQ Anti-Discrimination Commission Queensland (now the Queensland Human Rights Commission)
- AEbyE Aboriginal Experts by Experience
- AHCSA Aboriginal Health Council South Australia Limited
- AHEMGB Aboriginal Health Expert Member of (LHN) Governing Board
- AHHA Australian Healthcare and Hospitals Association
- AHP Aboriginal Health Improvement Plan
- AHMAC Australian Health Ministers’ Advisory Council
- AHP Aboriginal Health Practitioner
- AHRC Australian Human Rights Commission
- AHW Aboriginal Health Worker
- AIDA Australian Indigenous Doctors Association
- AIHW Australian Institute of Health and Welfare
- ALO Aboriginal Liaison Officer
- APHN Adelaide Primary Health Network
- ARRMHAC Aboriginal Resident Representative Member of a Health Advisory Council (HAC)
- ATODS Alcohol, Tobacco and Other Drugs Service
- ATSIHPFPM Aboriginal and Torres Strait Islander Health Performance Framework Performance Measures (AHMAC, 2011. Figure 1)
- CACAC Consumer and Community Advisory Committee
- CAESA Council of Aboriginal Elders of South Australia Inc.
- CALD Cultural and Linguistic Diversity
- CATSINaM Congress of Aboriginal and Torres Strait Islander Nurses & Midwives
- C&CES Consumer and Community Engagement Strategy
- CGCSC Closing the Gap Campaign Steering Committee
- CHSA Country Health SA
CLT  Cultural Learning Training
COAG  Council of Australian Governments
CQI  Continuous Quality Improvement
CSCF  Clinical Services Capability Framework
DHA  Department for Health and Ageing (South Australia)
DHW  Department for Health and Wellbeing (South Australia)
DoHA  Department of Health and Ageing (Commonwealth)
DPC  Department of the Premier and Cabinet (South Australia)
HAC  Health Advisory Council
HCA  Health Care Act 2008 (SA)
HHS  Hospital and Health Service (the Queensland equivalent of an LHN)
HPCSA  Health Performance Council, South Australia
HSPI  Health Service Performance Indicators
KPI  Key Performance Indicator
LHN  Local Health Network
LHNBoard  Local Health Network Board
MPHS  Multi-Purpose Health Service
NACCHO  National Aboriginal Community Controlled Health Organisation
NATSIHC  National Aboriginal and Torres Strait Islander Health Council
NATSIHP  National Aboriginal and Torres Strait Islander Health Plan 2013-2023
NHC  Nganampa Health Council
NHFA  National Heart Foundation of Australia
NHPA  National Health Performance Authority
NHRA  National Health Reform Agreement (COAG 2011)
NIRA  National Indigenous Reform Agreement (Closing the Gap) (COAG 2008)
NPACGIHO  National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes (COAG 2009)
NSQHSS  National Safety and Quality Health Service Standards (Second Edition)
OCPSE  Office of the Commissioner for Public Service Employment
PHN  Primary Health Network
PPHA  Potentially Preventable Hospital Admissions
QAIHC  Queensland Aboriginal and Islander Health Council
QH  Queensland Health
QHRC  Queensland Human Rights Commission
RAP  Reconciliation Action Plan
SA  Service Agreement (six regional LHNs)
SAACDC  South Australian Aboriginal Chronic Diseases Consortium
SAGAAAP  South Australian Government Aboriginal Affairs Action Plan 2019-2020
SAH  South Australia Health (SA Department of Health)
SAHACLF  SA Health Aboriginal Cultural Learning Framework
SAHMT  SA Health Matrix Template
SAHPF  SA Health Performance Framework
SAHMRI  South Australian Health & Medical Research Institute
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EXECUTIVE SUMMARY

Institutional racism has been identified in the Australian Government’s National Aboriginal and Torres Strait Islander Health Plan 2013-2013 and subsequent Implementation Plan as a significant barrier in the delivery of health care to Aboriginal and Torres Strait Islander people.

Institutional racism in South Australia’s local health networks (LHN) can be ameliorated in a number of ways by LHNs including:

- properly implementing relevant Australian and South Australian government closing the health gap policies;
- including Aboriginal people in the LHN governance structure, or in its advisory and consultative mechanisms;
- publicly and consistently reporting on progress and initiatives undertaken to close the Aboriginal health gap in LHN annual reports and on their websites in a way that invites public feedback and input into LHN processes;
- including both Tier 1 and Tier 2 Aboriginal health specific KPIs in LHN Service Level Agreements that properly reflect and address the current chronic disease and mental health crises in the Aboriginal community;
- providing culturally safe and appropriate health care services in accordance with nationally agreed health system performance standards;
- employing Aboriginal people in clinical and front-line services; and
- publicly and transparently reporting on Aboriginal health care funding and expenditure so that both the Aboriginal community and the general public can be assured that they are getting value for money for the services specifically provided to Aboriginal people.

These examples can act singularly or in concert to enable the optimal delivery of health services to Aboriginal people and support efforts to close the health gap. Inaction by LHNs across these areas will create barriers to achieving health equity for Aboriginal people.

On 8th August 2019 an Expert Workshop met in Adelaide to develop a Prototype SA Health Matrix Template (PSAHMT) to be used to conduct a preliminary institutional racism audit of South Australia’s ten LHNs. The PSAHMT is an adaptation of the Matrix for Identifying, Measuring and Monitoring Institutional Racism within Public Hospitals and Health Services (the Matrix) originally developed by Adrian and Henrietta Marrie in 2014. The Matrix was specifically designed to address and contribute to our understanding of institutional racism which has been identified as a barrier to effective healthcare to Aboriginal and Torres Strait Islander people in the public health system. The Matrix is based on the NSW Government Department of Education and Communities’ description of institutional racism as a:

…form of racism which [is] structured into political and social institutions. It occurs when organisations, institutions or governments discriminate, either deliberately or indirectly, against certain groups of people to limit their rights.

Validation was undertaken by a series of stakeholder webinars and interviews with Aboriginal health consumers, Aboriginal and non-Aboriginal health professionals, and Aboriginal and non-Aboriginal health administrators. The PSAHMT was then reviewed and amended to create the SA Health Matrix Template (SAHMT). This template became the auditing tool to conduct the institutional racism matrix audit of South Australia’s ten LHNs.

As an assessment tool, the Matrix offers a new approach in dealing with institutional racism providing a credible tool that can be used by government agencies, Aboriginal NGOs and researchers to assess the performance of public institutions over time in the services that they provide, and as a medium to promote public discussion and debate on the resolution of any issues that a Matrix audit might expose. In this capacity, the Matrix can act as a change agent.

In its construction, the criteria used for assessment are directly derived from the relevant national Closing the Gap partnership agreements and Federal and South Australian Closing the Gap health policies and implementation frameworks. The audit process uses only publicly available information provided, for example, in LHN annual reports, health service agreements, strategic and operational plans, agenda and minutes of LHN board meetings, and information provided on LHN web sites and social media platforms. By only using publicly available information in both the construction and assessment processes, this assures that the Matrix assessments are transparent, repeatable and verifiable. By using a simple scoring system in which each of the criteria used in the assessment process is assigned a number of points an overall score can be achieved. Thus each of the LHNs can be rated and compared, and the results of each audit can be used to focus discussions between LHNs, Aboriginal health experts, and the Aboriginal community-controlled health organisations (ACCHO) and communities within their region. The Matrix assessments can also be used to highlight examples of best practice which might be adopted by other LHNs as a part of their overall strategies to eliminate institutional racism.

Principal findings based on an analysis of the SAHMT audit results:

It is emphasised that the evidence used in the audits of the LHNs is gathered from publicly available information – primarily: LHN 2018 – 2019 annual reports and service level agreements (for the four established LHNs); regional HAC 2018 – 2019 annual reports; regional LHN 2019-2020 service agreements; LHN board meeting agenda and minutes for meetings held from July 2019; documents created by the LHNs such as strategic plans, community and consumer engagement plans; and other information available on individual LHN websites. Furthermore, the SA Health governance reforms commenced operation on 1 July 2019 when the South Australian Government established 10 LHNs with six new regional LHNs replacing the former Country Health SA LHN. The new LHN Governing Boards, with their respective Chief Executive Officer (CEO), have not had the opportunity to shape an annual report that would provide significant information for the SAHMT audit. The impact of the COVID 19 pandemic will also have affected the engagement of LHN Boards with Aboriginal communities and organisations.

The key points from the summary of findings contained in Part 4 are:

- low engagement at LHN Board level with the Aboriginal community/ies within their LHN region.
- very few LHN Aboriginal community-based consultative bodies.
- absence of evidence that LHN board members have undertaken cultural learning training (CLT) as per the SA Health Aboriginal Cultural Learning Framework.
- eight of the ten LHNs had Board Members who identified as Aboriginal people.
- nine of the ten LHNs had a stand-alone Aboriginal Health Division with an Aboriginal executive lead directly reporting to the LHN CEO.
- the inclusion of Aboriginal health within LHN Strategic Plans is incomplete.
- the Aboriginal health related Tier 2 KPIs in the current LHN Service Level Agreements do not adequately reflect or address the chronic disease and mental health burden of the Aboriginal community. There are no Aboriginal health related Tier 1 KPIs.
- more than half of the LHNs have a Reconciliation Action Plan (RAP).
- no newsletters were produced by LHNs for Aboriginal communities.
• Aboriginal community engagement and Aboriginal clinician engagement strategies were absent.
• SA Health annual reporting frameworks may not enable LHNs to properly account for the services they provide or reflect the diversity of the community they serve.
• The capacity for LHNs to provide information not deemed necessary for inclusion in their annual report may be hindered by the absence of dedicated LHN websites.
• two of the ten LHNs had an Aboriginal Health Plan.
• one of the ten LHNs was close to completing cultural safety training of their workforce.
• all LHNs reported on DAMA as a health performance indicator.
• one out of ten LHNs had an Aboriginal workforce plan.
• all LHNs reported on Aboriginal workforce representation.
• No LHNs disclosed details of funding for various Closing the Gap and other Aboriginal specific health programs received from the Commonwealth or the State.

The results of the audit indicate that nine of the 10 LHNs rate within the very high range of institutional racism, and one in the moderate range, although the Northern Adelaide LHN is on the borderline of being rated as high. The scores ranged from 21 to 84 out of a possible 200 points.

**Concluding Comments**

The audits of the ten LHNs were hampered by a lack of information to make assessments of the criteria and their sub-criteria. This information should, in-principle, have been available in LHN and HAC annual reports and on LHN websites. Information regarding Aboriginal participation in the health workforce, non-Indigenous completion rates of mandatory Cultural Safety Training programs, funding and expenditure for Aboriginal Health Closing the Gap programs and other health services, and data on health performance KPIs were unfortunately not available in the annual reports or on the websites. All this information is collected by the LHNs but is not publicly available. The standardised annual reporting requirements for all General Government Sector agencies laid out in the Premier and Cabinet’s Circular PC013: Annual reporting Requirements 2019-2020 appears to hamper the provision of detailed information within annual reports. On the other hand the LHN consumer and community engagement documents are far more “citizen-centric” reporting information that has meaning and relevance to the community, with the potential to pass an “Aboriginal citizen-centric” test. Ready access to detailed and quality information empowers Aboriginal people, organisations and communities to hold to account the LHNs for their delivery of health care and services to Aboriginal people, and enables them to more effectively participate in decision-making processes about the quality of their health care.

A second concern is that while there is a comprehensive range of KPIs selected in both the established and newly-formed regional LHN SLAs/SAs, only four Aboriginal Health-related KPIs were selected for the established LHNs and only two for the six regional LHNs. It is well known that Aboriginal people suffer disproportionately from a range of chronic health conditions, mental health issues, maternal and child-health conditions, and disruptions in the delivery of health care. More Aboriginal Health related KPIs within the SLAs/SAs, with the data recorded in LHN annual reports and on their websites, can enable public scrutiny that will enhance LHN accountability for health care delivery to Aboriginal people.
INTRODUCTION

1.1 Purpose of the report

The purpose of the report is to assess the levels of institutional racism that Aboriginal people are subject to in South Australia’s local health networks (LHN). This purpose will be accomplished by employing an adapted form of the Matrix for Identifying, Measuring and Monitoring Institutional Racism within Public Hospitals and Health Services (the Matrix) (Marrie and Marrie 2014), referred to as the SA Health Matrix Template (SAHMT), to assess each of South Australia’s ten LHNs. The Matrix was specifically designed to address and contribute to our understanding of institutional racism which has been identified as a barrier to effective healthcare to Aboriginal and Torres Strait Islander people in the public health system (see Section 1.3).

1.2 Racism in the public health system

In noting the effects of racism in the health system on the health and wellbeing of Aboriginal and Torres Strait Islander people, the Australian Indigenous Doctors’ Association’s (AIDA) Policy Statement: Racism in Australia’s health system states:

Healthcare provider racism can lead to poorer self-reported health status, lower perceived quality of care, underutilisation of health services, delays in seeking care, failure to follow recommendations, societal distrust, interruptions in care, mistrust of providers and avoidance of health care systems.³

In 2011 the Australian Institute of Health and Welfare (AIHW) reported that Indigenous Australians are more likely to end up in hospital than other Australians, particularly when the admission is potentially preventable. The rate of potentially preventable hospitalisations for Indigenous Australians was almost 5 times the rate for other Australians in 2008-09. For overall hospital admissions, the hospitalisation rate for Aboriginal and Torres Strait Islander people was almost 2.5 times the rate for other Australians.⁴

Launched in July 2013 by the Australian Government, the National Aboriginal and Torres Strait Islander Health Plan 2013-2023 (the Health Plan) identifies:

Racism [as] a key social determinant of health for Aboriginal and Torres Strait Islander people, and can deter people from achieving their full capabilities, by debilitating confidence and self-worth which in turn leads to poorer health outcomes. Evidence suggests that racism experienced in the delivery of health services contributes to low level of access to health services by Aboriginal and Torres Strait Islander peoples.⁵

The vision guiding the Health Plan is one in which:

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⁴ AIHW (2011, p. 2).
⁵ Australian Government (2013, pp. 14-15), citing Awefoso (2011). Of the new health plan, Pat Anderson, chair of the Lowitja Institute, commented that “there is one area in which this plan breaks new ground, and that is its identification of racism as a key driver of [Aboriginal and Torres Strait Islander] ill-health.” And that “there is a growing body of evidence that the health system itself does not provide the same level of care to indigenous people as to other Australians. This systemic racism is not necessarily the result of individual ill-will by health practitioners, but a reflection of inappropriate assumptions made about the health behaviour of people belonging to a particular group.” http://nacchocommuniqué.com/2014/02/28/naccho-aboriginal-health-and-racism-what-are-the-impacts-of-racism-on-aboriginal-health/ Accessed 19/03/2014.
The Australian health system is free of racism and inequality and all Aboriginal and Torres Strait Islander people have access to health services that are effective, high quality, appropriate and affordable. Together with strategies to address inequalities and determinants of health, this provides the necessary platform to realise health equality by 2031.  

The first of the key strategies identified in the Health Plan to achieve a “culturally respectful and non-discriminatory health system” is to: “Implement the National Anti-Racism Strategy 2010-2020”. In order to achieve a culturally respectful and non-discriminatory health system the Health Plan also promotes the need to: “Identify, promote and build on good practice initiatives to prevent and reduce systemic racism.”

In describing racism, the Australian Human Rights Commission (AHRC) points out that:

> It can also occur at a systemic or institutional level through policies, conditions or practices that disadvantage certain groups... On a structural level, racism serves to perpetuate inequalities in access to power, resources and opportunities across racial and ethnic groups.

The Close the Gap Campaign Steering Committee (CGCSC) argues for a:

> Genuine partnership, with shared decision-making power, in planning processes at the national, jurisdictional and community level is an extension of that clear articulation of where responsibility lies. It also further empowers: enabling communities to be heard in policy, service and program design and delivery.

However, as Howse has pointed out, the pace of the legal and policy reforms necessary for the recognition of Aboriginal and Torres Strait Islander peoples’ rights to be included in the stewardship, governance, administration and delivery of health services in which they are significant stakeholders has been “glacial”. However, there appears to be no dearth of good health policies to improve the

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6 National Aboriginal and Torres Strait Islander Health Plan 2013-2023, statement of vision guiding the Strategic Framework (Australian Government, 2013, p. 8)
7 AHRC (2012)
8 Op. cit., Note 5, p. 15. In its submission to the AHRC National Anti-Racism Strategy consultation, the Royal Australian College of General Practitioners National Faculty of Aboriginal and Torres Strait Islander Health recommended, inter alia, “inquiring into institutionalised racism towards Aboriginal and Torres Strait Islander peoples in the health system” (AHRC 2012b, p. 15).
9 AHRC (2012, p. 3). Unfortunately no working definitions are given to enable observers to identify and distinguish between systemic, institutional and structural forms of racism in the National Anti-Racism Strategy. In the context of the Matrix, structural racism is located at the legislative level as health care laws effectively provide the legislative architecture or infrastructure which structures governance, management, performance, employment, reporting and accountability arrangements. If the needs of the Indigenous population are not visible in the relevant laws, this has a flow-on effect within public hospitals and health services. Systemic racism is treated more as a senior and middle management phenomenon, particularly within the domain of human resources departments/units charged with the management of workplace relations. In identifying institutional racism, this is seen as a phenomenon that has many manifestations that can occur across all facets of an organisation’s activities and as reflected in the culture of an organisation as a whole - therefore, from a point of view of analysis and measurement institutions/organisations are treated holistically as discrete entities. In terms of their relationship, structural racism (in this case referring to health care laws) is the fundamental driver of institutional culture, institutional racism encompasses the various direct and indirect manifestations of racism within an institution as a whole, and systemic racism is a particular manifestation of racism primarily occurring within workplace management, and which can also be a primary site where interpersonal racism can occur.
10 Holland (2014, p. 9).
health and life expectancy of Indigenous Australians, many of which have been around for a decade or more\textsuperscript{12} – the problem appears to be more a case of the slow up-take and implementation of those policies particularly by public hospitals and health services at the local level, and a lack of accountability mechanisms, reinforced by legislation and regulation, to make them do so. In this context, Professor Mick Dodson expresses the perennial frustrations of a generation of people who have long sought to bring about changes in the way Indigenous affairs policies and practices are implemented:

In part the unfinished business is the myriad of reports, commissions, inquiries and studies we as a nation have conducted over decades. We’ve had health reports, housing reports, education reports, welfare reports, community violence reports, law reform reports, economic development reports, employment and unemployment reports, Social Justice Commissioner reports, death in custody reports, the taking of children away reports, the list is almost endless... and on top of this we’ve had assessments, evaluations, pilots, trials, umpteenth policies and policy approaches. And all of this paperwork would comfortably fill a couple of modest suburban libraries. And, it’s on the shelf where most of them have stayed. They’ve stayed their unread, unfinished, their recommendations unimplemented, and they’re very much unloved.\textsuperscript{13}

The fate of these reports is itself a manifestation of institutional racism.

One of the key messages in a recent report to the National Aboriginal Community Controlled Health Organisation (NACCHO)\textsuperscript{14} is that: “The failure of mainstream [health] programs to deliver adequately lies at the heart of the continuing disadvantage of Aboriginal and Torres Strait Islander people.”\textsuperscript{15}

Issues of racism affect Aboriginal and Torres Strait Islander health workforce employees and patients alike.\textsuperscript{16} Of paramount concern is the need to address issues of racism and racial discrimination, both individual/casual and institutional, in the delivery of healthcare services to Aboriginal and Torres Strait Islander people. The CGCSC, in its 2017 report, recommended that the Federal Government hold a national inquiry into racism and institutional racism in health care settings, and hospitals in particular, with the findings to be incorporated into the actioning of the Implementation Plan of the National Aboriginal and Torres Strait Islander Health Plan 2013-2023.\textsuperscript{17}

\textsuperscript{12} Many of these federal and state/territory Indigenous healthcare policies relate, for example, to increasing Indigenous participation in the health workforce, cultural learning/competency, and inclusion in senior decision-making levels, date back a decade or more. These include: AHMAC’s Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework (2002) and Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004-2009 (2004); the Department of Health and Ageing National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013 (2003); and at state level, the Aboriginal Health Care Plan 2010-2016 (SA Health 2010).

\textsuperscript{13} Dodson (2016), quoted in CGCSC (2017, p. 6).

\textsuperscript{14} National Aboriginal Community Controlled Health Organisation – the peak body representing the 150 Aboriginal community controlled health organisations around Australia.

\textsuperscript{15} Alford (2014, p. 9).

\textsuperscript{16} With regard to personal/casual racism against Aboriginal and Torres Strait Islander employees, see for example, Marrie H (2014), Addressing Allegations of Discrimination Against Aboriginal and Torres Strait Islander (ATSI) Employees of the Cairns & Hinterland Hospital and Health Service (CHHHS) and Review of Support Avenues for the ATSI Workforce (Report to the CEO, Cairns & Hinterland Hospital and Health Service), Bukal Consultancy Services P/L, Gordonvale Qld; Moreton-Robinson (2007); and AIDA (2016, p. 2) recognises that “systemic racism as well as racist remarks or behaviour, and inadequate reporting and follow-up mechanisms have a detrimental effect on the growth of the Aboriginal and Torres Strait Islander medical workforce.”

\textsuperscript{17} CGCSC (2017, p. 4).
In a paper which has particular implications for improving healthcare outcomes for Aboriginal people with chronic disease such as end-stage kidney disease where Aboriginal and Torres Strait Islander people have at least six times the age-standardised incidence as non-Indigenous Australians (and in rural and remote areas, rates are up to 15 times higher), Bourke et al (2020) identify institutional racism as one of the four intersecting domains that need to be addressed to improve the provision of kidney care to Aboriginal and Torres Strait Islander patients by non-Indigenous health care professionals and healthcare organisations.

In the WCHN Aboriginal Health Plan 2018-2022 (WCHN, 2018a), the impacts of racism were consistently raised throughout the state-wide consultations for the development of the plan as a major issue for Aboriginal people when accessing health services/care. Racism was consistently identified as a significant barrier, with individual and systemic or institutional racism being cited as something that needs to stop. Accordingly, the Aboriginal Health Steering Committee has endorsed an additional strategic priority, namely, Tackling Racism and Discrimination. Closing the gap between Aboriginal and non-Aboriginal life expectancy will be impossible if racism and discrimination is not addressed (p. 19).

In the SA Health Aboriginal Cultural Learning Framework (SA Health 2017a. pp. 2, 4, and16) with respect to Learning Outcomes – Respect for Aboriginal culture: Level 3 Organisational Learning, one of the learning outcomes is to: “rectify institutional racism.”

1.3 Institutional racism: a barrier to health equity

Racism can be broadly defined as the behaviours, practices, beliefs and prejudices that underlie avoidable and unfair inequalities across groups in society based on race, ethnicity, culture or religion.\(^\text{18}\) Racism can be expressed through stereotypes (racist beliefs), prejudice (racist emotions) or discrimination (racist behaviours and practices).\(^\text{19}\) Racism can occur at three conceptual levels - internalised, interpersonal and institutional - that are interrelated and frequently overlap in practice.\(^\text{20}\) Most importantly, as Dudgeon et al point out:

> An institution can engage in racist practices without any of its members being individually racist. This is an important point to comprehend if we are to understand the damaging health and educational outcomes affecting Indigenous people. The \textit{de jure} and \textit{de facto} rules of an institution, the aggregation of individual behaviours, and institutional culture can all achieve racist outcomes in the absence of a deliberate intention to do so by any individual within the institution.\(^\text{21}\)

Regarding the reference to institutional racism, in the discussion paper arising from the \textit{Racism and Indigenous Health} symposium held in November 2007 at Melbourne University (the Melbourne symposium), systemic racism is also referred to as institutional racism.\(^\text{22}\) However, a distinction is made here between institutional racism and systemic racism - for the purposes of the Matrix they are not seen as being synonymous. Institutional racism is contextualised in reference to organisations or institutions as discreet entities, and the institutional culture which exists within them which is largely created and driven by the decision-makers at board and executive levels. Boards and executive groups can exercise a degree of autonomy and flexibility within the limits of

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\(^{\text{19}}\) Paradies (2006).

\(^{\text{20}}\) Paradies et al (2008, p. 4). In this assertion, the term “institutional” has been substituted for “systemic” in the original.

\(^{\text{21}}\) Dudgeon et al (2010, p. 36).

\(^{\text{22}}\) Ibid.
the laws and policies under which the institution they govern must operate. Systemic racism refers more to the actual set policies, rules, health industry awards and procedures that exist (in this case across a state or territory’s public health service/system), their observance and management in the day-to-day operation of an organisation, and the decisions that flow from them that may unfairly impact people (both employees and clients) of a particular racial, ethnic, religious or cultural group. Systemic racism is sometimes referred to by Aboriginal people as “red-tape racism” and largely emanates from their experiences with Human Resource/People and Culture departments and can be closely associated with interpersonal racism.

Accordingly, and for the purposes of developing the Matrix, the NSW Government Department of Education and Communities’ description of institutional racism has been used, which describes institutional racism as a:

...form of racism which [is] structured into political and social institutions. It occurs when organisations, institutions or governments discriminate, either deliberately or indirectly, against certain groups of people to limit their rights.23

And systemic racism, in the context of the Matrix, refers to:

The observance and administration of policies, rules and procedures that purport to treat everybody equally, but are unfairly or inequitably administered or applied in dealings with people belonging to a particular racial, ethnic, religious or cultural group.

In noting the relationship between internalised,24 interpersonal,25 systemic and institutional racism, it is institutional racism that fundamentally underpins racial/ethnic inequalities in health. Institutional racism is the most pervasive form of racism across a range of life domains and influences other social determinants of Indigenous health such as housing, education, employment, and justice administration.26

The Melbourne symposium discussion paper also points out that “systemic [institutional] racism can persist in institutional structures and policies in the absence of prejudice at the individual level and that it is a fundamental cause of both internalised and interpersonal racism.”27

Both institutional and systemic racism also generally fall into the category of “indirect racism”. Indirect racism frequently arises out of policies that purport to treat everyone equally but which, nevertheless, impact groups differently and therefore results in an unequal distribution of power,

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24 Paradies et al (2008, p. 4) define internalised racism as the:

Acceptance of attitudes, beliefs or ideologies by members of stigmatised ethnic/racial groups about the inferiority of one’s own ethnic/racial group (e.g. an Indigenous person believing that Indigenous people are naturally less intelligent [or capable] than non-Indigenous people).

25 Ibid. Interpersonal racism refers to:

Interactions between people that maintain and reproduce avoidable and unfair inequalities across ethnic/racial groups (e.g. experiencing racial abuse).

26 This paragraph is largely derived from the following quote from the Melbourne symposium discussion paper:

Symposium participants readily acknowledged the importance of each of these levels of racism [ie, internalised, interpersonal and systemic racism], but noted that systemic racism is the level of racism that fundamentally underpins racial/ethnic inequalities in health. Systemic racism is the most pervasive form of racism across a range of life domains such as education, employment, and housing. These life domains have, in turn, been found to strongly influence health and wellbeing (Marmot & Wilkinson 1999).

27 Ibid.
access to resources and services, and opportunities across different racial, ethnic, cultural and religious groups. Aboriginal people often refer to this situation whereby everyone is to be treated equally, as “mainstreaming”, especially when services once delivered through community controlled organisations, are instead delivered to their communities via mainstream organisations such as some of the large charities, and training and employment providers, and in doing so, create a self-serving Indigenous industry feeding off the misery of Aboriginal people. This raises the issue of the cultural competency of such organisations to deliver services to Aboriginal people, and the spectre of the increased incidence of institutional racism as Aboriginal people are further removed from being included in decision-making structures regarding the design, planning, implementation and delivery of the services to be provided to them.

Aboriginal people as employees working in LHNs that exhibit a very high degree of institutional racism, also suffer consequences – disempowerment, marginalisation and de-moralisation. High levels of institutional racism can foster an institutional culture in which interpersonal and systemic racism can thrive. Furthermore, such a culture can discourage Aboriginal people from seeking employment in hospitals and health services – a serious consequence when Aboriginal participation in the health workforce is desperately needed to raise the overall cultural competency of LHNs. Systemic racism can fester in middle level management, for example, in decisions regarding the need for and number of identified positions for Aboriginal people in the health workforce and the public service level of their employment, fulfilling federal and state/territory Indigenous health workforce participation targets by only employing Aboriginal people in junior or non-clinical positions, denial of career advancement and training opportunities to Aboriginal health workers, workplace deployment, unnecessary demarcation/award disputes (such as over the respective duties and responsibilities of Aboriginal Health Workers and nurses), and criteria for patient assisted travel.

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28 See Ferdinand et al (2012, p. 3). In the Queensland Government’s Anti-Discrimination Human Resources Policy, for example, indirect discrimination is defined as:

Any outcomes of rules, practices and decisions which purport to treat people equally and therefore appear to be neutral, but which are unreasonable and reduce an individual’s chances of obtaining a benefit or opportunity eg height weight requirements for candidates for a role which are irrelevant (Queensland Government 2009, p. 7).


30 See, for example, Marrie H (2015).

31 As the Coalition for Aboriginal Health Equity Victoria reports:

Racism has flow on effects for individuals’ social cohesion and for their levels of workforce productivity and educational achievement. The effects of racism for employees and employers include high rates of absenteeism, low overall workplace morale and productivity, high staff turnover, and increased health care and social service costs (Coalition for Aboriginal Health Equity Victoria 2013, p. 3).

32 For example, Moreton-Robertson (2007:91), while serving as an expert witness for a case involving allegations of racially discriminatory behaviours by white nurses against an Aboriginal nurse in the Townsville Hospital in 2002, noted that the nurses could make statements consistent with racial stereotypes that position Aboriginal and Torres Strait Islander people as inferior, less than human and unworthy of the same treatment as non-indigenous people because they “felt safe in the institutional context to air such views. Their sense of safety signals that such comments are considered normal within the white space of the hospital.”

33 See, for example, Felton-Busch et al (2009, p. 4); AIDA (2016, p. 2).


35 For example, in the Northern Territory, Aboriginal patients needing medical treatment from a Health Centre may apply for patient travel assistance under the Patient Assisted Travel Scheme (PATS), however, it is not accessible for those patients who live within the 200km zone of the Health Centre. As Dunbar reports: “the objectives of a policy [in this case the PATS] to assist patients gain safe access to service can have quite the opposite effect if it is developed without knowledge about the social, demographic, environmental and cultural contexts for Aboriginal patients” (Dunbar 2011, pp. 10 and 16)
1.4 Diversity of South Australia’s LHNs
The primary responsibility for delivering public health care to South Australians is borne by ten local health networks (LHNs) – technically by nine LHNs and one statewide health service, the Women’s and Children’s Health Network. For the most part in this report, WCHN will be referred to as an LHN. The three metropolitan LHNs and the WCHN are the four established LHNs, and with the demise of the CHSALHN on 30th June 2019, six new regional LHNs were established and began operations on 1st July 2019.

Aboriginal people constitute approximately 2% of the South Australian population, and of that population, a little more than half (53%) reside in metropolitan Adelaide. As Table 1 indicates, the regional Aboriginal population is widely scattered throughout South Australia.

Table 1: SA LHNs non-Indigenous and Indigenous population data, and location of ACCHOs

<table>
<thead>
<tr>
<th>LHN</th>
<th>Total Pop.</th>
<th>Indigenous</th>
<th>% Indigenous</th>
<th>ACCHOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHFLHN</td>
<td>205,000</td>
<td>2,000</td>
<td>1.0</td>
<td>0</td>
</tr>
<tr>
<td>CALHN</td>
<td>444,912</td>
<td>4,975</td>
<td>1.1</td>
<td>2</td>
</tr>
<tr>
<td>EFNLHN</td>
<td>41,000</td>
<td>5,000</td>
<td>12.1</td>
<td>5 + NHC</td>
</tr>
<tr>
<td>FUNLHN</td>
<td>50,000</td>
<td>4,400</td>
<td>8.7</td>
<td>2</td>
</tr>
<tr>
<td>LCLHN</td>
<td>66,000</td>
<td>1,150</td>
<td>1.7</td>
<td>1</td>
</tr>
<tr>
<td>NALHN</td>
<td>388,396</td>
<td>8,054</td>
<td>2.1</td>
<td></td>
</tr>
<tr>
<td>RMCLHN</td>
<td>70,000</td>
<td>2,500</td>
<td>3.5</td>
<td>1</td>
</tr>
<tr>
<td>SALHN</td>
<td>355,549</td>
<td>4,218</td>
<td>1.2</td>
<td></td>
</tr>
<tr>
<td>WCHN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>YNLHN</td>
<td>77,000</td>
<td>1,800</td>
<td>2.3</td>
<td>0</td>
</tr>
</tbody>
</table>

1.5 Objectives of the audit
The primary objectives of the audit are to:
- Promote transparency in Closing the Gap policy implementation and accountability;
- Provide a framework for discussion about institutional racism in the public health sector;
- Establish base-line scores from which to monitor progress;
- Contribute to the national goal of a public health system free of racism and inequality; and
- Address other relevant national health standards.

1.5.1 Promote transparency in Closing the Gap policy implementation and accountability
During research conducted on the Cairns and Hinterland Hospital and Health Service (CHHHS) in December 2013-January 2014 to find out background information about the operations and culture of the public health system to help inform the preparation of a report concerning allegations of individual racist behaviours against Aboriginal and Torres Strait Islander employees, it became apparent that, in spite of excellent federal and Queensland Closing the Gap policies and frameworks, these were not being implemented in a way that was transparent, clear and consistent to someone outside the system. Furthermore there was great variation in public annual reporting between
neighbouring hospital and health services (HHSs) regarding what was being disclosed and how it was presented. For example, core Closing the Gap KPIs were not being consistently reported on and in a format that invited easy comparison. There was a universal disregard for financial transparency with regard to disclosure of Closing the Gap Commonwealth and Queensland funding contributions, and inconsistent reporting on workforce data regarding the employment of Aboriginal and Torres Strait Islander people. While all this data was being internally recorded by Queensland Health, it was not being publicly disclosed. It was difficult, for example, to find out exactly how a HHS was performing and contributing to Closing the Gap in Indigenous health outcomes via the publication of relevant data sets.

The Matrix addresses these issues by putting in place a set of criteria, which are in turn broken down, for most of the criteria, into sets of sub-criteria that can be consistently applied across all LHNs to measure LHN performance. This will also enable comparisons between LHNs to be made.

1.5.2 Provide a framework for discussion about institutional racism

Both the Matrix as an assessment tool, and the assessments of LHNs that it produces, can be used to promote discussion at the local LHN level. Despite the scores, Aboriginal people in some LHN areas may enjoy a good relationship with their LHN and be happy with the healthcare services they receive. Others may see a need for profound change in relation to, for example, LHN Board interaction with the Aboriginal community/ies within the LHN region, more effective consultation mechanisms, more Aboriginal people employed within the LHN, and better standards of public reporting and accountability in the LHN annual report and website so they get a clear picture of how the LHN is performing in relation to closing their Aboriginal health gap.

To facilitate such discussion, the Matrix is designed to do a number of things:

- In a broader sense, enable LHNs to “see what institutional racism looks like”, that is, its identification purpose.
- Measure LHN compliance with federal and South Australian policies for Closing the Gap in Indigenous Health Outcomes to encourage accountability of the LHN to the Aboriginal community for the health services it provide.
- Encourage and focus discussion and consultation with local Aboriginal communities to reflect both the local circumstances and the manner of their engagement with their local LHN.
- Incorporate examples of best practice within LHNs. Thus it can also be used as an aspirational tool by including things that should be happening to make LHNs more effective and accountable in providing health care to Aboriginal people and, thus by extension, speed up the process in Closing the Gap on Indigenous Health Outcomes.  
- Enable LHNs/HHSs within a state/territory, or nationally, to be rated and compared while taking into account different state/territory and local LHN/HHS circumstances and characteristics.
- Be used by a LHN as an internal monitoring tool – as a check list or annual report card.
- Enable public health administrators to confront institutionalised racism by “examining structures, policies, practices, and norms to identify the mechanisms of institutionalized racism”.

36 For example, following the lead of the WCHN by establishing their own Aboriginal Health Scorecard.

37 From this perspective it is no different from the National Health Performance Authority releasing data on, for example, rates of golden staph infections in hospitals around the country. “The release of such data which names and shames poor performing hospitals allows them to compare themselves to better performing hospitals and to see how they improved over time.” (Dunleavy 2014, quoting NHPA chief Dr Watson). According to Professor John Tunbridge who leads the program for national surveillance of antimicrobial resistance and antibiotic usage, “the public reporting of infection rates has driven hospitals to improve infection control” (Dunleavy 2014).
“racism” as it is only through intervening at the institutional level that profound and permanent change can occur.  

1.5.3 Establish baseline scores from which to monitor progress

This objective of the Matrix audit is to provide a set of base-line scores for all 10 LHNs so that future audits can be compared over time – the monitoring function of the Matrix. Notwithstanding that public health system priorities, and federal and state/territory health policies also change over time, once properly established as a credible assessment tool (used either internally by health departments and their LHNs, or externally by monitoring agencies), the Matrix should be able to serve as a tool for monitoring health system performance for the elimination of institutional racism, but also provide a gauge as to the economic costs of racism within the health system (see Section 3.1).

1.5.4 Contribute to the national goal of a health system free of racism and inequality

In 2015 the Australian Government released its Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023. Under the domain of health systems effectiveness, Strategy 1B is concerned that:

Mainstream health services are supported to provide clinically competent, culturally safe, accessible, accountable and responsive services to Aboriginal and Torres Strait Islander peoples in a health system that is free of racism and inequality.

One of the actions to support this strategy is that: “Systemic racism and discrimination is better understood, addressed and prevented”, and that by 2018:

System levers and accountability mechanisms established for addressing racism and discrimination have been developed and their implementation promoted.

It is hoped, therefore, that this Matrix audit of South Australia’s LHNs will assist in establishing the kind of system levers and accountability mechanisms necessary for the elimination of racism and inequality in mainstream health services, but particularly the public health system.

1.5.5 Address other relevant national health standards

1.5.5.1 Aboriginal and Torres Strait Islander Health Performance Framework Performance Measures (ATSIHPFPM)

The Aboriginal and Torres Strait Islander Health Performance Framework Performance Measures (ATSIHPFPM) (AHMAC, 2012) was designed to measure the impact of the National Strategic Framework for Aboriginal and Torres Strait Islander Health (NSFATSIH) and was an important tool in the development of the National Aboriginal and Torres Strait Islander Health Plan 2013-2023. The ATSIHPFPM monitors progress in Aboriginal and Torres Strait Islander health outcomes, health system performance and the broader determinants of health. The ATSIHPFPM covers the entire health system, including Indigenous-specific services and programs, and mainstream programs. The Matrix is concerned to measure health system performance particularly from the perspective of Aboriginal community engagement, LHN accountability and service delivery.

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38 Jones (2003, p. 11).
40 Ibid., pp. 10 and 12.
1.5.5.2 National Safety and Quality Health Service Standards (NSQHSS)

The National Safety and Quality Health Service (NSQHS) Standards were developed by the Australian Commission on Safety and Quality in Health Care in collaboration with the Australian Government, states and territories, the private sector, clinical experts, patients and carers. The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of health service provision. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure that expected standards of safety and quality are met (ACSQHC, 2017, p. 1). Table 2 below describes the NSQHSS Aboriginal and Torres Strait Islander standards.

Table 2: NSQHSS Aboriginal and Torres Strait Islander specific standards

<table>
<thead>
<tr>
<th>Standard</th>
<th>Item</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Clinical Governance</td>
<td>Governance, leadership, and culture</td>
<td>1.2 The governing body ensures that the organisation’s safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people.</td>
</tr>
<tr>
<td></td>
<td>Organisational leadership</td>
<td>1.4 The health service organisation implements and monitors strategies to meet the organisation’s safety and quality priorities for Aboriginal and Torres Strait Islander people.</td>
</tr>
<tr>
<td></td>
<td>Safety and quality training</td>
<td>1.21 The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients</td>
</tr>
<tr>
<td></td>
<td>Safe environment</td>
<td>1.33 The health service organisation demonstrates a welcoming environment that recognizes the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people</td>
</tr>
<tr>
<td>2. Partnering with Consumers</td>
<td>Partnerships in healthcare governance planning, design, measurement, and evaluation</td>
<td>2.13 The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs</td>
</tr>
<tr>
<td>5. Comprehensive Care</td>
<td>Planning for comprehensive care</td>
<td>The health service organisation has processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin and record this information in administrative and clinical information systems.</td>
</tr>
</tbody>
</table>

Source: ACSQHC, 2017.

The Prototype Matrix has incorporated criteria and sub-criteria to specifically address NSQHS Standards 1.21, 2.13 and 5.8.

MATRIX FOR IDENTIFYING, MEASURING AND MONITORING INSTITUTIONAL RACISM WITHIN PUBLIC HOSPITALS AND HEALTH SERVICES ("the Matrix"
Within the overall framework for Closing the Gap on Indigenous Health Outcomes, there appear to be no indicators or assessment tools to measure public health sector engagement and inclusion of Aboriginal people directly in, for example, decision-making processes at board and executive levels, policy formulation and implementation, and service and program design and delivery of the health services provided to Aboriginal communities – particularly at the local level of health service delivery. It is also critically important that Aboriginal people are engaged in community consultative mechanisms to help guide the above processes. Such engagement is necessary if local LHNs are to provide culturally secure, responsive, respectful, appropriate and clinically safe health care to Aboriginal people and their communities.

The Matrix has therefore been developed as a tool for external assessment purposes to provide an objective, evidence-based, straight-forward and easy way to identify, measure and monitor racism in an institutional setting and to provide a measure for public health sector engagement with Aboriginal people in the decision-making, planning, implementation and accountability processes regarding Aboriginal community healthcare needs and service delivery. As such, it is also intended to complement those assessment tools that have been developed for internal assessment purposes – to broaden the range of tools available. In using the Matrix, the information needed both in framing

41 Cultural security is defined as:
...the final stage in a continuum of development from cultural awareness, safety, and competency to security. Key principles for implementation of a cultural security policy include: changing service providers’ behaviour; improving understanding of service providers’ own cultural influences; actions at the structural, systemic and individual levels; ongoing organisational cultural competency evaluations that involve industry partners and Indigenous clients. Critically, this definition operates within the human rights agenda. It encompasses an active conceptualisation of cultural security, emphasising ‘behaviour’ over ‘attitude’ and ‘action’ over ‘understandings’. ... cultural security is inclusive of the other cultural states on the cultural continuum: awareness, safety and competency. (Dunbar, 2011, p. 4, citing Coffin, 2007. See also Dunbar et al, 2009)

42 Koolin Balit: Victorian Government strategic directions for Aboriginal Health 2012-2022 defines ‘cultural responsiveness’ as referring to “healthcare services being respectful of, and relevant to, the health beliefs, health practices and cultural needs of Aboriginal communities” (Victorian Government 2012, p. 60).

43 The first of the nine principles underpinning the 2002 Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework is cultural respect – ‘ensuring that the cultural diversity, rights, views, values and expectations of Aboriginal and Torres Strait Islander Peoples are respected in the delivery of culturally appropriate health services’ (AHMAC 2002, p. 2). Cultural Respect, as defined in the Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004-2009, is the: “recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander Peoples.” Furthermore:

Cultural Respect is about shared respect. Cultural Respect is achieved when the health system is a safe environment for Aboriginal and Torres Strait Islander peoples and where cultural differences are respected. It is a commitment to the principle that the construct and provision of services offered by the Australian health care system will not unwittingly compromise the legitimate cultural rights, practices, values and expectations of Aboriginal and Torres Strait Islander peoples. The goal of Cultural Respect is to uphold the rights of Aboriginal and Torres Strait Islander peoples to maintain, protect and develop their culture and achieve equitable health outcomes. (AHMAC, 2004, p. 7).

44 The terms cultural awareness/competence/respect/responsiveness and safety are each briefly defined in the Victorian Government Department of Human Services Aboriginal Cultural Competence Framework (2008, p. 56), and also more recently in the Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health (AHMAC 2016, p. 18).

45 These terms have also been further refined for use in the new Cultural Respect Framework 2016 – 2026 for Aboriginal and Torres Strait Islander Health (AHMAC 2016, p. 18). For a recent discussion of these concepts, see also Bainbridge et al (2015, pp. 23-24).

46 That is, evidence that can be found in officially sanctioned information made available to the public.
the criteria and sub-criteria and measuring responses can be found in publicly available documents, most notably, annual reports, federal and state/territory health sector reports, service agreements, LHN websites, and federal and state/territory policies. Once the state/territory policy settings have been initially determined as a prelude to the assessment of the LHNS/HHSs within their jurisdiction, and the sub-criteria have been established, then assessments should be able to be undertaken via desktop analysis. It is also important for legal reasons that the information be publicly available or in the public domain.

Based on research to date, the Matrix appears to be unique in that:

1) It relies on publicly available sources of information to score each of the criteria and sub-criteria. In this respect, LHN annual reports, for example, as documents of public accountability are assessed as much on what they contain, as on what they don’t.

2) It is intended as an external as well as internal assessment tool. Tools reviewed to date have all been intended for internal assessment purposes. Internal assessments usually remain “in-house”, will probably remain that way so that the public is none the wiser, and do not and are not intended to create comparative data. In this respect, the Matrix would enable, for example, health research institutes, peak Indigenous health bodies, industry bodies like the Australian Healthcare and Hospitals Association and the Social Determinants of Health Alliance, or relevant government agencies to undertake LHN/HHS assessments within any state or territory and compare results.

3) Through its reliance on publicly available information, it establishes an assessment process which is open, transparent, verifiable and publicly available and which reflects the current health policy environment.

4) It is simple and cost effective to administer. Once the policy settings have been established for each state/territory jurisdiction as a prelude to assessing the LHNS/HHSs within that jurisdiction, and the sub-criteria have been developed, assessments can essentially be undertaken by a single individual via desktop search of the relevant publicly available sources of information.

5) In keeping with its simplicity and cost effectiveness, it is designed to be able to regularly monitor a LHN’s/HHS’s progress in reducing and ultimately eliminating institutional racism over time.

6) It can be adapted/reconfigured for used by members of a single racial, ethnic, religious or cultural community or other group which experiences discrimination to enable them to undertake their own assessments of agencies/organisations/service providers that they interact with. Current internal assessment tools tend not to focus on specific groups, but address workplace diversity in all its manifestations.

7) Scores obtained by using the Matrix have the potential to be correlated with other Health System Performance data, including clinical data, to provide measures of the cost-effectiveness of the elimination of institutional racism from LHNs/HHSs.

The Matrix has been developed to speed up the process of identifying and addressing the institutional factors that exclude or impede Aboriginal people from fully participating in the design and delivery of public health services for their communities. The Matrix can therefore provide a useful tool for Aboriginal communities through their peak representative health bodies, such as the Aboriginal Health Council of South Australia (AHCSA), public health administrators and academics, and human rights agencies and advocates to rate and make accountable the public LHNs that provide healthcare services to, in this instance, Aboriginal people and their communities.

47 Policies also include agreements, plans, strategies, frameworks, etc.
48 While the Matrix has been designed specifically for hospitals and health services, it can be adapted for other kinds of services and agencies in which Aboriginal people have a direct interest. Such agencies include
1.6 Brief history of the Matrix

Developed in 2014 as an unfunded initiative by its creators Adrian and Henrietta Marrie, the Matrix was first used to conduct an audit of the Cairns and Hinterland Hospital and Health Service (CHHHS) to provide a case study of its application. The development of the Matrix is a by-product of a confidential report *Addressing Allegations of Discrimination Against Aboriginal and Torres Strait Islander (ATSI) Employees of the Cairns & Hinterland Hospital and Health Service (CHHHS) and Review of Support Avenues for the ATSI Workforce* 49 commissioned by the Chief Executive of the CHHHS in November 2013. In the course of interviews and background research, it became clear that signifiers of institutional racism were also evident, and that elements of important federal and Queensland Aboriginal and Torres Strait Islander Closing the Gap health policies were largely being ignored by the CHHHS. A number of Aboriginal and Torres Strait Islander interviewees were frustrated and demoralised, and felt marginalised by the loss of many of their colleagues during the Queensland Public Service 2012-13 restructure and the forced redundancy of the Indigenous executive director of the Aboriginal and Torres Strait Islander Health Division and its amalgamation into a “super division”- the Division of Strategy, Planning, Performance and Aboriginal and Torres Strait Islander Health headed by a non-Indigenous person. A number of the interviewees also pointed out that, unlike the Townsville Hospital and Health Service, there was no Indigenous board member – this for a HHS serving some 40,000 Aboriginal and Torres Strait Islander people in far north Queensland, and in a hospital where, anecdotally, and as a consequence of the disproportionate share of the burden of disease, roughly a third of the patients were Indigenous. However, it was necessary to expose the situation in an objective and constructive way. A literature search of institutional racism on the internet in early 2014 did not reveal the existence of a suitable tool capable of delivering an evidence-based external assessment of the nature and extent of institutional racism as it manifested within a particular organisation or institution, although there were some tools that provided some direction as to how this might be achieved. One such tool was produced by the Seattle Human Services Coalition, *Identifying Institutional Racism Folio: Tools to assist human service organisations identify and eliminate institutional racism in their organization* 50, and was used to help establish the structure of the Matrix.

The Matrix was developed initially as a national template during February-April 2014, and then adapted to Queensland Health’s legislative and policy environment. The Matrix was trialled on the CHHHS in June 2014. 51 The CHHHS scored 14 points out of a possible 140 – placing it at the extreme end of the scale of institutional racism. The case study was delivered to the CHHHS Chief Executive, with copies sent to the AHRC and ADCQ. The far northern regional manager of the ADCQ, with the endorsement of the Commissioner, established the Optimal Health Project Team to address issues raised by the CHHHS Matrix assessment with senior staff of the CHHHS and senior representatives of three local Aboriginal and Torres Strait Islander Community Controlled Health Services (ATSICCHS), local public health academics, and the two directors of Bukal Consultancy Services P/L – the authors of the CHHHS case study. The Team met bi-monthly for nearly two years.

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49 Marrie H (2014).


51 Marrie and Marrie (2014).
During 2015, the CHHHS Matrix assessment case study was quite widely distributed and was made available on the internet by Dr Mark Lock, and copies personally delivered at interviews with AHHA and AIHW senior personnel, and to representatives of the Close the Gap Steering Committee and the Lowitja Institute.

In September 2015, ADCQ’s Commissioner invited Robyn McDermott, Professor of Public Health Medicine, Centre for Chronic Disease Prevention, Australian Institute of Tropical Health and Medicine to review the Matrix. In her review, Professor McDermott stated:

This is a valuable and important development which can improve transparency, accountability and ultimately the performance of HHS in service delivery to Aboriginal and Torres Strait Islanders.

Further she recommended that:

The Matrix should be reviewed by an expert panel in population and health services to identify areas for improvement in the measures, if any, and make comments on the utility or otherwise of the Matrix in this and other jurisdictions.

The Matrix attracted a lot of interest from within Australia and overseas. The Close the Gap Campaign Steering Committee in its Progress and priorities report 2016 welcomed … the ongoing work of member the Australian Healthcare and Hospitals Association and its partners to validate the Marrie Institutional Racism Matrix (MIRM). This was developed in 2014 as ‘a tool for external assessment purposes to identify, measure and monitor racism in an institutional setting’ and ‘to provide a measure of public health sector engagement with Aboriginal and Torres Strait Islander people in the decision-making, planning, implementation and accountability processes regarding Aboriginal and Torres Strait Islander community healthcare needs and service delivery’. It is hoped the MIRM will make a significant contribution to understanding institutional racism in health services over the next decade.

In February-April 2016, the Matrix creators conducted a preliminary Matrix assessment of Queensland Health’s 16 HHSs. As a result, the Matrix was substantially revised. In July 2016, the ADCQ’s Commissioner, in partnership with the Queensland Aboriginal and Islander Health Council (QAIHC), contracted Adrian Marrie to conduct a full Matrix audit of the state’s HHSs. The report Addressing Institutional Barriers to Health Equity for Aboriginal and Torres Strait Islander People in Queensland’s Public Hospital and Health Service (Marrie 2017) (the ADCQ report) was delivered to the Commissioner in March 2017.

Given the severity of the report’s findings, and to avoid potentially unwanted media attention, the ADCQ report was embargoed for 20 months and not publicly released until December 2018 with an attendant media release. During that period Queensland Health crafted its own response to the report, including drafting the Statement of Action towards Closing the Gap in health outcomes (the Statement of Action) and hosting an expert workshop (the Expert Workshop) with ADCQ and QAIHC

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53 Professor McDermott’s review is available as Appendix 1 of the ADCQ report (Marrie 2017, pp. 251-2).

54 CGCSC (2016, p. 23).


to review the Matrix with the aim of having a tool which can be used repeatedly to measure change and improvements in the health system over time.\textsuperscript{57}

Returning to the CHHHS in 2018, the site of the original Matrix study, and noting that considerable changes were taking place, particularly regarding the inclusion of Aboriginal and Torres Strait Islander people in the governance structure, Bourke \textit{et al} (2018) reported on some of those changes, and where gaps still existed (Aboriginal and Torres Strait Islander employment and financial accountability), in their paper “Transforming institutional racism at an Australian hospital”.\textsuperscript{58} From an original Matrix assessment score in 2014 of 14/140, by 2018 the score had improved by 25 points to 39/140, leading the authors to conclude that the CHHHS has, aided by an effective external assessment tool, started to transform an organisational heritage of institutional racism (Bourke, \textit{et al.}, 2018, pp. 614-5).

In early 2019, the Queensland Minister for Health and Ambulance Services convened an expert panel to provide advice on Queensland Health’s governance framework as established by the \textit{Hospital and Health Boards Act}. The panel referred directly to the findings of the ADCQ report (Marrie 2017), which the panel referred to as the Health Equity Report\textsuperscript{59}, in making recommendations to amend the \textit{Hospital and Health Boards Act 2011} to:

- strengthen the commitment to health equity for Aboriginal people and Torres Strait Islander people and strengthen the capability and effectiveness of Hospital and Health Boards by:
  - including as a guiding principle a commitment to achieving health equity and delivery of responsive, capable and culturally competent health care to Aboriginal people and Torres Strait Islander people\textsuperscript{60};
  - requiring each Hospital and Health Service to have a strategy for achieving health equity for Aboriginal people and Torres Strait Islander people\textsuperscript{61}; and
  - requiring each Hospital and Health Board to have one or more Aboriginal persons and/or Torres Strait Islander persons as members\textsuperscript{62}.

In keeping with the Matrix’s monitoring function, the second audit of Queensland’s 16 HHSs will be carried out shortly based on the 2018-2019 reporting year using the Expert Workshop’s revised Matrix. Considering Queensland Health’s \textit{Statement of Action} and the Panel’s recommendations for amending the \textit{Hospital and Health Boards Act}, both in response to the ADCQ report, it is anticipated that Queensland HHSs will improve their Matrix score by 40 to 50 points. While the original audit found that 10 of the 16 HHSs were rated at the extreme level of institutional racism and the other six very high, it is hoped that the second audit will see the HHSs rated at moderate (60-79/140) to low (80-109/140) levels.

1.7 The five key indicators of institutional racism

The Matrix has been configured around five key indicators of institutional racism and a set of criteria for each indicator. The five key indicators focus on areas in which institutional racism is


\textsuperscript{58} This paper is available at: https://www.publish.csiro.au/AH/pdf/AH18062


\textsuperscript{61} See Clause 13, HLAB 2019. Ibid.

\textsuperscript{62} See Clause 11, HLAB 2019. Ibid.
commonly noted or experienced by Aboriginal people: (i) inclusion in governance; (ii) policy implementation; (iii) service delivery; (iv) employment; and (v) financial accountability.  

### 1.7.1 Inclusion in governance

For the purposes of the Matrix, the governance structure includes the relevant legislation, composition of board memberships as reflective of the expertise required to operate a LHN, and the executive management structure - specifically the basic management structure as reflected in the make-up of the divisions tasked with particular responsibilities within the overall structure of a LHN, and includes the composition or membership of the executive management team or group.

For Aboriginal people, as key stakeholders in public LHNs, exclusion from the governance structure is a primary signifier of institutional racism as it addresses the critical strategic question at the heart of institutional racism: where does power reside? Their direct involvement in the decision-making processes regarding the design, planning and delivery of health care services to their communities is a priority issue, and is a federal policy directive. It is essential to achieving the best outcomes in primary and acute care, and preventative, clinical and allied health services. Failure to directly engage Aboriginal people in decision-making will negatively impact on their access to and delivery of these services, compromise the cultural and clinical safety of healthcare provision, and therefore diminish the effectiveness of initiatives, services and programs designed to close the gap on Indigenous health outcomes.

### 1.7.2 Policy implementation

The policy environment for this key indicator is provided by the 2008 COAG National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes (NPACGIHO) and The National Indigenous Reform Agreement (NIRA) and the suite of policies that the agreements have generated at state/territory levels. Community engagement is also fundamental for the successful implementation of Closing the Gap health policy. However, there has to be readily available sources of information to Aboriginal people if community engagement is to be effective. Such information, in the first instance, should be made available in the LHN annual reports and on their websites.

### 1.7.3 Service delivery

In order to achieve effective healthcare delivery there must be an integrated and coordinated approach between the public health and Indigenous community controlled health service sectors as embodied in the mutual development of local level health service plans. Effective and culturally safe and appropriate health service delivery to Aboriginal people also hinges on having a culturally

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63 A recent study in New Zealand where there is a 7.3 year disparity in life expectancy between Maori and non-Maori lists five sites of institutional racism in public health policy making: (i) decision making practices; (ii) (mis)use of evidence; (iii) deficiencies in cultural (and political) competency; (iv) flawed consultation practices; and (v) impact of crown filters [“crown” essentially refers to ministerial and departmental authority and responsibility](Came 2014). Came (p. 214) also notes that “the Ministry of Health has recognized institutional racism as a determinant of health in policy documents since the 1990s...”.  

64 See Came and McCreanor (2015, p. 33) in relation to Lukes’s (Hayward and Lukes 2008) three-dimensional analysis of power examining the cultural and institutional roots of policies:

The first dimension is the processes and outcomes of overt decision-making. The second dimension is the process of shaping or framing an issue so that certain ideas are considered, discussed, and esteemed while others are not. Finally, the third dimension is characterised by the ability to define or determine what is considered to be a relevant issue for discussion through setting agendas and determining priorities. (cited in Came and McCreanor 2015, p. 33).

This third dimension becomes particularly apparent when considering how many times substantive Aboriginal and Torres Strait Islander health issues are discussed in HHB meetings – see Table 4.

65 See, for example, NHFA and AHHA (2010, pp. 10, 12, 14-19).
competent non-Indigenous health workforce.\textsuperscript{66} Evidence is sought as to the existence of a cultural competency training plan or strategy, whether the LHN has the capacity to deliver such training, and the number or percentage of the non-Indigenous workforce to have actually completed training. To assist in the measurement of service delivery a number of Tier 3 Health System Performance Measures (HSPM) have been selected from the \textit{Aboriginal and Torres Strait Islander Health Performance Framework endorsed by AHMAC in 2011.}

1.7.4 Recruitment and employment
This indicator is focused on whether there is a published plan or strategy for Aboriginal health workforce development, who has responsibility for ensuring that the plan or strategy is implemented, and the level of Aboriginal employment assessed against the proportion of Aboriginal people of the total population in the local LHN region. It is also important to record where Aboriginal people are being employed within a LHN and at what level. While sometimes employment percentages can be impressive, many Aboriginal people are employed in clerical positions and in support services (as cleaners, bed washers, patient transporters, etc) and not in front line services as doctors, nurses and in other allied health professions. Given their important roles within LHNs, Aboriginal health practitioners, health workers and liaison officers should also be separately identified.

1.7.5 Financial accountability
This indicator is based on the premise that both the Aboriginal community and the Australian community at large have a right to know how the considerable amounts of funding allocated by both the Commonwealth and the states/territories to Closing the Gap in Indigenous Health Outcomes is actually being spent. This indicator is included to promote transparency and accountability in funding arrangements at the local LHN level by including a financial statement in the annual report as the most appropriate reporting vehicle.

1.8 Prototype SA Health Matrix Template

1.8.1 Development of the Prototype SA Health Matrix Template (PSAHMT)
The Australian Healthcare & Hospitals Association (AHHA) was contracted by Health Performance Council South Australia (HPC SA) in 2019 to develop of a prototype customised South Australian institutional racism measuring and monitoring tool, the PSAHMT.\textsuperscript{67} The PSAHMT is the result of a series of consultations with key South Australian stakeholders in Aboriginal health followed by an expert workshop. The expert workshop jurisdictionally nuanced the Queensland institutional racism matrix for the South Australian context by actively co-designing the PSAHMT to measure institutional racism within South Australia’s ten Local Health Networks (LHNs). The focus was on the selection of criteria and associated sub-criteria that would most accurately reflect the structure, governance, policy and administrative arrangements of the LHNs. AHHA took the concepts and feedback, identified through the pre-consultation and the expert workshop, and developed a prototype customised South Australian institutional racism measuring and monitoring tool. This work included scoring of the criteria, their associated sub-criteria, and their weightings.

\textsuperscript{66} As the Close The Gap Campaign Steering Committee has pointed out: Health services and professionals need to foster culturally supportive and culturally safe environments to ensure Aboriginal and Torres Strait Islander patients feel comfortable identifying. This needs to be complemented by approaches to address systemic racism within the health service (Holland 2014, p. 18).

\textsuperscript{67} https://www.hpcsa.com.au/reports/institutional-racism
1.8.2 COVID-19 disruption of the planned development process

The presence of the COVID-19 pandemic from February impacted both the planned schedule for the stakeholder validation of the prototype customised South Australian institutional racism measuring and monitoring tool – the SA Health matrix template, and ultimately the institutional racism audit of South Australia’s ten LHNs. For example, three stakeholder validation workshops were planned involving Aboriginal health consumers, Aboriginal and non-Aboriginal health professionals and Aboriginal and non-Aboriginal health administrators for March 2020. These face to face workshops had to be cancelled at short notice as the gravity of the pandemic became apparent. In their place the project team deployed a novel use of the Delphi structured communication method [see section 2.3.4]. Based on two rounds of webinars, and subsequent interviews, with representatives of each of the stakeholder groups, these took place during the weeks of the 6 – 10 and 20 – 24 July after the first draft of the audit report had been delivered using the prototype customised Matrix developed by the Expert Group in Adelaide in August 2019.

The audit itself was also impacted in terms of the scoring of some of the criteria and sub-criteria. The pandemic prevented business as usual for all of the state’s LHNs. Scheduled meetings and forums were delayed and others called to put in place LHN emergency strategies to ensure the health and well-being of their communities, and deal with any medical emergencies caused by the pandemic. In many instances face-to-face meetings were replaced by telephone and video meetings. This caused delays, particularly for the newly established regional LHNs, to the development of mandatory strategies involving, for example, consumer and community engagement and clinical and workforce engagement – both included in the audit. Some regional LHNs had to cancel planned Aboriginal Expert Health Forums, board member attendance at which was also part of the audit assessment. Allowances were made in the audit scoring process for both the delays in strategic plan development and the cancellation of the scheduled forums.
### 2.3.3 The SA Health Matrix Template (SAHMT)

SA Health Matrix Template for LHN audits taking into account SA Health’s legislative, policy and administrative settings (1)

<table>
<thead>
<tr>
<th>Key Indicators and Criteria</th>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Participation in LHN governance (2)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>1.1 Good governance (3)</strong></td>
<td>Total out of 10</td>
</tr>
<tr>
<td>1.1.1 Board interaction with Aboriginal community (4)</td>
<td>2</td>
</tr>
<tr>
<td>1.1.2 LHN Aboriginal health performance indicators on Board agenda for every meeting (5)</td>
<td>2</td>
</tr>
<tr>
<td>1.1.3 Direct input to Board by LHN Aboriginal Community Consultative Committee or Aboriginal Experts by Experience (6)</td>
<td>2</td>
</tr>
<tr>
<td>1.1.4 LHN Board members are educated about Aboriginal health in their LHN (7)</td>
<td>2</td>
</tr>
<tr>
<td>1.1.5 LHN Board members receive cultural learning training (8)</td>
<td>2</td>
</tr>
<tr>
<td><strong>1.2 Aboriginal representation at board level (9)</strong></td>
<td>Total out of 10</td>
</tr>
<tr>
<td><strong>1.3 Inclusion in Executive Management Structure</strong></td>
<td>Total out of 10</td>
</tr>
<tr>
<td>1.3.1 A stand-alone Aboriginal Health Division (10)</td>
<td>5</td>
</tr>
<tr>
<td>1.3.2 Aboriginal LHN lead directly reports to the LHN CEO (11)</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>30</strong></td>
</tr>
<tr>
<td><strong>2. Policy Implementation (12)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>2.1 Improving Aboriginal Health Outcomes</strong></td>
<td>Total out of 20</td>
</tr>
<tr>
<td>2.1.1 Explicitly identified as a strategic priority in LHN Strategic Plan (13)</td>
<td>10</td>
</tr>
<tr>
<td>2.1.2 Aboriginal health outcome KPIs reflective of LHN key responsibilities identified in LHN Service Agreement (14)</td>
<td></td>
</tr>
<tr>
<td>(i) Tier 1 KPIs (15)</td>
<td>5</td>
</tr>
<tr>
<td>(ii) Tier 2 KPIs (16)</td>
<td>5</td>
</tr>
<tr>
<td><strong>2.2 Community engagement (17)</strong></td>
<td>Total out of 20</td>
</tr>
<tr>
<td>2.2.1 Aboriginal community consultative body (18)</td>
<td>4</td>
</tr>
<tr>
<td>2.2.2 Aboriginal community engagement embedded within overall community engagement strategy (19)</td>
<td>4</td>
</tr>
<tr>
<td>2.2.3 LHN Aboriginal community newsletter/e-letter/social media (20)</td>
<td>3</td>
</tr>
<tr>
<td>2.2.4 At least one Aboriginal community forum/meeting per year convened by the LHN chief executive officer (21)</td>
<td>3</td>
</tr>
<tr>
<td>2.2.5 Reconciliation Action Plan (22)</td>
<td>3</td>
</tr>
<tr>
<td>2.2.6 Aboriginal health professionals caring for patients included within clinical engagement strategy (23)</td>
<td>3</td>
</tr>
<tr>
<td><strong>2.3 Public Reporting and Accountability (via LHN website or annual report) (24)</strong></td>
<td>Total out of 30</td>
</tr>
<tr>
<td>2.3.1 Traditional Owner Acknowledgement</td>
<td>2</td>
</tr>
<tr>
<td>2.3.2 Improving Aboriginal health outcomes</td>
<td></td>
</tr>
<tr>
<td>(i) Separate section in report devoted to Aboriginal health</td>
<td>3</td>
</tr>
<tr>
<td>(ii) Reporting on KPIs contained in current service level agreement (SLA) (25)</td>
<td>3</td>
</tr>
<tr>
<td>(iii) Report on Aboriginal community engagement</td>
<td>3</td>
</tr>
<tr>
<td>(iv) Report on Aboriginal specific National Safety and Quality Health Service Standard Assessment (26)</td>
<td>3</td>
</tr>
<tr>
<td>(v) Chronic disease management and care planning (27)</td>
<td>3</td>
</tr>
<tr>
<td><strong>2.3.3 Cultural learning completion rates (28)</strong></td>
<td>2</td>
</tr>
<tr>
<td><strong>2.3.4 Aboriginal health division/unit placement on LHN organisational structure/chart</strong></td>
<td>1</td>
</tr>
</tbody>
</table>
### 2.3.5 Data on Aboriginal access to and delivery of services (29)

<table>
<thead>
<tr>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Aboriginal Workforce Framework (planning, recruitment, etc)</td>
<td>2</td>
</tr>
<tr>
<td>(ii) Data on Aboriginal employment</td>
<td>3</td>
</tr>
</tbody>
</table>

**Total** 5

### 2.3.6 Aboriginal employment

(i) Aboriginal Workforce Framework (planning, recruitment, etc) (30) 2

(ii) Data on Aboriginal employment (31) 3

**Total** 5

### 2.3.7 Other recognition (e.g., awards, scholarships, etc) (32) 2

**Total** 70

### 3. Service delivery and partnerships (33)

#### 3.1 Aboriginal LHN Plan (34)

<table>
<thead>
<tr>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-designed in partnership with ACCHO(s), or other Aboriginal organisations, or Aboriginal Experts by Experience in LHN region</td>
<td>2</td>
</tr>
<tr>
<td>Partnership with ACCHO(s) in LHN region</td>
<td>2</td>
</tr>
<tr>
<td>Commitment to Continuous Quality Improvement</td>
<td>2</td>
</tr>
<tr>
<td>Co-designed KPIs</td>
<td>2</td>
</tr>
<tr>
<td>Clear statement of ACCHO and LHN responsibilities and conflicts</td>
<td>2</td>
</tr>
</tbody>
</table>

**Total** 10

#### 3.2 Cultural safety (35)

<table>
<thead>
<tr>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation of cultural safety policy/strategy</td>
<td>5</td>
</tr>
<tr>
<td>Proportion of staff trained</td>
<td>5</td>
</tr>
</tbody>
</table>

**Total** 10

#### 3.3 Selected LHN health performance indicators reported publicly (38)

<table>
<thead>
<tr>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated level of completion of Indigenous status – specifically the reporting of ‘not stated’ on admission</td>
<td>3</td>
</tr>
<tr>
<td>Discharged against medical advice (DAMA)</td>
<td>4</td>
</tr>
<tr>
<td>Potentially preventable hospitalisations (PPHA)</td>
<td>3</td>
</tr>
<tr>
<td>Access to mental health services as reported at service level agreement</td>
<td>3</td>
</tr>
<tr>
<td>Low birth-weight babies</td>
<td>3</td>
</tr>
<tr>
<td>Healthcare outcome differential measures (eg. Discharge summary timeliness)</td>
<td>4</td>
</tr>
</tbody>
</table>

**Total** 20

### 4. Recruitment and employment (45)

#### 4.1 Aboriginal health workforce development reporting (46)

<table>
<thead>
<tr>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation of Aboriginal workforce strategy</td>
<td>4</td>
</tr>
<tr>
<td>LHN KPI for Aboriginal employment</td>
<td>4</td>
</tr>
<tr>
<td>Number of Aboriginal health practitioners, health workers and liaison officers</td>
<td>3</td>
</tr>
<tr>
<td>Number of identified Aboriginal positions</td>
<td>3</td>
</tr>
<tr>
<td>Number of salary bands occupied by Aboriginal employees</td>
<td>3</td>
</tr>
<tr>
<td>Number of long-term Aboriginal employees</td>
<td>3</td>
</tr>
</tbody>
</table>

**Total** 20

#### 4.2 Aboriginal participation in the health workforce (53)

<table>
<thead>
<tr>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative</td>
<td>3</td>
</tr>
<tr>
<td>Medical Professionals</td>
<td>4</td>
</tr>
<tr>
<td>Nurses/Midwives</td>
<td>4</td>
</tr>
<tr>
<td>Operational Services</td>
<td>3</td>
</tr>
<tr>
<td>Allied Health/Scientific/Technical</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
</tr>
</tbody>
</table>

**Total** 20

### 5. Financial Accountability and Reporting: Closing the Gap Funding (60)

#### 5.1 Commonwealth contributions for Aboriginal health programs to LHN (61)

**Total** 10

#### 5.2 South Australian contributions to Aboriginal specific health services and programs including activity-based funding loading for Aboriginal patients (62)

**Total** 10
Notes

1. Each audit will begin with a basic description of the LHN including population demographics, size and proportion of the Aboriginal population, Aboriginal medical facilities, ACCHOs, health services provided, etc.

INDICATOR 1: PARTICIPATION IN LHN GOVERNANCE

2. ATSIHPFPM Tier 3: Health System Performance – 3.13: Competent governance. This indicator generally addresses matters of competent governance in the delivery of healthcare to Aboriginal people by requiring that the Aboriginal community within a LHN region have representation and agency in the governance structure defined as comprising the board and the executive management group. LHN Boards operate according to the Charter for Local Health Network Governing Boards established under the Health Care Act 2008 (Volume 1) (SA Health 2019e). Each LHN Governing Board must also outline its Board governance mechanisms, policies, procedures and processes of the Board (Volume 2).

Criterion: good governance

3. One of the principles to be applied in connection with the operation and administration of the HCA is that, in accordance with s. 5(b), “Aboriginal people and Torres Strait Islanders should be recognised as having a special heritage and the health system should, in interacting with Aboriginal people and Torres Strait Islanders, support the values that respect their historical and contemporary cultures.” This criterion and associated sub-criteria are designed to measure the levels of interaction with the local Aboriginal community including an understanding of their particular health issues, that the board is taking an active interest in improving the health of that community through a particular focus on their LHN’s Closing the Gap performance and initiatives based on selected KPIs, and that the non-Aboriginal board members have significant level of cultural awareness and competence in accordance with the SA Health Aboriginal Cultural Learning Framework (SA Health 2017a). As LHN boards generally meet monthly and are required to publish the agenda and minutes for each meeting on their website, information concerning the five sub-criteria should form a part of the board’s monthly reporting. Absence of such reporting will attract a score of 0 per sub-criterion. After reviewing the monthly Board agendas and minutes of a number of LHNs, it was found that information was being provided that did not readily match the sub-criteria agreed at the Expert Workshop. Board meeting charts have been prepared for each LHN and included as part of their Matrix audits. Additional headings have been added regarding: invited Aboriginal guests [these could include, for example, the E/D Aboriginal Health, an Aboriginal health consumer presenter, an Aboriginal Expert by Experience, a community Elder, cultural consultant, etc.]; Aboriginal health as an agenda item; Aboriginal health discussed (as a non-agenda item); SLA Tiers 1 and 2 Aboriginal health KPIs [currently there are no Tier 1 KPIs for Aboriginal health included in the 2018-19 SLAs for the WCHN and the three metropolitan LHNs, and the 2019-20 SAs for the six regional LHNs] included as part of Contract Performance Meeting (CPM) information shared with the Board [It is noted that it is required that at least one CPM will focus on Aboriginal health specific deliverables and KPIs in accordance with the 2018-2019 SLA Schedule concerning the SA Health Performance Framework];
and Aboriginal membership of Board committees [In accordance with the Healthcare Governance Amendment Act 2019: Schedule 3-9(1), Boards are required to establish Finance and Performance, Clinical Governance, Audit and Risk and Consumer, Community and Clinical Engagement committees. They also have the discretion to establish additional Board committees that reflect additional responsibilities that have been assigned, for example, the EFNLHN has responsibility for delivering the statewide Trachoma Elimination Program, while the BHFLHN is the host LHN for rural and remote Mental Health services].

4. Board interaction with local community. Examples of activities that indicate board interaction with the local Aboriginal community include, holding at least one of their monthly board meetings within the financial year at either one of the LHN Aboriginal health facilities or at a local ACCHO; board member attendance/participation in LHN and local NAIDOC and/or Reconciliation Week activities; attendance at a special event hosted by the local Aboriginal community (eg, opening of a community facility; launching of an event; a community awards night, etc.)

5. Performance against the Tier 1 and Tier 2 KPIs identified for each of the four performance domains identified in the SA Health Performance Framework 2018-19 are published monthly by DHW and are also the subject of the monthly Contract Performance Meetings between DHW and each LHN as required in each LHN SLA/SA (SA Health 2018b, pp. 4 and 6). The four performance domains are: Access and Flow; Productivity and Efficiency; Safe and Effective Care; and People and Culture. Information regarding each LHN’s Aboriginal performance indicators should therefore be available for LHN board monthly meetings. However, with regard to some LHNs, the Aboriginal community, the (E)D Aboriginal Health, or Aboriginal health unit staff, may want to see additional KPIs reflective of their LHN’s core responsibilities, and which are not included in the LHN’s SLA/SA. Using WCHN, as an example, such KPIs might include birth weights, gestational diabetes and smoking.

6. Direct input to Board by LHN Aboriginal Community Consultative Committee or Aboriginal Experts by Experience. Under their consumer and community engagement policies, most LHNs will have established an Aboriginal community consultative body. The establishment of a register of Aboriginal Experts by Experience was an initiative of CHSALHN to facilitate its Aboriginal Community and Consumer Engagement Strategy to promote and encourage Aboriginal participation in the planning and delivery of health services and programs (CHSALHN 2015a, p. 10). SA Health maintains a register of Aboriginal Experts by Experience. As at January 2018 there were 166 registered Aboriginal Experts by Experience across the now six regional LHNs: Eyre, Flinders & Far North – West (now EFNLHN) 28; Eyre Flinders & Far North - East (now FUNLHN) 46; Riverland Murray Coorong (now RMCLHN) 37; Yorke & Northern (now YNLHN) 14; South East (now LCLHN) 13; and Barossa, Hills, Fleurieu (now BHFLHN) 28 (HPCSA 2019, p. 25).
At least one meeting within the financial year, the LHNB should invite the consultative body, or its delegation, or the LHN’s Aboriginal Experts by Experience to present to the Board and for Q&As.

7. LHN Board members are educated about Aboriginal health in their LHN. At least once in every financial year, Board members should attend an “in-house” forum or seminar conducted by the LHN E/D of Aboriginal Health, members of the Aboriginal Health/Liaison Unit, Aboriginal Experts by Experience (where available), and relevant specialists/clinicians to receive up-dates on the health status of the Aboriginal community within their LHN district.

8. LHN Board members receive cultural learning training. The DHW’s metropolitan LHN and WCHN SLAs for 2018-2019, in the Schedule of Funding and Performance Indicators for the period of: 1 July 2018 – 30 June 2019, there is a Tier 2 KPI for People and Culture performance domain regarding the workforce: Completion of the Aboriginal Cultural Learning Program (Bi-Annual), with the measure: %
of employees who have completed an Aboriginal cultural learning program (bi-annual), with a target of 100%. (e.g., CALHN, SLA 2018—19, p. 7). However, this Tier 2 KPI is not included in the six regional LHN SAs for 2019-2020. The primary tool for cultural learning training is the SA Health Aboriginal Cultural Learning Framework (SA Health 2017a) (SAHACLFW). It is noted that the application of the SAHACLFW does not extend to board members. The Expert Workshop, however, recommends that all board members should undertake Organisational Level (Level 3) training at least once in every financial year.

**Criterion: Aboriginal representation at board level**

9. Size of the board and whether it has Aboriginal representation. LHNs are established as incorporated hospitals under Part 5, s. 29 of the HCA. With regard to the composition of governing boards for incorporated hospitals, under s.33B(1) boards can consist of 6 to 8 members, however, “At least 1 member of a governing board must be a person who has expertise, knowledge or experience in relation to Aboriginal health.” [s.33B(4)], thus there is no requirement that that person be an Aboriginal person. The acronym AHEMGB – Aboriginal Health Expertise Member of the Governing Board - is used to indicate the governing board member who has “expertise, knowledge or experience in relation to Aboriginal health” and that member may not necessarily identify as an Aboriginal person. Because significant weighting is given to Aboriginal representation in the governance structure by the Expert Workshop the score is given on an “all-or-nothing” basis. There must be published evidence (e.g., annual report, website) to indicate whether the AHEMGB is an Aboriginal person or not. If there is no such evidence a score of 0/10 will be recorded.

**Criterion: Inclusion in Executive Management Structure**

10. The organisational structure of the LHN should include a stand-alone Division of Aboriginal Health. This division could be responsible for, for example, (i) oversight of Closing the Gap and other Aboriginal health programs and budgets as per the LHN’s SLA; (ii) monitoring quality and safety of health service provision to Aboriginal clients as per the relevant NSQHS standards (see Table 2); (iii) cultural safety training to the non-Aboriginal LHN workforce; (iv) Aboriginal workforce development; (v) patient liaison services; (vi) intra-LHN interdepartmental liaison; and (vii) external liaison with ACCHOs within the LHN region, including oversight of the Aboriginal LHN plan (criterion 3.1). A stand-alone division would score 5/5. However, should this entity exist at a lower level within the LHN administrative hierarchy, and/or have a non-Aboriginal director, it will attract a lower score. The position/status of this division/unit should be indicated in the organisational chart of the LHN in the annual report (see sub-criterion 2.3.4).

11. In the context of the key priority Develop Skills and Potential of the SA Health Aboriginal Workforce Framework 2017-2022, SA Health wants to see:
   - Strong Aboriginal leadership across SA Health; and
   - An increase in the number of Aboriginal people in Executive roles (SA Health 2017b, p. 11).
Statistics provided in the Framework indicate that there were 4 Aboriginal people and 99 non-Aboriginal people employed by SA Health in executive positions, or 3.9% of the executive workforce in 2017 (SA Health 2017b, p. 5).
This sub-criterion reflects the desired status of the director of the division of Aboriginal health – that this person should be an Aboriginal person and a member of the executive management group. The profile of the director should also be given along with the profiles of other executive level staff in the LHN in the annual report or on the LHN web page. There must be published evidence to indicate whether the director is an Aboriginal person or not. If there is no such evidence a score of 0/5 will be recorded.
INDICATOR 2: POLICY IMPLEMENTATION

Criterion: Improving Aboriginal Health Outcomes

12. The policy environment for this key indicator is linked to the 2008 COAG National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes (NPACGIGO), The National Indigenous Reform Agreement (NIRA), and the suite of policies that the agreements have generated at the state level. Community engagement is also fundamental for the successful implementation of Closing the Gap health policy. However, there has to be readily available sources of information to Aboriginal people if community engagement is to be effective. Such information, in the first instance, should be made available in the LHN annual reports and websites.

13. The parent documents regarding LHN strategic plans are the SA Health Strategic Plan 2017 to 2020 (SA Health, 2017c) and the SA Health Strategic Plan 2017 to 2020: Early Actions (SA Health, 2017d). One of the early actions to respond to the Strategic Plan is: 3. Create strategic and business plan to implement the SA Health strategic plan, whereby “each Local Health Network has their own strategic management plan informed by the SA Health strategic plan” (SA Health, 2017d, p. 6. See also SA Health, 2017c, p. 15).

As this audit was undertaken before most of the newly established regional LHNs could finalise and publish their strategic plans, in part due to delays caused by the COVID-19 pandemic, the Matrix scoring was amended to allow a discretionary half score for this sub-criterion for the regional LHNs, that is a score of 5/10.

14. Annual identification of KPIs, including Aboriginal health KPIs, occurs in each LHN SLA/SA. KPIs are prioritised as Tier 1 or Tier 2. Tier 1 KPIs set out clear expectations within critical performance areas and Tier 2 (supporting KPIs) provide a broader assessment of performance within each of the four performance domains established in SA Health’s annual performance framework (SA Health, 2018b, pp. 4-5) [see Note 5]. Performance against the KPIs for each domain is published monthly by DHW (SA Health, 2018b, p. 4). The DHW’s metropolitan LHN and WCHN SLAs for 2018-2019, in the Schedule of Funding and Performance Indicators for the period of: 1 July 2018 – 30 June 2019, contain four Tier 2 KPIs specifically related to Aboriginal Health. However, there are only two Tier 2 KPIs included in the six regional LHN SAs for 2019-2020.

Instead of a set of identical KPIs for the metro LHNs + WCHN and for the six regional LHNs, this sub-criterion is designed to reflect key responsibilities which may differ between LHNs. As indicated in Note 5, using WCHN as an example, its SLA might include KPIs for low birth-weight Aboriginal babies, gestational diabetes among expectant Aboriginal women, and for ear health among Aboriginal Under 8s. Similarly, a KPI could be created to measure progress with regard to the statewide Trachoma Elimination Program being delivered by the EFNLHN (EFNLHN Service Agreement 2019-2020, p. 37).

15. Tier 1 Key Performance Indicators (Tier 1 KPIs) are critical system markers which operate as intervention triggers. This means that underperformance triggers immediate action, analysis of the cause of deviation, and consideration of the need for intervention. This provides an early warning system to enable appropriate intervention as a performance issue arises within critical performance areas (definition found in WCHN Service Level Agreement 2018-2019, p. 6).

16. Tier 2 Key Performance Indicators (Tier 2 KPIs) are used as supporting indicators to assist in providing context to Tier 1 KPIs when triggered within a specific domain and to assist the organisation to improve provision of safe and efficient care (definition found in WCHN Service Level Agreement 2018-2019, p. 6)
**Criterion: Community engagement**

17. Effective community engagement is essential to good/competent governance and is therefore a relevant indicator responding to ATSIHPFPM Tier 3: Health System Performance – 3.13: Competent governance. Community engagement can occur through different mechanisms. For example, via community consultative committees with membership drawn from the LHN region, a community reference group with membership based on expressions of interest, or an Aboriginal consultative body. A Reconciliation Action Plan might also be another mechanism to promote community engagement.

This criterion is scored out of 20, with six sub-criteria selected by the Expert Workshop to reflect different aspects of LHN engagement with the Aboriginal community. The presence of an Aboriginal community consultative body [2.2.1] should be indicated in the LHN annual report; evidence of the inclusion of mechanisms for Aboriginal community engagement in the community engagement strategy [2.2.2] should be found in the LHN’s own publicly available strategy; the LHN Aboriginal community newsletter [2.2.3] should be published on the LHN website or social media page; reporting on the Aboriginal community forum/meeting with the LHN CEO [2.2.4] could either be reported in the annual report, on the website, or in the newsletter; the RAP [2.2.5] should exist as a separate published document; and a section given to the inclusion of Aboriginal health professionals caring for patients in the LHN clinical engagement strategy [2.2.6] should appear in the published document itself.

18. Aboriginal community consultative body (ACCB). These provide an important mechanism for input into LHN decision-making and feed-back processes at various levels (Governing Board, LHN CEO, Aboriginal Health Directorate, etc.). LHN consumer and community engagement strategies sometimes establish an ACCB, or an ACCB might be established as an Aboriginal community grass-roots initiative. In other instances, Aboriginal Experts by Experience offer an alternative avenue for consultation (see Note 6).

19. Up until mid-2019, the two principal mechanisms through which the community and consumers could provide input into the management and administration of an LHN is through the LHN board and its Health Advisory Council (HAC).

With regard to input via the LHN board, in accordance with s.33A (1)(b) of the HCA, the governing board for an incorporated hospital (that is, in this context an LHN) must develop and publish “a strategy to promote consultation with health consumers and members of the community about the provision of health services by the incorporated hospital (a consumer and community engagement strategy)[original emphasis].” The following documents are relevant to this sub-criterion: SA Health Guide for Engaging with Aboriginal People (DHA, 2013b); Consumer and Community Engagement Governance Model – consumer and community advisory groups (SA Health, 2018); Policy Guideline: Consumer and Community Advisory Committee/ Group (CACAC/CAG) Policy Guideline and Toolkit (SA Health, 2015).

In terms of engagement via LHN HACs, this second option is only available to consumers and communities within the six country LHN regions. Under Schedule 3A – Dissolution of Health Advisory Councils, of the Health Care (Governance) Amendment Bill 2019 (SA), the Women’s and Children’s Health Network, Northern Adelaide LHN, Central Adelaide LHN and Southern Adelaide LHN Health Advisory Councils were dissolved. However, the 39 regional HACs within the six country LHNs continue to operate.

HACs are established by the Minister under s. 15(1) of the HCA to, *inter alia*, “undertake an advocacy role on behalf of the community”. HACs operate according to a constitution or set of rules for which the Minister must develop a model [s.17(8)]. HACs can have between 6 and 15 members with an appropriate balance of skills, qualifications, or experience, examples of which include, *inter alia*, “knowledge or experience of the needs of People of Aboriginal or Torres Strait Islander Descent.” [Example taken from Barossa and Districts Health Advisory Council Inc. Constitution – original dated...
2008, and as amended, Articles 9 and 10]. Note that there is no requirement for the member of the HAC who has the requisite knowledge or experience of the needs of Aboriginal people and Torres Strait Islanders to be an Aboriginal or Torres Strait Islander person. This avenue for consumer and community engagement was not considered by the Expert Workshop, however an analysis of information provided in the 2018-2019 annual reports of the regional HACs was undertaken. Together with the minutes of all LHN board meetings, and consumer and community engagement strategies where they were published, this information was used to inform the scores for this sub-criterion.

20. LHN Aboriginal community newsletter/e-letter/social media post. Important Aboriginal health information could be conveyed to the LHN’s Aboriginal communities using platforms such as an e-newsletter, or via a social media platform such as Facebook, Twitter or Instagram.

21. The Performance Framework 2018-19 (SA Health 2018b, pp. 6-7) requires that monthly Contract Performance Meetings be held between DHW and LHN where performance on delivery against SLA KPIs will be reviewed and monitored. A Bi-annual performance review is also required to identify key priorities for resolution in year, to inform any mid-year budget allocation/changes and variations to the SLA and to support negotiations in relation to the development of the SLA for the following year. The DHW’s SLAs for 2018-2019 for CALHN, NALHN, SALHN and WCHN, in Schedule 5: SA Health Performance Framework, with regard to Performance Review Processes, include processes for monitoring performance against key deliverables (as outlined in Schedule 4 of the SLA). One of these processes include: “Contract Performance Meetings to review performance, particularly in relation to the key indicators (Tier 1), and to discuss and develop mitigation strategies where appropriate and to monitor progress. At least one meeting will focus on Mental Health specific deliverables and KPIs and at least one meeting will focus on Aboriginal Health specific deliverables and KPIs.” (eg, CALHN, SLA 2018—19, pp. 61-2). In the context of this sub-criterion, it would seem appropriate that the LHN CEO hold an Aboriginal community forum/meeting preparatory to the scheduled Contract Performance Meeting with DHW at which the Aboriginal Health specific deliverables and KPIs are to be discussed.

22. The RAP should draw on SA Health’s Reconciliation Framework for Action 2014-2019 (SA Health, 2014). Described as a “high level strategic document which provides the guiding principles for the Department and the Local Health Networks to develop their own respective Reconciliation Action Plans”, the Framework will inform the development of RAPs by each LHN based on the three key themes as expressed by Reconciliation Australia:

- Relationships
- Respect
- Opportunities

SA Health was to have developed governance and reporting structures across the LHNs to track performance against their RAP commitments across the three themes (SA Health, 2014, p. 4).

23. In accordance with s.33A (1)(a) of the HCA, the governing board for an incorporated hospital (that is, in this context an LHN) must develop and publish “a strategy to promote consultation with health professionals working in the incorporated hospital (a clinician engagement strategy)[original emphasis].” The governing board are required to consult with health professionals working in the incorporated hospital in developing the strategy [s. 33A(2)(a)]. This requirement should extend to include Aboriginal health professionals working in the LHN.
Criterion: Public Reporting and Accountability (via LHN website or annual report)

24. The SA Health website is the official portal to public health services, hospitals, health information and health careers in South Australia, and which can also be accessed via its Facebook, Instagram and Twitter accounts. LHNs, in effect, do not have their own customised websites. Internet searches for a particular LHN inevitably lead to the SA Health website, where links are provided to a LHN page. The page contains a number of portals also containing links to other sources of information. This sub-criterion encourages LHNs to create an Aboriginal Health portal on their page to enable viewers to access a range of Aboriginal Health related information and data, concerning, for example: identification or acknowledgement of the Traditional Owner groups in their region, reporting on SLA/SA KPIs; results of the six Aboriginal-specific standards (see Table 2) in NSQHS assessments; cultural learning completion rates for non-Aboriginal staff; and data on Aboriginal LHN workforce employment across the six health employment categories. This will offer Aboriginal people and others an easier way of accessing information, and will also assist in making LHNs more transparent and accountable to the Aboriginal community.

Annual reports are also primary documents for institutional public accountability. LHN boards as well as the regional LHN HACs are required to submit annual reports. LHN boards are required to hold an annual public meeting between 1 October and 31 December to present the annual report and in which members of the public are entitled to address the meeting [HCA Schedule 3 - s.7]. A formal annual review of performance under the SLA/SA will be undertaken between the SA Health CE and the CEO of each LHN. The annual review will consider performance against all KPIs and broader performance components and assess capability to achieve the outcomes identified for the following year. An annual review will also be undertaken to assess LHN capability to achieve the outcomes identified in the SLAs/SAs (SA Health 2018b, p. 11). Information could also be conveyed through regular LHN bulletins, websites, etc. The primary purpose of this criterion is the degree to which annual reports demonstrate recognition, respect and inclusivity towards the Aboriginal community within each LHN – that the LHN is also “their” health service, also operating on their behalf, and how it is delivering healthcare and health services to meet their needs. Traditional Owner acknowledgement, progress on Closing the Gap (e.g., by reporting on national Key Performance Indicators as contained in, for example, the ATSIHPF Tier 3 Performance Measures), Aboriginal health workforce employment data, special achievement – these could all serve as indicators of how the LHN is respecting and serving the Aboriginal community. Comprehensive and quality information is also essential to enable Aboriginal communities to give informed advice and guidance to their representatives involved in LHN governance. LHN public reporting and open disclosure on performance are also essential indicators of good/competent governance and reflective of ATSIHPFPM Tier 3: Health System Performance – 3.13: Competent governance.

Scored out of 20, this criterion is broken down into sub-criteria which reflect the kinds of information that the Expert Workshop considered should occur in an annual report. For the most part the sub-criteria are marked on the presence or absence of the designated information.

Annual reporting requirements are laid out in the Premier and Cabinet Circular PC103 Annual Reporting Requirements 2019-2020 and mandated for all South Australian Government agencies and entities in the General Government Sector which are presenting annual reports to the South Australian Parliament. In terms of the principles of annual reporting, annual reports must be:

- Transparent and accountable
- Concise
- Open
- Performance-based
- Factual
- Citizen-centric
- Accessible
- Digital (pp. 2-3)
See also part 4. Annual report template (pp. 8-9). This template applies for both LHN and HAC annual reports.

25. Service Level Agreement Aboriginal health related KPIs. The 2018-2019 LHN SLAs for CALHN, NALHN, SALHN and WCHN in Schedule 4 contain the following Aboriginal health specific KPIs:

**Performance Domain: Access and Flow**
Emergency Department Tier 2 KPI: Left at Own Risk
Measure: % of Aboriginal presentations. Target <=3%.

**Performance Domain: Safe and Effective Care**
Aboriginal Health Tier 2 KPI: Aboriginal Patients Who Left Hospital Against Medical Advice [DAMA]
Measure: % of overnight Aboriginal and/or Torres Strait Islander patients who left hospital against medical advice. Target: <=4.5%

**Performance Domain: People and Culture**
Workforce Tier 2 KPI: Aboriginal Employee Participation Rate
Measure: % of employees who identified as being of Aboriginal or Torres Strait Islander origin. Target: >=4%

Workforce Tier 2 KPI: Completion of the Aboriginal Cultural Competence Program
Measure: % of employees who have completed Aboriginal cultural competence training. Target: 100%

# These two KPIs are also included in the *Schedule of Funding and Performance Indicators for the period of 1 July 2018 – 30 June 2019* which forms part of the SLA.
(eg, CALHN, SLA 2018–19, pp. 55, 59, 74)
The Service Agreements (SAs) for 2019-2020 for the six regional LHNs only contain two Tier 2 KPIs: for DAMA and for the Aboriginal employment participation rate.

26. NSQHSS assessment. The DHW’s LHN SLAs for 2018-2019 for the CALHN, NALHN, SALHN and WCHN in Schedule 4: Performance Indicators and Targets includes a statement in relation to supporting the delivery of the Closing the Gap agenda and citing the NSQHSS, that: “In order to support the delivery of the Closing the Gap agenda, and implementation of the National Safety and Quality Health Service Standards related to Aboriginal and Torres Strait Islander health, wherever possible performance data will be collated for the population as a whole and for Aboriginal and Torres Strait Islander peoples.” (eg, CALHN, SLA 2018–19, p. 52). See Table 2.
The NSQHS Standards for Aboriginal and Torres Strait Islander people include:
- Cultural safety [1.4]
- Partnering with Aboriginal consumers [2.13]
- Comprehensive care [1.21]
- Meeting the health needs of Aboriginal people [1.2]
- Welcoming environments [1.33]
- Identification of Aboriginal patients [5.8]

Information regarding LHN performance against these standards in the triennial assessments conducted by the ACSQHC is not made public, however, the Expert Workshop argues that system wide KPIs to measure these standards should be established and reported upon in LHN annual reports and on their websites.

27. Chronic disease management and care planning. The South Australian Aboriginal Chronic Disease Consortium (SAACDC) is a collaborative, jurisdictional partnership formed to govern and lead the effective implementation of the:
- *South Australian Aboriginal Cancer Control Plan 2016-2021*
- *South Australian Aboriginal Heart and Stroke Plan 2017-2021*
This sub-criterion also addresses ATSIHFPM Tier 3: Health System Performance – 3.05 Chronic disease management; and 3.18 Care planning for chronic diseases measures.

28. The relevant policy references for this sub-criterion are: SA Health Aboriginal Cultural Learning Framework (SA Health, 2017a); and SA Health Aboriginal Culture and History Handbook (DHA, 2013a)

29. Data on Aboriginal access to and delivery of services. This sub-criterion responds to ATSIHPFPM Tier 3: Health System Performance – 3.06: Access to hospital procedures; 3.14: Access to services compared with need.

30. The relevant policy reference for this sub-criterion is the SA Health Aboriginal Workforce Framework 2017-2022 (SA Health, 2017b).

31. Data on Aboriginal employment.

32. In the context of the key priority Recognise and Reinforce of the SA Health Aboriginal Workforce Framework 2017-2022, SA Health will:
   - Collaborate with awards’ program officers to review and consider new categories of excellence awards to support the Framework
   - Promote Aboriginal employees’ participation in excellence awards (SA Health 2017b, p. 9). LHNs can participate in this process, inter alia, by publicly recognizing Aboriginal employee achievements in their annual reports (for example, promotions, awards, scholarships, traineeships, length of service, etc).

INDICATOR 3: SERVICE DELIVERY AND PARTNERSHIPS

33. Effective healthcare requires an integrated and coordinated approach between the public health sector and Indigenous community-controlled health services embodied in the co-design of local level health service plans. Effective healthcare for Aboriginal people depends upon a culturally safe non-Indigenous health workforce. Evidence is sought as to the existence of a cultural safety training plan or strategy, whether the LHN has the capacity to deliver such training, and the number or percentage of the non-Indigenous workforce to have actually completed training. To assist in the measurement of service delivery a number of Tier 3 Health System Performance Measures (HSPM) have been selected from the Aboriginal and Torres Strait Islander Health Performance Framework endorsed by AHMAC in 2011.

Criterion: Aboriginal LHN Plan

34. According to the Australian Government Primary Health Care 2009 report:
   The complex, fragmented and often uncoordinated delivery systems that operate across primary health care have implications for the services individuals receive, how they pay for them, and how care providers interact and provide care... [T]he primary health care sector...is less successful at dealing with the needs of people with more complex conditions or in enabling access to specific population groups that are hard to reach (quoted in Alford, 2014:25).

Most LHNs will also have at least one ACCHO within their area (see Table 1). There may also be separate independent community-controlled facilities for aged care, drug and alcohol rehabilitation, mental health and harm prevention, and child-care/youth services. Also, as Alford (2014: 21) points out in her report to NACCHO:
The lack of a coherent Indigenous primary health care policy or strategy and associated funding commitments results in inadequate and poorly distributed government expenditure on Aboriginal health, and in particular on Indigenous-specific, community based and controlled health care services. The predictable result is that too much money is being spent on hospitals. High levels of avoidable admissions and avoidable deaths primarily reflect inadequacies in the provision of primary health care [original emphasis].

While the policy issues emanate from higher up at the government level, one way of addressing these issues, including government expenditure on Aboriginal health, is at the local level. It is important that the public health and Aboriginal health services sectors, and their respective funding allocations, are properly integrated and coordinated in their responsibilities for delivering healthcare for Aboriginal people. This can only be effectively achieved through a mutually developed and costed health service plan. This reflects ATSIHPFPM Tier 3: Health System Performance – 3.17: Regular GP or health service; and 3.18 Care planning for chronic diseases measures.

Among the key principles articulated in the SA Rural Medical Workforce Plan 2019 – 24 (SA Health 2019d) is that: Collaboration with the Aboriginal community-controlled sector must continue as a priority, to ensure coordinated workforce planning across rural South Australia to meet the needs of Aboriginal communities and consumers (p. 18).

Under Strategy Theme Two, Strategy 2.4 involves the creation of integrated geographic networks of hospitals within LHNs, with rural hospitals collaborating to provide clinical and professional support across the network, with the key lead being undertaken by the regional LHNs. One of their actions involves each geographic network to further consider the resources, role and potential contribution of the primary care and Aboriginal community-controlled health services in their geographic area (p. 27).

These HPF measures are embodied in the requirement for a health plan to be established between a LHN and the ACCHO(s) that operate within their region to ensure regular and ongoing access to medical treatment after referral or discharge from a LHN facility. Within the context of a plan, many other aspects of effective/appropriate/efficient healthcare delivery can also be more readily addressed, such as antenatal care [3.01]; immunisation [3.02]; health promotion [3.03]; early detection of health conditions and their early treatment [3.04]; and chronic disease management [3.05].

LHN SLAs/SAs, with regard to LHN accountabilities, hold that the LHN CEO is responsible for, inter alia, “Developing effective and working partnerships with Aboriginal Community Health and ensuring health needs of Aboriginal people are considered in all health plans, programs and models of care developed by the LHN.” (eg, CALHN SLA 2018-2019, p. 10). This also addresses the NSQHS Standard:

2. Partnering with Consumers

Partnerships in healthcare governance planning, design, measurement, and evaluation

2.13 The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs

Policy documents include: Aboriginal Health Care Plan 2010-2016 (SA Health 2010); and A Framework for Comprehensive Primary Health Care Services for Aboriginal People (SA Health 2011). This criterion and associated sub-criteria reflect the essential elements required of an Aboriginal health plan established between an LHN and Aboriginal health and allied services within the LHN region. The presence of absence of these elements will be marked accordingly.
Criterion: Cultural Safety

35. Culturally unsafe healthcare contributes to persistent health inequalities for Aboriginal and Torres Strait Islander people. The *SA Health Aboriginal Cultural Learning Framework* (SAHACLF) (SA Health 2017a) has been developed to enable SA Health to provide a consistent approach to the improvement of the cultural competency within its workforce in order to meet the needs of Aboriginal consumers (p. 1). The SAHACLF will enable LHNs to meet NSQHSS Standard 1: Clinical Governance – Item: Governance, leadership and culture – Action 1.21 The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients (p. 5). The SAHACLF notes that the following indicators from the ATSIHPFPM are also relevant:

- 3.08 cultural competency
- 3.09 discharge against medical advice
- 3.12 Aboriginal and Torres Strait Islander people in the health workforce
- 3.22 recruitment and retention of Aboriginal staff (p. 11).

The SAHACLF also aligns with the vision, aims, guiding principles and the six domains of the *Cultural Respect Framework 2016-2023 for Aboriginal and Torres Strait Islander Health* (AHMAC 2016) (p. 5)

Elements of the SAHACLF cover:

- Impact of Aboriginal history on Health Outcomes
- Respect for Aboriginal Culture
- Health of Aboriginal People
- Communicating with Aboriginal People
- Development of Cultural Self Awareness (p. 14)

Employing Adult Learning Principles, the Aboriginal cultural learning outcomes are organised around three levels of learning:

- Individual level: knowledge and Awareness (Level One)
- Work Practice or System Level (Level Two)
- Organisational Level (Level Three) (pp. 8, 13-19).

How training will be delivered will depend on a number of factors, including the geographical location/distribution of staff, numbers of staff to be trained, availability of suitable staff to develop and deliver- in-house training, and resources to outsource training (p. 10).

The *SA Health Aboriginal Culture and History Handbook* (DHA 2013a) is a primary resource book used in Levels 1 and 2 learning programs.

The DHW’s LHN SLAs for CALHN, NALHN, SALHN and WCHN for 2018-2019, in the Schedule of Funding and Performance Indicators for the period of: 1 July 2018 – 30 June 2019, there is a Tier 2 KPI for People and Culture performance domain regarding the workforce: Completion of the Aboriginal Cultural Learning Program (Bi-Annual), with the measure: % of employees who have completed an Aboriginal cultural learning program (bi-annual), with a target of 100%. (eg, CALHN, SLA 2018—19, p. 7).

36. In line with the SAHACLF, LHNs will be required to develop:

- governance structures to enable the development and delivery of training, monitoring, reporting and reviewing of their implementation of the SAHACLF. They will also be required to ensure that the concepts from the SAHACLF are embedded in policies, procedures and guidelines. Aboriginal staff and consumers need to play an integral part in the development of any training, and this should be entrenched in the LHN governance structure (p. 6).
- implementation plans and report regularly on progress against the plan, which could include reporting against the RAP and include compliance as part of their annual Performance Development and Review (p. 11).

In relation to Theme Two – New and sustainable workforce models for rural health care outlined in the *SA Rural Medical Workforce Plan 2019 – 24* (SA Health 2019d), one of the actions to implement...
strategy 2.9 – review training programs and professional development opportunities for the existing rural medical workforce and determine any additional supports that can be provided, is to review existing programs with the aim of ensuring the rural medical workforce can access, and is supported to access, *inter alia*, training in the provision of culturally appropriate health services (p. 29).

37. The SAHACLF mandates that all staff across SA Health will engage in learning at their respective levels. All staff will be expected to achieve the learning outcomes defined for levels one and two, and additionally, with regard to Level 3, this includes all staff with a leadership and management responsibility will be required to achieve the learning outcomes defined for this level. Staff in executive roles have an additional responsibility to support a whole of SA Health approach to the governance of the SAHACLF (p. 7).

In the context of the key priority Evaluate and Measure of the *SA Health Aboriginal Workforce Framework 2017-2022*, SA Health wants to see:

- All SA Health employees completing cultural awareness training and developing greater cultural sensitivity and skills

and will:

- Establish targets and monitor progress to implement the Aboriginal Cultural Learning Framework across SA Health and ensure these are embedded in Service Level Agreements and performance agreements (SA Health 2017b, p. 12).

While the requirements for delivering cultural learning are clear, the assessment for scoring does not consider the quality or mode of delivery of such training - only whether it has been delivered or not, and if so, if the information is available, the completion rate against the target of 100% set in the SLAs. This KPI is not included in the regional LHN SAs for 2019-2020.

**Criterion: Selected LHN health performance indicators reported publicly**

38. The sub-criteria selected by the Expert Workshop include a number of health system performance indicators from the *Aboriginal and Torres Strait Islander Health Performance Framework: Health System Performance* (AHMAC, 2012). The Aboriginal and Torres Strait Islander Health Performance Framework (HPF) was designed to measure the impact of the National Strategic Framework for Aboriginal and Torres Strait Islander Health (NSFATSIH) and was an important tool in the development of the *National Aboriginal and Torres Strait Islander Health Plan 2013-2023*. The HPF monitors progress in Aboriginal and Torres Strait Islander health outcomes, health system performance and the broader determinants of health. The HPF covers the entire health system, including Indigenous-specific services and programs, and mainstream programs. The matrix is concerned to measure health system performance particularly from the perspective of Aboriginal community engagement, LHN accountability and service delivery.

39. The NHRA, in Schedule B in reference to the Independent Hospital Pricing Authority (IHPA), in para. B13 states:

In determining adjustments to the national efficient price, the IHPA must have regard to legitimate and unavoidable variations in wage costs and other inputs which affect the costs of service delivery, including:

- patient complexity, including Indigenous status.

While not included as a Tier 3 HSPM, nevertheless, much has been written about the need to improve the rates of Indigenous identification in the healthcare system as a policy imperative. Incomplete and inaccurate identification of the Aboriginal population is commonplace in health administration and clinical information systems in services across Australia. Poor recording of Aboriginal status results in Aboriginal people being recorded as ‘non-Indigenous’ or ‘not stated’ within collection systems, and their records not included in monitoring and analysis of health system utilisation and patient outcomes. This in turn under-estimates the burden of disease and service
utilisation, and underplays inequalities in health. In addition, it is unknown whether the characteristics of these ‘missing’ individuals are similar or different to those who are identified as Aboriginal, potentially biasing analysis and reporting. Improving identification rates of Aboriginal people in health services has been prioritised as part of the COAG commitment to Closing the Gap in the NIRA. Queensland Health (QH), for example, has issued *A guide for improving the identification of Aboriginal and Torres Strait Islander people in health care* to support and inform HHS staff so that they can “ensure the care and services they provide are both clinically and culturally responsive.” QH uses “Indigenous status – reporting of ‘not stated’ on admission” to record this data (Marrie 2017:67). NSQHSS Standard 5: Comprehensive Care – Item: Planning for comprehensive care – Action 5.8 The health service organisation has processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander Origin, and record this information in administrative and clinical information systems. The DHW’s LHN SLAs for CALHN, NALHN, SALHN and WCHN for 2018-2019, in Schedule 4: Performance Indicators and Targets includes a statement in relation to supporting the delivery of the Closing the Gap agenda and citing the NSQHSS, that: “The LHN should implement processes to identify patients as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems.” (eg, CALHN, SLA 2018—19, p. 52)

40. Reference: ATSIHPFPM Tier 3: Health System Performance – 3.09: Discharge against medical advice (DAMA). The DHW’s LHN SLAs for CALHN, NALHN, SALHN and WCHN for 2018-2019, in Schedule 4: Performance Indicators and Targets, in relation Safe and Effective Care in terms of Aboriginal Health, there is a Tier 2 KPI Aboriginal Patients Who Left Hospital Against Medical Advice, with the measure: % of overnight Aboriginal and/or Torres Strait Islander patients who left hospital against medical advice, with the target: <=4.5% (eg, CALHN, SLA 2018—19, p. 59). This KPI is also included in the SAs of the regional LHNs for 2019-2020.

41. Reference: ATSIHPFPM Tier 3: Health System Performance – 3.07: Selected potentially preventable hospital admissions (PPHA). The DHW’s LHN SLAs for CALHN, NALHN, SALHN and WCHN for 2018-2019, in Schedule 4: Performance Indicators and Targets, in relation Safe and Effective Care in terms of Quality and Effectiveness, there is a Tier 2 KPI for Potentially Preventable Admissions, with the measure: % of total separations with the target: Monitor against national rate. (eg, CALHN, SLA 2018—19, p. 58). In the regional LHN SAs for 2019-2020 there is a Tier 2 KPI for Potentially Preventable Admissions measured as a percentage of total separations with a 2019-20 target of <=8% (eg, EFNLHN SA 2019-2020, p. 42). However, with regard to the metropolitan LHN and WCHN SLAs and the regional LHN SAs this KPI does not specifically apply to PPA for Aboriginal people.

42. Reference: ATSIHPFPM Tier 3: Health System Performance – 3.10: Access to mental health services.

43. Reference: ATSIHPFPM Tier 3: Health System Performance – 3.01: Antenatal care; Tier 1: Health Status and Outcomes – Health conditions: 1.01 Low birthweight.

44. Health outcome differential measures (eg, patient discharge summary timeliness). In the CALHN, NALHN, SALHN and WCHN SLAs for 2018-2019, there is a Tier 2 KPI for Discharge Summary Transmission Rate measured by the percentage of discharge summaries transmitted within 48 hours of separation with a target of >=80% (eg, CALHN SLA 2018-2019, p. 56). While there are a considerable number of KPIs that could be used to indicate differential levels of treatment for Aboriginal and non-Aboriginal patients, some such as: Admission to Stroke Unit, Individual Care Plans for Rehabilitation, Mental Health Cute 28 Day Readmission Rates, and Emergency Department Unplanned Re-attendances within 48 hours.
INDICATOR 4: RECRUITMENT AND EMPLOYMENT

45. The recruitment and employment indicator measures the existence and effectiveness of employment strategies for recruiting and retaining Aboriginal people into an organisation’s health workforce against local LHN population equity targets for Aboriginal employment. The primary document, the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2011 – 2015*, is informed by health workforce elements within National Partnership Agreements for Closing the Gap In Indigenous Health Outcomes, Indigenous Early Childhood Development and Indigenous Economic Participation (Marrie 2017: 47). The primary policy reference for the Aboriginal health workforce in SA is the *SA Health Aboriginal Workforce Framework 2017-2022* (SA Health 2017b). The implementation of the Framework will assist SA Health to meet the requirements of the NSQHSS for Aboriginal and Torres Strait Islander consumers. In addition, the Framework complements SA Health RAPs, which outline practical action to build strong relationships and enhance respect between Aboriginal people and non-Aboriginal people (SA Health 2017b, p. 3). This indicator is focused on whether there is a published plan or strategy for Aboriginal health workforce development, who has responsibility for ensuring that the plan or strategy is implemented, and the level of Aboriginal employment assessed against the proportion of Aboriginal people of the total population in the local LHN region. It is also important to record where Aboriginal people are being employed within an LHN and at what level. While sometimes employment percentages can be impressive, many Aboriginal people are employed in clerical positions and in support services (as cleaners, bed washers, patient transporters, etc) and not in frontline services as doctors, nurses and in other (allied) health professions. Aboriginal health practitioners, health workers and liaison officers have important roles within LHNs and should be separately identified. Reference: ATSIHPFPM Tier 3: Health System Performance – 3.12: Aboriginal and Torres Strait Islander people in the health workforce.

The DHW’s LHN SLAs for CALHN, NALHN, CALHN and WCHN for 2018-2019, in the *Schedule of Funding and Performance Indicators for the period of: 1 July 2018 – 30 June 2019*, there is a Tier 2 KPI for People and Culture regarding the workforce: Aboriginal Employee Participation Rate: % of employees who identified as being of Aboriginal or Torres Strait Islander origin, with a target of >=4%. (eg, CALHN, SLA 2018—19, p. 74). The same target has been set for the six regional LHNs in their SAs for 2019-2020 (eg, EFNLHN, SA 2019-2020, p. 43).

**Criterion: Aboriginal health workforce development reporting**


47. In the context of the key priority Evaluate and Measure of the *SA Health Aboriginal Workforce Framework 2017-2022*, SA Health will:
   - Develop Aboriginal health workforce action plans in each LHN, SAAS and DHA aligned to the framework in consultation with key Aboriginal stakeholders (SA Health 2017b, p. 12).

48. In the context of the key priority Evaluate and Measure of the *SA Health Aboriginal Workforce Framework 2017-2022*, SA Health will:
   - Regularly review and update Service Level Agreement targets, including profession-specific targets, relating to Aboriginal workforce outcomes (SA Health 2017b, p. 12).

49. In the context of the key priority Recognise and Reinforce of the *SA Health Aboriginal Workforce Framework 2017-2022*, SA Health will:
   - Promote consistent application of classifications for specialist Aboriginal Health clinical and non-clinical roles, including but not limited to Aboriginal Health Practitioner, Aboriginal
Health Worker and Aboriginal Health Liaison Officer/Cultural Consultant roles (SA Health 2017b, p. 9).

Among the key principles articulated in the SA Rural Medical Workforce Plan 2019 – 24 (SA Health 2019d) is that:

The rural medical workforce is only able to deliver high-quality care in conjunction with well trained and accessible nursing and midwifery staff, allied health professionals, Aboriginal health workers, paramedics and ancillary staff. Many workforce solutions need a multidisciplinary approach (p. 18).

Among the actions for strategy 1.13 – advocate for SA high school students to have preferential access to SA medical school positions, is to explore the impact and outcomes of university sub-quotas for medical school entry for, inter alia, students of Aboriginal and Torres Strait Islander descent (p. 24). With regard to strategy 2.12 – support multidisciplinary workforce models to support GPs, one of the actions is to grow the Aboriginal community health worker workforce (p. 30).

50. In the context of the key priority Evaluate and Measure of the SA Health Aboriginal Workforce Framework 2017-2022, SA Health will:

- Monitor use of the Equal Employment Opportunity exemption granted to permit SA Health to advertise for and preference the appointment of Aboriginal people when filling vacancies in a number of specified Aboriginal health roles (SA Health 2017b, p. 13).

In the context of the key priority Develop Skills and Potential of the SA Health Aboriginal Workforce Framework 2017-2022, SA Health will:

- Support and encourage Aboriginal employees employed in Aboriginal designated positions to pursue career development opportunities in line with their career aspirations, included in non-designated Aboriginal positions (SA Health 2017b, p. 11).

51. In the context of the key priority Evaluate and Measure of the SA Health Aboriginal Workforce Framework 2017-2022, SA Health will:

- Ensure performance reviews for all Executive level roles (and equivalent) include objectives for Aboriginal employment and culturally respectful workplaces (SA Health 2017b, p. 12).

52. Number of long-term Aboriginal employees. This sub-criterion, to some extent, is reflective of Aboriginal employee workplace satisfaction.

Criterion: Aboriginal participation in the health workforce

53. Aboriginal health workforce staff are a key and integral part of providing culturally safe health care for Aboriginal clients. Aboriginal people make up 2% of South Australia’s population, with more than half of this population (53.8% living in metropolitan Adelaide (SA Health 2017b, p. 3. Citing ABS 2016 Census Data). The Government of South Australia’s Strategic Plan has set a target to increase the participation of Aboriginal people in the public sector, across all classifications, to 2%, while the Aboriginal workforce participation rate within SA Health in 2017 overall is approximately 1% (SA Health 2017b, p. 3). The OCPSE also cautions that the workforce data presented in the Workforce Information Report 2018-19 is likely to under represent the true level of Aboriginal employment in public sector agencies due to difficulties associated with, inter alia, collecting data that relies on self-identification (OCPSE 2019, pp. 60-1). The SA Public Sector recognises five major remuneration structures: Administrative Services, Operational Services, Professional Officers, Technical Grades and Allied Health Professionals (OCPSE 2019, p. 58). The occupational groups, identified in terms of the health services, and as identified in the SA Health Aboriginal Workforce Framework 2017-2022 are: the administrative workforce; medical professionals; nurses and midwives; operational services; allied health, scientific and technical staff; and others (SA Health 2017b, p. 5), and excludes
Paramedics and Ambulance Officers, and Dental and Visiting Dental Officers for the purposes of this report. The number or percentage of Aboriginal people employed within each of these occupational groups should be published in each LHN annual report, and the classification level at which they are employed within the following three categories:

- Executive and Senior Officer roles: EL, EX, MLS, SAES (OCPSE 2019, p. 58) The executive classifications in the CALHN Annual Report 2018-19 are: SAES1, SAES2, and EXEC0A (p. 25)
- Middle Manager roles: AO6, AO7 and AO8 positions, or their equivalent.
- Lower Level roles: AO2- AO5 positions.

This criterion addresses ATSIHP Tier 3: Health System Performance

- 3.12 “Aboriginal and Torres Strait Islander people in the health workforce” under the heading “Responsive”.
- 3.20: Aboriginal and Torres Strait Islander peoples training for health-related disciplines.

Additional weighting is given to those employment streams that provide clinical and frontline services.

54. Administrative workforce. In 2017 Aboriginal people comprised 3% of the administrative workforce (SA Health 2017b, p. 5)
55. Medical professionals. In 2017 Aboriginal people comprised 0.17% of medical professionals (SA Health 2017b, p. 5)
56. Nurses and midwives. In 2017 Aboriginal people comprised 0.54% of nurses and midwives (SA Health 2017b, p. 5)
57. Operational services. In 2017 Aboriginal people comprised 1.975% of operational services staff (SA Health 2017b, p. 5)
58. Allied Health, Scientific and Technical staff. In 2017 Aboriginal people comprised 0.22% of allied health, scientific and technical staff (SA Health 2017b, p. 5)
59. Other. In 2017 no Aboriginal people were employed in the category reserved for “others” (SA Health 2017b, p. 5). However, this category generally covers Aboriginal people who provide services as cultural consultants, Aboriginal Experts by Experience and as contractors.

INDICATOR 5: FINANCIAL ACCOUNTABILITY AND REPORTING: CLOSING THE GAP FUNDING

60. In The Report of the National Commission of Audit (2014), it is pointed out that transparency and accountability “are the hallmarks of responsible government.” In a general summation of the problems regarding Commonwealth public sector accountability and performance, the National Commission of Audit notes that:

The availability of good information on the performance of government programmes and activities is crucial to ensuring taxpayers funds are well spent and government is held to account. … Current arrangements make it difficult for the community to determine whether money is well spent, whether spending programmes meet their objectives and how efficiently and effectively the public sector is performing.

In the Australian Government’s Implementation Plan 2007-2013 for the National Strategic Framework for Aboriginal and Torres Strait Islander Health, in relation to accountability, one of the objectives is the:

Increased reciprocity of information between governments, providers and consumers of Aboriginal and Torres Strait Islander health services.

As an immediate priority action, one of the specific strategies is to: “Improve accountability requirements of funded organisations...” Further, with regard to appropriateness of mainstream health services and programs, another action to improve accountability is by: “Including in funding agreements for mainstream services (where applicable) an accountability requirement for improving outcomes for Indigenous Australians through mainstream and specific programs.” (DoHA 2007, p. 54).
43). However, Alford notes that there is still a lack of balance in government funding on Indigenous primary health care expenditure:

Too much money is being spent on hospitals [compared to Aboriginal Community Controlled Health services as more effective providers of primary health care]. Government funding issues include rationing Aboriginal health expenditure, under-utilisation of mainstream services, mainstreaming Indigenous expenditure, false economies resulting in avoidable and expensive hospital usage, sustainability and reporting issues, and failure to distribute funding equitably by a coherent, transparent, formal process. **Up to two-thirds of Aboriginal people rely on Indigenous-specific primary health care services. Yet three-quarters of all government Indigenous health expenditure is on mainstream services and nearly half (48.4%) of all expenditure is on hospitals** (ROGS E 2012 Table 5.2). Maldistribution of funding adversely impacts on services and clients, in New South Wales, Tasmania and Queensland severely, and Victoria considerably.

Financial accountability and reporting with regard to money allocated/granted for Aboriginal health is extremely important whether under the Closing the Gap strategy, or in relation to other federal and state/territory allocations. Aboriginal people, as well as the community at large, want, and have a right to know how the money is spent on programs targeted to address Aboriginal health needs. Open and transparent financial accountability is therefore essential. Financial Statements included as annual reporting requirements, should routinely include, as part of their income-expenditure statements, separate statements regarding funding which has been specifically allocated to Aboriginal healthcare and service delivery (either through federal or state allocations) or through special grants programs – for example, for clinical trials, NHMRC grants, allied health services (ATODS, Mental Health, Dialysis), employment and training, or delivery of cultural competency training under Closing the Gap funding. Sub-criteria could be added to reflect local/regional funding circumstances (Marrie 2017: 48-9).

This indicator is based on the premise that both the Aboriginal community and the South Australian community at large have a right to know how the considerable amounts of funding allocated by both the Commonwealth and the SA governments to Closing the Gap in Indigenous Health Outcomes are actually being spent. This indicator is included to promote transparency and accountability in funding arrangements at the local LHN level by including a financial statement in the annual report as the most appropriate reporting vehicle.

This indicator responds to ATSIHPFPM Tier 3: Health System Performance – 3.21: Expenditure on Aboriginal and Torres Strait Islander health compared to need.

**Criterion: Commonwealth contributions for Aboriginal health programs to LHN**

61. Data on Commonwealth expenditure on Indigenous health within the public health system is exceedingly difficult to find, partly because it is derived from different programs, and is not delivered as a consolidated amount. However, LHNs should be able to identify these sources and quantify the funds received.

**Criterion: South Australian contributions to Aboriginal specific health services and programs including activity-based funding loading for Aboriginal patients**

62. As with the Commonwealth, there appears to be a reluctance to disclose sources and amounts of funding received for the diverse array of Aboriginal health programs and services, including for activity-based funding loadings for Aboriginal patients. Activity based funding (ABF) refers to the ABF framework which allocates health funding to hospitals based on the standardized costs of health care services. The framework promotes smarter health care choices and better care by placing greater focus on the value of the health care delivered for the amount of money allocated (definition taken from CALHN Service Level Agreement 2018-2019, p. 36).
The first example of funding disclosure in Queensland to come to the attention of the consultant is provided by the Torres and Cape Hospital and Health Service in the Annual Report 2016-17, p. 19. However, the table identifying 20 funded programs totaling $9,092,382 does not fully identify whether the sources are Commonwealth or State, or joint contribution. Nevertheless, it can serve as a model of how funding for Aboriginal health programs and services can be presented.68

2.3.4 Stakeholder validation – modified Delphi approach

Stakeholder validation of the prototype customised South Australian institutional racism measuring and monitoring tool was undertaken in July 2020 with a series of webinars and teleconferences involving a panel of Aboriginal consumers as well as Aboriginal, and non-Aboriginal, health professionals and health administrators. The validation deployed a novel use of the Delphi approach where consecutive individual webinars with the panelists were followed up by subsequent teleconferences in which the anonymised collated feedback from the previous webinars was discussed and considered separately by each panelist.

The Delphi method is a structured communication method, originally developed as a systematic, interactive forecasting method which relies on a panel of experts. The technique has been used since the 1960s to forecast long-term trends. It has successfully adapted by AHHA for use as a consultation tool that allows the identification and confirmation of the views of stakeholders around trend, themes and influences.69 This method was chosen because it could efficiently produce the desired outcome within a reasonable timeline. In comparison to the usual roundtable, or focus group, methodology it enables all panelists to make an equal contribution and can lead to a consensus based upon deeper reflection. The logistic difficulties, and COVID-19 issues, in bringing the panel together for face-to-face dialogues were also overcome. Delphi methods have been deployed with Indigenous communities in Australia and North America.70

For this validation three panels were purposively selected from each stakeholder group:

- Aboriginal health consumers,
- Aboriginal and non-Aboriginal health professionals, and
- Aboriginal and non-Aboriginal health administrators.

Four people is usually regarded as enough for a case study.71 Using three consultants, including two experienced Aboriginal facilitators, individual webinars of around 60 minutes were undertaken with ten (10) panel members to elicit their opinions and views about the draft prototype customised South Australian institutional racism measuring and monitoring tool. The panel members were then be provided with a summary of the anonymised responses from the webinars. Anonymising panel members responses from the other panelists can enable more robust discussion and reduces panel member’s perceptions of any risk from commenting. Eight panel members were then interviewed by teleconference, using semi-structured questions, a week after the webinars later for a further 60 minutes, to refine and narrow down their responses as well as shape recommendations for change. Key questions that were asked during the interviews were:

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68 The TCHHS Annual report 2016-17 is available at: https://www.publications.qld.gov.au/dataset/torres-cape-hhs-annual-reports/resource/fe3efd99-dac6-4f98-a746-8e3fbb7aa1d0
70 Griew et al (2008); Hart et al (2009); Maar et al (2010); and Yin (2014)
71 Yin (2014)
• Could direct input to the LHN Board be provided by Aboriginal Experts by Experience as an alternative to an LHN Aboriginal Community Consultative Committee? (sub-criteria 1.1.3 and 2.2.1)
• Should the reference to the LHN Strategic Plan be substituted with the LHN Service Level Agreement? (sub-criteria 2.1.2)
• Was social media, specifically Facebook, an appropriate and useful way to disseminate information to the LHN Aboriginal community(ies)? (sub-criteria 2.2.3)
• Is using the LHN RAP as a reporting framework feasible or desirable? (criterion 2.3)
• Should the LHN website be the primary place for information reporting with the Annual Report as an alternative? (criterion 2.3)
• Could an alternative to the ACCHO(s), for co-design of the LHN Aboriginal health plan, be the Aboriginal Experts by Experience or another Aboriginal organisation? (sub-criteria 3.1.1 and 3.1.4)
• Should partnership(s) with the ACCHO(s) be preferred to a formal agreement? (sub-criteria 3.1.2)
• Should the activity-based funding loadings for Aboriginal patients not be separated out as a sub-criteria? (sub-criteria 5.2.2)

This process delivered a well-considered and robust validation of the draft prototype customised South Australian institutional racism measuring and monitoring tool with deeply considered recommendations for changes. The recommendations from this validation have been incorporated into the final matrix.

1.9 Methodology

1.9.1 Reporting period: FY2018 – June 2020
The audit is focused on the 2018-2019 annual reporting period for the three metropolitan LHNS and WCHN, however it has been extended to include the full year for 2018 up to June 2020. For the six regional LHNS the reporting period extends from FY2019 to June 2020. It is acknowledged that many of the documents used to source information for the audit in addition to the 2018-2019 annual report (service agreements, strategic plans, policies, etc.) overlap, either partially or fully, the audit period. Some end within this period, others take effect towards the end and continue into the next few years. Generally information from these “overlapping documents” is used in the audit process to inform the scores. However, as much and as consistently as possible, the audit is restricted to the FY2018-June 2020 period as it includes the possibility that the audit process will be repeated (its monitoring function) for a later period.

1.9.2 An assessment process based only on publicly available information
As in the construction of the Matrix, only publicly available information is used in the assessment/audit process. This information is gleaned from a range of documents that includes LHN annual reports, health service agreements, internally generated documents (such as consumer and community engagement strategies, operational plans), LHN board meeting agendas and minutes, community newsletters and websites. Through its reliance on publicly available information, the matrix establishes an assessment process which is open, transparent, verifiable, repeatable and publicly available and which reflects the current health policy environment. Once the Matrix settings have been established for a State/Territory jurisdiction, all the LHNS/HHSs within that jurisdiction can be scored and rated against each other, and periodic assessments can be undertaken as a desktop exercise to monitor progress towards the elimination of institutional racism within each LHN.
Ultimately, the matrix provides assessments of local level LHN accountability for the implementation of commonwealth and jurisdictional policies for Closing the Gap in Indigenous Health Outcomes.

This process invites the notion of a public information availability test. In order to support claims of transparency and accountability, information regarding, for example funding, employment, Closing the Gap KPIs, etc. should be freely and publicly available without having to resort to detailed searches or Freedom of Information requests.

In carrying out the audit no contact was made with any LHN employees or representatives to seek information or comment for the purposes of the audit.

1.9.3 Documents referred to

The policies and other relevant official documents referred to in this report are listed below.

Commonwealth Government

- Australian Health Ministers’ Advisory Council: *Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health* (2016)
- Australian Government: *National Aboriginal and Torres Strait Islander Health Plan 2013 – 2023*.
- Department of Health: *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023* (2015)
- Department of Social Services: *Aboriginal and Torres Strait Islander Workforce Strategy and Implementation Plan 2015-2018* (2015)

Council of Australian Governments (COAG)

- *National Health Reform Agreement* (2011) (NHRA)

South Australian Government

- Premier and Cabinet *Circular PC013 Annual Reporting Requirements 2019-2020*

SA Health (Department for Health and Ageing [DHA], Department for Health and Wellbeing [DHW])

- *SA Health Aboriginal Cultural Learning Framework* (DHA 2017a)
- *SA Health Guide for Engaging with Aboriginal People* (DHA 2013b)
- *SA Health Strategic Plan 2017 to 2020* (SA Health 2017a)
- *SA Health Strategic Plan 2017 to 2020: Early Actions* (SA Health 2017b)

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72 The Implementation Plan contains a list of some fifteen strategies either in place, or under development, which are included in the plan (DoH 2015, p. 8).
• Performance Framework 2018-19 (SA Health 2018b)
• SA Health Performance Framework 2019-2020 (SA Health, 2019c)
• Reconciliation Framework for Action 2014-2019 (SA Health 2014)
• Consumer and Community Advisory Committee / Group (CACAC/CAG): Policy Guideline and Toolkit (SA Health 2015)
• Consumer and Community Engagement Governance Model – consumer and community advisory groups (SA Health 2018a)
• SA Health Aboriginal Workforce Framework 2017-2022 (SA Health 2017b)
• South Australian Health and Wellbeing Strategy 2020-2025 (SA Health 2020)
• State Public Health Plan 2019-2024. (SA Health 2018c)
• SA Rural Medical Workforce Plan 2019-24 (SA Health 2019d)
• Charter for Local Health Network Governing Boards established under the Health Care Act 2008 (Volume 1) (SA Health 2019e)

South Australia Health Reports

• Annual Report 2018-2019

South Australian legislation

• Health Care Act 2008 (SA) [Version: 1.7.2019]
• Health Care Regulations 2012 (SA) [Version: 1.7.2019]
• Health Care (Governance) Amendment Act 2018 (SA) [No. 8 of 2018 assented to 2.8.2018]
• Health Care (Governance) Amendment Bill 2019 (SA) [Legislative Council – No 94] - the Health Care (Governance) Amendment Act 2019 (SA) [still before the Legislative Council]
• Equal Opportunity Act 1984 (SA) [Version: 2.9.2019]
• South Australian Public Health Act 2011 (SA) [Version: 5.3.2020]

Local Health Network Documents

• Annual Report 2018-2019
• Board Meeting Agenda and Minutes (from July 2019)
• Service Level Agreement 2018/19, 2019/20.
• Strategic Plan
• Operational Plan
• Consumer and community engagement (strategic) plan
• HAC Constitution
• HAC Annual Report 2018-2019

There is some inconsistency across LHNs with regard to the availability of some documents, and the information available. LHN documents have been listed at the end of each audit – the list also includes those that were not able to be found through a search of the relevant LHN website.

Aboriginal Health Council South Australia

• AHCSA Strategic Direction 2019-2024 (AHCSA 2019)
1.9.4 Important policy documents not sighted


_South Australia Strategic Plan 2011_ (cited in SA Health 2017b, p. 3) – for information regarding explicit targets regarding, for example, reducing the number of low birth weight Aboriginal babies, increasing Aboriginal life expectancy, and increasing Aboriginal leadership and public sector employments. SA Health website search for this document on 29 April 2020 was unsuccessful.

1.9.5 Scoring system

The scoring system, using simple metrics, is based on five key indicators (see section 2.2) under which a number of criteria have been assigned each addressing a particular federal or South Australian policy element relevant to Closing the Gap in Indigenous health outcomes. Most of the criteria has an assessment value of 10 points, although some have been scored out of 20. Most of the criteria are then broken down into a number of sub-criteria, each with its own point value, but adding up to the total point value assigned to the criterion.

The scoring system is deliberately weighted around certain priorities as reflected in the overall federal and state/territory health policy environments and settings, otherwise a simple “yes/no” \([\text{yes}=1; \text{no}=0]\) system would suffice. For example, particular priority is given to Aboriginal representation in the governance structure of the HHSs, as participation at this level will be a major determinant of how well a LHN engages with and delivers culturally safe and competent healthcare services to the local Aboriginal community, and holds itself accountable to that community. Participation on boards and within the executive management structure (through direct membership on the board, directorate status for Aboriginal health within the divisional structure and hence membership of the executive management team/group, and whether or not the divisional director is an Aboriginal person or not) is a case of “either it exists, or it doesn’t”, in which case either full points for that criterion/sub-criteria are awarded, or none at all.

One of the fundamental purposes of the matrix is to encourage reporting of relevant information about progress and initiatives undertaken to close the gap in Indigenous health outcomes, most importantly in LHN annual reports, so that such information is easily accessible to the public. However, in terms of scoring, this means that some things may be taking place, but they are not being reported in a way which is easily accessible, the information instead being contained in internal LHN and departmental documents and data bases. Perhaps the best example of this, and possibly the most controversial in terms of scoring, concerns the employment of Aboriginal people in the workforce of a LHN. All the state’s LHNs employ Aboriginal people, but the reporting of this fact is very poor in the annual reports. Despite the fact that Aboriginal people are employed, if information about their employment is not recorded, or only partially recorded (e.g., an overall percentage but no information regarding their participation in the different employment streams) in the annual report either zero scores will result, or there will be a very diminished score against the relevant criteria and sub-criteria.

1.10 Matrix limitation: Not designed to address individual or casual racism within LHNs

The Matrix is not designed to address or measure the incidence of individual acts of racism and racial discrimination occurring within a LHN. Other assessments tools, such as the _Workplace Diversity and Anti-Discrimination Assessment Tool_ developed by Trenerry and Paradies, are better suited for this purpose. However, it is argued that individual racist and discriminatory behaviours and institutional

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73 Trenerry and Paradies (2012b).
racism cannot be disassociated: high or very high levels of institutional racism could create a LHN culture or environment in which individual racist acts and racial discrimination can proliferate. In such environments, Aboriginal LHN employees can feel marginalised, disrespected and disempowered and have little faith in internal procedures for dealing with allegations of racist and discriminatory behaviours.\textsuperscript{74}

1.11 Methodological considerations regarding the transition of Country Health SA LHN into six country health LHNs

On the 1 July 2019, Country Health South Australia Local Health Network was dissolved and six regional Local Health Networks (LHNs) led by Governing Boards took over responsibility and accountability for publicly-funded health services in country South Australia. The six regional LHNs are supported by a Rural Support Service which has Aboriginal Health as one of its functional streams. The Aboriginal Health functions realigned to regional LHNs as of 1 July 2019 concerned specific Aboriginal health projects and a high-level strategy, policy and advocacy service (CHSALHN 2019, pp. 2 and 65). Other important arrangements concern BHFLHN as the host for the Rural and Remote Mental Health Service residing at the Glenside campus in metropolitan Adelaide (p. 31), and similarly for the Rural Support Service with a base at Nuriootpa (p. 50).

CHSALHN created a policy legacy for the six new LHNs as they set about creating their own LHN-specific policies for clinical, and consumer and community engagement. This legacy includes the Aboriginal Community & Consumer Engagement Strategy (CHSALHN 2015a) and Country Health SA Reconciliation Action Plan 2018-2020 (CHSA 2018). The other important legacy was the continuation of the local Health Advisory Councils (HACs), originally established in 2008, as an avenue for local level consumer and community engagement with the LHNs with their roles recognised in each LHN consumer and community engagement strategy/framework, and how HAC presiding members would work with their LHN Governing Board.

From a methodological perspective, in terms of the audit and individual regional LHN assessments, the transition phase is not quite complete insofar as they have not yet served their first full year of operation. Important strategies and frameworks, such as the clinical and workforce engagement strategies, and consumer and community engagement strategies are in the final stages of development and were not available for assessment. Similarly, the first annual reports for 2019-2020 will not be available until after September 2020. The important sources of information relied upon for the audit were the agendas and minutes of LHN Board meetings from July 2019 to April 2020, the LHN Service Agreements for 2019-2020, and the regional HAC annual reports 2018-2019, and which, for the most part were focussed on matters concerning the transition from CHSALHN into the new regional LHN arrangement. Information was also sourced, where possible from each LHN website, which effectively meant visiting the SA Health website and searching the particular LHN page and its portals and links.

\textsuperscript{74} See, for example, Marrie H (2014) in relation to the CHHHS, and Moreton-Robinson (2007) regarding the THHS.
INDIVIDUAL LHN AUDITS

1.12 SA metropolitan LHNs
There are three metropolitan LHNs, Central Adelaide, Northern Adelaide and Southern Adelaide which also have responsibility for delivering particular services statewide. Together with the Women’s and Children’s Health Network, these LHNs are sometimes referred to in this report as the “established LHNs”. From a methodological perspective, the main difference in the sources of information used in the audit concerning the established LHNs as distinct from the six regional LHNs is that the HACs for each of the established LHNs were dissolved by Schedule 3A – Dissolution of Health Advisory Councils of the Health Care (Governance) Amendment Bill 2019. These HACS delivered their last annual reports for the period 2018-2019, however, these annual reports were largely focused on the winding-up process and were not used in the audit assessments for this report.
### 1.12.1 Central Adelaide Local Health Network (CALHN)

#### CENTRAL ADELAIDE LOCAL HEALTH NETWORK (CALHN) MATRIX AUDIT FY2018-June 2020 (1)

<table>
<thead>
<tr>
<th>Key Indicators and Criteria</th>
<th>Scoring</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Participation in LHN governance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1.1 Good governance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1.1 Board interaction with Aboriginal community</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2)</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>1.1.2 LHN Aboriginal health performance indicators on Board agenda</td>
<td></td>
<td></td>
</tr>
<tr>
<td>for every meeting (3)</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>1.1.3 Direct input to Board by LHN Aboriginal Community Consultative Committee or Aboriginal Experts by Experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(4)</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>1.1.4 LHN Board members are educated about Aboriginal health in their LHN (5)</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>1.1.5 LHN Board members receive cultural learning training (6)</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td><strong>1.2 Aboriginal representation at board level</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aboriginal representation at board level (7)</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td><strong>1.3 Inclusion in Executive Management Structure</strong></td>
<td></td>
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</tr>
<tr>
<td>1.3.1 A stand-alone Aboriginal Health Division</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>(8)</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>1.3.2 Aboriginal LHN lead directly reports to the LHN CEO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(9)</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td>30</td>
</tr>
<tr>
<td><strong>2. Policy Implementation</strong></td>
<td></td>
<td>24</td>
</tr>
<tr>
<td><strong>2.1 Improving Aboriginal Health Outcomes</strong></td>
<td></td>
<td></td>
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<tr>
<td>2.1.1 Explicitly identified as a strategic priority in LHN Strategic Plan (10)</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>(i)</td>
<td>5</td>
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<tr>
<td>2.1.2 Aboriginal health outcome KPIs reflective of LHN key responsibilities identified in LHN Service Agreement (11)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(i) Tier 1 KPIs (12)</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>(ii) Tier 2 KPIs (13)</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td><strong>2.2 Community engagement</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.2.1 Aboriginal community consultative body</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>(14)</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>2.2.2 Aboriginal community engagement embedded within overall community engagement strategy (15)</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>2.2.3 LHN Aboriginal community newsletter/e-letter/social media (16)</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>2.2.4 At least one Aboriginal community forum/meeting per year convened by the LHN chief executive officer (17)</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>2.2.5 Reconciliation Action Plan (18)</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>2.2.6 Aboriginal health professionals caring for patients included within clinical engagement strategy (19)</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td><strong>2.3 Public Reporting and Accountability (via LHN annual report) (20)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3.1 Traditional Owner Acknowledgement (21)</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>2.3.2 Improving Aboriginal health outcomes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(i) Separate section in report devoted to Aboriginal health (22)</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>(ii) Reporting on KPIs contained in current service level agreement (SLA) (23)</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>(iii) Report Aboriginal community engagement (24)</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>(iv) Report on Aboriginal specific National Safety and Quality Health Service Standards Assessment (25)</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>(v) Chronic disease management care and planning (26)</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td><strong>2.3.3 Cultural learning completion rates</strong></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>2.3.4</td>
<td>Aboriginal health division/unit placement on LHN organisational structure/chart (28)</td>
<td>1</td>
</tr>
<tr>
<td>2.3.5</td>
<td>Data on Aboriginal access to and delivery of services (29)</td>
<td>3</td>
</tr>
</tbody>
</table>
| 2.3.6 | Aboriginal employment  
(i) Aboriginal Workforce Framework (planning, recruitment, etc) (30) | 2 | 2 |
|       | (ii) Data on Aboriginal employment (31) | 3 | 0 |
| 2.3.7 | Other recognition (e.g., awards, scholarships, etc.) (32) | 2 | 0 |
|        | TOTAL | 70 | 4 |

### 3. Service delivery and partnerships

#### 3.1 Aboriginal LHN Plan

| 3.1.1 | Co-designed in partnership with ACCHO(s), or other Aboriginal organisations, or Aboriginal Experts by Experience in LHN region (33) | 2 | 0 |
| 3.1.2 | Partnership with ACCHO(s) in LHN region (34) | 2 | 0 |
| 3.1.3 | Commitment to Continuous Quality Improvement (35) | 2 | 0 |
| 3.1.4 | Co-designed KPIs (36) | 2 | 0 |
| 3.1.5 | Clear statement of ACCHO and LHN responsibilities and conflicts (37) | 2 | 0 |
|        | TOTAL | 20 | 0 |

#### 3.2 Cultural safety

| 3.2.1 | Implementation of cultural safety policy/strategy (38) | 5 | 0 |
| 3.2.2 | Proportion of staff trained (39) | 5 | 0 |
|        | TOTAL | 0 | 0 |

#### 3.3 Selected LHN health performance indicators reported publicly

| 3.4.1 | Estimated level of completion of Indigenous status – specifically the reporting of ‘not stated’ on admission (40) | 3 | 0 |
| 3.4.2 | Discharged against medical advice (DAMA) (41) | 4 | 0 |
| 3.4.3 | Potentially preventable hospitalisations (PPHA) (42) | 3 | 0 |
| 3.4.4 | Access to mental health services as reported at service level agreement (43) | 3 | 0 |
| 3.4.5 | Low birth-weight babies (44) | 3 | 0 |
| 3.4.6 | Healthcare outcome differential measures (eg. Discharge summary timeliness) (45) | 4 | 0 |
|        | TOTAL | 40 | 0 |

### 4. Recruitment and employment

#### 4.1 Aboriginal health workforce development reporting

| 4.1.1 | Implementation of Aboriginal workforce strategy (46) | 4 | 0 |
| 4.1.2 | LHN KPI for Aboriginal employment (47) | 4 | 0 |
| 4.1.3 | Number of Aboriginal health practitioners, health workers and liaison officers (48) | 3 | 1 |
| 4.1.4 | Number of identified Aboriginal positions (49) | 3 | 0 |
| 4.1.5 | Number of salary bands occupied by Aboriginal employees (50) | 3 | 0 |
| 4.1.6 | Number of long-term Aboriginal employees (51) | 3 | 0 |
|        | TOTAL | 40 | 1 |

#### 4.2 Aboriginal participation in the health workforce

| 4.2.1 | Administrative (52) | 3 | 0 |
| 4.2.2 | Medical Professionals (53) | 4 | 0 |
| 4.2.3 | Nurses/Midwives (54) | 4 | 0 |
| 4.2.4 | Operational Services (55) | 3 | 0 |
| 4.2.5 | Allied Health/Scientific/Technical (56) | 3 | 0 |
| 4.2.6 | Other (57) | 3 | 0 |
|        | TOTAL | 40 | 1 |
5. Financial Accountability and Reporting: Closing the Gap Funding

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Total out of 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 Commonwealth contributions for Aboriginal health programs to LHN</td>
<td>10 0</td>
</tr>
<tr>
<td>5.2 South Australian contributions to Aboriginal specific health services and programs including activity-based funding loading for Aboriginal patients</td>
<td>10 0</td>
</tr>
</tbody>
</table>

**TOTAL** 20 0

Institutional Rating scored against criteria

<table>
<thead>
<tr>
<th>Score</th>
<th>&lt;=39</th>
<th>40-79</th>
<th>80-119</th>
<th>120-159</th>
<th>&gt;=160</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence of Inst. Racism:</td>
<td>Very High</td>
<td>High</td>
<td>Moderate</td>
<td>Low</td>
<td>Very Low</td>
</tr>
</tbody>
</table>

**Notes:**

1. **Central Adelaide Local Health Network (CALHN)**

Located on the traditional country of the Kaurna people, the 2016 ABS Census estimated population (usual residence) for the CALHN region is 444,912 (the CALHN Service Level Agreement 2018-2019, p. 20 estimates the central Adelaide metropolitan population it serves as 396,000), with an Aboriginal and Torres Strait Islander population of 4,975 (1.1% of the total population) (APHN, 2020. https://profile.id.com.au/aphn/population?WebID=310). CALHN entered formal Organisational and Financial Recovery in November 2018 (CALHN Annual Report 2018-19, p. 12). The Aboriginal & Torres Strait Islander Liaison Unit (ATSILU) is located at the Royal Adelaide Hospital and appeared to offer services and support specific to the RAH. However, it is mentioned that the ATSILU is there to: “Assist CALHN sites and departments to provide culturally safe care.” (https://www.rah.sa.gov.au/patients-and-visitors/aboriginal-and-torres-strait-islander-support).

There are two ACCHOs in the CALHN region: the Aboriginal Sobriety Group Inc. and Nunkuwarrin Yunti of South Australia Inc. – both in Wakefield Street (AHCSA: https://ahcsa.org.au/members/)

**INDICATOR 1: PARTICIPATION IN LHN GOVERNANCE**

**Criterion: Good governance**

The following chart provides an overview of the CALHN references to and discussion concerning Aboriginal health and related matters. In addition to the listed sub-criteria, other headings have been included to cover information not readily assigned to the listed sub-criteria. Where Aboriginal health matters have been discussed, the Agenda item numbers have been indicated in the monthly columns. Also note that the Acknowledgement of Country of the Kaurna people is a standing item under Agenda Item 1.1 in all meetings, and is not included in the chart below

**Legend:**

x = no information relevant to the sub-criterion heading was provided.
? = minutes were not uploaded onto SA Health website at the time of this analysis (30 May 2020).
AHEMGB – Aboriginal Health Expert Member of Governing Board (this person may/may not be an Aboriginal person)
Tier 1 committee = a Board committee which reports to the Board
Tier 2 committee = an internal LHN committee which reports to the CEO
Tier 3 committee = a community-based committee established in accordance with, for example, a LHN consumer and community engagement plan/framework/strategy and which can provide input to, or respond to the LHNB or LHN CEO.

CALHN Board meetings: good governance sub-criteria summary for July 2019 – April 2020

<table>
<thead>
<tr>
<th>Meeting:</th>
<th>July</th>
<th>Aug. 14&lt;sup&gt;th&lt;/sup&gt;</th>
<th>Sept. 24&lt;sup&gt;th&lt;/sup&gt;</th>
<th>Oct. 2nd</th>
<th>Nov.</th>
<th>Dec. 4th</th>
<th>Feb. 5th</th>
<th>March 31&lt;sup&gt;st&lt;/sup&gt; (V)</th>
<th>April</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-criteria:</td>
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<tr>
<td>1.1.1 LHN inter. With Aboriginal Com.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>5.2</td>
<td>?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1.2 AHPI on Mtg Agenda</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1.3 ACCC direct input to LHNB</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1.4 LHNB educ’d re Aboriginal Health</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>4.1</td>
<td>X</td>
<td>?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>1.1.5 LHNB Receives CCT</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>?</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Additional sub-criteria</td>
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<td></td>
<td></td>
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<tr>
<td>Invited Aboriginal Guest</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aboriginal Health Agenda Item</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aboriginal Health Discussed</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>4.1/8.1</td>
<td>X</td>
<td>?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>SLA Tier 1 &amp; 2 Aboriginal Health KPIs Discussed</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>7.1</td>
<td>X</td>
<td>?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aboriginal Membership of Brd Committees</td>
<td></td>
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</tbody>
</table>

Summary of matters addressed:

December 4<sup>th</sup>:
**Agenda Item 4.1:** Chair Report – Thanked Ms Morey (board member) and Professor Dwyer (board member) and the Aboriginal and Torres Strait Islander Liaison Unit for preparation of recent Aboriginal Health Forum.

**Agenda Item 7.1:** Integrated Quality and Performance report – Board noted, *inter alia*, the Spotlight Report reflecting Tier2 KPIs relating to CALHN’s Aboriginal population. It was reported that six new Aboriginal Health priority strategies were presented to the November Clinical Governance Committee. The Board noted the importance of document strategies rather than simply focussing on data.

**Agenda Item 8.1:** Workforce report – It was noted that the workforce dashboard did not include SCSS [Statewide Clinical Support Services], which may point to an undercount in Aboriginal employment.

Feb. 5<sup>th** Agenda Item 5.2:** CEO Report – The CEO advised the Board that an invitation would be sent for the Board to participate in a Kaurna Cultural Tour, being organised by the Director, Aboriginal Health and Research Translation, which was intended to foster conversation and learning about Kaurna. The tour will explore connectivity of culture and country to the care CALHN provides to our Aboriginal consumers.
2. **Board interaction with Aboriginal community**
   At its Feb. 5th 2020 meeting (Agenda Item 5.2) the CEO advised the CALHNB of a pending invitation for the Board to participate in a Kaurna Cultural Tour intended to foster conversation and learning about Kaurna and the connectivity of culture and country to the care CALHN provides to our Aboriginal consumers. **Score = 2 / 2**

3. **LHN Aboriginal Health performance indicators on Board agenda for every meeting**
   Based on the information provided in the Agenda and the Minutes, there is no evidence of Aboriginal Health performance indicators being provided to or being discussed at CALHNB meetings. **Score = 0 / 2**

4. **Direct input to Board by LHN Aboriginal Community Consultative Committee or Aboriginal Expert by Experience**
   Based on the information provided in the Agenda and the Minutes, there is no evidence of an Aboriginal Community Consultative Committee (a Tier 3 committee) providing input at CALHNB meetings. **Score = 0 / 2**

5. **LHN Board members are educated about Aboriginal health in their LHN**
   At its Dec. 4th 2019 meeting (Agenda Item 4.1) there is indication that the CALHNB received education about Aboriginal health within the LHN region via an Aboriginal Health Forum prepared by two of its members and the Aboriginal and Torres Strait Islander Liaison Unit. **Score = 2 / 2**

6. **LHN Board members receive cultural learning training**
   Based on the information provided in the Agenda and the Minutes, there is no evidence of the CALHNB having undertaking cultural learning as per the *SA Health Aboriginal Cultural Learning Framework* (SA Health 2017a). **Score = 0 / 2**

**Criterion: Aboriginal representation at board level**

7. **Aboriginal representation at board level**
   From an initial transition Governing Board of 7 members fully operational from 1 July 2019, the current board has 6 members, one of whom identifies as an Aboriginal person. Another member also has expertise in Indigenous health. *Central Adelaide Local Health Network (CALHN) Governing Board: Fact Sheet*. Accessed 6/5/2020

**Criterion: Inclusion in Executive Management Structure**

8. **A stand-alone Aboriginal Health Division**
   The Director Aboriginal Health and Research Translation – a non-executive position (one of 14 directorates – 7 of which [including the Chief Operating Officer] are headed by executive directors) (CALHN Annual Report 2018-19, p. 8)  **Score = 5 / 5**

9. **Aboriginal LHN lead directly reports to the LHN CEO**
   The Director of Aboriginal Health and Translation, who is an Aboriginal person, reports on a day-to-day basis to Integration and Partnerships (i.e., to the Executive Director Allied Health, and Strategic Integration and Partnerships – not to the LHN CEO) (CALHN Annual Report 2018-19, p. 10), however, according to the Executive Group organisational chart accessed on 13 June 2020 at:
https://www.sahealth.sa.gov.au/wps/wcm/connect/04e2c687-c203-4b6c-818a-fa86f0209bff/CALHN+Organisational+chart+-+Corporate+Executive+WEB+20200527.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-04e2c687-c203-4b6c-818a-fa86f0209bff-n9kFv9m the Director of Aboriginal Health and Translation reports directly to the CEO. Score = 5 / 5

**INDICATOR 2: POLICY IMPLEMENTATION**

**Criterion: Improving Aboriginal Health Outcomes**

10. **Explicitly identified as a strategic priority in LHN Strategic Plan**
   Apart from CALHN’s Organisational and Financial Recovery Plan no CALHN Strategic Plan has been located on the SA Health website CALHN page. Score = 0 / 10

11. **Aboriginal health outcome KPIs reflective of LHN key responsibilities identified in LHN Service Level Agreement** The CALHN Service Level Agreement 2018-2019, in Schedule 4: Performance Indicators and Targets (excluding SA Dental Service KPIs) contains 60 KPIs (22 Tier 1 and 38 Tier 2) (pp. 55-59). In the section designated for Aboriginal Health, there is only one KPI – DAMA, a Tier 2 KPI (p. 59). Some of the CALHN SLA KPIs include patient sub-sets, for example, the Emergency Department Tier 2 KPI: Left at Own Risk which measures three patient sub-sets: (i) % of all ED presentations; (ii) % of Aboriginal presentations; and (iii) % of Mental Health presentations – all with a target of <=3%.

The purpose of the following two sub-criteria is to suggest additional KPIs to the four KPIs already included in the metropolitan LHNs and for the WCHN, namely the Tier 2 KPIs: Left at Own Risk; DAMA; Aboriginal Employee Participation Rate; and Completion of the Aboriginal Cultural Competence Program. Given the excess burden of disease within the Aboriginal community, and particularly in relation to cancer, heart and stroke, diabetes, kidney disease and mental health, there should be a range of both Tier 1 and 2 KPIs to address these health crises. The KPIs selected below, except for one (Indigenous status reporting), are already in the CALHN SLA, and use a sub-set for Aboriginal patients as employed above with regard to the Emergency Department Tier 2 KPI: Left at Own Risk. The basis for scoring is that, given the excess burden of disease among Aboriginal people and the health crises faced by many Aboriginal communities, these KPIs (with Aboriginal people constituting a KPI sub-set, should already be included in the current SLA. The fact that they are not results in a penalty score.

12. **Tier 1 KPIs**

   * Elective Surgery: Tier 1 – Timely Admissions: % of elective surgery patients admitted within clinically recommended times; % of Aboriginal patients admitted for elective surgery within clinically recommended times. Target 100%.

   * Emergency Department: Tier 1 – Length of Stay Less Than or Equal to 4 hours: % of presentations to an ED where the time from the presentation to the time of physical departure (i.e. the length of the ED stay) is less than or equal to 4 hours; % of Aboriginal presentations to an ED where the time from the presentation to the time of physical departure (i.e. the length of the ED stay) is less than or equal to 4 hours. Target >=90%

   * Emergency Department: Tier 1 – Seen on Time: % of patients attending ED who commenced treatment within clinically accepted timeframes; % of Aboriginal patients attending ED who commenced treatment within clinically accepted timeframes. Target varies from 100% for Category 1 patients to >=70% for Category 5 patients.

   * Mental Health: Tier 1 – Mental Health - Adult/Older Persons Acute 28 Day Readmission Rate: % of patients who had a readmission within 28 days of discharge (non-short stay); % of
Aboriginal patients who had a readmission within 28 days of discharge (non-short stay).
Target <=12%

* Mental Health: Tier 1 – Suicide of persons in Inpatient Mental Health Units: # of suicides that occur in admitted patient specialised mental health services; # of Aboriginal suicides that occur in admitted patient specialised mental health services. Target - Monitor

Score = 0 / 5

13. Tier 2 KPIs
* Aboriginal Health: Tier 2 – Indigenous status reporting: % ‘not stated’ on admission. Target: ?
* Mental Health: Tier 2 - Post Discharge Community Follow Up Rate: % of people receiving one or more mental health service contacts while in the community within 7 days post discharge; % of Aboriginal people receiving one or more mental health service contacts while in the community within 7 days post discharge. Target >=70%.
* Clinical pathways: Tier 2 - Stroke (RAH) Admissions to Stroke Unit: % of stroke patients where the patient spent part of their stay in a stroke ward; % of Aboriginal stroke patients where the patient spent part of their stay in a stroke ward. Target >=90%.
* Clinical Pathways: Tier 2 - Rehabilitation: Individual Care Plan: % of rehabilitation patients who leave hospital with an individualised care plan; % of Aboriginal rehabilitation patients who leave hospital with an individualised care plan. Target >=90%.
* Occupancy: Tier 2 – Discharge Summary Transmission Rate: % of discharge summaries transmitted with 48 hours of separation; % of Aboriginal patient discharge summaries transmitted with 48 hours of separation. Target >=80%

Score = 0 / 5

Criterion: Community Engagement

14. Aboriginal community consultative body
In the Independent Auditor’s Report attached to the CALHN Annual Report 2018-19, Note 37 concerns Board and committee members who were entitled to receive income from membership. There are 29 entities named, none of which explicitly refers to some form of Aboriginal community consultative body. A search of the SA Health website CALHN page (and portals and their links) did not indicate the existence of a CALHN Aboriginal community consultative body Score = 0 / 4

15. Aboriginal community engagement embedded within overall community engagement strategy
In accordance with Schedule 3A – Dissolution of Health Advisory Councils, of the Health Care (Governance) Amendment Bill 2019 (SA), CALHN Health Advisory Council was dissolved. The CAHLN Consumer engagement portal does not indicate the existence of a Consumer and Community Engagement Strategy, and only provides contact details regarding consumer engagement. A 15 member CALHN Consumer Engagement Working Committee has been formed, with representation from consumers and carers with different background, including Aboriginal and Torres Strait Islander people [see https://www.sahealth.sa.gov.au/wps/wcm/connect/5971ef29-9980-4fd7-ac6b-c3e271ed585a/CALHN+Consumer+Engagement+Working+Committee+fact+sheet+20180830.pdf?MOD=AJPERES&CACHSIDE=ROOTWORKSPACE-5971ef29-9980-4fd7-ac6b-c3e271ed585a-n5ii878]
The purpose of the committee is to build a consumer perspective into operational projects for services provided by CALHN. The goal is to continuously improve the care and safety and quality of services delivered by CALHN. In the absence of a strategy, no points can be awarded. Score = 0 / 4

16. LHN Aboriginal community newsletter/e-letter /social media
A search of the SA Health website CALHN page (and portals and their links) did not indicate the existence of a CALHN Aboriginal community newsletter or e-letter. CALHN has a Facebook page
@centraladILHN and a Twitter account @CentralAdILHN, CALHN posts Aboriginal health related information on the Facebook page. **Score = 1 / 3**

17. **At least one Aboriginal community forum/meeting per year convened by the LHN chief executive officer**

The CALHN SLA for 2018-2019, in Schedule 5: SA Health Performance Framework, with regard to Performance Review Processes, includes processes for monitoring performance against key deliverables (as outlined in Schedule 4 of the SLA). One of these processes includes "Contract Performance Meetings to review performance, particularly in relation to the key indicators (Tier 1), and to discuss and develop mitigation strategies where appropriate and to monitor progress. At least one meeting will focus on Mental Health specific deliverables and KPIs and at least one meeting will focus on Aboriginal Health specific deliverables and KPIs.” (CALHN, SLA 2018—19, pp. 61-2). In the context of this sub-criterion, it would seem appropriate that the CALHN CEO hold an Aboriginal community forum/meeting preparatory to the scheduled Contract Performance Meeting with DHW at which the Aboriginal Health specific deliverables and KPIs are to be discussed. Evidence has not emerged that such a meeting has taken place. **Score = 0 / 3**

18. **Reconciliation Action Plan**

A search of the SA Health website CALHN page (and portals and their links) did not indicate the existence of a CALHN RAP. **Score = 0 / 3**

19. **Aboriginal health professionals caring for patients included within clinical engagement strategy**

At its Dec. 4th 2019 meeting (Agenda Item 7.1), regarding presentation of the Integrated Quality and Performance report, the CALHN noted, **inter alia**, the Spotlight Report reflecting Tier2 KPIs relating to CALHN’s Aboriginal population. It was reported that six new Aboriginal Health priority strategies were presented to the November Clinical Governance Committee. The Board noted the importance of document strategies rather than simply focussing on data. However, the CALHN’s Clinical Engagement Strategy has not yet been sighted. **Score = 0 / 3**

**Criterion: Public Reporting and Accountability (via LHN website or annual report)**

20. The CALHN, in effect, does not have its own website. An internet search for “Central Adelaide Local Health Network” will lead to the SA Health website ([www.sahealth.sa.gov.au](http://www.sahealth.sa.gov.au)) which provides a link to CALHN: [https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+local+health+networks/central+adelaide+local+health+network/central+adelaide+local+health+network%20(2018-19)](https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+local+health+networks/central+adelaide+local+health+network/central+adelaide+local+health+network%20(2018-19)). The CALHN page contains a number of portals. As at 7th June 2020, there are five CALHN portals: (i) Breastscreen SA; (ii) Freedom of Information - Central Adelaide Local Health Network; (iii) Geriatric Services; (iv) Consumer engagement - CALHN; (v) CALHN Organisational and Financial Recovery. Each portal provides links to enable access to additional information. There is no portal presenting a snap-shot of the CALHN providing basic information about population demographics (including the Aboriginal population and Traditional Owners), geographic region served, brief description of the health workforce, a resident health profile/dashboard, and summary of services provided. None of the information sought below is readily available on the CALHN page (including its portals and their links) (“the CALHN page”) on the SA Health website. Information regarding, for example, Aboriginal employment in the health workforce, cultural competency training completion rates, and Aboriginal health outcome KPIs must be sought via other portals and links on the SA Health website.

The annual report referred to is the CALHN Annual Report 2018-19.
21. **Traditional Owner acknowledgement**
The SA Health website CALHN page and the CALHN *Annual Report 2018-19* contain no acknowledgement of the Kaurna Traditional Owners
**Score = 0 / 2**

22. **Improving Aboriginal health outcomes: (i) Separate section in report devoted to Aboriginal health**
The SA Health website CALHN page does not provide a portal for Aboriginal health. In the CALHN *Annual Report 2018-19*, there is no separate section (as per the Contents page) under the section on “The agency’s performance” devoted to Aboriginal health. However, the annual report does contain two sections in relation to “Agency specific objectives and performance” summarising Aboriginal health related initiatives. One in relation to the agency objective to “Be a great place to work and learn” with an indicator for “Improved focus of Aboriginal health across CALHN...” with its Performance describing CALHN utilisation of Closing the Gap funding. The second in relation to “Employment opportunity programs” in regard to CALHN’s performance in relation to the South Australian Public Sector Aboriginal Employment Register. However, as there is CALHN portal for Aboriginal health, and no separate section in the annual report providing a comprehensive summary of Aboriginal health related outcomes, a zero score results. **Score = 0 / 3**

23. **Improving Aboriginal health outcomes: (ii) Reporting on KPIs contained in current service level agreement (SLA)**
The CALHN SLA 2018—19 Schedule 4 contains the following Aboriginal health specific KPIs:

**Performance Domain: Access and Flow**
Emergency Department Tier 2 KPI: Left at Own Risk
Measure: % of Aboriginal presentations. Target <=3%.

**Performance Domain: Safe and Effective Care**
Aboriginal Health Tier 2 KPI: Aboriginal Patients Who Left Hospital Against Medical Advice
Measure: % of overnight Aboriginal and/or Torres Strait Islander patients who left hospital against medical advice. Target: <=4.5%

**Performance Domain: People and Culture**
Workforce Tier 2 KPI: Aboriginal Employee Participation Rate
Measure: % of employees who identified as being of Aboriginal or Torres Strait Islander origin.
Target: >=4%#

Workforce Tier 2 KPI: Completion of the Aboriginal Cultural Competence Program
Measure: % of employees who have completed Aboriginal cultural competence training. Target: 100%#

# These two KPIs are also included in the *Schedule of Funding and Performance Indicators for the period of 1 July 2018 – 30 June 2019* which forms part of the SLA. However, in the *Schedule* regarding Aboriginal Cultural competence training, the KPI uses the following wording: Tier 2: Completion of the Aboriginal Cultural Learning Program (Bi-Annual), with the Measure: % of employees who have completed and Aboriginal cultural learning program (bi-annual). Target = 100%.
(CALHN, SLA 2018—19, pp. 55, 59, 74). Performance against these KPIs is not reported on the CALHN page (and portals and their links), nor in the annual report. **Score = 0 / 3**

24. **Improving Aboriginal health outcomes: (iii) Report on Aboriginal community engagement**
The CALHN page portal (Consumers – CALHN) for community engagement provides a number of links, however, while inclusive of Aboriginal people, none of these provide specific information regarding Aboriginal community and consumer engagement. The annual report makes no mention regarding Aboriginal community engagement. **Score = 0 / 3**
25. **Improving Aboriginal health outcomes: (iv) Report on Aboriginal specific National Safety and Quality Health Service Standards assessment**

The CALHN SLA for 2018-2019, in Schedule 4: Performance Indicators and Targets includes a statement in relation to supporting the delivery of the Closing the Gap agenda and citing the NSQHSS, that: “In order to support the delivery of the Closing the Gap agenda, and implementation of the National Safety and Quality Health Service Standards related to Aboriginal and Torres Strait Islander health, wherever possible performance data will be collated for the population as a whole and for Aboriginal and Torres Strait Islander peoples.” (CALHN, SLA 2018—19, p. 52). However, none of this data is recorded in the CALHN annual report.

Table 2 lists six Aboriginal and Torres Strait Islander specific standards. Neither the CALHN page nor the annual report provide data on how these standards are being met, although the annual report does address NSQHSS Action 1.22 in relation to the clinical workforce (CALHN Annual Report 2018-19, p. 22). Score = 0 / 3

26. **Improving Aboriginal health outcomes: (v) Chronic disease management and care planning.**

While CALHN is a member/partner of the South Australian Aboriginal Chronic Disease Consortium (SAACDC), no mention in made on the CALHN page or in the annual report regarding SAACDC activities/outcomes in relation to CALHN. Score = 0 / 3

27. **Cultural learning completion rates**

The CALHN page provides no data on cultural learning completion rates. In the context of encouraging Aboriginal employment via the South Australian Public Sector Aboriginal Employment Register, the annual report mentions that CALHN “is currently promoting the.... SA Health Aboriginal and Torres Strait Islander Cultural Learning Framework ...., and is actively working on imbedding Aboriginal and Torres Strait Islander Workforce Initiatives to compliment the Framework.” It also refers to the SA Health Aboriginal and Torres Strait Islander Workforce Framework in this context. (CALHN Annual Report 2018-19, p. 20). However, it has not provided any data on actual completion rates. Score = 0 / 2

28. **Aboriginal health division/unit placement on LHN organisational structure/chart**

The Director Aboriginal Health and Research Translation is shown on both the Organisational chart and the Interim Organisational Chart – Corporate Executive June 2019 (CALHN Annual Report 2018-19, pp. 8 and 10). Score = 1 / 1

29. **Data on Aboriginal access to and delivery of services**

Neither the CALHN page nor the annual report provide data on Aboriginal access to and delivery of services. Score = 0 / 3

30. **Aboriginal employment: (i) Aboriginal Workforce Framework (planning, recruitment, etc)**

The annual report mentions that CALHN “is currently promoting the SA Health Aboriginal and Torres Strait Islander Workforce Framework ...., and is actively working on imbedding Aboriginal and Torres Strait Islander Workforce Initiatives to compliment the Framework.” CALHN also “actively monitors the Public Sector 2% target and participates to increase employment of Aboriginal people across the South Australian public sector” (CALHN Annual Report 2018-19, p. 20). The CALHN page currently does not have a portal or links providing information on how the LHN is implementing the Aboriginal Workforce Framework. Based on the information in the annual report full points are awarded. Score = 2 / 2

31. **Aboriginal employment: (ii) Data on Aboriginal employment**
Neither the CALHN page or the annual report provide data on Aboriginal employment within the LHN. **Score = 0 / 3**

32. **Other recognition (e.g., awards, scholarships, etc.)**
Neither the CALHN page nor the annual report have a link or section regarding staff awards, achievements, etc., including for Aboriginal staff. **Score = 0 / 2**

**INDICATOR 3: SERVICE DELIVERY AND PARTNERSHIPS**

**Criterion: Aboriginal LHN Plan**

33. **Co-designed in partnership with ACCHO(s), or Aboriginal organisations, or Aboriginal experts by Experience in LHN region**

The CALHN SLA, with regard to LHN accountabilities, holds that the LHN CEO is responsible for, *inter alia*, “Developing effective and working partnerships with Aboriginal Community Health and ensuring health needs of Aboriginal people are considered in all health plans, programs and models of care developed by the LHN.” (CALHN SLA 2018-2019, p. 10). It is also stated that: “CALHN will work collaboratively with DHW, other relevant health services, support organisations and Aboriginal community controlled health services to continue to implement the regional Aboriginal Health Improvement Plan to ensure that services are tailored specifically to the needs of the local Aboriginal population” (p. 27). Despite having two ACCHOs within the CAHLN region: the Aboriginal Sobriety Group and Nunkuwarrin Yunti – both in the Adelaide CBD, no evidence has emerged in the CALHN Annual Report 2018 – 2019 or on the SA Health website CALHN page (including portals and their links) of some form of Aboriginal Health Plan having been developed. **Score = 0 / 2**

34. **Partnership with ACCHO(s) in LHN region**
See Note 33 **Score = 0 / 2**

35. **Commitment to Continuous Quality Improvement**
See Note 33 **Score = 0 / 2**

36. **Co-designed KPIs**
See Note 33 **Score = 0 / 2**

37. **Clear statement of ACCHO and LHN responsibilities and conflicts**
See Note 33 **Score = 0 / 2**

**Criterion: Cultural Safety**

38. **Implementation of cultural safety policy/strategy**
No evidence has emerged on the SA Health website CALHN page, the annual report, and in the CALHNB meeting documentation (agenda and minutes), of the existence of a CALHN-specific cultural safety policy or strategy. **Score = 0 / 5**

39. **Proportion of staff trained**
The CALHN SLA for 2018-2019, in the *Schedule of Funding and Performance Indicators for the period of: 1 July 2018 – 30 June 2019*, there is a Tier 2 KPI for the People and Culture performance domain regarding the workforce: Completion of the Aboriginal Cultural Learning Program (Bi-Annual), with the measure: % of employees who have completed an Aboriginal cultural learning program (bi-annual), with a target of 100%. (CALHN, SLA 2018—19, p. 74). See also Note 27. No information is available on the SA Health website CALHN page, or in the annual report, regarding progress towards achieving the Aboriginal Cultural Learning Program target. **Score = 0 / 5**
Criterion: Selected LHN health performance indicators reported publicly

40. **Estimated level of completion of Indigenous status – specifically the reporting of ‘not stated’ on admission**

The CALHN SLA for 2018-2019, in Schedule 4: Performance Indicators and Targets, includes a statement in relation to supporting the delivery of the Closing the Gap agenda and citing the NSQHSS, that: “The LHN should implement processes to identify patients as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems.” (CALHN, SLA 2018—19, p. 52). The CALHN SLA does not have a KPI for addressing the estimated level of completion of Indigenous status. This would appear to breach NSQHSS Aboriginal and Torres Strait Islander specific standard 5.8 in relation to planning for comprehensive care (see Table 2). **Score = 0 / 3**

41. **Discharges against medical advice (DAMA)**

The CALHN SLA for 2018-2019, in Schedule 4: Performance Indicators and Targets, in relation to Safe and Effective Care in terms of Aboriginal Health, there is a Tier 2 KPI Aboriginal Patients Who Left Hospital Against Medical Advice, with the measure: % of overnight Aboriginal and/or Torres Strait Islander patients who left hospital against medical advice, with the target: <=4.5% (CALHN, SLA 2018—19, p. 59). In the Access and Flow performance domain with regard to the Emergency Department, there is also a Tier 2 KPI: Left at Own Risk, with the Measure which includes percentages of (i) all ED presentations, (ii) Aboriginal presentations, and (iii) Mental Health presentations, with the target for all three categories: <=3% (CALHN, SLA 2018—19, p. 55). The CALHN Annual Report 2018-2019 and the SA Health website CALHN page (and portals and their links) provide no information on the rates of DAMA within the CALHN hospitals. **Score = 0 / 4**

42. **Potentially preventable hospital admissions (PPHA)**

The CALHN SLA for 2018-2019, in Schedule 4: Performance Indicators and Targets, in relation to Safe and Effective Care in terms of Quality and Effectiveness, there is a Tier 2 KPI for Potentially Preventable Admissions, with the measure: % of total separations, with the target: Monitor against national rate (CALHN, SLA 2018—19, p. 58). There is no specific KPI for potential preventable admissions for Aboriginal people.

**Score = 0 / 3**

43. **Access to mental health services as reported at service level agreement**

There is no KPI regarding access to mental health services by Aboriginal people in the CALHN SLA 2018-19. **Score = 0 / 3**

44. **Low birth-weight babies**

There is no KPI regarding low birth-weight Aboriginal babies in the CALHN SLA 2018-19. **Score = 0 / 3**

45. **Healthcare outcome differential measures (eg, discharge summary timeliness)**

There are no KPIs for healthcare outcome differential measures for Aboriginal people in the CALHN SLA 2018-19. **Score = 0 / 4**

**INDICATOR 4: RECRUITMENT AND EMPLOYMENT**

Criterion: Aboriginal health workforce development reporting

46. **Implementation of Aboriginal workforce strategy**

Note 30 records that CALHN “is currently promoting the SA Health Aboriginal and Torres Strait Islander Workforce Framework …, and is actively working on imbedding Aboriginal and Torres Strait Islander Workforce Initiatives to compliment the Framework.” However, CALHN meeting
documents (agenda and minutes), and a visit to the SA Health website CALHN page, provide no evidence that the CALHN has its own Aboriginal workforce strategy. There is no mention of the development of a concrete and downloadable plan or strategy with, for example, employment and training targets across the various health services offered by CALHN to increase employment of Aboriginal people in CALHN’s workforce. **Score = 0 / 4**

47. **LHN KPI for Aboriginal employment**
The CALHN SLA for 2018-2019, in Schedule 4: Performance Indicators and Targets, there is a Tier 2 KPI for People and Culture regarding the workforce: Aboriginal Employee Participation Rate: % of employees who identified as being of Aboriginal or Torres Strait Islander origin, with a target of >=4%. (CALHN, SLA 2018—19, p. 59. See also p. 74). Elsewhere, with regard to Aboriginal Health Services “CALHN is required to achieve a minimum of 4% Aboriginal and Torres Strait Islander employment in the health system” (p. 27). The Workforce Information Report 2018-19 provides the following employment data for CALHN (as at 30 June 2019): FTE = 11,597; Total head count = 14,113 (female, male and other); Aboriginal employees = 85 (OCPSE 2019, p. 48). However, it is unclear whether the number of Aboriginal employees is based on the FTE data, or on the head count data. In the absence of clarification in the report, it is assumed that the number of Aboriginal employees is included in the head count data, which include persons counted as employees in a range of circumstances, including National Indigenous Cadetship Program (NICP) participants who are undertaking a 12-month temporary placement (OCPSE 2019, p. 55). The percentage of Aboriginal employees for the FTE and Head Count totals are: 0.73% and 0.60%. At the Dec. 4th 2019 CALHNB meeting (Agenda Item 8.1) with regard to the Workforce report, it was noted that the workforce dashboard did not include SCSS [Statewide Clinical Support Services], which may point to an undercount in Aboriginal employment. However, based on data extrapolated from the OCPSE 2019 report, CALHN is a long way from achieving the 4% Aboriginal employee target set in its SLA 2018-2019. **Score = 0 / 4**

48. **Number of Aboriginal health practitioners, health workers and liaison officers**
The SA Health website CALHN page, and the CALHN Annual Report 2018-19 do not provide any information regarding the number of Aboriginal people employed in these roles, however, the annual report notes that CALHN is using Closing the Gap funding to, inter alia, “develop and integrate the role of five Aboriginal health practitioners into acute settings” (CALHN Annual Report 2018-19, p. 17). **Score = 1 / 3**

49. **Number of identified Aboriginal positions**
The SA Health website CALHN page, and the CALHN Annual Report 2018-19 do not provide any information regarding the number of Aboriginal identified positions within CALHN. **Score = 0 / 3**

50. **Number of salary bands occupied by Aboriginal employees**
The SA Health website CALHN page, and the CALHN Annual Report 2018-19 do not provide any information regarding the number of salary bands occupied by Aboriginal employees within CALHN. **Score = 0 / 3**

51. **Number of long term Aboriginal employees** The SA Health website CALHN page, and the CALHN Annual Report 2018-19 do not provide any information regarding the number of long term Aboriginal employees within CALHN. **Score = 0 / 3**

Criterion: Aboriginal participation in the health workforce

52. **Administrative**
No information is available on the SA Health website CALHN page and in the CALHN Annual Report 2018-2019 regarding the number of Aboriginal people employed in administrative positions at CALHN  
Score = 0 / 3

53. Medical Professional
No information is available on the SA Health website CALHN page and in the CALHN Annual Report 2018-2019 regarding the number of Aboriginal people holding medical professional positions at CALHN  
Score = 0 / 4

54. Nurses/Midwives
No information is available on the SA Health website CALHN page and in the CALHN Annual Report 2018-2019 regarding the number of Aboriginal people employed as nurses or midwives at CALHN  
Score = 0 / 4

55. Operational Services
No information is available on the SA Health website CALHN page and in the CALHN Annual Report 2018-2019 regarding the number of Aboriginal people providing operational services at CALHN  
Score = 0 / 3

56. Allied Health/Scientific/Technical
No information is available on the SA Health website CALHN page and in the CALHN Annual Report 2018-2019 regarding the number of Aboriginal people allied health, scientific or technical roles at CALHN  
Score = 0 / 3

57. Other
No information is available on the SA Health website CALHN page and in the CALHN Annual Report 2018-2019 regarding the number of Aboriginal people engaged in other positions at CALHN such as, cultural consultants, experts by experience, or contractors  
Score = 0 / 3

INDICATOR 5: FINANCIAL ACCOUNTABILITY AND REPORTING – CLOSING THE GAP FUNDING

In the CALHN Service Level Agreement 1 July 2018 – 30 June 2019 (CALHN SLA), with regard to the provision of Aboriginal Health Services:

- CALHN provides services specifically targeting Aboriginal people, including those provided through the Closing the Gap program. Each LHN has brokered schedules (agreements) outlining additional funding to support programs contributing to Closing the Gap and are required to provide 6 monthly updates on KPIs and milestones contained within the schedules and which will be reviewed at LHN Contract Meetings (p. 27).
- CALHN participates in the South Australian Aboriginal Chronic Disease Consortium to progress the three statewide strategies regarding cancer control, heart and stroke, and diabetes, and to consider opportunities to reorientate or reform services aligned with these strategies. CALHN is also required to achieve a minimum of 4% Aboriginal and Torres Strait Islander employment in the health system (p. 27).
- CALHN receives specific purchasing and funding commitments for the following nine identified service programs:
  - Aboriginal Oral Health Program (Closing the Gap)
  - Enhancing In Hospital Care (Closing the Gap)
  - Aged Care Assessment Program (ACAP)
  - Care Awaiting Placement (CAP)
  - Chronic Pain Model of Care
  - Transvaginal mesh multi-disciplinary team
• Community Support Scheme – Mental Health (CSS)
• Direct Observational Therapy
• Transition Care Program (TCP) (pp. 40-45)

The Aboriginal Oral Health Program (Closing the Gap) receives $347,368, and the Enhancing In Hospital Care (Closing the Gap) program receives $829,757. No funding allocations within the other seven service programs have been specified for Aboriginal Health services/needs.

**Criterion: Commonwealth contributions for Aboriginal health programs to LHN**

58. **Commonwealth contributions for Aboriginal health programs to LHN**
Commonwealth contributions for Aboriginal health programs at CALHN are not identified in the CALHN Annual Report 2018-2019 or on the SA Health website CALHN page (including its portals and their links). **Score = 0 / 10**

**Criterion: South Australian contributions to Aboriginal specific services and programs including activity-based funding loading for Aboriginal patients**

59. **Reporting on contributions for Aboriginal specific health services and programs including activity-based funding loading**
The CALHN Annual Report 2018-2019 and the SA Health website CALHN page contain no data on South Australian contributions to Aboriginal specific health services and programs, nor information concerning activity-based funding loadings for Aboriginal patients **Score = 0 / 10**

**CALHN documents consulted**
- *Service Level Agreement* (1 July 2018 – 30 June 2019)
- *Annual Report 2018-19*
- *Annual Report 2017-18*
- *Health Advisory Council (HAC) Annual Report 2017-18*
  - “ “ “ “ 31 Mar. 2020 / ?
- *CALHN Health Advisory Council Inc. Constitution*
- *Disability Access and Inclusion Plan 2019-2023*
- *CALHN Facebook page - @centraladLHN*

**CALHN documents not sighted**
- HAC Annual Report 2018-19
1.12.2 Northern Adelaide Local Health Network (NALHN)

NORTHERN ADELAIDE LOCAL HEALTH NETWORK (NALHN) MATRIX AUDIT FY2018-June 2020

<table>
<thead>
<tr>
<th>Key Indicators and Criteria</th>
<th>Scoring</th>
<th>Score</th>
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<tbody>
<tr>
<td>1. Participation in LHN governance</td>
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<tr>
<td>1.1 Good governance</td>
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<tr>
<td>1.1.1 Board interaction with Aboriginal community (2)</td>
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<td>1.1.2 LHN Aboriginal health performance indicators on Board agenda for every meeting (3)</td>
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<td>1.1.3 Direct input to Board by LHN Aboriginal Community Consultative Committee or Aboriginal Experts by Experience (4)</td>
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<td>1.1.4 LHN Board members are educated about Aboriginal health in their LHN (5)</td>
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<td>1.1.5 LHN Board members receive cultural learning training (6)</td>
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<td>1.2 Aboriginal representation at board level</td>
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<td>1.3 Inclusion in Executive Management Structure</td>
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<td>1.3.1 A stand-alone Aboriginal Health Division (8)</td>
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<td>1.3.2 Aboriginal LHN lead directly reports to the LHN CEO (9)</td>
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<td>2. Policy Implementation</td>
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<tr>
<td>2.1 Improving Aboriginal Health Outcomes</td>
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<tr>
<td>2.1.1 Explicitly identified as a strategic priority in LHN Strategic Plan (10)</td>
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<td>2.1.2 Aboriginal health outcome KPIs reflective of LHN key responsibilities identified in LHN Service Agreement (11)</td>
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<td>(i) Tier 1 KPIs (12)</td>
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<td>(ii) Tier 2 KPIs (13)</td>
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<td>2.2 Community engagement</td>
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<td>2.2.1 Aboriginal community consultative body (14)</td>
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<td>2.2.2 Aboriginal community engagement embedded within overall community engagement strategy (15)</td>
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<td>2.2.3 LHN Aboriginal community newsletter/e-letter/social media (16)</td>
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<td>2.2.4 At least one Aboriginal community forum/meeting per year convened by the LHN chief executive officer (17)</td>
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<td>2.2.5 Reconciliation Action Plan (18)</td>
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<td>2.2.6 Aboriginal health professionals caring for patients included within clinical engagement strategy (19)</td>
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<td>2.3 Public Reporting and Accountability (via LHN website or annual report) (20)</td>
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<td>2.3.1 Traditional Owner Acknowledgement (21)</td>
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<td>2.3.2 Improving Aboriginal health outcomes</td>
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<td>(i) Separate section in report devoted to Aboriginal health (22)</td>
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<td>(ii) Reporting on KPIs contained in current service level agreement (SLA) (23)</td>
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<td>(iii) Report Aboriginal community engagement (24)</td>
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<td>(iv) Report on Aboriginal specific National Safety and Quality Health Service Standards Assessment (25)</td>
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<td>(v) Chronic disease management and care planning (26)</td>
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<td>2.3.3 Cultural Learning completion rates (27)</td>
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2.3.4 Aboriginal health division/unit placement on LHN organisational structure/chart (28) 1 1
2.3.5 Data on Aboriginal access to and delivery of services (29) 3 0
2.3.6 Aboriginal employment
   (i) Aboriginal Workforce Framework (planning, recruitment, etc) (30) 2 2
   (ii) Data on Aboriginal employment (31) 3 0
2.3.7 Other recognition (e.g., awards, scholarships, etc.) (32) 2 1

**TOTAL** 70 16

3. Service delivery and partnerships

3.1 Aboriginal LHN Plan
3.1.1 Co-designed in partnership with ACCHO(s), or other Aboriginal organisations, or Aboriginal Experts by Experience in LHN region (33) 2 0
3.1.2 Partnership with ACCHO(s) in LHN region (34) 2 0
3.1.3 Commitment to Continuous Quality Improvement (35) 2 0
3.1.4 Co-designed KPIs (36) 2 0
3.1.5 Clear statement of ACCHO and LHN responsibilities and conflicts (37) 2 0

**Total out of 10**

3.2 Cultural safety
3.2.1 Implementation of cultural safety policy/strategy (38) 5 0
3.2.2 Proportion of staff trained (39) 5 0

**Total out of 10**

3.3 Selected LHN health performance indicators reported publicly
3.4.1 Estimated level of completion of Indigenous status – specifically the reporting of ‘not stated’ on admission (40) 3 0
3.4.2 Discharged against medical advice (DAMA) (41) 4 0
3.4.3 Potentially preventable hospitalisations (PPHA) (42) 3 0
3.4.4 Access to mental health services as reported at service level agreement (43) 3 0
3.4.5 Low birth-weight babies (44) 3 0
3.4.6 Healthcare outcome differential measures (eg. Discharge summary timeliness) (45) 4 0

**TOTAL** 40 0

4. Recruitment and employment

4.1 Aboriginal health workforce development reporting
4.1.1 Implementation of Aboriginal workforce strategy (46) 4 0
4.1.2 LHN KPI for Aboriginal employment (47) 4 1.5
4.1.3 Number of Aboriginal health practitioners, health workers and liaison officers (48) 3 0
4.1.4 Number of identified Aboriginal positions (49) 3 0
4.1.5 Number of salary bands occupied by Aboriginal employees (50) 3 0
4.1.6 Number of long-term Aboriginal employees (51) 3 0

**Total out of 20**

4.2 Aboriginal participation in the health workforce
4.2.1 Administrative (52) 3 0
4.2.2 Medical Professionals (53) 4 0
4.2.3 Nurses/Midwives (54) 4 0
4.2.4 Operational Services (55) 3 0
4.2.5 Allied Health/Scientific/Technical (56) 3 0
4.2.6 Other (57) 3 0

**Total out of 20**

5. Financial Accountability and Reporting: Closing the Gap Funding
5.1 Commonwealth contributions for Aboriginal health programs to LHN  
Commonwealth contributions for Aboriginal health programs to LHN (58)  
Total out of 10  
10 0

5.2 South Australian contributions to Aboriginal specific health services and programs including activity-based funding loading for Aboriginal patients  
5.2.1 Reporting on contributions for Aboriginal specific health services and programs including activity-based funding loading (59)  
Total out of 10  
10 0

TOTAL 20 0

Total Score 200 39.5

Institutional Rating scored against criteria

Score:  
>=160  
120-159  
80-119  
40-79  
<=39

Evidence of Inst. Racism:  
Very Low  
Low  
Moderate  
High  
Very High

Notes:

1. Northern Adelaide Local Health Network (NALHN)  
Located on the traditional country of the Kaurna people and to the north of the Adelaide CBD, the 2016 ABS Census estimated population (usual residence) for the NALHN region is 388,396, with an Aboriginal and Torres Strait Islander population of 8,054 (2.1% of the total population) (APHN, 2020. https://profile.id.com.au/aphn/population?WebID=300). NALHN’s Aboriginal Health Services include: (i) Aboriginal Hospital Liaison Officers for patients at the Lyell McEwin Hospital and the Modbury Hospital; (ii) Aboriginal Maternal Infant Care Workers for birthing women and their families; (iii) Aboriginal and Torres Strait Islander Cultural Advisor; (iv) Transition Care Program; and (v) Northern Area Geriatric Service. NALHN provides pathways to the Watto Purrunna (Branch of Life) Aboriginal Primary Health Care Service, Watto Purrunna has four sites: (i) Muna Paiendi – Elizabeth; (ii) Maringga Turtpandi – Hillcrest; (iii) Kanggawodli – Dudley Park; and (iv) Wonggangga Turtpandi – Port Adelaide. Watto Purrunna Aboriginal Primary Health Care provides Clinical, Well Being and Allied Health Services for Aboriginal Clients. Watto Purrunna Allied Health Services includes Podiatry and Diabetes Education. Kanggawodli provides a step up and step down service for Aboriginal people from rural and remote locations. Watto Purrunna does not provide transport services to hospitals. (DHA, 2014, pp. 4-5)

INDICATOR 1: PARTICIPATION IN LHN GOVERNANCE  
The following chart provides an overview of the NALHN references to and discussion concerning Aboriginal health and related matters. In addition to the listed sub-criteria, other headings have been included to cover information not readily assigned to the listed sub-criteria. Where Aboriginal health matters have been discussed, the Agenda item numbers have been indicated in the monthly columns. Also note that the Acknowledgement of Country of the Kaurna people is a standing item under Agenda Item 1.1 in all meetings and is not included in the chart below.

Legend:

x = no information relevant to the sub-criterion heading was provided.
? = minutes were not uploaded onto SA Health website at the time of this analysis (30 May 2020).
AHEMGGB – Aboriginal Health Expert Member of Governing Board (this person may/may not be an Aboriginal person)
Tier 1 committee = a Board committee which reports to the Board
Tier 2 committee = an internal LHN committee which reports to the CEO
Tier 3 committee = a community-based committee established in accordance with, for example, a LHN consumer and community engagement plan/framework/strategy and which can provide input to, or respond to the LHNB or LHN CEO.

**NALHN Board meetings: good governance sub-criteria summary for July 2019 – April 2020**

<table>
<thead>
<tr>
<th>Meeting:</th>
<th>July 3rd</th>
<th>Aug. 7th</th>
<th>Sept. 4th</th>
<th>Oct. 2nd</th>
<th>Nov. 6th</th>
<th>Dec. 4th</th>
<th>Feb. 5th</th>
<th>March 4th</th>
<th>April 1st</th>
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<tbody>
<tr>
<td><strong>Sub-criteria:</strong></td>
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<tr>
<td>1.1.1 LHN inter. With Aboriginal Com.</td>
<td>Y</td>
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<td>X</td>
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<tr>
<td>1.1.2 AHPI on Mtg Agenda</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>1.1.3 ACCC direct input to LHN</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>1.1.4 LHNB educ’d re Aboriginal Health</td>
<td>X</td>
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<td>1.1.5 LHNB Receives CCT</td>
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</tbody>
</table>

**Additional sub-criteria**

- Invited Aboriginal Guest: X X X X X X Y Y
- Aboriginal Health Agenda Item: X X X X X X X X
- Aboriginal Health Discussed: X X X X X X X X
- SLA Tier 1 & 2 Aboriginal Health KPIs Discussed: X X X X X X X X
- Aboriginal Membership of Brd Committees: X X X X X X X X

**Summary of matters addressed:**

**July 3rd:** The inaugural Board meeting was held at the Maringga Turtpandi Aboriginal Health Service GP Plus Super Clinic, Hillcrest.

**Dec. 4th Agenda Item 7.1:** Innovation Opportunity – Noted the Power Community Limited (PCL) Annual Report video. PCL programs highlight some of the key issues confronting young people in society, *inter alia*, cultural awareness and reconciliation. Success of the programs discussed together with opportunities for NALHN to explore partnering with sporting clubs, stakeholders and community groups to improve health outcomes for our younger consumers, especially with a focus on Aboriginal and Torres Strait Islander .... Populations in the north and northeast.

**April 1st Agenda Item 3.2:** Clinical Services Plan 2020-25 – The Aboriginal Health Impact Statement in the paper was discussed, noting the plan is to be cognisant of the needs and demographics of all Aboriginal and Torres Strait Islander communities that access NALHN services.

**Criterion: Good governance**

2. **Board interaction with Aboriginal community**
   The inaugural NALHN Board meeting on July 3rd 2019 was held at the Maringga Turtpandi Aboriginal Health Service GP Plus Super Clinic, Hillcrest, indicating a level of engagement with the local Aboriginal community **Score = 2 / 2**

3. **LHN Aboriginal Health performance indicators on Board agenda for every meeting**
LHN Aboriginal Health performance indicators were not specifically discussed at their meetings. The **Score**, based on information provided in the NALHNB meetings (agenda and minutes), = 0 / 2

4. **Direct input to Board by LHN Aboriginal Community Consultative Committee or Aboriginal Expert by Experience**
   Based on information provided in the NALHNB meetings (agenda and minutes), there is no evidence to suggest the existence of an Aboriginal Community Consultative Committee operating within the NALHN region. **Score = 0 / 2**

5. **LHN Board members are educated about Aboriginal health in their LHN**
   Based on information provided in the NALHNB meetings (agenda and minutes), there is no evidence to suggest that the NALHNB were given any specific education about the health status and issues of the local Aboriginal community. **Score = 0 / 2**

6. **LHN Board members receive cultural learning training**
   Based on information provided in the NALHNB meetings (agenda and minutes), there is no record of the NALHNB receiving Aboriginal Cultural learning training. **Score = 0 / 2**

**Criterion: Aboriginal representation at board level**

7. **Aboriginal representation at board level**

**Criterion: Inclusion in Executive Management Structure**

8. **A stand-alone Aboriginal Health Division**
   NALHN has a stand-alone Division of Aboriginal Health (one of 21 directorates – 8 of which [including the Chief Operating Officer and Chief Finance Officer] are headed by executive directors) (NALHN *Annual Report 2018-19*, pp. 7-9) **Score = 5 / 5**

9. **Aboriginal LHN lead directly reports to the LHN CEO**
   The Executive Director of Aboriginal Health, who is an Aboriginal person, reports directly to the CEO (NALHN *Annual Report 2018-19*, p. 7) **Score = 5 / 5**

**INDICATOR 2: POLICY IMPLEMENTATION**

**Criterion: Improving Aboriginal Health Outcomes**

10. **Explicitly identified as a strategic priority in LHN Strategic Plan**
    NALHN has recently released its *Strategic Plan 2020-25* (NALHN, 2019) in response to the *SA Health Strategic Plan 2017-2020* (SA Health 2017c). The Plan is based on six strategic imperatives to focus on over the next five years: 1. Inclusive Culture; 2. Service Design; 3. Digitally Smart; 4. Sustainability; 5. Exceptional People; and 6. Partnering (p. 5). These strategic imperatives have been “co-designed with our staff, Aboriginal people and diverse community” (p. 13). With regard to Strategic Imperative 2: Service Design, one of the goals (excellent and compassionate health services delivered to our key population groups) is to be achieved by “working in partnership with specific communities, including Aboriginal and Torres Strait Islander people...” and “improving end of life care...”
for Aboriginal people by supporting specialist palliative care to work in partnership with NALHN Aboriginal health services” (p. 17). The only other strategic imperative to specifically include Aboriginal people is the sixth, Partnering, whereby “NALHN meaningfully engages with and responds to consumers, their carers and the community by “c. working with specific communities, including Aboriginal and Torres Strait Islander People, …”(p. 25). While it is clear that Aboriginal people are involved in the co-design of the Plan, and are specifically included, along with other community groups in two of the strategic imperatives, there is no explicit strategic priority devoted to improving Aboriginal health outcomes.  

Score = 5 / 10

11. Aboriginal health outcome KPIs reflective of LHN key responsibilities identified in LHN Service Level Agreement

The NALHN Service Level Agreement 2018-2019, in Schedule 4: Performance Indicators and Targets contains four Aboriginal health-related KPIs already included in the metropolitan LHNs and for the WCHN, namely the Tier 2 KPIs: Left at Own Risk; DAMA; Aboriginal Employee Participation Rate; and Completion of the Aboriginal Cultural Competence Program (pp. 55-59). In the section designated for Aboriginal Health, there is only one KPI – DAMA, a Tier 2 KPI (p. 59). Some of the NALHN SLA KPIs include patient sub-sets, for example, the Emergency Department Tier 2 KPI: Left at Own Risk which measures three patient sub-sets: (i) % of all ED presentations; (ii) % of Aboriginal presentations; and (iii) % of Mental Health presentations – all with a target of <=3%.

The purpose of the following two sub-criteria is to suggest additional KPIs to the existing four. Given the excess burden of disease within the Aboriginal community, and particularly in relation to cancer, heart and stroke, diabetes, kidney disease and mental health, there should be a range of both Tier 1 and 2 KPIs to address these health crises. The KPIs selected below, except for one (Indigenous status reporting), are already in the SALHN SLA, and use a sub-set for Aboriginal patients as employed above with regard to the Emergency Department Tier 2 KPI: Left at Own Risk. The basis for scoring is that, given the excess burden of disease among Aboriginal people and the health crises faced by many Aboriginal communities, these KPIs (with Aboriginal people constituting a KPI sub-set, should already be included in the current SLA. The fact that they are not results in a penalty score.

12. Tier 1 KPIs

* Elective Surgery: Tier 1 – Timely Admissions: % of elective surgery patients admitted within clinically recommended times; % of Aboriginal patients admitted for elective surgery within clinically recommended times. Target 100%.

* Emergency Department: Tier 1 – Length of Stay Less Than or Equal to 4 hours: % of presentations to an ED where the time from the presentation to the time of physical departure (i.e. the length of the ED stay) is less than or equal to 4 hours; % of Aboriginal presentations to an ED where the time from the presentation to the time of physical departure (i.e. the length of the ED stay) is less than or equal to 4 hours. Target >=90%

* Emergency Department: Tier 1 – Seen on Time: % of patients attending ED who commenced treatment within clinically accepted timeframes; % of Aboriginal patients attending ED who commenced treatment within clinically accepted timeframes. Target varies from 100% for Category 1 patients to >=70% for Category 5 patients.

* Mental Health: Tier 1 – Mental Health - Adult/Older Persons Acute 28 Day Readmission Rate: % of patients who had a readmission within 28 days of discharge (non-short stay); % of Aboriginal patients who had a readmission within 28 days of discharge (non-short stay). Target <=12%

* Mental Health: Tier 1 – Suicide of persons in Inpatient Mental Health Units: # of suicides that occur in admitted patient specialised mental health services; # of Aboriginal suicides that occur in admitted patient specialised mental health services. Target - Monitor

Score = 0 / 5
13. Tier 2 KPIs

* Aboriginal Health: Tier 2 – Indigenous status reporting: % ‘not stated’ on admission.
  Target: ?
* Mental Health: Tier 2 - Post Discharge Community Follow Up Rate: % of people receiving one or more mental health service contacts while in the community within 7 days post discharge; % of Aboriginal people receiving one or more mental health service contacts while in the community within 7 days post discharge. Target >=70%.
* Clinical pathways: Tier 2 - Stroke (LMH) Admissions to Stroke Unit: % of stroke patients where the patient spent part of their stay in a stroke ward; % of Aboriginal stroke patients where the patient spent part of their stay in a stroke ward. Target >=90%.
* Clinical Pathways: Tier 2 - Rehabilitation: Individual Care Plan: % of rehabilitation patients who leave hospital with an individualised care plan; % of Aboriginal rehabilitation patients who leave hospital with an individualised care plan. Target >=90%.
* Occupancy: Tier 2 – Discharge Summary Transmission Rate: % of discharge summaries transmitted with 48 hours of separation; % of Aboriginal patient discharge summaries transmitted with 48 hours of separation. Target >=80%

Score = 0 / 5

Criterion: Community Engagement

14. Aboriginal community consultative body

The SA Health website NALHN page (and its portals and their links), the NALHN Annual Report 2018-2019, NALHNB meeting documents (agenda and minutes), and the NALHN Draft Strategic Plan 2020-25, have not provided evidence of the existence of some form of Aboriginal community consultative body operating within the NALHN region. Score = 0 / 4

15. Aboriginal community engagement embedded within overall community engagement strategy

In accordance with Schedule 3A – Dissolution of Health Advisory Councils, of the Health Care (Governance) Amendment Bill 2019 (SA), NALHN Health Advisory Council was dissolved. NALHN’s Consumer + Community Engagement Strategy 2020-25 (p. 14) expresses NALHN’s commitment “to collaborating with Aboriginal and Torres Strait Islander people to maximise their lifelong health outcomes. The voice of the Aboriginal and Torres Strait Islander population will be reflected in our consultations and services. It is also incorporated into our governance structure and through direct reporting to the NALHN Chief Executive Officer.” Score = 4 / 4

16. LHN Aboriginal community newsletter/e-letter/social media

NALHN once published The Northern Health Times, however, a search of the SA Health website NALHN page, did not reveal the existence of an NALHN Aboriginal community newsletter. A search of the SA Health website NALHN page (and portals and their links) did not indicate the existence of a NALHN Aboriginal community newsletter or e-letter. While SA Health has Facebook, Instagram and Twitter accounts, none of these are specific to NALHN. Score = 0 / 3

17. At least one Aboriginal community forum/meeting per year convened by the LHN chief executive officer

The NALHN SLA for 2018-2019, in Schedule 5: SA Health Performance Framework, with regard to Performance Review Processes, includes processes for monitoring performance against key deliverables (as outlined in Schedule 4 of the SLA). One of these processes includes “Contract Performance Meetings to review performance, particularly in relation to the key indicators (Tier 1), and to discuss and develop mitigation strategies where appropriate and to monitor progress. At least one meeting will focus on Mental Health specific deliverables and KPIs and at least one meeting will focus on Aboriginal Health specific deliverables and KPIs.” (NALHN, SLA 2018—19, 75 This KPI is not included in the CALHN SLA 2018-2019.)
pp. 60-1). In the context of this sub-criterion, it would seem appropriate that the NALHN CEO hold an Aboriginal community forum/meeting preparatory to the scheduled Contract Performance Meeting with DHW at which the Aboriginal Health specific deliverables and KPIs are to be discussed. Based on the Agenda and Minutes of NALHN8 meetings, no discussion appears to have taken place about an Aboriginal Health Community Forum, which the CEO might be expected to convene.  
Score = 0 / 3

18. Reconciliation Action Plan
NALHN does not have its own RAP, and based on the NALHN8 meeting agenda and minutes, no discussion appears to have taken place concerning the development of a RAP. Score = 0 / 3

19. Aboriginal health professionals caring for patients included within clinical engagement strategy
At its April 1st 2020 meeting (Agenda Item 3.2), the NALHN8 addressed the Clinical Services Plan 2020-25, and the Aboriginal Health Impact Statement in the paper was discussed, noting the plan is to be cognisant of the needs and demographics of all Aboriginal and Torres Strait Islander communities that access NALHN services. The plan is still under development and a web search did not produce a draft of the plan. Score = 0 / 3

Criterion: Public Reporting and Accountability (via LHN website or annual report)

20. The NALHN, in effect, does not have its own website. An internet search for “Northern Adelaide Local Health Network” will lead to the SA Health website (www.sahealth.sa.gov.au) which provides a link to NALHN: https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content(sa+health+internet/about+us/our+local+health+networks/northern+adelaide+local+health+network/northern+adelaide+local+health+network?OpenDocument. The NALHN page contains a number of portals. As at 7th June 2020, there are six NALHN portals: (i) NALHN Strategic Plan 2020-25; (ii) General Practice Liaison Unit; (iii) NALHN Research Secretariat; (iv) Freedom of Information - Northern Adelaide Local Health Network (v) Consumer Advisory Council; and (vi) Department of Orthopaedics and Trauma at NALHN. Each portal provides links to enable access to additional information. There is no portal presenting a snap-shot of the NALHN providing basic information about population demographics (including the Aboriginal population and Traditional Owners), geographic region served, brief description of the health workforce, a resident health profile/dashboard, and summary of services provided. None of the information sought below is readily available on the NALHN page (including its portals and their links) (“the NALHN page”) on the SA Health website. Information regarding, for example, Aboriginal employment in the health workforce, cultural competency training completion rates, and Aboriginal health outcome KPIs must be sought via other portals and links on the SA Health website.

The annual report referred to is the NALHN Annual Report 2018-2019.

21. Traditional Owner acknowledgement
Neither the NALHN page nor the NALHN Annual Report 2018-19 contain an acknowledgement of the Kaurna Traditional Owners. Score = 0/2

22. Improving Aboriginal health outcomes: (i) Separate section in report devoted to Aboriginal health
The NALHN page does not provide an Aboriginal health specific portal. There is no separate section in the Annual Report, as indicated in the table of contents (p. 5), or in the body of the report. Information concerning Aboriginal health is instead scattered in several locations within the report (NALHN Annual Report 2018-19, pp. 4, 6, 7, 14, 15, 16) Score = 0 / 3
23. Improving Aboriginal health outcomes: (ii) Reporting on KPIs contained in current service level agreement (SLA)

The NALHN SLA 2018-19 Schedule 4 contains the following Aboriginal health specific KPIs:

**Performance Domain: Access and Flow**

Emergency Department Tier 2 KPI: Left at Own Risk
Measure: % of Aboriginal presentations. Target <=3%.

**Performance Domain: Safe and Effective Care**

Aboriginal Health Tier 2 KPI: Aboriginal Patients Who Left Hospital Against Medical Advice
Measure: % of overnight Aboriginal and/or Torres Strait Islander patients who left hospital against medical advice. Target: <=4.5%

**Performance Domain: People and Culture**

Workforce Tier 2 KPI: Aboriginal Employee Participation Rate
Measure: % of employees who identified as being of Aboriginal or Torres Strait Islander origin. Target: >=4%

Workforce Tier 2 KPI: Completion of the Aboriginal Cultural Competence Program
Measure: % of employees who have completed Aboriginal cultural competence training. Target: 100%

(NALHN, SLA 2018—19, pp. 52, 55, 59). Performance against these KPIs is not reported on the NALHN page, nor in the annual report. Score = 0/3

24. Improving Aboriginal health outcomes: (iii) Report on Aboriginal community engagement

The NALHN page Consumer Advisory Council portal provides a link to NALHN’s Consumer + Community Engagement Strategy 2020-25. While the Annual Report, in the context of agency objectives, mentions community engagement, and its performance achievements, which include those of the NAHLN Consumer Advisory Council (CAC) (p. 13), there is no specific mention of initiatives, activities, etc., regarding Aboriginal community engagement. While the Consumer + Community Engagement Strategy 2020-25 has only recently come into operation, there is no information regarding activities, meetings with, for example, NALHN executives, and their outcomes.

Score = 0/3

25. Improving Aboriginal health outcomes: (iv) Report on Aboriginal specific National Safety and Quality Health Service Standards assessment

Table 2 lists six Aboriginal and Torres Strait Islander specific standards. The NALHN SLA for 2018-2019, in Schedule 4: Performance Indicators and Targets includes a statement in relation to supporting the delivery of the Closing the Gap agenda and citing the NSQHSS, that: “In order to support the delivery of the Closing the Gap agenda, and implementation of the National Safety and Quality Health Service Standards related to Aboriginal and Torres Strait Islander health, wherever possible performance data will be collated for the population as a whole and for Aboriginal and Torres Strait Islander peoples.” (NALHN, SLA 2018—19, p. 52). Neither the NALHN page nor the annual report provide data on how these standards are being met.

Score = 0/3

26. Improving Aboriginal health outcomes: (v) Chronic disease management and care planning

While NALHN is a member/partner of the South Australian Aboriginal Chronic Disease Consortium (SAACDC), no specific mention in made in the annual report of the SAACDC. However, in relation to “Developing effective and working partnerships with Aboriginal Health Community and ensuring health needs of Aboriginal people are considered in all health care plans, programs and models of care developed by NALHN” (see also SLA, p. 10), achievements include a Chronic Disease Management service, and establishing the Care Opportunities team to focus on improving Aboriginal identification and supporting early identification of risk factors and disease through opportunistic screening of chronic diseases. ... The program prioritises screening for chronic diseases, creates links to follow-up new diagnoses, encourages self-management through targeted health education and

27. Cultural learning completion rates
In the context of Agency Specific Objectives and Performance: Ensuring the environment and patterns of patient care respect the ethnic, cultural and religious rights, views, values and expectations of all peoples, NALHN “In support of the Aboriginal Cultural Learning Framework, online training is mandatory for all staff and all managers must also attend face-to-face training.” (NALHN Annual Report 2018-19, pp. 13-14). However, neither the NALHN page nor the Annual Report provide data on actual completion rates across the three levels of cultural learning. Score = 0/2

28. Aboriginal health division/unit placement on LHN organisational structure/chart
The diagram of the NALHN organisational structure indicates the Executive Director Aboriginal Health (NALHN Annual Report 2018-19, p. 7). Score = 1 / 1

29. Data on Aboriginal access to and delivery of services
While the Annual Report indicates a range of Aboriginal specific health services (four dedicated Aboriginal healthcare sites, Aboriginal traditional healing services [Ngangkari], the Northern Aboriginal Birthing Program, Chronic Disease Management services, the Aboriginal Under 8s Ear Health and Hearing Program, and scheduled free Aboriginal Well Health Check for Aboriginal children aged 5-13 years participating in the SACA Aboriginal Cricket Blast Cup) (NALHN Annual Report 2018-19, pp. 6, 14-15), no data is provided on the level of utilisation of these services. Score = 0 / 3

30. Aboriginal employment: (i) Aboriginal workforce framework (planning, recruitment, etc.)
No specific reference is made to the SA Health Aboriginal Workforce Framework 2017-2022 in the Annual Report, however, in relation to “Developing effective and working partnerships with Aboriginal Health Community and ensuring health needs of Aboriginal people are considered in all health care plans, programs and models of care developed by NALHN” (see also SLA, p. 10), achievements include: “Establishment of an Aboriginal Workforce committee to lead the development of strategies to increases the number, representation and retention of the NALHN Aboriginal workforce.” With regard to the employment opportunity programs in relation to the Aboriginal Employment Program: “NALHN is working to increase the employment of Aboriginal people in the South Australian Public Sector. ... towards the target of 4%.” (NALHN Annual Report 2018-19, pp. 14-15 and 16). Score = 2 / 2

31. Aboriginal employment: (ii) Data on Aboriginal employment
Neither the NALHN page, nor the Annual Report provide even minimal data, such as the current percentage of Aboriginal people in the NALHN workforce. Score = 0/3

31. Other recognition (e.g., awards, scholarships, etc.)
The annual report does not have a section regarding staff awards, achievements, etc., including for Aboriginal staff, however, the CEO in her report, notes that NALHN received four Health SA awards in 2018, one of which was to the Watto Purrrunna Aboriginal Health Service who won the Excellence and Innovation in Aboriginal Health Award for the Integrating Care – Closing the Gap on Diabetes program. (NALHN Annual Report 2018-19, p. 4). Score = 1 / 2

INDICATOR 3: SERVICE DELIVERY AND PARTNERSHIPS

Criterion: Aboriginal LHN Plan
33. **Co-designed in partnership with ACCHO(s), or Aboriginal organisations, or Aboriginal Experts by Experience in LHN region**

The NALHN SLA, with regard to LHN accountabilities, holds that the LHN CEO is responsible for, *inter alia*, “Developing effective and working partnerships with Aboriginal Community Health and ensuring health needs of Aboriginal people are considered in all health plans, programs and models of care developed by the LHN.” (NALHN SLA 2018-2019, p. 10). While NALHN does not have any ACCHOs within its region (the two metropolitan ACCHOs are located in the Adelaide CBD), however it does offer extensive range of health services to the local Aboriginal community through the Watto Purruna Aboriginal Primary Health Care Service at its four sites. However, based on a web search, and the agenda and minutes of the NALHNB meetings, there appears to be no evidence or discussion about the formulation of an overall Aboriginal Health Plan for NALHN.

*Score = 0 / 2*

34. **Partnership with ACCHO(s) in LHN region**

See Note 33  *Score = 0 / 2*

35. **Commitment to Continuous Quality Improvement**

See Note 33  *Score = 0 / 2*

36. **Co-designed KPIs**

See Note 33  *Score = 0 / 2*

37. **Clear statement of ACCHO and LHN responsibilities and conflicts**

See Note 33  *Score = 0 / 2*

**Criterion: Cultural Safety**

38. **Implementation of cultural safety policy/strategy**

In NALHN’s Strategic Plan 2020-25 (NALHN, 2020), in relation to Strategic Imperative 5: Exceptional People, with regard to achieving a “welcoming culture that values and empowers all staff, through: a. investing in a ‘culture building’ strategy that ... promotes a high standard of cultural safety and competency” (p. 23), no specific reference is made to the SA Health Aboriginal Cultural Learning Framework (SA Health 2017a) or the development of some form of policy or strategy to deliver cultural safety/competency training to NALHN staff.  *Score = 0 / 5*

39. **Proportion of staff trained**

The NALHN SLA for 2018-2019, in Schedule 4: Performance Indicators and Targets there is a Tier 2 KPI for the People and Culture performance domain regarding the workforce: Completion of the Aboriginal Cultural Competence Program, with the measure: % of employees who have completed an Aboriginal cultural competence training, with a target of 100% (NALHN, SLA 2018—19, p. 59). There is no information in the NALHN Annual Report 2018-2019, or on the SA Health website NALHN page (including the portals and their links) on completion rates for the Aboriginal Cultural Competence Program.  *Score = 0 / 5*

**Criterion: Selected LHN health performance indicators reported publicly**

40. **Estimated level of completion of Indigenous status – specifically the reporting of ‘not stated’ on admission**

NALHN receives funding for the Opportunistic Screening program focusing on improving identification of Aboriginal people with chronic disease, and in management of Aboriginal adults with chronic disease in the acute, intermediate and primary health care settings (NALHN SLA 2018-2019, p. 44), which provides assistance in ensuring that Aboriginal patients are properly identified in
the records. The NALHN SLA for 2018-2019, in Schedule 4: Performance Indicators and Targets, includes a statement in relation to supporting the delivery of the Closing the Gap agenda and citing the NSQHSS, that: “The LHN should implement processes to identify patients as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems.” (NALHN, SLA 2018—19, p. 52). The NALHN SLA does not have a KPI for addressing the estimated level of completion of Indigenous status. This would appear to breach NSQHSS Aboriginal and Torres Strait Islander specific standard 5.8 in relation to planning for comprehensive care (see Table 2). **Score = 0 / 3**

41. **Discharges against medical advice (DAMA)**
The NALHN SLA for 2018-2019, in Schedule 4: Performance Indicators and Targets, in relation to Safe and Effective Care in terms of Aboriginal Health, there is a Tier 2 KPI Aboriginal Patients Who Left Hospital Against Medical Advice, with the measure: % of overnight Aboriginal and/or Torres Strait Islander patients who left hospital against medical advice, with the target: <=4.5% (NALHN, SLA 2018—19, p. 59). In the Access and Flow performance domain with regard to the Emergency Department, there is also a Tier 2 KPI: Left at Own Risk, with the Measure which includes percentages of (i) all ED presentations, (ii) Aboriginal presentations, and (iii) Mental Health presentations, with the target for all three categories: <=3% (NALHN, SLA 2018—19, p. 55). The NALHN Annual Report 2018-2019 and the SA Health website NALHN page (and portals and their links) provide no information on the rates of DAMA within the NALHN hospitals. **Score = 0 / 4**

42. **Potentially preventable hospital admissions (PPHA)**
The NALHN SLA for 2018-2019, in Schedule 4: Performance Indicators and Targets, in relation to Safe and Effective Care in terms of Quality and Effectiveness, there is a Tier 2 KPI for Potentially Preventable Admissions, with the measure: % of total separations, with the target: Monitor against national rate. (NALHN, SLA 2018—19, p. 58). There is no specific KPI for potentially preventable admissions for Aboriginal people. **Score = 0 / 3**

43. **Access to mental health services as reported at service level agreement**
Despite funding the Cultural Healing – Improving Mental Health Care Access (Closing the Gap) program to develop a more culturally responsive approach to managing presentations of severe mental illness and psychological distress by Aboriginal people in NALHN (NALHN SLA 2018-2019, p. 43), there is no KPI regarding access to mental health services by Aboriginal people in the NALHN SLA 2018-19 by which to judge the success of the program. **Score = 0 / 3**

44. **Low birth-weight babies**
Despite funding The First Thousand Days program to improve perinatal outcomes for all Aboriginal women and mothers of Aboriginal babies attending NALHN services (NALHN SLA 2018-2019, pp. 43-4), there is no KPI regarding low birth-weight Aboriginal babies in the NALHN SLA 2018-19. **Score = 0 / 3**

45. **Healthcare outcome differential measures (eg, discharge summary timeliness)**
There are no KPIs for healthcare outcome differential measures for Aboriginal people in the NALHN SLA 2018-19. **Score = 0 / 4**

**INDICATOR 4: RECRUITMENT AND EMPLOYMENT**

**Criterion: Aboriginal health workforce development reporting**

46. **Implementation of Aboriginal workforce strategy**
In NALHN’s Strategic Plan 2020-25 (NALHN, 2019), in relation to Strategic Imperative 5: Exceptional People, development of the Aboriginal workforce is not specifically included in the development of
NALHN’s workforce plan (p. 23). However, NALHNB meeting documents (agenda and minutes), and a visit to the SA Health website NALHN page, provide no evidence that the NALHN has its own Aboriginal workforce strategy. There is no mention of the development of a concrete and downloadable plan or strategy with, for example, employment and training targets across the various health services offered by NALHN to increase employment of Aboriginal people in NALHN’s workforce.  

Score = 0 / 4

47. LHN KPI for Aboriginal employment
The NALHN SLA for 2018-2019, in Schedule 4: Performance Indicators and Targets, there is a Tier 2 KPI for People and Culture regarding the workforce: Aboriginal Employee Participation Rate: % of employees who identified as being of Aboriginal or Torres Strait Islander origin, with a target of >=4%. (NALHN, SLA 2018—19, p. 59). Elsewhere, with regard to Aboriginal Health Services “NALHN is required to achieve a minimum of 4% Aboriginal and Torres Strait Islander employment in the health system” (p. 28). The Workforce Information Report 2018-19 provides the following employment data for NALHN (as at 30 June 2019): FTE = 3,942; Total head count = 4,807 (female, male and other); Aboriginal employees = 75 (OCPSE 2019, p. 49). However, it is unclear whether the number of Aboriginal employees is based on the FTE data, or on the head count data. In the absence of clarification in the report, it is assumed that the number of Aboriginal employees is included in the head count data, which include persons counted as employees in a range of circumstances, including National Indigenous Cadetship Program (NICP) participants who are undertaking a 12-month temporary placement (OCPSE 2019, p. 55). The percentage of Aboriginal employees for the FTE and Head Count totals are: 1.90% and 1.56%. Based on an extrapolation of the OCPSE report data, NALHN is making some progress towards achieving the Aboriginal employment target of 4%.  

Score = 1.5 / 4

48. Number of Aboriginal health practitioners, health workers and liaison officers
The SA Health website NALHN page, and the NALHN Annual Report 2018-19 do not provide any information regarding the number of Aboriginal people employed in these roles.  

Score = 0 / 3

49. Number of identified Aboriginal positions
The SA Health website NALHN page, and the NALHN Annual Report 2018-19 do not provide any information regarding the number of Aboriginal identified positions within NALHN.  

Score = 0 / 3

50. Number of salary bands occupied by Aboriginal employees
The SA Health website NALHN page, and the NALHN Annual Report 2018-19 do not provide any information regarding the number of salary bands occupied by Aboriginal employees within NALHN.  

Score = 0 / 3

51. Number of long term Aboriginal employees
The SA Health website NALHN page, and the NALHN Annual Report 2018-19 do not provide any information regarding the number of long term Aboriginal employees within NALHN.  

Score = 0 / 3

Criterion: Aboriginal participation in the health workforce

52. Administrative
No information is available on the SA Health website NALHN page and in the NALHN Annual Report 2018-2019 regarding the number of Aboriginal people employed in administrative positions at NALHN  

Score = 0 / 3

53. Medical Professional
No information is available on the SA Health website NALHN page and in the NALHN Annual Report 2018-2019 regarding the number of Aboriginal people holding medical professional positions at NALHN  Score = 0 / 4

54. Nurses/Midwives
No information is available on the SA Health website NALHN page and in the NALHN Annual Report 2018-2019 regarding the number of Aboriginal people employed as nurses or midwives at NALHN  Score = 0 / 4

55. Operational Services
No information is available on the SA Health website NALHN page and in the NALHN Annual Report 2018-2019 regarding the number of Aboriginal people providing operational services at NALHN  Score = 0 / 3

56. Allied Health/Scientific/Technical
No information is available on the SA Health website NALHN page and in the NALHN Annual Report 2018-2019 regarding the number of Aboriginal people allied health, scientific or technical roles at NALHN  Score = 0 / 3

57. Other
No information is available on the SA Health website NALHN page and in the NALHN Annual Report 2018-2019 regarding the number of Aboriginal people engaged in other positions at NALHN such as, cultural consultants, experts by experience, or contractors  Score = 0 / 3

INDICATOR 5: FINANCIAL ACCOUNTABILITY AND REPORTING – CLOSING THE GAP FUNDING
In the NALHN Service Level Agreement 1 July 2018 – 30 June 2019 (NALHN SLA), with regard to the provision of Aboriginal Health Services:

NALHN provides services specifically targeting Aboriginal people, including those provided through the Closing the Gap program. Each LHN has brokered schedules (agreements) outlining additional funding to support programs contributing to Closing the Gap and are required to provide 6 monthly updates on KPIs and milestones contained within the schedules and which will be reviewed at LHN Contract Meetings (p. 27).

NALHN participates in the South Australian Aboriginal Chronic Disease Consortium to progress the three statewide strategies regarding cancer control, heart and stroke, and diabetes, and to consider opportunities to reorientate or reform services aligned with these strategies. NALHN is also required to achieve a minimum of 4% Aboriginal and Torres Strait Islander employment in the health system (p. 28).

NALHN receives specific purchasing and funding commitments for the following ten identified service programs:

- Aged Care Assessment Program (ACAP)
- Allied Health Orthopaedic Substitution Clinic
- Care Awaiting Placement (CAP)
- Chronic Pain Model of Care
- Community Support Scheme – Mental Health (CSS)
- Cultural Healing – Improving Mental Health Care Access (Closing the Gap)
- First Thousand Days
- Opportunistic Screening
- Under 8’s Ear Health (Closing the Gap)
- Transition Care Program (TCP) (pp. 40-46)

The Cultural Healing – Improving Mental Health Care Access (Closing the Gap) receives $467,590, and the Under 8’s Ear Health (Closing the Gap) program receives $70,393.13. Services to Aboriginal
people are also the focus of The First Thousand Days ($825,769) [to improve perinatal outcomes for all Aboriginal women and mothers of Aboriginal babies attending NALHN services] and Opportunistic Screening ($787,564) [focusing on improving Aboriginal identification... an improvements in management of Aboriginal adults with chronic disease in the acute, intermediate and primary health care settings] programs.

Criterion: Commonwealth contributions for Aboriginal health programs to LHN

58. Commonwealth contributions for Aboriginal health programs to LHN
Commonwealth contributions for Aboriginal health programs at NALHN are not identified in the NALHN Annual Report 2018-2019 or on the SA Health website NALHN page (including its portals and their links). Score = 0 / 10

Criterion: South Australian contributions to Aboriginal specific services and programs including activity-based funding loading for Aboriginal patients

59. Reporting on contributions for Aboriginal specific health services and programs including activity-based funding loading
The NALHN Annual Report 2018-2019 and the SA Health website NALHN page (including its portals and their links) contain no data on South Australian contributions to Aboriginal specific health services and programs, nor information concerning activity-based funding loadings for Aboriginal patients. Score = 0 / 10

NALHN documents consulted
- Service Level Agreement (1 July 2018 – 30 June 2019)
- Annual Report 2018-19
- Annual Report 2017-18
- Health Advisory Council (HAC) Annual Report 2017-18
- Governing Board Meetings: Agenda 3 July 2019 / Minutes 3 July 2019
- NALHN Health Advisory Council Inc. Constitution
- Disability Access and Inclusion Plan 2019-2023
- Strategic Plan 2020-25 (NALHN, 2020)
- Consumer + Community Engagement Strategy 2020-25

NALHN documents not sighted
- NALHN Reconciliation Action Plan (Google searched 18/5/2020)
- Clinical Services Plan 2020-25
### 1.12.3 Southern Adelaide Local Health Network (SALHN)

**SOUTHERN ADELAIDE LOCAL HEALTH NETWORK (SALHN) MATRIX AUDIT FY2018-June 2020** (1)

<table>
<thead>
<tr>
<th>Key Indicators and Criteria</th>
<th>Scoring</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Participation in LHN governance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1.1 Good governance</strong></td>
<td>Total out of 10</td>
<td></td>
</tr>
<tr>
<td>1.1.1 Board interaction with Aboriginal community (2)</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>1.1.2 LHN Aboriginal health performance indicators on Board agenda for every meeting (3)</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>1.1.3 Direct input to Board by LHN Aboriginal Community Consultative Committee or Aboriginal Experts by Experience (4)</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>1.1.4 LHN Board members are educated about Aboriginal health in their LHN (5)</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>1.1.5 LHN Board members receive cultural learning training (6)</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td><strong>1.2 Aboriginal representation at board level</strong></td>
<td>Total out of 10</td>
<td></td>
</tr>
<tr>
<td>Aboriginal representation at board level (7)</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td><strong>1.3 Inclusion in Executive Management Structure</strong></td>
<td>Total out of 10</td>
<td></td>
</tr>
<tr>
<td>1.3.1 A stand-alone Aboriginal Health Division (8)</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>1.3.2 Aboriginal LHN lead directly reports to the LHN CEO (9)</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>30</td>
<td>12</td>
</tr>
</tbody>
</table>

| **2. Policy Implementation** |         |       |
| 2.1 Improving Aboriginal Health Outcomes | Total out of 20 |       |
| 2.1.1 Explicitly identified as a strategic priority in LHN Strategic Plan (10) | 10 | 0 |
| 2.1.2 Aboriginal health outcome KPIs reflective of LHN key responsibilities identified in LHN Service Agreement (11) | 5 | 0 |
| (i) Tier 1 KPIs (12) | 5 | 0 |
| (ii) Tier 2 KPIs (13) | 5 | 0 |
| **2.2 Community engagement** | Total out of 20 |       |
| 2.2.1 Aboriginal community consultative body (14) | 4 | 4 |
| 2.2.2 Aboriginal community engagement embedded within overall community engagement strategy (15) | 4 | 4 |
| 2.2.3 LHN Aboriginal community newsletter/e-letter/social media (16) | 3 | 1 |
| 2.2.4 At least one Aboriginal community forum/meeting per year convened by the LHN chief executive officer (17) | 3 | 0 |
| 2.2.5 Reconciliation Action Plan (18) | 3 | 3 |
| 2.2.6 Aboriginal health professionals caring for patients included within clinical engagement strategy (19) | 3 | 0 |
| **2.3 Public Reporting and Accountability (via LHN website or annual report)** | Total out of 30 |       |
| 2.3.1 Traditional Owner Acknowledgement (21) | 2 | 0 |
| 2.3.2 Improving Aboriginal health outcomes |         |       |
| (i) Separate section in report devoted to Aboriginal health (22) | 3 | 0 |
| (ii) Reporting on KPIs contained in current service level agreement (SLA) (23) | 3 | 0 |
| (iii) Report Aboriginal community engagement (24) | 3 | 0 |
| (iv) Report on Aboriginal specific National Safety and Quality Health Service Standards Assessment (25) | 3 | 0 |
| (v) Chronic disease management and care planning (26) | 3 | 0 |
| 2.3.3 Cultural learning completion rates (27) | 2 | 0 |
2.3.4 Aboriginal health division/unit placement on LHN organisational structure/chart (28) 1 1
2.3.5 Data on Aboriginal access to and delivery of services (29) 3 0
2.3.6 Aboriginal employment
(i) Aboriginal Workforce Framework (planning, recruitment, etc) (30) 2 1
(ii) Data on Aboriginal employment (31) 3 0
2.3.7 Other recognition (e.g., awards, scholarships, etc.) (32) 2 0
TOTAL 70 14

3. Service delivery and partnerships
3.1 Aboriginal LHN Plan
3.1.1 Co-designed in partnership with ACCHO(s), or other Aboriginal organisations, or Aboriginal Experts by Experience in LHN region (33) 2 0
3.1.2 Partnership with ACCHO(s) in LHN region (34) 2 0
3.1.3 Commitment to Continuous Quality Improvement (35) 2 0
3.1.4 Co-designed KPIs (36) 2 0
3.1.5 Clear statement of ACCHO and LHN responsibilities and conflicts (37) 2 0
TOTAL out of 10

3.2 Cultural safety
3.2.1 Implementation of cultural safety policy/strategy (38) 5 0
3.2.2 Proportion of staff trained (39) 5 0
TOTAL out of 10

3.3 Selected LHN health performance indicators reported publicly
3.4.1 Estimated level of completion of Indigenous status – specifically the reporting of ‘not stated’ on admission (40) 3 0
3.4.2 Discharged against medical advice (DAMA) (41) 4 0
3.4.3 Potentially preventable hospitalisations (PPHA) (42) 3 0
3.4.4 Access to mental health services as reported at service level agreement (43) 3 0
3.4.5 Low birth-weight babies (44) 3 0
3.4.6 Healthcare outcome differential measures (eg. Discharge summary timeliness) (45) 4 0
TOTAL 40 2

4. Recruitment and employment
4.1 Aboriginal health workforce development reporting
4.1.1 Implementation of Aboriginal workforce strategy (46) 4 1
4.1.2 LHN KPI for Aboriginal employment (47) 4 1
4.1.3 Number of Aboriginal health practitioners, health workers and liaison officers (48) 3 0
4.1.4 Number of identified Aboriginal positions (49) 3 0
4.1.5 Number of salary bands occupied by Aboriginal employees (50) 3 0
4.1.6 Number of long-term Aboriginal employees (51) 3 0
TOTAL out of 20

4.2 Aboriginal participation in the health workforce
4.2.1 Administrative (52) 3 0
4.2.2 Medical Professionals (53) 4 0
4.2.3 Nurses/Midwives (54) 4 0
4.2.4 Operational Services (55) 3 0
4.2.5 Allied Health/Scientific/Technical (56) 3 0
4.2.6 Other (57) 3 0
TOTAL 40 2

5. Financial Accountability and Reporting: Closing the Gap Funding
5.1 Commonwealth contributions for Aboriginal health programs to LHN
Commonwealth contributions for Aboriginal health programs to LHN (58)
Total out of 10
10 0

5.2 South Australian contributions to Aboriginal specific health services and programs including activity-based funding loading for Aboriginal patients
5.2.2 Reporting on contributions for Aboriginal specific health services and programs including activity-based funding loading (59)
Total out of 10
10 0

TOTAL 20 10

Total Score 200 28

Institutional Rating scored against criteria
Score: >=160 120-159 80-119 40-79 <=39
Evidence of Inst. Racism: Very Low Low Moderate High Very High

Notes:

1. Southern Adelaide Local Health Network (SALHN)
Located on the traditional country of the Kaurna people and to the south of the Adelaide CBD, the 2016 ABS Census estimated population (usual residence) for the SALHN region is 355,549, with an Aboriginal and Torres Strait Islander population of 4,218 (1.2% of the total population) (APHN, 2020). [https://profile.id.com.au/aphn/population?WebID=320](https://profile.id.com.au/aphn/population?WebID=320). SALHN has Aboriginal Family Clinics at Noarlunga and Clovelly Park providing health services for Aboriginal and Torres Strait Islander People. It also delivers specialty services for Aboriginal and Torres Strait Islander peoples who live in the Northern Territory and Western New South Wales (SALHN, 2019b, p. 7). SALHN also has the Karpa Ngarrattendi Aboriginal Hospital Liaison Unit based at Flinders Medical Centre (FMC) and which extends services to the Noarlunga Hospital (SALHN 2020, p. 12 and [https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/services/hospitals/flinders+medical+centre/services+and+clinics+at+flinders+medical+centre/services+at+flinders+medical+centre/aboriginal+hospital+liaison+unit+at+flinders+medical+centre](https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/services/hospitals/flinders+medical+centre/services+and+clinics+at+flinders+medical+centre/services+at+flinders+medical+centre)). The unit, which began operating from FMC in November 1997, has the traditional Kaurna name Karpa Ngarrattendi, meaning ‘to support, to heal’. Between one and five per cent of all patients who use SALHN hospitals are of Aboriginal or Torres Strait Islander descent.

**INDICATOR 1: PARTICIPATION IN LHN GOVERNANCE**

**Criterion: Good governance**
The following chart provides an overview of the SALHNB references to and discussion concerning Aboriginal health and related matters. In addition to the listed sub-criteria, other headings have been included to cover information not readily assigned to the listed sub-criteria. Where Aboriginal health matters have been discussed, the Agenda item numbers have been indicated in the monthly columns. Also note that the Acknowledgement of Country of the Kaurna people is a standing item under Agenda Item 1.1 in all meetings, and is not included in the chart below.

**Legend:**
x = no information relevant to the sub-criterion heading was provided.
? = minutes were not uploaded onto SA Health website at the time of this analysis (30 May 2020).
AHEMGB – Aboriginal Health Expert Member of Governing Board (this person may/may not be an Aboriginal person)
Tier 1 committee = a Board committee which reports to the Board
Tier 2 committee = an internal LHN committee which reports to the CEO
Tier 3 committee = a community-based committee established in accordance with, for example, a LHN consumer and community engagement plan/framework/strategy and which can provide input to, or respond to the LHNB or LHN CEO.

**SALHN BOARD meetings: good governance sub-criteria summary for July 2019 – April 2020**

<table>
<thead>
<tr>
<th>Meeting</th>
<th>July 4th</th>
<th>Aug. 1st</th>
<th>Sept. 5th</th>
<th>Oct. 3rd</th>
<th>Nov. 7th</th>
<th>Dec. 5th</th>
<th>Feb. 6th</th>
<th>Mar 5th</th>
<th>April 2nd (V)</th>
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<tr>
<td><strong>Sub-criteria:</strong></td>
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<tr>
<td>1.1.1</td>
<td>LHNB inter.</td>
<td>X</td>
<td>X</td>
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<td>X</td>
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<td>X</td>
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<td>With Aboriginal Com.</td>
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<td>1.1.2</td>
<td>AHPI on Mtg Agenda</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>1.1.3</td>
<td>ACCC direct input to LHNB</td>
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<td>X</td>
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<td>1.1.4</td>
<td>LHNB educ’d re Aboriginal Health</td>
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<td>11.6</td>
<td>11.7</td>
<td>10.1</td>
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<td>1.1.5</td>
<td>LHNB Receives CCT</td>
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<td>X</td>
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<tr>
<td><strong>Additional sub-criteria</strong></td>
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<td>Invited Aboriginal Guest</td>
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<td>Aboriginal Health Agenda Item</td>
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<td>SLA Tier 1 &amp; 2 Aboriginal Health KPIs Discussed</td>
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<td>Aboriginal Membership of Brd Committees</td>
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</table>

**Summary of matters addressed:**

**Aug. 1st Agenda Item 11.6:** Among the matters for noting: Aboriginal Health Impact Statements

**Sept. 5th Agenda Item 11.7:** Among the matters for noting: Aboriginal Health Expert Board Members System-Level Information Session 11 October. The Board noted the correspondence, with the Executive to confirm invitee list from SALHN from the DHW.

**Oct. 3rd Agenda Item 10.1:** Clinical Governance Sub-committee. The Board discussion included the need for more discussion to enhance the quality of care for Aboriginal and Torres Strait Islander patients; and opportunities to learn from 11 October meeting of Board members with Aboriginal Health expertise. The AHEMGB to feedback to Board Chair after 11 October 2019 meeting.

**Nov. 7th Agenda Item 9.1:** Clinical Governance Sub-committee. The Clinical Governance Sub-committee is due to meet on 14 November 2019. The Chair spoke to the development and importance of the Innovate Reconciliation Action Plan 2019-2021 (RAP 2019-21). The RAP 2019-21 was considered by the Sub-committee members out of session as part of SALHN’s overall framework of supporting the improvement of health care for Aboriginal and Torres Strait Islander peoples. The Sub-committee recommended the Board endorse the Plan. The Board discussion included:

- The time required to address differences in understanding of reconciliation across SALHN;
The importance of language;
The conditional endorsement by Reconciliation Australia of the Plan
The potential for the Plan to evolve over time and to be used to underpin improvements in:
  a. Education
  b. Leadership; and
  c. Broader health and healing within SALHN.
• The need for regular reporting to the Sub-committee on progress against each of the actions and deliverables of the RAP 2019-21; and an annual report to the Board.

Dec. 5th Agenda Item 11.1: Clinical Governance Sub-committee. The Clinical Governance Sub-committee met on 14 November 2019. The Chair highlighted key actions and decisions including the evolution of the Quality report; future reporting against milestones of the Reconciliation Action Plan; and the development of a work plan for 2020.

February 6th:
Agenda Item 6.1: Spotlight sessions. Spotlight 1 – Division of Rehabilitation, Age Care and Palliative Care. The Board discussed, inter alia, the Division’s opportunities to create culturally appropriate palliative care services ‘on country’ for Aboriginal and Torres Strait Islander people.
Agenda Item 6.2: Spotlight sessions. Spotlight 2 – Women’s and Children’s Division. The Board discussed, inter alia, the Division’s consideration of culturally appropriate screening tools for Aboriginal and Torres Strait Islander patients.

March. 5th Agenda Item 6.2: Spotlight 2 – Mental Health Division. The Board discussed, inter alia, the Division’s approach to culturally-appropriate assessment of suicide risk within Aboriginal and Torres Strait Islander peoples with mental health issues.

2. Board interaction with Aboriginal community
Based on the Agenda and Minutes of the SALHNB meetings, there is no record of the Board holding a meeting, or meetings with the local Aboriginal community, or otherwise interacting with them through participation in, for example, NAIDOC or Reconciliation Week activities. Score = 0 / 2

3. LHN Aboriginal Health performance indicators on Board agenda for every meeting
Based on the Agenda and Minutes of the SALHNB meetings, there is no record of Aboriginal Health performance indicators being on the Board agenda at every meeting. Score = 0 / 2

4. Direct input to Board by LHN Aboriginal Community Consultative Committee or Aboriginal Experts by Experience
The SALHN Consumer Engagement Framework and Plan 2019-2021 (SALHN 2019c) establishes the Aboriginal and Torres Strait Islander Consumer and Community Group (ATSIC&CG) within the consumer engagement governance and management structure (pp. 3, 4 and 6) [see also Note 12]. Input at SALHNB meetings by the ATSIC&CG was not recorded in the Agenda or Minutes of the SALHNB meetings. Score = 0 / 2

5. LHN Board members are educated about Aboriginal health in their LHN
On 11 October 2019 NALHN Board members met with Aboriginal Health expertise which would have provided an opportunity for the Board to become educated about the health status and issues of the local Aboriginal community. Score = 2 / 2
6. **LHN Board members receive cultural learning training**
   There is no evidence in the Agenda and Minutes of the SALHN Board meetings that the Board members have undergone cultural learning training. **Score = 0 / 2**

**Criterion: Aboriginal representation at board level**

7. **Aboriginal representation at board level**

**Criterion: Inclusion in Executive Management Structure**

8. **A stand-alone Aboriginal Health Division**
   The SALHN does not have a stand-alone Aboriginal health division. Responsibility for Aboriginal health care is incorporated into the Division of Allied Health, Intermediate Care and Aboriginal Health Services (*SALHN Annual Report 2018-19*, p. 5) **Score = 0 / 5**

9. **Aboriginal LHN lead directly reports to the LHN CEO**
   The SALHN has an executive team of 15 members, none of whom in the brief summaries of their responsibilities, identify as an Aboriginal and/or Torres Strait Islander person. (*SALHN Annual Report 2018-19*, pp. 6-8) **Score = 0 / 5**

**INDICATOR 2: POLICY IMPLEMENTATION**

**Criterion: Improving Aboriginal Health Outcomes**

10. **Explicitly identified as a strategic priority in LHN Strategic Plan**
    SALHN has developed a *Strategic Direction Map 2019-24* (SALHN, 2019b) in response to the *SA Health Strategic Plan 2017-2020* (SA Health 2017a). The Map is built around four strategic direction pillars: (i) Our clinical services; (ii) Our consumers; (iii) Our relationships; and (iv) Our research, with a focus on a “commitment to improve the health and wellbeing of our vulnerable community members throughout their lives by supporting their empowerment and protection”. Aboriginal and Torres Strait Islander people are identified as a separate cohort among the eight population cohorts for both vulnerable young people and vulnerable older people (*SALHN 2019b*, p. 9). With regard to the strategic direction pillars, Aboriginal and Torres Strait Islander people are only mentioned once – in relation to (ii) Our consumers, whereby the consumer engagement strategy will ensure that they have “their voice heard at all levels of SAHLN” (p. 14). While not ignored, the health outcomes of Aboriginal people are not explicitly identified as a strategic priority within the Map. **Score = 0 / 10**

11. **Aboriginal health outcome KPIs reflective of LHN key responsibilities identified in LHN Service Level Agreement**
    The SALHN *Service Level Agreement 2018-2019*, in Schedule 4: Performance Indicators and Targets contains four Aboriginal health-related KPIs already included in the metropolitan LHNs and for the WCHN, namely the Tier 2 KPIs: Left at Own Risk; DAMA; Aboriginal Employee Participation Rate; and Completion of the Aboriginal Cultural Competence Program (pp. 55-59). In the section designated for Aboriginal Health, there is only one KPI – DAMA, a Tier 2 KPI (p. 59). Some of the SALHN SLA KPIs include patient sub-sets, for example, the Emergency Department Tier 2 KPI: Left at Own Risk which measures three patient sub-sets: (i) % of all ED presentations; (ii) % of Aboriginal presentations; and (iii) % of Mental Health presentations – all with a target of <=3%. **Score = 0 / 10**
The purpose of the following two sub-criteria is to suggest additional KPIs to the existing four. Given the excess burden of disease within the Aboriginal community, and particularly in relation to cancer, heart and stroke, diabetes, kidney disease and mental health, there should be a range of both Tier 1 and 2 KPIs to address these health crises. The KPIs selected below, except for one (Indigenous status reporting), are already in the SALHN SLA, and use a sub-set for Aboriginal patients as employed above with regard to the Emergency Department Tier 2 KPI: Left at Own Risk. The basis for scoring is that, given the excess burden of disease among Aboriginal people and the health crises faced by many Aboriginal communities, these KPIs (with Aboriginal people constituting a KPI sub-set, should already be included in the current SLA. The fact that they are not results in a penalty score.

12. **Tier 1 KPIs**

* **Elective Surgery:** Tier 1 – Timely Admissions: % of elective surgery patients admitted within clinically recommended times; % of Aboriginal patients admitted for elective surgery within clinically recommended times. Target 100%.

* **Emergency Department:** Tier 1 – Length of Stay Less Than or Equal to 4 hours: % of presentations to an ED where the time from the presentation to the time of physical departure (i.e. the length of the ED stay) is less than or equal to 4 hours; % of Aboriginal presentations to an ED where the time from the presentation to the time of physical departure (i.e. the length of the ED stay) is less than or equal to 4 hours. Target >=90%

* **Emergency Department:** Tier 1 – Seen on Time: % of patients attending ED who commenced treatment within clinically accepted timeframes; % of Aboriginal patients attending ED who commenced treatment within clinically accepted timeframes. Target varies from 100% for Category 1 patients to >=70% for Category 5 patients.

* **Mental Health:** Tier 1 – Mental Health - Adult/Older Persons Acute 28 Day Readmission Rate: % of patients who had a readmission within 28 days of discharge (non-short stay); % of Aboriginal patients who had a readmission within 28 days of discharge (non-short stay). Target <=12%

* **Mental Health:** Tier 1 – Suicide of persons in Inpatient Mental Health Units: # of suicides that occur in admitted patient specialised mental health services; # of Aboriginal suicides that occur in admitted patient specialised mental health services. Target - Monitor

**Score = 0 / 5**

13. **Tier 2 KPIs**

* **Aboriginal Health:** Tier 2 – Indigenous status reporting: % ‘not stated’ on admission. Target: ?

* **Mental Health:** Tier 2 - Post Discharge Community Follow Up Rate: % of people receiving one or more mental health service contacts while in the community within 7 days post discharge; % of Aboriginal people receiving one or more mental health service contacts while in the community within 7 days post discharge. Target >=70%.

* **Clinical pathways:** Tier 2 - Stroke (FMC) Admissions to Stroke Unit: % of stroke patients where the patient spent part of their stay in a stroke ward; % of Aboriginal stroke patients where the patient spent part of their stay in a stroke ward. Target >=90%.

* **Clinical Pathways:** Tier 2 - Rehabilitation: Individual Care Plan: % of rehabilitation patients who leave hospital with an individualised care plan; % of Aboriginal rehabilitation patients who leave hospital with an individualised care plan. Target >=90%.

* **Occupancy:** Tier 2 – Discharge Summary Transmission Rate: % of discharge summaries transmitted with 48 hours of separation; % of Aboriginal patient discharge summaries transmitted with 48 hours of separation. Target >=80%

**Score = 0 / 5**
Criterion: Community Engagement

14. Aboriginal community consultative body

In the Independent Auditor’s Report attached to the SALHN Annual Report 2018-19, Note 36 concerns Board and committee members who were entitled to receive income from membership. There are 23 entities named, none of which explicitly refers to some form of Aboriginal community consultative body.

The SALHN Consumer Engagement Framework and Plan 2019-2021 (SALHN 2019c), developed by the Partnering with Consumers’ Advisory Group (PWCAG), and which uses as one of its SA Health policy directives the SA Health Guide for Engaging with Aboriginal People (DHA 2013b), establishes the Aboriginal and Torres Strait Islander Consumer and Community Group (ATSIC&CG) within the consumer engagement governance and management structure (pp. 3, 4 and 6). In accordance with the Framework and Plan, during 2019 each of SALHN’s eight divisions (Mental Health Services; Medicine, Cardiac and Critical Care; Clinical Support Services; Corporate Services; Intermediate Care Services and Aboriginal Health; Rehabilitation, Aged and Palliative Care; Surgery and Peri-operative Medicine; and Women’s and Children’s) will establish a Consumer Engagement Plan that aligns with the SALHN Consumer Engagement Strategy (p. 10).

The December 2019 Southern Health News (SALHN, 2019d, p. 9) notes the establishment of the 13-member ATSIC&CG which:

… aims to support Aboriginal and Torres Strait Islander people to partner with SALHN to form a genuine partnership and forum for ongoing engagement. The group will have a significant role in:

* Providing advice, feedback and improvement suggestions relating to the healthcare needs and issues of Aboriginal and Torres Strait Islander people to enable SALHN to achieve better health and wellbeing outcomes for our community.

* Identifying, promoting and reflecting Aboriginal and Torres Strait Islander heritage and culture within SALHN buildings and spaces.

* Providing feedback and input to SALHN on its services, planning and performance in relation to the care and support provided to Aboriginal and Torres Strait Islander people.

The April 2020 edition of Southern Health News (SALHN, 2019d, p. 9) Score = 4 / 4

15. Aboriginal community engagement embedded within overall community engagement strategy

The ATSIC&CG has membership of the PWCAG, and, together with the other consumer engagement groups (Health Literacy Group, Consumer Experience Performance Group, and Person and Family Centred Care Group) has input into SALHN’s eight divisional consumer engagement plans. The PWCAG reports through the SALHN Executive to the Board (SALHN 2019c, p. 4). It is also noted that, in accordance with Schedule 3A – Dissolution of Health Advisory Councils, of the Health Care (Governance) Amendment Bill 2019 (SA), SALHN Health Advisory Council was dissolved. Score = 4 / 4

16. LHN Aboriginal community newsletter/e-letter/social media

SALHN publishes a downloadable quarterly newsletter Southern Health News. The December 2019 edition does make some references to Aboriginal health (pp. 2, 5 and 9. See also Note 12), and the April 2020 edition also refers to Aboriginal health services (SALHN 2020, pp. 2, 10 and 11), however, SALHN does not have a dedicated Aboriginal community newsletter. Late in 2019, the 13 assessors from ACHS assessed SALHN against eight NSQHS Standards. The assessors visited, among other facilities, the Aboriginal Family Clinic (Clovelly Park and Noarlunga) and the Karpa Ngarrattendi Aboriginal Hospital Liaison Unit. The assessors found that SALHN met all the NSQHS Standards (SALHN 2020, pp. 11, 12-13). This presented an opportunity, not taken, to specifically mention SALHN’s performance against the NSQHS six Aboriginal and Torres Strait Islander specific standards listed in Table 2. The SA Health website SALHN page has Facebook, Instagram and Twitter accounts. Some recognition is given to the fact that the Southern Health News includes articles related to Aboriginal people and Aboriginal health matters. Score = 1 / 3
17. At least one Aboriginal community forum/meeting per year convened by the LHN chief executive officer The SALHN SLA for 2018-2019, in Schedule 5: SA Health Performance Framework, with regard to Performance Review Processes, includes processes for monitoring performance against key deliverables (as outlined in Schedule 4 of the SLA). One of these processes includes “Contract Performance Meetings to review performance, particularly in relation to the key indicators (Tier 1), and to discuss and develop mitigation strategies where appropriate and to monitor progress. At least one meeting will focus on Mental Health specific deliverables and KPIs and at least one meeting will focus on Aboriginal Health specific deliverables and KPIs.” (SALHN, SLA 2018—19, pp. 60-1). In the context of this sub-criterion, it would seem appropriate that the SALHN CEO hold an Aboriginal community forum/meeting preparatory to the scheduled Contract Performance Meeting with DHW at which the Aboriginal Health specific deliverables and KPIs are to be discussed. The April 2020 edition of Southern Health News reports that SALHN held its inaugural Annual Public Meeting late in 2019. The meeting was held in the Noarlunga Arts Centre, and after a Greeting to Country was performed by a senior Kaurna representative, presentations were made by the CEO, Chair of the Governing Board and the COO. Other sessions included a Q and A with a panel of SALHN senior staff, and a Listening Post, which included the Operations Manager Aboriginal Health Services (SALHN 2020, p. 10). While on 11 October 2019 NALHN Board members met with Aboriginal Health expertise, no evidence has emerged of the CEO convening a forum or meeting with the local Aboriginal community. Score = 0 / 3

18. Reconciliation Action Plan
As recorded in their meetings of the 7th November and 5th December 2019, the SALHNB and the Clinical Governance Sub-committee have shown a keen interest in the development of SALHN’s Innovate Reconciliation Action Plan 2019-2022 (SALHN, 2019) as providing an important framework supporting the improvement of health care to Aboriginal and Torres Strait Islander people within the region. Score = 3 / 3

19. Aboriginal health professionals caring for patients included within clinical engagement strategy
Under the SALHN Consumer Engagement Framework and Plan 2019-2021 (SALHN 2019c, p. 10), the Clinical Support Services Division is required to establish its Consumer Engagement Plan. A search of the SA Health website SALHN page (and portals and links) did not find the Clinicians Engagement Plan. Score = 0 / 3

Criterion: Public Reporting and Accountability (via LHN website or annual report)
20. The SALHN, in effect, does not have its own website. An internet search for “Southern Adelaide Local Health Network” will lead to the SA Health website (www.sahealth.sa.gov.au) which provides a link to SALHN: https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+local+health+networks/southern+adelaide+local+health+network/southern+adelaide+local+health+network+salhn The SALHN page contains a number of portals. As at 7th June 2020, there are nine SALHN portals: (i) About Us; (ii) Our Services; (iii) Careers and Training; (iv) Governance; (v) Engaging with us; (vi) News and Publications; (vii) SALHN Research; (viii) Contact Us; and (ix) the COVID-19 Mental Health Support Web Portal. Each portal provides links to enable access to additional information. For example, the Governance portal provides links to Board membership, meetings (agenda and minutes), and expenses. There is no portal presenting a snap-shot of the SALHN providing basic information about population demographics (including the Aboriginal population and Traditional Owners), geographic region served, brief description of the health workforce, a resident health profile/dashboard, and summary of services provided. None of the information sought below is readily available on the SALHN page (including its portals and their links) (“the SALHN page”) on
the SA Health website. Information regarding, for example, Aboriginal employment in the health workforce, cultural competency training completion rates, and Aboriginal health outcome KPIs must be sought via other portals and links on the SA Health website.

The annual report referred to is the SALHN Annual Report 2018-19.

21. **Traditional Owner acknowledgement**

Neither the SALHN page nor the SALHN Annual Report 2018-19 contain an acknowledgement of the Kaurna Traditional Owners, although information provided by the Karpa Ngarrattendi link indicates a connection to the Kaurna people.  

**Score = 0 / 2**

22. **Improving Aboriginal health outcomes: (i) Separate section in report devoted to Aboriginal health**

The SALHN page does not a section devoted to Aboriginal health. Its alphabetical prompt provides a link to the Aboriginal Health Liaison Unit at the FMC and a directory for its services, but no data on Aboriginal health for the SALHN region. There is no separate section in the Annual Report, as indicated in the table of contents (p. 3), or in the body of the report. Information concerning Aboriginal health care is instead scattered in a couple of locations within the report (SALHN Annual Report 2018-19, pp. 11, 22).  

**Score = 0 / 3**

23. **Improving Aboriginal health outcomes: (ii) Reporting on KPIs contained in current service level agreement (SLA)**

The SALHN SLA 2018-19 Schedule 4 contains the following Aboriginal health specific KPIs:

**Performance Domain: Access and Flow**

Emergency Department Tier 2 KPI: Left at Own Risk  
Measure: % of Aboriginal presentations. Target <=3%.

**Performance Domain: Safe and Effective Care**

Aboriginal Health Tier 2 KPI: Aboriginal Patients Who Left Hospital Against Medical Advice  
Measure: % of overnight Aboriginal and/or Torres Strait Islander patients who left hospital against medical advice. Target: <=4.5%

**Performance Domain: People and Culture**

Workforce Tier 2 KPI: Aboriginal Employee Participation Rate  
Measure: % of employees who identified as being of Aboriginal or Torres Strait Islander origin.  
Target: >=4%#

Workforce Tier 2 KPI: Completion of the Aboriginal Cultural Competence Program  
Measure: % of employees who have completed Aboriginal cultural competence training. Target: 100%#

# These two KPIs are also included in the Schedule of Funding and Performance Indicators for the period of 1 July 2018 – 30 June 2019 which forms part of the SLA. However, in the Schedule regarding Aboriginal Cultural competence training, the KPI uses the following wording: Tier 2: Completion of the Aboriginal Cultural Learning Program (Bi-Annual), with the Measure: % of employees who have completed and Aboriginal cultural learning program (bi-annual). Target = 100%. (SALHN, SLA 2018—19, pp. 55, 59, 76). Performance against these KPIs is not reported on the NALHN page, nor in the annual report.  

**Score = 0 / 3**

24. **Improving Aboriginal health outcomes: (iii) Report on Aboriginal community engagement**

Note 14 refers to the Aboriginal and Torres Strait Islander Consumer and Community Group (ATSI&C&G) established within the SALHN consumer engagement governance and management structure. However, neither the SALHN page (and its “Engage with us” portal and links), nor the annual report provide information regarding Aboriginal community engagement activities, meetings with, for example, NALHN executives, and their outcomes.  

**Score = 0 / 3**
25. **Improving Aboriginal health outcomes: (iv) Report on Aboriginal specific National Safety and Quality Health Service Standards assessment**

The SALHN SLA for 2018-2019, in Schedule 4: Performance Indicators and Targets includes a statement in relation to the delivery of the Closing the Gap agenda and citing the NSQHSS, that: “In order to support the delivery of the Closing the Gap agenda, and implementation of the National Safety and Quality Health Service Standards related to Aboriginal and Torres Strait Islander health, wherever possible performance data will be collated for the population as a whole and for Aboriginal and Torres Strait Islander peoples.” (SALHN, SLA 2018—19, p. 52). However, none of this data is recorded in the SALHN annual report.

Table 2 lists six Aboriginal and Torres Strait Islander specific standards. Neither the SALHN page nor the annual report provide data on how these standards are being met. **Score = 0 / 3**

26. **Improving Aboriginal health outcomes: (v) Chronic disease management and care planning**

The SALHN page, via its alphabetical prompt, does not mention the South Australian Aboriginal Chronic Diseases Consortium, and the annual report makes no mention of SAHLN being a member of the Consortium, or of any plans that the SALHN might have in addressing chronic disease amongst the Aboriginal population. **Score = 0 / 3**

27. **Cultural learning completion rates**

Neither the SALHN page, nor the annual report mention the SA Health Aboriginal Cultural Learning Framework, or provide data on non-Aboriginal staff completion rates for the Cultural Learning Program for the three levels. **Score = 0/2**

28. **Aboriginal health division/unit placement on LHN organisational structure/chart**

The body responsible for Aboriginal health care services is located within the Directorate of Allied Health, Intermediate Care and Aboriginal Health Services (SALHN Annual Report 2018-19, p. 5). **Score = 1 / 1**

29. **Data on Aboriginal access to and delivery of services**

The Karpa Ngarrattendi Aboriginal Hospital Liaison Unit link provided via the SALHN page alphabetical prompt lists a range of support services provided through the Unit. The annual report provides no data on Aboriginal access to and delivery of services. However, the report does note in relation to Agency specific objectives and performance that one of the indicators refers to “Aboriginal Family Clinics provide services for Aboriginal and Torres Strait Islander peoples from two locations, Noarlunga and Clovelly Park (SALHN Annual Report 2018-19, p. 11). However, nothing is reported in relation to performance regarding these two clinics. The SALHN page, likewise, provides no data on Aboriginal access and use of its services. **Score = 0 / 3**

30. **Aboriginal employment: (i) Aboriginal Workforce Framework (planning, recruitment, etc)**

**Score = 0 / 2**

The SALHN page makes no reference to the Aboriginal Workforce Framework. The annual report makes no reference to any plans or initiatives it might have in relation to Aboriginal workforce planning and recruitment. However, it does mention in the Corporate performance summary in relation to Employment opportunity programs, the Aboriginal and Torres Strait Islander Pre-Employment Program and Aboriginal Traineeships and Cadetships, and in relation to its performance that SAHLN has: “Maximised job readiness for candidates and provided a pathway to employment.” However, it does not provide any data on the number of Aboriginal people who have gone through these programs. **Score = 1 / 2**

31. **Aboriginal employment: (ii) Data on Aboriginal employment**
The SALHN page does not provide any data on Aboriginal employment within its workforce. While the annual report records that it has: “More than 7,500 staff across 20 sites”, it provides no further information regarding the SALHN workforce. **Score = 0 / 3**

32. **Other recognition (e.g., awards, scholarships, etc.)**
Neither the SALHN page, nor the annual report have a section regarding staff awards, achievements, etc., including for Aboriginal staff. **Score = 0 / 2**

**INDICATOR 3: SERVICE DELIVERY AND PARTNERSHIPS**

**Criterion: Aboriginal LHN Plan**

33. **Co-designed in partnership with ACCHO(s), or Aboriginal organisations, or Aboriginal Experts by Experience in LHN region**

The SALHN SLA, with regard to LHN accountabilities, holds that the LHN CEO is responsible for, *inter alia*, “Developing effective and working partnerships with Aboriginal Community Health and ensuring health needs of Aboriginal people are considered in all health plans, programs and models of care developed by the LHN.” (NALHN SLA 2018-2019, p. 10). While SALHN does not have any ACCHOs within its region (the two metropolitan ACCHOs are located in the Adelaide CBD), SALHN has Aboriginal Family Clinics at Noarlunga and Clovelly Park providing health services for Aboriginal and Torres Strait Islander People. It also delivers specialty services for Aboriginal and Torres Strait Islander peoples who live in the Northern Territory and Western New South Wales (SALHN, 2019b, p. 7). SALHN also has the Karpa Ngarrattendi Aboriginal Hospital Liaison Unit However, based on a web search, and the agenda and minutes of the NALHN meetings, there appears to be no evidence or discussion about the formulation of an overall Aboriginal Health Plan for NALHN. **Score = 0 / 2**

34. **Partnership with ACCHO(s) in LHN region**
See Note 33 **Score = 0 / 2**

35. **Commitment to Continuous Quality Improvement**
See Note 33 **Score = 0 / 2**

36. **Co-designed KPIs**
See Note 33 **Score = 0 / 2**

37. **Clear statement of ACCHO and LHN responsibilities and conflicts**
See Note 33 **Score = 0 / 2**

**Criterion: Cultural Safety**

38. **Implementation of cultural safety policy/strategy**

Under the SALHN *Consumer Engagement Framework and Plan 2019-2021* (SALHN 2019c, p. 8), one of the deliverables is “to have 80 per cent of staff within Divisions complete the Partnering with Consumers and Community online training, and will increase the number of staff training sessions that engage consumers or share consumer experience stories.” However, the Plan does not contain a similar framework or strategy for delivering Aboriginal Cultural Safety training to SALHN staff. **Score = 0 / 5**

39. **Proportion of staff trained**

The SALHN SLA for 2018-2019, in the *Schedule of Funding and Performance Indicators for the period of: 1 July 2018 – 30 June 2019*, there is a Tier 2 KPI for People and Culture performance domain
regarding the workforce: Completion of the Aboriginal Cultural Learning Program (Bi-Annual), with the measure: % of employees who have completed an Aboriginal cultural learning program (bi-annual), with a target of 100%. (SALHN, SLA 2018—19, p. 76) [see also Note 27]. However, neither the SALHN page nor the Annual Report provide data on actual completion rates for the Aboriginal Cultural Learning Program across the three levels of cultural learning, or on the mode(s) of delivery. Score = 0 / 5

Criterion: Selected LHN health performance indicators reported publicly

40. Estimated level of completion of Indigenous status – specifically the reporting of ‘not stated’ on admission
The SALHN SLA for 2018-2019, in Schedule 4: Performance Indicators and Targets, includes a statement in relation to supporting the delivery of the Closing the Gap agenda and citing the NSQHSS, that: “The LHN should implement processes to identify patients as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems.” (SALHN, SLA 2018—19, p. 52). The SALHN SLA does not have a KPI for addressing the estimated level of completion of Indigenous status. This would appear to breach NSQHSS Aboriginal and Torres Strait Islander specific standard 5.8 in relation to planning for comprehensive care (see Table 2). Score = 0 / 3

41. Discharges against medical advice (DAMA)
The SALHN SLA for 2018-2019, in Schedule 4: Performance Indicators and Targets, in relation Safe and Effective Care in terms of Aboriginal Health, there is a Tier 2 KPI Aboriginal Patients Who Left Hospital Against Medical Advice, with the measure: % of overnight Aboriginal and/or Torres Strait Islander patients who left hospital against medical advice, with the target: <=4.5% (SALHN, SLA 2018—19, p. 59). In the Access and Flow performance domain with regard to the Emergency Department, there is also a Tier 2 KPI: Left at Own Risk, with the Measure which includes percentages of (i) all ED presentations, (ii) Aboriginal presentations, and (iii) Mental Health presentations, with the target for all three categories: <=3% (SALHN, SLA 2018—19, p. 55). The SALHN Annual Report 2018-2019 and the SA Health website SALHN page (and portals and their links) provide no information on the rates of DAMA within the NALHN hospitals. Score = 0 / 4

42. Potentially preventable hospital admissions (PPHA)
The SALHN SLA for 2018-2019, in Schedule 4: Performance Indicators and Targets, in relation to Safe and Effective Care in terms of Quality and Effectiveness, there is a Tier 2 KPI for Potentially Preventable Admissions, with the measure: % of total separations, with the target: Monitor against national rate. (SALHN, SLA 2018—19, p. 58). There is no specific KPI for potential preventable admissions for Aboriginal people. Score = 0 / 3

43. Access to mental health services as reported at service level agreement
At its March. 5th 2020 meeting (Agenda Item 6.2), the SALHN Board discussed, inter alia, the Mental Health Division’s approach to culturally-appropriate assessment of suicide risk within Aboriginal and Torres Strait Islander peoples with mental health issues. However, there is no KPI in the SALHN Service Level Agreement 2018-2019 which addresses Aboriginal access to mental health services. Score = 0 / 3

44. Low birth-weight babies
There is no KPI in the SALHN Service Level Agreement 2018-2019 which addresses low birth-weight rates with respect to Aboriginal babies. Score = 0 / 3

45. Healthcare outcome differential measures (eg, discharge summary timeliness)
There are no KPIs in the SALHN Service Level Agreement 2018-2019 which address healthcare outcome differential measures with respect to Aboriginal patients. Score = 0 / 4
INDICATOR 4: RECRUITMENT AND EMPLOYMENT

Criterion: Aboriginal health workforce development reporting

46. Implementation of Aboriginal workforce strategy
At its Feb. 6th 2020 meeting (Agenda Item 9), in the context of the Operations Report, the SALHN Board discussed, *inter alia*, Aboriginal employment growth initiatives. While it is of obvious concern, a search of the SA Health website SALHN page has not revealed the existence of a SALHN Aboriginal workforce strategy. **Score = 1 / 4**

47. LHN KPI for Aboriginal employment
The SALHN SLA for 2018-2019, in Schedule 4: Performance Indicators and Targets, there is a Tier 2 KPI for People and Culture regarding the workforce: Aboriginal Employee Participation Rate: % of employees who identified as being of Aboriginal or Torres Strait Islander origin, with a target of >=4%. (SALHN, SLA 2018—19, p. 59. See also p. 76). Elsewhere, with regard to Aboriginal Health Services: “SALHN is required to achieve a minimum of 4% Aboriginal and Torres Strait Islander employment in the health system” (p. 24). The *Workforce Information Report 2018-19* provides the following employment data for SALHN (as at 30 June 2019): FTE = 5,711; Total head count = 7,232 (female, male and other); Aboriginal employees = 59 (OCPSE 2019, p. 50). However, it is unclear whether the number of Aboriginal employees is based on the FTE data, or on the head count data. In the absence of clarification in the report, it is assumed that the number of Aboriginal employees is included in the head count data, which include persons counted as employees in a range of circumstances, including National Indigenous Cadetship Program (NICP) participants who are undertaking a 12-month temporary placement (OCPSE 2019, p. 55). The percentage of Aboriginal employees for the FTE and Head Count totals are: 1.03% and 0.82%. Based on an extrapolation of the OCPSE report data, SALHN is making some progress towards achieving the Aboriginal employment target of 4%. **Score = 1 / 4**

48. Number of Aboriginal health practitioners, health workers and liaison officers
The SA Health website SALHN page, and the SALHN *Annual Report 2018-19* do not provide any information regarding the number of Aboriginal people employed in these roles. **Score = 0 / 3**

49. Number of identified Aboriginal positions
The SA Health website SALHN page, and the SALHN *Annual Report 2018-19* do not provide any information regarding the number of Aboriginal identified positions within SALHN. **Score = 0 / 3**

50. Number of salary bands occupied by Aboriginal employees
The SA Health website SALHN page, and the SALHN *Annual Report 2018-19* do not provide any information regarding the number of salary bands occupied by Aboriginal employees within SALHN. **Score = 0 / 3**

51. Number of long term Aboriginal employees
The SA Health website SALHN page, and the SALHN *Annual Report 2018-19* do not provide any information regarding the number of long term Aboriginal employees within SALHN. **Score = 0 / 3**

Criterion: Aboriginal participation in the health workforce

52. Administration
No information is available on the SA Health website SALHN page and in the SALHN *Annual Report 2018-2019* regarding the number of Aboriginal people employed in administrative positions at SALHN. **Score = 0 / 3**
53. **Medical Professional**
No information is available on the SA Health website SALHN page and in the SALHN *Annual Report 2018-2019* regarding the number of Aboriginal people holding medical professional positions at SALHN  
**Score = 0 / 4**

54. **Nurses/Midwives**
No information is available on the SA Health website SALHN page and in the SALHN *Annual Report 2018-2019* regarding the number of Aboriginal people employed as nurses or midwives at SALHN  
**Score = 0 / 4**

55. **Operational Services**
No information is available on the SA Health website SALHN page and in the SALHN *Annual Report 2018-2019* regarding the number of Aboriginal people providing operational services at SALHN  
**Score = 0 / 3**

56. **Allied Health/Scientific/Technical**
No information is available on the SA Health website SALHN page and in the SALHN *Annual Report 2018-2019* regarding the number of Aboriginal people allied health, scientific or technical roles at SALHN  
**Score = 0 / 3**

57. **Other**
No information is available on the SA Health website SALHN page and in the SALHN *Annual Report 2018-2019* regarding the number of Aboriginal people engaged in other positions at SALHN such as, cultural consultants, experts by experience, or contractors  
**Score = 0 / 3**

**INDICATOR 5: FINANCIAL ACCOUNTABILITY AND REPORTING – CLOSING THE GAP FUNDING**

In the SALHN *Service Level Agreement 1 July 2018 – 30 June 2019* (SALHN SLA), with regard to the provision of Aboriginal Health Services:

SALHN provides services specifically targeting Aboriginal people, including those provided through the Closing the Gap program. Each LHN has brokered schedules (agreements) outlining additional funding to support programs contributing to Closing the Gap and are required to provide 6 monthly updates on KPIs and milestones contained within the schedules and which will be reviewed at LHN Contract Meetings (p. 23).

SALHN participates in the South Australian Aboriginal Chronic Disease Consortium to progress the three statewide strategies regarding cancer control, heart and stroke, and diabetes, and to consider opportunities to reorientate or reform services aligned with these strategies (pp. 23-4).

SALHN receives specific purchasing and funding commitments for the following ten identified service programs:
- Aboriginal Well Health Checks (Closing the Gap)
- Aged Care Assessment Program (ACAP)
- Care Awaiting Placement (CAP)
- Chronic Pain Model of Care
- Community Support Scheme – Mental Health (CSS)
- Quit Smoking Initiatives (Closing the Gap)
- Transition Care Program (TCP)
- Under 8’s Ear Health (pp. 40-45)

The Aboriginal Well Health Checks (Closing the Gap) receives $497,299, the Quit Smoking Initiatives (Closing the Gap) receives $1,128,578, and the Under 8’s Ear Health program receives $110,153.47.
The SALHN SLA contains four Tier 2 KPIs for Aboriginal health: Left at Own Risk (in relation to Emergency Department presentations) (p. 55); DAMA (p. 59); Aboriginal Employee Participation Rate (p. 59); and Completion of the Aboriginal Cultural Competence Program (p. 59).

Criterion: Commonwealth contributions for Aboriginal health programs to LHN

58. Commonwealth contributions for Aboriginal health programs to LHN
Commonwealth contributions for Aboriginal health programs at SALHN are not identified in the SALHN Annual Report 2018-2019 or on the SA Health website SALHN page (including its portals and their links). Score = 0 / 10

Criterion: South Australian contributions to Aboriginal specific services and programs including activity-based funding loading for Aboriginal patients

59. Reporting on contributions for Aboriginal specific health services and programs including activity-based funding loading
The SALHN Annual Report 2018-2019 and the SA Health website SALHN page (including its portals and their links) contain no data on South Australian contributions to Aboriginal specific health services and programs Score = 0 / 10

SALHN documents consulted
- Service Level Agreement (1 July 2018 – 30 June 2019)
- Annual Report 2018-19
- Annual Report 2017-18
- Health Advisory Council (HAC) Annual Report 2017-18
- Governing Board Meetings: Agenda 4 July 2019 / Minutes 4 July 2019
  "  "  "  "  1 Aug. 2019 / "  1 Aug. 2019
  "  "  "  "  5 Sept. 2019 / "  5 Sept. 2019
  "  "  "  "  3 Oct. 2019 / "  3 Oct. 2019
  "  "  "  "  7 Nov. 2019 / "  7 Nov. 2019
  "  "  "  "  5 Dec. 2019 / "  5 Dec. 2019
  "  "  "  "  6 Feb. 2020 / "  6 Feb. 2020
  "  "  "  "  5 Mar. 2020 / "  5 Mar. 2020
  "  "  "  "  2 Apr. 2020 / "  2 Apr. 2020
- SALHN Health Advisory Council Inc. Constitution
- Disability Access and Inclusion Plan 2019-2023
- Strategic Direction Map 2019-2024 (SALHN, 2019b)
- Consumer Engagement Framework and Plan 2019-2021 (SALHN, 2019c)
- Southern Health News, December 2019 (SALHN, 2019d)
- Southern Health News, April 2020 (SALHN, 2020)

SALHN documents not sighted
### Key Indicators and Criteria

<table>
<thead>
<tr>
<th>Key Indicators and Criteria</th>
<th>Scoring</th>
<th>Score</th>
</tr>
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<tbody>
<tr>
<td><strong>1. Participation in LHN governance</strong></td>
<td></td>
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<tr>
<td><strong>1.1 Good governance</strong></td>
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<td>1.1.1 Board interaction with Aboriginal community (2)</td>
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<td>1.1.2 LHN Aboriginal health performance indicators on Board agenda for every meeting (3)</td>
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<td>1.1.3 Direct input to Board by LHN Aboriginal Community Consultative Committee or Aboriginal Experts by Experience (4)</td>
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<td>1.1.4 LHN Board members are educated about Aboriginal health in their LHN (5)</td>
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<tr>
<td>1.1.5 LHN Board members receive cultural learning training (6)</td>
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<tr>
<td><strong>1.2 Aboriginal representation at board level</strong></td>
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<tr>
<td><strong>Total out of 10</strong></td>
<td>10</td>
<td>10</td>
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<tr>
<td><strong>1.3 Inclusion in Executive Management Structure</strong></td>
<td></td>
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<tr>
<td>1.3.1 A stand-alone Aboriginal Health Division (8)</td>
<td>5</td>
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<tr>
<td>1.3.2 Aboriginal LHN lead directly reports to the LHN CEO (9)</td>
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<tr>
<td><strong>Total</strong></td>
<td>30</td>
<td>21</td>
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<tr>
<td><strong>2. Policy Implementation</strong></td>
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<td><strong>2.1 Improving Aboriginal Health Outcomes</strong></td>
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<tr>
<td>2.1.1 Explicitly identified as a strategic priority in LHN Strategic Plan (10)</td>
<td>10</td>
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<td>2.1.2 Aboriginal health outcome KPIs reflective of LHN key responsibilities identified in LHN Service Agreement (11)</td>
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<tr>
<td>(i) Tier 1 KPIs (12)</td>
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<td>(ii) Tier 2 KPIs (13)</td>
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<td><strong>2.2 Community engagement</strong></td>
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<td>2.2.1 Aboriginal community consultative body (14)</td>
<td>4</td>
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<td>2.2.2 Aboriginal community engagement embedded within overall community engagement strategy (15)</td>
<td>4</td>
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<td>2.2.3 LHN Aboriginal community newsletter/e-letter/social media (16)</td>
<td>3</td>
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<td>2.2.4 At least one Aboriginal community forum/meeting per year convened by the LHN chief executive officer (17)</td>
<td>3</td>
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<td>2.2.5 Reconciliation Action Plan (18)</td>
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<td>2.2.6 Aboriginal health professionals caring for patients included within clinical engagement strategy (19)</td>
<td>3</td>
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<tr>
<td><strong>2.3 Public Reporting and Accountability (via LHN website or annual report)</strong></td>
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<td><strong>2.3.1 Traditional Owner Acknowledgement (21)</strong></td>
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<tr>
<td>2.3.2 Improving Aboriginal health outcomes</td>
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<tr>
<td>(i) Separate section in report devoted to Aboriginal health (22)</td>
<td>3</td>
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<tr>
<td>(ii) Reporting on KPIs contained in current service level agreement (SLA) (23)</td>
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<td>(iii) Report Aboriginal community engagement (24)</td>
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<tr>
<td>(iv) Report on Aboriginal specific National Safety and Quality Health Service Standards Assessment (25)</td>
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<td>(v) Chronic disease management and care planning (26)</td>
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<tr>
<td>2.3.3 Cultural learning completion rates (27)</td>
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</table>
2.3.4 Aboriginal health division/unit placement on LHN organisational structure/chart (28) 1 1
2.3.5 Data on Aboriginal access to and delivery of services (29) 3 0
2.3.6 Aboriginal employment
   (i) Aboriginal Workforce Framework (planning, recruitment, etc) (30) 2 2
   (ii) Data on Aboriginal employment (31) 3 0
2.3.7 Other recognition (e.g., awards, scholarships, etc.) (32) 2 0

TOTAL 70 26

3. Service delivery and partnerships
   3.1 Aboriginal LHN Plan
      3.1.1 Co-designed in partnership with ACCHO(s), or other Aboriginal organisations, or Aboriginal Experts by Experience in LHN region (33) 2 2
      3.1.2 Partnership with ACCHO(s) in LHN region (34) 2 2
      3.1.3 Commitment to Continuous Quality Improvement (35) 2 2
      3.1.4 Co-designed KPIs (36) 2 2
      3.1.5 Clear statement of ACCHO and LHN responsibilities and conflicts (37) 2 1

   3.2 Cultural safety
      3.2.1 Implementation of cultural safety policy/strategy (38) 5 5
      3.2.2 Proportion of staff trained (39) 5 4.5

   3.3 Selected LHN health performance indicators reported publicly
      3.4.1 Estimated level of completion of Indigenous status – specifically the reporting of ‘not stated’ on admission (40) 3 0
      3.4.2 Discharged against medical advice (DAMA) (41) 4 0
      3.4.3 Potentially preventable hospitalisations (PPHA) (42) 3 0
      3.4.4 Access to mental health services as reported at service level agreement (43) 3 0
      3.4.5 Low birth-weight babies (44) 3 0
      3.4.6 Healthcare outcome differential measures (eg. Discharge summary timeliness) (45) 4 0

TOTAL 40 18.5

4. Recruitment and employment
   4.1 Aboriginal health workforce development reporting
      4.1.1 Implementation of Aboriginal workforce strategy (46) 4 4
      4.1.2 LHN KPI for Aboriginal employment (47) 4 2.5
      4.1.3 Number of Aboriginal health practitioners, health workers and liaison officers (48) 3 3
      4.1.4 Number of identified Aboriginal positions (49) 3 0
      4.1.5 Number of salary bands occupied by Aboriginal employees (50) 3 0
      4.1.6 Number of long-term Aboriginal employees (51) 3 1.5

   4.2 Aboriginal participation in the health workforce
      4.2.1 Administrative (52) 3 3
      4.2.2 Medical Professionals (53) 4 0
      4.2.3 Nurses/Midwives (54) 4 0.5
      4.2.4 Operational Services (55) 3 3
      4.2.5 Allied Health/Scientific/Technical (56) 3 1
      4.2.6 Other (57) 3 0

TOTAL 40 18.5

5. Financial Accountability and Reporting: Closing the Gap Funding
5.1 Commonwealth contributions for Aboriginal health programs to LHN
Commonwealth contributions for Aboriginal health programs to LHN (58)  
Total out of 10  
10 0

5.2 South Australian contributions to Aboriginal specific health services and programs including activity-based funding loading for Aboriginal patients
Reporting on contributions for Aboriginal specific health services and programs including activity-based funding loading (59)  
Total out of 10  
10 0

TOTAL 20 0

Institutional Rating scored against criteria

Score:  
>=160 120-159 80-119 40-79 <=39

Evidence of Inst. Racism:  
Very Low Low Moderate High Very High

Notes:

1. Women’s and Children’s Health Network (WCHN)
The Women’s and Children’s Health Network (WCHN) is the statewide provider of public tertiary and quaternary care for infants, children and women. With an annual budget of over $430 million and over 2,600 FTE, WCHN provides comprehensive acute inpatient and outpatient services including emergency and elective paediatrics, obstetrics, neonatology and gynaecology as well as a number of state-wide services (WCHN Service Level Agreement 2018-2019, p. 20).

According to the 2016 Census, the proportion of the South Australian population who are Aboriginal is 2.0%. In terms of WCHN’s key demographics, 4.0% of children (0 to 19 years) and 2.6% of women in the 15 to 39 year age groups are Aboriginal (WCHN, Aboriginal Workforce Strategy 2018 – 2022, p. 7).

WCHN has an Aboriginal Health Steering Committee (AHSC), a Tier One B (1B) Committee (and one of seven Tier 1B entities), chaired by the WCHN CEO and reporting directly to the WCHN Strategic Executive Committee. Currently, WCHN is the only LHN to have embedded an Aboriginal Health Committee to assist to fulfil its key role of corporate and clinical governance of the WCHN (WCHN, Aboriginal Workforce Strategy 2018 – 2022, pp. 10 and 17). The AHSC “provides strategic Aboriginal health leadership and is the key enabler fostering service and system improvements and reform for the implementation of Aboriginal health strategic directions and is essential for ensuring effective continuous safety and quality improvements” (WCHN Annual Report 2018-19, p. 19).

INDICATOR 1: PARTICIPATION IN LHN GOVERNANCE

Criterion: Good governance
The following chart provides an overview of the WCHNB references to and discussion concerning Aboriginal health and related matters. In addition to the listed sub-criteria, other headings have been included to cover information not readily assigned to the listed sub-criteria. Where Aboriginal health matters have been discussed, the Agenda item numbers have been indicated in the monthly columns. Also note that the Acknowledgement of Country is a standing item under Agenda Item 1.1 in all meetings, and is not included in the chart below.

Legend:
x = no information relevant to the sub-criterion heading was provided.
? = minutes were not uploaded onto SA Health website at the time of this analysis (30 May 2020).

AHEMGB – Aboriginal Health Expert Member of Governing Board (this person may/may not be an Aboriginal person)

Tier 1 committee = a Board committee which reports to the Board
Tier 2 committee = an internal LHN committee which reports to the CEO
Tier 3 committee = a community-based committee established in accordance with, for example, a LHN consumer and community engagement plan/framework/strategy and which can provide input to, or respond to the LHNB or LHN CEO.

### WCHN BOARD meetings: good governance sub-criteria summary for July 2019 – April 2020

<table>
<thead>
<tr>
<th>Meeting:</th>
<th>July 4th</th>
<th>Aug. 8th</th>
<th>Sept. 5th</th>
<th>Oct.</th>
<th>Nov. 7th</th>
<th>Dec. 5th</th>
<th>Feb. 6th</th>
<th>Mar</th>
<th>April 2nd (V)</th>
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<tr>
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<tr>
<td>1.1.1 LHN inter. With Aboriginal Com.</td>
<td>X</td>
<td>4.1/7.1</td>
<td>Y</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td></td>
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<td>1.1.2 AHPI on Mtg Agenda</td>
<td>X</td>
<td>X</td>
<td>4.5.2</td>
<td>X</td>
<td>X</td>
<td>4.3</td>
<td>X</td>
<td></td>
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<td>1.1.3 ACCC direct input to LHNB</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>1.1.4 LHNB educ’d re Aboriginal Health</td>
<td>X</td>
<td>X</td>
<td>??</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>1.1.5 LHNB Receives CCT</td>
<td>X</td>
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<td>X</td>
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<td>Additional sub-criteria</td>
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<td>Invited Aboriginal Guest</td>
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<td>X</td>
<td>Y</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>Aboriginal Health Agenda Item</td>
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<td>4.3</td>
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<td>Aboriginal Health Discussed</td>
<td>3.2/3.5</td>
<td>4.1.1</td>
<td>4.5.5/5.2</td>
<td>2.5</td>
<td>4.1/</td>
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<td>X</td>
<td>4.3</td>
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<tr>
<td>SLA Tier 1 &amp; 2 Aboriginal Health KPIs Discussed</td>
<td>X</td>
<td>4.5</td>
<td>4.7</td>
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<td>Aboriginal Membership of Brd Committees</td>
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### Summary of matters addressed:

**July 4th:**

**Agenda Item 3.2:** Adoption of WCHN Values, Vision and Branding – re: the tag line “CREATE Together”. **Action:** That the translation of the tag line into the Kaurna language be explored. It was raised that there are several other Aboriginal cultures and languages in SA so there is a need to ensure these are also captured. The CEO advised that advice is being sought from the Aboriginal Health Division (WCHN) and Elders.

In the ensuing Board observations and suggestions, *inter alia*, it was noted the Aboriginal smoking rates and the stop smoking programs that are proving successful with the Cancer Council SA needed to be further built upon.

**Agenda Item 3.5:** Adoption of Board Committees’ Terms of Reference – Among the matters raised by members was: the removal of newborns from families whilst in hospital was raised as a concern for the Aboriginal community. **Action:** That intervention orders under the *Children and Young People (Safety) Act 2017* and associated regulations be referred to the Clinical Governance Committee for further discussion and advice.

**Agenda Item 4.1.1:** Report from Chief Executive Officer – Following presentation of the CEO’s overview, comments and suggestions were made concerning, *inter alia*, a recent Syphilis outbreak which was noted to be occurring in various communities and that there is a need for increased
testing. Feedback was received from clinicians delivering services to Aboriginal clients indicating that they were not aware of the necessary prevention programmes. The question of whether the Network is actively contributing as part of the neonatal program was raised. Response: The COO agreed to take this item on notice and for the Board to note that regular visits to APY Lands occur with Dr Prue McEvoy (Department for Child Protection).

August 8th:

**Agenda Item 3.1:** Adoption of WCHN Values, Vision and Branding – The Board, *inter alia*, supported the preferred Aboriginal graphic device (1A) to represent CREATE together, subject to input from the Aboriginal Health Directorate and Strategic Operations Executive Committee.

**Agenda Item 4.1:** Report from the Chief Executive Officer – The CEO noted the success of NAIDOC week, particularly the Grand Round and invited panel members.

**Agenda Item 4.5:** Performance Report (Service agreement 2018-19) – The Chair noted the report that was distributed and read. **Action:** It was agreed that the CEO present some specific KPIs for Aboriginal Health to the Board such as, low birth weight in Aboriginal communities, neonatal mortality rates, to be discussed at the February 2020 board meeting.

**Agenda Item 7.1:** other Business – It was discussed how beneficial the site visits are prior to each Board meeting and the importance of scheduling these across the different WCHN locations. The CEO reported that September’s Board meeting will be held at South Terrace, Adelaide where CaFHS and Aboriginal Health Division are located. The services based at South Terrace will be visited prior to the September meeting commencing.

September 5th:

**Agenda Item 2.5:** Action List – The Chair noted that the action referring to Aboriginal KPIs has been brought forward to today’s meeting (Action 8.8. 19 – 12)

**Agenda Item 4.5.1:** Aboriginal Health Update. The Chair welcomed Jackie Ah Kit Director, Aboriginal health Division to the meeting. The Chair noted that the report that was distributed with the meeting papers and taken as read. The Chair invited the COO and the Director, Aboriginal Health to present the report and take questions from the Board.

Following discussion the Director, Aboriginal Health advised that tackling racism and discrimination is a current priority and this involves working with the reconciliation subcommittee to work with relevant networks to address this.

The Director Aboriginal Health advised that the Aboriginal Birthing Program should be prioritised as this is providing a healthy start to the lives of Aboriginal children.

The Director, Aboriginal Health also noted the focus on making this service and experience available to as many as possible and that the Department of Health and Wellbeing is working with WCHN’s Aboriginal Health team to develop a state-wide Aboriginal model of care. The Board noted the progress to date of actions outlined in the Aboriginal Health Action Plan.

**Agenda Item 4.5.2:** Aboriginal Health Scorecard. The Chair noted that the report that was distributed with the meeting papers and taken as read. The Chair invited the COO and the Director, Aboriginal Health to present the report and take questions from the Board.

The information presented in the draft Aboriginal Health Scorecard was discussed and it was requested that cardiac and stroke data be included and reported on the action plan. **Action:** The Director, Aboriginal Health to incorporate data on cardiac and stroke rates in the Aboriginal Health Scorecard. The Scorecard to be reported at each Strategic Operations Executive Committee and Aboriginal Health Steering Committee [meeting]. The Board noted the progress outlined in the draft Aboriginal Health Scorecard.

**Agenda Item 4.5.3:** Aboriginal Health Reconciliation Action Plan Evaluation - The Chair noted that the report that was distributed with the meeting papers and taken as read. The Chair invited the COO and the Director, Aboriginal Health to present the report and take questions from the Board.
The Board noted the progress outlined in the WCHN Reconciliation Action Plan (RAP) interim evaluation.

**Agenda Item 4.7**: Performance Report (Service Agreement) - The Chair noted the report that was distributed with the meeting papers and taken as read. The Chair invited the COO to present the report and take questions from the Board. The COO is advocating through the Service Agreement process, that in relation to the hearing test KPI this should be measured on the second scheduled test.

**Agenda Item 5.2**: Aboriginal Health System level information session - The Chair noted the report that was distributed with the meeting papers and taken as read. The Board:

- Noted that WCHN will be hosting a state-wide Aboriginal Health Community Forum
- Noted that the Board Chair, CEO and Aboriginal Health Expert Board Members will co-host the community forum
- Noted this forum is in addition to an information session being held on October 11 for Aboriginal Health Expert Board Members.

**November 7th:**

**Agenda Item 4.1**: Report from Chief Executive - The Chair noted the report that was distributed with the meeting papers and taken as read. General discussion regarding the nWCH project: The Chair requested to take on notice to follow-up with DCP to ascertain whether Aboriginal workers are involved in conducting the assessments with regard to the removal of infants. **Action**: The CEO to provide a copy of the documentation that is used at WCH as part of the recording of notification of infants to Director Miller. The Chair noted this item is to remain on the action list and collaboration with DCP on how children can be returned to parents.

**Agenda Item 4.3**: Finance and Performance Report - The Chair noted the report that was distributed with the meeting papers and taken as read. The Chair invited the CFO to present the report and take questions from the Board. **Action**: The Board Secretary to upload to Diligent the report on outpatient data regarding failure to attend rates. Including the scorecard with the Aboriginal health data in this area.

**Feb. 6th Agenda Item 4.3**: Aboriginal Health KPIs (Action 12 8/8/19 meeting) - The Chair noted the report that was distributed with the meeting papers and taken as read. The Chair invited the COO to present the report and take questions from the Board. The COO noted that the Aboriginal Health KPIs are being tracked through monthly performance meetings and also through the Aboriginal Health Division and will be reported to the Board on a quarterly basis. The Board discussed that the following KPIs were of particular interest: birth weights, gestational diabetes and smoking. The Board noted the progress outlined in the Aboriginal Health Scorecard.

**April. 2nd Agenda Item 4.3**: Finance and Performance Report - . The COO noted that the Aboriginal Health KPIs are being tracked through monthly performance meetings and also through the Aboriginal Health Division and will be reported to the Board on a quarterly basis. The Board discussed that the following KPIs were of particular interest: birth weights, gestational diabetes and smoking. The Board noted the revised format of the report that was very easy to read and interpret. The Board noted the progress outlined in the Aboriginal Health Scorecard.

2. **Board interaction with Aboriginal community**

Based on information contained in the Agenda and Minutes for the August 8th 2019 WCHNB meeting (Agenda Items 3.1 and 4.1), regarding the success of NAIDOC Week and the engagement of an Aboriginal artist to create a graphic device to represent CREATE.together, these two activities suggest a level of Board engagement with the Aboriginal community. **Score = 2 / 2**

3. **LHN Aboriginal Health performance indicators on Board agenda for every meeting**
At a number of WCHNB meetings (August 8th, Sept. 5th, Feb. 6th, and April 2nd), discussion took place concerning KPIs which could be incorporated into, for example, the Aboriginal Health Scorecard, and the Service Level Agreement. KPIs discussed included: low birth weights, gestational diabetes, neonatal mortality rates, smoking, a hearing test KPI, and data on cardiac and stroke rates. Presentation by the CEO on these KPIs would be in addition to Performance Reports as required by the SLA. At the April 2nd meeting (Agenda Item 4.3), the COO noted that the Aboriginal Health KPIs are being tracked through monthly performance meetings and also though the Aboriginal Health Division and will be reported to the Board on a quarterly basis. **Score = 2 / 2**

4. **Direct input to Board by LHN Aboriginal Community Consultative Committee or Aboriginal Expert by Experience**

The *WCHN Aboriginal Workforce Strategy 2018-2022* (p. 17) indicates a number of Aboriginal committees: the Aboriginal Health Steering Committee, Aboriginal Workforce Committee, the Reconciliation Committee and the Senior Aboriginal Leadership Committee. The Aboriginal Health Steering Committee is a Tier 1B Committee, chaired by the CEO and reporting directly to WCHN Strategic Executive Committee (p. 10). However, none of these committees appear to be community-based, and according to the agenda and minutes of the WCHNB meetings, no Aboriginal Community Consultative Committee has met directly with the Board. **Score = 0 / 2**

5. **LHN Board members are educated about Aboriginal health in their LHN**

Evidence is provided in the 5th September 2019 WCHN Board meeting Agenda Item 5.2 that the Board have been educated about Aboriginal health within the WCHN. The Board:

- Noted that WCHN will be hosting a state-wide Aboriginal Health Community Forum
- Noted that the Board Chair, CEO and Aboriginal Health Expert Board Members will co-host the community forum
- Noted this forum is in addition to an information session being held on October 11 for Aboriginal Health Expert Board Members.

**Score = 2 / 2**

6. **LHN Board members receive cultural learning training**

Based on information provided in the agenda and minutes of the WCHN Board meetings, Board members have not undergone cultural learning training. **Score = 0 / 2**

**Criterion: Aboriginal representation at board level**

7. **Aboriginal representation at board level**

The WCHN Board has eight members, two of whom identify as Aboriginal people. Information accessed 13/5/2020 at: [https://www.sahealth.sa.gov.au/wps/wcm/connect/f18befa6-a0f3-4ec6-af68-097283960e8b/Board+Fact+sheet+-+WCHN+Governing+Board.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-f18be.wav-a0f3-4ec6-af68-097283960e8b-n5ioVR2](https://www.sahealth.sa.gov.au/wps/wcm/connect/f18befa6-a0f3-4ec6-af68-097283960e8b/Board+Fact+sheet+-+WCHN+Governing+Board.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-f18be.wav-a0f3-4ec6-af68-097283960e8b-n5ioVR2) **Score = 10 / 10**

**Criterion: Inclusion in Executive Management Structure**

8. **A stand-alone Aboriginal Health Division**

The Aboriginal Health Division is the executive responsibility of the Chief Operating Officer, who also oversees eight other divisions and services, including Allied Health (*WCHN Annual Report 2018-19*, pp. 8 and 11) **Score = 0 / 5**

9. **Aboriginal LHN lead directly reports to the LHN CEO**

The Director of Aboriginal Health, who is an Aboriginal person, reports on a day-to-day basis to the Chief Operating Officer (*WCHN Annual Report 2018-19*, p. 8). However, the WCHN currently lists the

INDICATOR 2: POLICY IMPLEMENTATION

Criterion: Improving Aboriginal Health Outcomes

10. Explicitly identified as a strategic priority in LHN Strategic Plan

One of the Early Actions of the SA Health Strategic Plan 2017-2020 is that by June 2018 each Local Health Network will develop their Local Strategic Management Plan. The WCHN Local Strategic Management Plan will encompass our individual strategic priority plans, including this Aboriginal Health Plan to clearly identify and prioritise the needs of our Aboriginal babies, children, young people and women (WCHN Aboriginal Health Plan 2018-2022, p. 6). Score = 10 / 10

11. Aboriginal health outcome KPIs reflective of LHN key responsibilities identified in LHN Service Level Agreement

The WCHN Service Level Agreement 2018-2019, in Schedule 4: Performance Indicators and Targets contains four Aboriginal health-related KPIs already included in the metropolitan LHNs and for the WCHN, namely the Tier 2 KPIs: Left at Own Risk; DAMA; Aboriginal Employee Participation Rate; and Completion of the Aboriginal Cultural Competence Program (pp. 56-59). In the section designated for Aboriginal Health, there is only one KPI – DAMA, a Tier 2 KPI (p. 59). Some of the WCHN SLA KPIs include patient sub-sets, for example, the Emergency Department Tier 2 KPI: Left at Own Risk which measures three patient sub-sets: (i) % of all ED presentations; (ii) % of Aboriginal presentations; and (iii) % of Mental Health presentations – all with a target of <=3%

The purpose of the following two sub-criteria is to suggest additional KPIs to the existing four. Given the excess burden of disease within the Aboriginal community, and particularly in relation to cancer, heart and stroke, diabetes, kidney disease and mental health, there should be a range of both Tier 1 and 2 KPIs to address these health crises. The KPIs selected below, except for one (Indigenous status reporting), are already in the WCHN SLA, and use a sub-set for Aboriginal patients as employed above with regard to the Emergency Department Tier 2 KPI: Left at Own Risk. The basis for scoring is that, given the excess burden of disease among Aboriginal people and the health crises faced by many Aboriginal communities, these KPIs (with Aboriginal people constituting a KPI sub-set), should already be included in the current SLA. The fact that they are not results in a penalty score.

12. Tier 1 KPIs

* Elective Surgery: Tier 1 – Timely Admissions: % of elective surgery patients admitted within clinically recommended times; % of Aboriginal patients admitted for elective surgery within clinically recommended times. Target 100%.
* Emergency Department: Tier 1 – Length of Stay Less Than or Equal to 4 hours: % of presentations to an ED where the time from the presentation to the time of physical departure (i.e. the length of the ED stay) is less than or equal to 4 hours; % of Aboriginal presentations to an ED where the time from the presentation to the time of physical departure (i.e. the length of the ED stay) is less than or equal to 4 hours. Target >=90%
* Emergency Department: Tier 1 – Seen on Time: % of patients attending ED who commenced treatment within clinically accepted timeframes; % of Aboriginal patients attending ED who commenced treatment within clinically accepted timeframes. Target varies from 100% for Category 1 patients to >=70% for Category 5 patients.
* Mental Health: Tier 1 – Mental Health - Adult/Older Persons Acute 28 Day Readmission Rate: % of patients who had a readmission within 28 days of discharge (non-short stay); % of
Aboriginal patients who had a readmission within 28 days of discharge (non-short stay).
Target <=12%

- Mental Health: Tier 1 – Suicide of persons in Inpatient Mental Health Units: # of suicides that occur in admitted patient specialised mental health services; # of Aboriginal suicides that occur in admitted patient specialised mental health services. Target - Monitor

Score = 0 / 5

13. Tier 2 KPIs

- Aboriginal Health: Tier 2 – Indigenous status reporting: % ‘not stated’ on admission.
  Target: ?

- Mental Health: Tier 2 - Post Discharge Community Follow Up Rate: % of people receiving one or more mental health service contacts while in the community within 7 days post discharge; % of Aboriginal people receiving one or more mental health service contacts while in the community within 7 days post discharge. Target >=70%.

- Quality and Effectiveness: Tier 2 – Proportion of Babies with Neonatal Hearing Screening Undertaken within Benchmark Time: % of eligible infants screened within 1 month; % of eligible Aboriginal infants screened within 1 month. Target >=97%

- Clinical Pathways: Tier 2 - Rehabilitation: Individual Care Plan: % of rehabilitation patients who leave hospital with an individualised care plan; % of Aboriginal rehabilitation patients who leave hospital with an individualised care plan. Target >=90%.

- Occupancy: Tier 2 – Discharge Summary Transmission Rate: % of discharge summaries transmitted with 48 hours of separation; % of Aboriginal patient discharge summaries transmitted with 48 hours of separation. Target >=80%

Score = 0 / 5

Criterion: Community Engagement

14. Aboriginal community consultative body

One of the actions to support Goal One of WCHN’s Consumer, Carer and Community Engagement Strategy 2019-2024 (WCHN, 2019) is to: “Work in partnership with the WCHN Aboriginal Health Division to develop and implement strategies to increase Aboriginal consumer presentation in the WCHN governance framework, for example, create an Aboriginal Consumer Advisory Committee [Goal 1 Action 1.2] (p. 12). The Strategy names seven consumer operational committees which report through WCHN’s Senior Executive Leadership Team (SELT) (p. 21), so presumably, once established, the Aboriginal Consumer Advisory Committee (ACAC) will also report through SELT. On the basis that while the ACAC was not established when the Strategy was developed (it is also not mentioned in the WCHN Annual Report 2018-19), but there is a clear intention to do so, a penalty score is given. Score = 2 / 4

15. Aboriginal community engagement embedded within overall community engagement strategy

In accordance with Schedule 3A – Dissolution of Health Advisory Councils, of the Health Care (Governance) Amendment Bill 2019 (SA), WCHN Health Advisory Council was dissolved. WCHN’s Consumer, Carer and Community Engagement Strategy 2019-2024 (WCHN, 2019) has six goals: “GOAL ONE: To build strong, genuine and meaningful partnerships with Aboriginal consumers, organisations and communities to meet their healthcare needs” (p. 12). The goal supports the NSQHSS 2.13: The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs. It also supports the other standards (see Table 2). This standard is also incorporated into GOAL SIX: To have consumer, carer and community engagement across all facets of the design, implementation and evaluation of the new Women’s and Children’s Hospital (p. 20). Goal One supports seven actions to produce an outcome whereby: Aboriginal people, families and communities recognise WCHN as a culturally inclusive, responsive and respectful health service provider; and effective partnerships with Aboriginal community organisations are developed and maintained. This is evidenced by increased
engagement with Aboriginal consumers and communities both leading and influencing the
design and delivery of services, and broader policy decisions that impact them. (p. 12).
Aboriginal community engagement is embedded within WCHN’s overall community engagement
strategy. **Score = 4 / 4**

16. LHN Aboriginal community newsletter/e-letter/social media
No information has emerged via a search of the SA Health WCHN page (including its portals and their
links) of a WCHN Aboriginal community newsletter. However, WCHN has a Facebook page,
@WCHNetwork, with multiple entries and posts Aboriginal health related information. **Score = 1 / 3**

17. At least one Aboriginal community forum/meeting per year convened by the LHN chief
executive officer The WCHN SLA for 2018–2019, in Schedule 5: SA Health Performance Framework,
with regard to Performance Review Processes, includes processes for monitoring performance
against key deliverables (as outlined in Schedule 4 of the SLA). One of these processes includes
“Contract Performance Meetings to review performance, particularly in relation to the key indicators
(Tier 1), and to discuss and develop mitigation strategies where appropriate and to monitor
progress. At least one meeting will focus on Mental Health specific deliverables and KPIs and at least
one meeting will focus on Aboriginal Health specific deliverables and KPIs.” (WCHN, SLA 2018—19,
pp. 61-2). In the context of this sub-criterion, it would seem appropriate that the WCHN CEO hold an
Aboriginal community forum/meeting preparatory to the scheduled Contract Performance Meeting
with DHW at which the Aboriginal Health specific deliverables and KPIs are to be discussed. At its
Sept. 5th meeting (Agenda Item 5.2), with regard to an Aboriginal Health System level information
session, it was agreed that the Board Chair, CEO and Aboriginal Health Expert Board Members would
co-host a state-wide Aboriginal Health Community Forum. **Score = 3 / 3**

18. Reconciliation Action Plan
2017–2020 Continuing our Journey ... (WCHN, 2017). **Score = 3 / 3**

19. Aboriginal health professionals caring for patients included within clinical engagement
strategy A search of the SA Health website and the WCHN page (including its portals and their links)
did not find WCHN’s clinical engagement strategy. **Score = 0 / 3**

Criterion: Public Reporting and Accountability (via LHN website of annual report)

20. The SA Health website is the official portal to public health services, hospitals, health information
and health careers in South Australia, and which can also be accessed via its Facebook, Instagram
and Twitter accounts. The WCHN, in effect, does not have its own website. An internet search for
“Women’s and Children’s Health Network” will lead to the SA Health website
(www.sahealth.sa.gov.au) which provides a link to WCHN:
https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/o ur+local+health+networks/womens+and+childrens+health+network/womens+and+childrens+health +network. The WCHN page contains a number of portals. As at 7th June 2020, there are two WCHN
portals: (i) WCHN – Contact Details; and (ii) Freedom of Information - Women’s and Children’s
Health Network. Each portal provides links to enable access to additional information. There is no
portal presenting a snap-shot of the WCHN providing basic information about population
demographics (including the Aboriginal population and Traditional Owners), geographic region
served, brief description of the health workforce, a resident health profile/dashboard, and summary
of services provided. None of the information sought below is readily available on the WCHN page
(including its portals and their links) (“the WCHN page”) on the SA Health website. Information
regarding, for example, Aboriginal employment in the health workforce, cultural competency
training completion rates, and Aboriginal health outcome KPIs must be sought via other portals and links on the SA Health website.

The annual report referred to is the **WCHN Annual Report 2018-19**.

21. **Traditional Owner acknowledgement**
The WCHN page does not provide an acknowledgement of the State’s Traditional Owners. The WCHN Annual Report 2018-19 contains no acknowledgement of the Traditional Owners. It is conceded that there are many Traditional Owner groups throughout SA, however a general acknowledgement would be appropriate. However, such acknowledgement occurs in other Aboriginal specific WCHN documents:

> The Women’s and Children’s Health Network acknowledge Aboriginal people as the traditional owners of country throughout South Australia and that we respect their continuing connection to land, sea and community. We also pay our respects to the cultural authority of Aboriginal and Torres Strait Islander people from other areas of Australia who reside in South Australia (WCHN Aboriginal Workforce Strategy 2018 – 2022). **Score = 0 / 2**

22. **Improving Aboriginal health outcomes: (i) Separate section in report devoted to Aboriginal health**
The WCHN page does not provide a specific link for Aboriginal health. There is no separate section in the Annual Report, as indicated in the table of contents (pp. 2-3), or in the body of the report. Information concerning Aboriginal health is instead scattered in several locations within the report (WCHN Annual Report 2018-19, pp. 3, 7, 8, 18, 19, 30, 32) **Score = 0 / 3**

23. **Improving Aboriginal health outcomes: (ii) Reporting on KPIs contained in current service level agreement (SLA)**
The WCHN SLA 2018-19 Schedule 4 contains the following Aboriginal health specific KPIs:

**Performance Domain: Access and Flow**
- Emergency Department Tier 2 KPI: Left at Own Risk
  - Measure: % of Aboriginal presentations. Target <=3%

**Performance Domain: Safe and Effective Care**
- Aboriginal Health Tier 2 KPI: Aboriginal Patients Who Left Hospital Against Medical Advice
  - Measure: % of overnight Aboriginal and/or Torres Strait Islander patients who left hospital against medical advice. Target: <=4.5%

**Performance Domain: People and Culture**
- Workforce Tier 2 KPI: Aboriginal Employee Participation Rate
  - Measure: % of employees who identified as being of Aboriginal or Torres Strait Islander origin.
  - Target: >=4%
- Workforce Tier 2 KPI: Completion of the Aboriginal Cultural Competence Program
  - Measure: % of employees who have completed Aboriginal cultural competence training. Target: 100%

(WCHN, SLA 2018—19, pp. 56, 59). Performance against these KPIs is not reported on the NALHN page, nor in the Annual Report. **Score = 0 / 3**

24. **Improving Aboriginal health outcomes: (iii) Report on Aboriginal community engagement**
WCHN’s Aboriginal Health Plan 2018-2022 (WCHN, 2018a) contains five strategic priorities, one of which concerns: Engaging Aboriginal people, families and communities (pp. 24-5). While the Annual Report contains references to a “refreshed Consumer and Community Engagement Framework and strategy … released in September 2019” (p. 15), and the development of the WCHN Aboriginal Health Plan 2018-2022 (p. 19), no mention is made of, for example, any progress made in the Focus areas for action listed for the strategic priority regarding Aboriginal community engagement. The WCHN page does not provide information about Aboriginal community engagement activities, such
as, meetings that may have taken place with WCHN executives, or how engagement is taking place with its rural and remote Aboriginal communities. **Score = 0 / 3**

25. **Improving Aboriginal health outcomes:** (iv) **Report on Aboriginal specific National Safety and Quality Health Service Standards assessment**

In the Annual Report, WCHN records that one of its key objectives for 2018-19 was to: “Maintain health service standards to ensure ongoing accreditation under the National Safety and Quality Health Service Standards” (WCHN Annual Report 2018-19, p. 7). The WCHN SLA for 2018-2019, in Schedule 4: Performance Indicators and Targets includes a statement in relation to supporting the delivery of the Closing the Gap agenda and citing the NSQHSS, that: “In order to support the delivery of the Closing the Gap agenda, and implementation of the National Safety and Quality Health Service Standards related to Aboriginal and Torres Strait Islander health, wherever possible performance data will be collated for the population as a whole and for Aboriginal and Torres Strait Islander peoples.” (WCHN, SLA 2018—19, p. 52). However, none of this data is recorded in the WCHN annual report.

Table 2 lists six Aboriginal and Torres Strait Islander specific standards. Neither the WCHN page nor the annual report provide data on how these standards are being met. **Score = 0 / 3**

26. **Improving Aboriginal health outcomes:** (v) **Chronic disease management and care planning**

While WCHN is a member/partner of the South Australian Aboriginal Chronic Disease Consortium (SAACDC), no specific mention is made in the Annual Report of the SAACDC, or to the management of chronic diseases amongst Aboriginal women and children. While the WCHN is required and funded to deliver the Paediatric Model of Care for Chronic Pain management (WCHN SLA 2018-2019, p. 45), the WCHN page provides no information about chronic disease management and care planning for its Aboriginal patients. **Score = 0 / 3**

27. **Cultural learning completion rates**

Neither the WCHN page, nor the annual report mention the SA Health Aboriginal Cultural Learning Framework, or provide data on non-Aboriginal staff completion rates for the Cultural Learning Program for the three levels. **Score = 0 / 3**

28. **Aboriginal health division/unit placement on LHN organisational structure/chart**

The Directorate for Aboriginal Health and Directorate for Allied Health & Aboriginal Liaison are both located on the organisational chart (WCHN Annual Report 2018-19, p. 8). **Score = 1 / 1**

29. **Data on Aboriginal access to and delivery of services**

WCHN is funded to deliver a number of Closing the Gap health programs for Aboriginal women and children (see WCHN SLA 2018-19, pp. 45-48). The Annual Report makes reference to the Aboriginal Family Birthing Program provided in partnership between Aboriginal Maternal Infant Care workers and midwives, and the development of the WCHN Aboriginal Health Scorecard (WCHN Annual Report 2018-19, pp. 18 and 19). No data is provided on the utilisation of these and other services. **Score = 0 / 3**

30. **Aboriginal employment:** (i) **Aboriginal Workforce Framework (planning, recruitment, etc.)**

The Annual Report mentions that WCHN has in place its own Aboriginal Workforce Strategy 2018-2022 (WCHN 2018b) which addresses workforce planning, training and recruitment, etc. (WCHN Annual Report 2018-19, p. 19). **Score = 2 / 2**

31. **Aboriginal employment:** (ii) **Data on Aboriginal employment**

Despite having its own Aboriginal Workforce Strategy 2018-2022, the WCHN page provides no current data on Aboriginal employment in its workforce. The Annual Report also provides no data on
Aboriginal participation in the WCHN workforce. With respect to WCHN’s engagement with various employment opportunity programs, the Aboriginal employment program is not mentioned. Under the Nursing and Midwifery Graduate Recruitment – Transition to Professional Practice program, there were 36 graduate nurses and 15 graduate midwives employed, however, none were identified as being Aboriginal graduates (see WCHN Annual Report 2018-19, p. 21).  

Score = 0 / 3

32. Other recognition (e.g., awards, scholarships, etc.) 
Neither the WCHN page, nor the annual report have a section regarding staff awards, achievements, etc., including for Aboriginal staff.  
Score = 0 / 2

INDICATOR 3: SERVICE DELIVERY AND PARTNERSHIPS

Criterion: Aboriginal LHN Plan

33. Co-designed in partnership with ACCHO(s), or Aboriginal organisations, or Aboriginal Experts by Experience in LHN region 
The WCHN SLA, with regard to LHN accountabilities, holds that the LHN CEO is responsible for, inter alia, “Developing effective and working partnerships with Aboriginal Community Health and ensuring health needs of Aboriginal people are considered in all health plans, programs and models of care developed by the LHN.” (WCHN SLA 2018-2019, p. 10). The WCHN Aboriginal Health Plan 2018-2022 was developed after extensive consultation with Aboriginal Elders, communities and organisations including ACCHOs, and the Aboriginal Health Council of South Australia (AHCSA) (see pp. 14-17, and 43-44). The Plan comprises five Strategic Priorities, one of which involves Monitoring and Accountability, and includes as one of its focus areas for action: “Focussing on outcomes, we will support our directorates/divisions to develop action plans, linked to our Aboriginal Health Plan, which will have consistent elements in each plan” (p. 29). In terms of Next Steps – Where to from here?, it is intended that: “Each Executive Director will develop a specific action plan for their area, with progress reported quarterly to the Aboriginal Health Steering Committee and the Strategic Executive Committee. Leadership and monitoring will be provided by the Aboriginal Health Steering Committee and the Strategic Executive Committee” (p. 42).  
Score = 2 / 2

34. Partnership with ACCHO(s) in LHN region 
While partnerships with individual ACCHOs in the context of a statewide plan would not be appropriate, the fact that they and their peak body AHCSA were an integral part of creating the plan could constitute a level of partnership and cooperation.  
Score = 2 / 2

35. Commitment to Continuous Quality Improvement A commitment to CQI is evident in the Plan  
Score = 2 / 2

36. Co-designed KPIs 
Rather than an agreed set of KPIs, sets of focus areas for action were identified, some of which can be used to co-design KPIs.  
Score = 2 / 2

37. Clear statement of ACCHO and LHN responsibilities and conflicts 
Leadership and monitoring of the Plan will be provided by the WCHN’s Aboriginal Health Steering Committee and the Strategic Executive Committee. Whether the AHCSA has a role in leadership and monitoring is not stated.  
Score = 1 / 2

Criterion: Cultural Safety

38. Implementation of cultural safety policy/strategy 
In the WCHN Aboriginal Health Plan 2018-2022, it is noted that:
The Aboriginal Health Steering Committee recently endorsed the delivery of a series of cultural competency workshops. Subsequently, the Flinders University’s Poche Centre for Indigenous Health and Well-Being has begun to deliver the workshops to WCHN executive and middle-management staff. The workshops are currently being evaluated and will inform the design and delivery of future workshops to improve cultural competency (p. 11).

Evidence that WCHN has a strategy in place. **Score = 5 / 5**

### 39. Proportion of staff trained

The WCHN SLA for 2018-2019, in Schedule 4: Performance Indicators and Targets, there is a Tier 2 KPI for People and Culture performance domain regarding the workforce: Completion of the Aboriginal Cultural Competence Program, with the Measure: % of employees who have completed Aboriginal cultural competence training, with a Target of 100% (WCHN, SLA 2018—19, p. 59). In the WCHN Aboriginal Workforce Strategy the following statement occurs:

> WCHN acknowledges the importance of a culturally competent workforce and since 2011 has provided Aboriginal Cultural Respect Training (ACRT) to its staff. ACRT is mandatory, attendance for this training is recorded and compliance is monitored, at 7 February, 2018, the compliance rate was 85.98% (WCHN 2018b, p. 4).

Note that this is a slight improvement on the rate of 84.92% recorded on 8 November 2017 (WCHN, 2018a, p. 11). See also Note 27. Scoring is on the basis of 1 point = 0-20%; 2 = 21-40%; 3= 41-60%; 4 =61-80% and 81-100% = 5. **Score = 4.5 / 5**

**Criterion: Selected LHN health performance indicators reported publicly**

### 40. Estimated level of completion of Indigenous status – specifically the reporting of ‘not stated’ on admission

The WCHN SLA for 2018-2019, in Schedule 4: Performance Indicators and Targets, includes a statement in relation to supporting the delivery of the Closing the Gap agenda and citing the NSQHSS, that: “The LHN should implement processes to identify patients as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems.” (WCHN, SLA 2018—19, p. 53) The WCHN SLA does not have a KPI for addressing the estimated level of completion of Indigenous status. This would appear to breach NSQHSS Aboriginal and Torres Strait Islander specific standard 5.8 in relation to planning for comprehensive care (see Table 2). **Score = 0 / 3**

### 41. Discharges against medical advice (DAMA)

The WCHN SLA for 2018-2019, in Schedule 4: Performance Indicators and Targets, in relation to Safe and Effective Care in terms of Aboriginal Health, there is a Tier 2 KPI Aboriginal Patients Who Left Hospital Against Medical Advice, with the measure: % of overnight Aboriginal and/or Torres Strait Islander patients who left hospital against medical advice, with the target: <=4.5% (WCHN, SLA 2018—19, p. 59). In the Access and Flow performance domain with regard to the Emergency Department, there is also a Tier 2 KPI: Left at Own Risk, with the Measure which includes percentages of (i) all ED presentations, (ii) Aboriginal presentations, and (iii) Mental Health presentations, with the target for all three categories: <=3% (WCHN, SLA 2018—19, p. 56). The WCHN Annual Report 2018-2019 and the SA Health website WCHN page (and portals and their links) provide no information on the rates of DAMA within the Women’s & Children’s Hospital. **Score = 0 / 4**

### 42. Potentially preventable hospital admissions (PPHA)

The WCHN SLA for 2018-2019, in Schedule 4: Performance Indicators and Targets, in relation to Safe and Effective Care in terms of Quality and Effectiveness, there is a Tier 2 KPI for Potentially Preventable Admissions, with the Measure: % of total separations, with the Target: Monitor against
national rate. (WCHN, SLA 2018—19, p. 58). There is no specific KPI for potential preventable admissions for Aboriginal people. Score = 0 / 3

43. Access to mental health services as reported at service level agreement
Three Closing the Gap programs: Journey Home, KATU (Kunpungku Atunymankunytjaku Tjitji Uwarkara), and Strengthening Families are variously designed to provide culturally appropriate social and emotional wellbeing services and support for Aboriginal people (WCHN SLA 2018-2019, pp. 46-8). However, there is no KPI in the SLA to specifically monitor Aboriginal access to mental health services. Score = 0 / 3

44. Low birth-weight babies
While the Collaborative Approach Antenatal to 2 years (Closing the Gap) program is not specifically designed to reduce the number of low birth-weight Aboriginal babies, it will do so through the model of psycho-social care it provides to pregnant Aboriginal women and/or women having an Aboriginal infant (WCHN SLA 2018-2019, p. 45). However, there is no KPI in the SLA to monitor and reduce the incidence of low birth-weight Aboriginal babies. Score = 0 / 3

45. Healthcare outcome differential measures (eg, discharge summary timeliness)
There are no KPIs for healthcare outcome differential measures for Aboriginal people in the WCHN SLA 2018-19. Score = 0 / 4

INDICATOR 4: RECRUITMENT AND EMPLOYMENT

Criterion: Aboriginal health workforce development reporting

46. Implementation of Aboriginal workforce strategy
The WCHN Aboriginal Workforce Strategy 2018-2022 has been developed by the WCHN Aboriginal Workforce Sub-committee in response to the SA Health Aboriginal Workforce Framework 2017 – 2022 (WCHN 2018b, pp. 4 and 16). The WCHN’s Strategy is based on the principle that “the proportion of Aboriginal staff should be representative of the proportion of Aboriginal consumers using the services” (p. 8) The services identified are: the Women’s & Children’s Hospital, the Children and Family Health Service (CaFHS), Child and Adolescent Mental Health Service (CAMHS) and Youth Women’s Safety and Wellbeing Service (YWSWS). One of the significant finds of the Gap Analysis of WCHN’s Aboriginal workforce participation is the “lack of representation of Aboriginal staff in WCHN’s core disciplines of nursing, midwifery and medicine, given the significant impact these roles have on Aboriginal consumers and health outcomes” (p. 11). It is also noted in the Strategy that:

The Aboriginal workforce employed at WCHN has a very different occupational profile from the WCHN workforce more generally. This is reflected in the very small numbers of Aboriginal nurses, midwives, doctors and allied health professionals currently working at WCHN. These professions comprise nearly 75% of the total WCHN workforce, however, less than 30% of the Aboriginal workforce is employed within these professions. Aboriginal workforce is disproportionately skewed to administrative roles (60%) and Operational Services roles (11%) (p. 9).

An Aboriginal Workforce Sub-committee has been tasked to lead the workforce planning of key Aboriginal services across WCHN as informed by the WCHN Aboriginal Health Plan 2018-2022, and to provide strategic oversight to the development and implementation of new and emerging roles in the field of Aboriginal health (WCHN 2018b, p. 14). Score = 4 / 4

47. LHN KPI for Aboriginal employment
In the WCHN Aboriginal Workforce Strategy 2018-2022, it is noted that at November 2017 there were 65 WCHN employees who identified as Aboriginal, representing 1.7% of the total workforce (WCHN 2018b, p. 9). Recommendation 10 of the Strategy states that:
WCHN will implement a 4% Aboriginal employment target across the Network consistent with Office for Public Sector identification priorities. This will be a staged strategy with priority given to nursing and midwifery, and interim targets set by, and reported to, the Aboriginal Workforce Sub-committee (p. 14).

Recommendation 8 of the Strategy states that: WCHN [is] to improve Aboriginal employee identification through HR systems, and explore benefits of regular reporting on its Aboriginal workforce (p. 14).

The WCHN SLA for 2018–2019, in Schedule 4: Performance Indicators and Targets, there is a Tier 2 KPI for People and Culture regarding the workforce: Aboriginal Employee Participation Rate: % of employees who identified as being of Aboriginal or Torres Strait Islander origin, with a target of >=4%. (WCHN, SLA 2018—19, p. 59). Elsewhere, with regard to Aboriginal Health Services “WCHN is required to achieve a minimum of 4% Aboriginal and Torres Strait Islander employment in the health system” (p. 21). The Workforce Information Report 2018–19 provides the following employment data for WCHN (as at 30 June 2019): FTE = 2,762; Total head count = 3,673 (female, male and other); Aboriginal employees = 71 (OCPSE 2019, p. 50). However, it is unclear whether the number of Aboriginal employees is based on the FTE data, or on the head count data. In the absence of clarification in the report, it is assumed that the number of Aboriginal employees is included in the head count data, which include persons counted as employees in a range of circumstances, including National Indigenous Cadetship Program (NICP) participants who are undertaking a 12-month temporary placement (OCPSE 2019, p. 55). The percentage of Aboriginal employees for the FTE and Head Count totals are: 2.57% and 1.93%. Score = 2.5 / 4

48. Number of Aboriginal health practitioners, health workers and liaison officers
In the WCHN Aboriginal Workforce Strategy 2018-2022, it is noted that at November 2017, the Aboriginal workforce is significantly under-represented within WCHN’s acute services, with less than 0.5% of the workforce in this area being Aboriginal. Community /non-hospital areas had a higher proportion of the workforce identifying as Aboriginal (just under 5%) (p. 9). It is assumed that this sector of the workforce is predominantly comprised of Aboriginal health practitioners, health workers and liaison officers. Based on an overall benchmark 4% target of Aboriginal employment for this group of Aboriginal employees in the workforce, Score = 3 / 3

49. Number of identified Aboriginal positions
The WCHN Aboriginal Workforce Strategy 2018-2022 did not provide data on the number of identified Aboriginal positions within the WCHN workforce. Score = 0 / 3

50. Number of salary bands occupied by Aboriginal employees
The WCHN Aboriginal Workforce Strategy 2018-2022, did not provide data on the number and range of salary bands occupied by Aboriginal employees within WCHN. Score = 0 / 3

51. Number of long term Aboriginal employees
In the WCHN Aboriginal Workforce Strategy 2018-2022, it is noted that at November 2017, Aboriginal employees have, on average, been with the organisation for approximately half the time of non-Aboriginal employees. Average length of service for the Aboriginal workforce is five years compared with 10 years for the non-Aboriginal workforce (WCHN, 2018b, p. 9). Score = 1.5 / 3

Criterion: Aboriginal participation in the health workforce

52. Administrative
In the WCHN Aboriginal Workforce Strategy 2018-2022, in the administrative classification, 5.4% of the employees identify as Aboriginal, and where Aboriginal specific roles (e.g. Aboriginal Cultural Consultants) contribute to the higher percentages (WCHN 2018b, p. 11). Based on an overall benchmark 4% target of Aboriginal employment in the workforce, Score = 3 / 3.
53. **Medical Professional**  
Medical professionals represent 12% of WCHN’s employees. The Aboriginal participation rate in this group is less than 1% (0.2%) ([WCHN Aboriginal Workforce Strategy 2018-2022](#), p. 11). Based on an overall benchmark 4% target of Aboriginal employment in the workforce, **Score = 0 / 4**

54. **Nurses/Midwives**  
While nursing and midwifery professional account for almost 50% of all WCHN employees, the Aboriginal participation rate is less than 1% (0.6%) ([WCHN Aboriginal Workforce Strategy 2018-2022](#), p. 11). Based on an overall benchmark 4% target of Aboriginal employment in the workforce, as Aboriginal nurses and midwives constitute less than 1%, **Score = 0.5 / 4.**

55. **Operational Services**  
A higher proportion (6%) of Aboriginal staff work in the Operational Services classification. This classification only represents 3.3% of the total workforce, however, it is used for some Aboriginal clinical roles (e.g. Aboriginal Maternal Infant Care Workers) ([WCHN Aboriginal Workforce Strategy 2018-2022](#), p. 11). Based on an overall benchmark 4% target of Aboriginal employment in the workforce. **Score = 3 / 3**

56. **Allied Health/Scientific/Technical**  
Allied Health professionals represent 12% of WCHN employees, with the Aboriginal participation rate of 1.5% ([WCHN Aboriginal Workforce Strategy 2018-2022](#), p. 11). Based on an overall benchmark 4% target of Aboriginal employment in the workforce. **Score = 1 / 3**

57. **Other**  
The [WCHN Aboriginal Workforce Strategy 2018-2022](#) (p. 11) provided no data for this category. **Score = 0 / 3**

**INDICATOR 5: FINANCIAL ACCOUNTABILITY AND REPORTING – CLOSING THE GAP FUNDING**

In the [WCHN Service Level Agreement 1 July 2018 – 30 June 2019](#) (WCHN SLA), with regard to the provision of Aboriginal Health Services:  
WCHN provides services specifically targeting Aboriginal people, including those provided through the Closing the Gap Program (funding until June 2020). Each LHN have brokered schedules (agreements) outlining additional funding to support programs contributing to Closing the Gap and are required to provide bi-annual updates on Key Performance Indicators (KPIs) and milestones contained within the schedules and which will be reviewed at LHN Contract Meetings (p. 21).  
WCHN participates in the South Australian Aboriginal Chronic Disease Consortium to progress the three statewide strategies regarding cancer control, heart and stroke, and diabetes, and to consider opportunities to reorientate or reform services aligned with these strategies (p. 21).  
WCHN receives specific purchasing and funding commitments for the following identified service programs:  
- Chronic Pain Model of Care  
- Collaborative Approach Antenatal to 2 years (Closing the Gap) - $968,770  
- Journey Home (Closing the Gap) - $609,041  
- KATU (Kunpungku Atunymanunytyjaku Tjitji Uwarkara) (Closing the Gap) - $907,445  
- Strengthening Families (Closing the Gap) - $648,781  
- Under 8’s Ear Health (Closing the Gap) - $226,850.75 (pp. 45-48)

**Criterion:** Commonwealth contributions for Aboriginal health programs to LHN
58. **Commonwealth contributions for Aboriginal health programs to LHN**
Commonwealth contributions for Aboriginal health programs at WCHN are not identified in the WCHN Annual Report 2018-2019 or on the SA Health website WCHN page (including its portals and their links). **Score = 0 / 10**

**Criterion: South Australian contributions to Aboriginal specific services and programs including activity-based funding loading for Aboriginal patients**

59. **Reporting on contributions for Aboriginal specific health services and programs including activity-based funding loading**
The WCHN Annual Report 2018-2019 and the SA Health website WCHN page (including its portals and their links) contain no data on South Australian contributions to Aboriginal specific health services and programs **Score = 0 / 10**

**WCHN documents consulted**

- *Service Level Agreement* (1 July 2018 – 30 June 2019)
- *Annual Report 2018-19*
- *Annual Report 2017-18*
- *Health Advisory Council (HAC) Annual Report 2017-18*
- Governing Board Meetings: *Agenda* 4 July 2019 / *Minutes* 4 July 2019
- *WCHN Health Advisory Council Inc. Constitution*
- *Disability Access and Inclusion Plan 2019-2023*
- *Aboriginal Health Plan 2018-2022* (WCHN 2018a)
- *Aboriginal Workforce Strategy 2018-2022* (WCHN 2018b)
- *WCHN Facebook page* - @WCHNetwork

**WCHN documents not sighted**

- WCHN Clinical Engagement Strategy
1.14 SA country LHNs

1.14.1 Barossa Hills Fleurieu Local Health Network (BHFLHN)

BAROSSA HILLS FLEURIEU LOCAL HEALTH NETWORK (BHFLHN) MATRIX AUDIT FY2019-June 2020

(1)

<table>
<thead>
<tr>
<th>Key Indicators and Criteria</th>
<th>Scoring</th>
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<tr>
<td><strong>1. Participation in LHN governance</strong></td>
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<tr>
<td><strong>1.1 Good governance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1.1 Board interaction with Aboriginal community (2)</td>
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<td>1.1.2 LHN Aboriginal health performance indicators on Board agenda for every meeting (3)</td>
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<td>1.1.3 Direct input to Board by LHN Aboriginal Community Consultative Committee or Aboriginal Experts by Experience (4)</td>
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<td>1.1.4 LHN Board members are educated about Aboriginal health in their LHN (5)</td>
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<td>1.1.5 LHN Board members receive cultural learning training (6)</td>
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<td><strong>1.2 Aboriginal representation at board level</strong></td>
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<tr>
<td>Aboriginal representation at board level (7)</td>
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<tr>
<td><strong>1.3 Inclusion in Executive Management Structure</strong></td>
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<td>1.3.1 A stand-alone Aboriginal Health Division (8)</td>
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<td>1.3.2 Aboriginal LHN lead directly reports to the LHN CEO (9)</td>
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<tr>
<td><strong>TOTAL</strong></td>
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<td>8</td>
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</table>

| **2. Policy Implementation**                                                                |         |       |
| **2.1 Improving Aboriginal Health Outcomes**                                               |         |       |
| 2.1.1 Explicitly identified as a strategic priority in LHN Strategic Plan (10)              | 10      | 5     |
| 2.1.2 Aboriginal health outcome KPIs reflective of LHN key responsibilities identified in LHN Service Agreement (11) |         |       |
| (i) Tier 1 KPIs (12)                                                                       | 5       | 0     |
| (ii) Tier 2 KPIs (13)                                                                       | 5       | 0     |
| **2.2 Community engagement**                                                                |         |       |
| 2.2.1 Aboriginal community consultative body (14)                                          | 4       | 1     |
| 2.2.2 Aboriginal community engagement embedded within overall community engagement strategy (15) | 4       | 0.5   |
| 2.2.3 LHN Aboriginal community newsletter/e-letter/social media (16)                        | 3       | 1     |
| 2.2.4 At least one Aboriginal community forum/meeting per year convened by the LHN chief executive officer (17) | 3       | 3     |
| 2.2.5 Reconciliation Action Plan (18)                                                       | 3       | 1     |
| 2.2.6 Aboriginal health professionals caring for patients included within clinical engagement strategy (19) | 3       | 1.5   |
| **2.3 Public Reporting and Accountability (via LHN website or annual report)**             |         |       |
| 2.3.1 Traditional Owner Acknowledgement (21)                                               | 2       | 0     |
| 2.3.2 Improving Aboriginal health outcomes                                                  |         |       |
| (i) Separate section in report devoted to Aboriginal health (22)                            | 3       | 0     |
| (ii) Reporting on KPIs contained in current service level agreement (SLA) (23)             | 3       | 0     |
| (iii) Report Aboriginal community engagement (24)                                          | 3       | 0     |
| (iv) Report on Aboriginal specific National Safety and Quality Health Service Standards Assessment (25) | 3       | 0     |
(v) Chronic disease management and care planning (26) 3  0
2.3.3 Cultural learning completion rates (27) 2  0

2.3.4 Aboriginal health division/unit placement on LHN organisational structure/chart (28) 1  0
2.3.5 Data on Aboriginal access to and delivery of services (29) 3  0
2.3.6 Aboriginal employment
  (i) Aboriginal Workforce Framework (planning, recruitment, etc) (30) 2  0
  (ii) Data on Aboriginal employment (31) 3  0
2.3.7 Other recognition (e.g., awards, scholarships, etc.) (32) 2  0

TOTAL 70 13

3. Service delivery and partnerships

3.1 Aboriginal LHN Plan

3.1.1 Co-designed in partnership with ACCHO(s), or other Aboriginal organisations, or Aboriginal Experts by Experience in LHN region (33) 2  0
3.1.2 Partnership with ACCHO(s) in LHN region (34) 2  0
3.1.3 Commitment to Continuous Quality Improvement (35) 2  0
3.1.4 Co-designed KPIs (36) 2  0
3.1.5 Clear statement of ACCHO and LHN responsibilities and conflicts (37) 2  0

3.2 Cultural safety

3.2.1 Implementation of cultural safety policy/strategy (38) 5  0
3.2.2 Proportion of staff trained (39) 5  0

3.3 Selected LHN health performance indicators reported publicly

3.4.1 Estimated level of completion of Indigenous status – specifically the reporting of ‘not stated’ on admission (40) 3  0
3.4.2 Discharged against medical advice (DAMA) (41) 4  0
3.4.3 Potentially preventable hospitalisations (PPHA) (42) 3  0
3.4.4 Access to mental health services as reported at service level agreement (43) 3  0
3.4.5 Low birth-weight babies (44) 3  0
3.4.6 Healthcare outcome differential measures (eg. Discharge summary timeliness) (45) 4  0

TOTAL 40 0

4. Recruitment and employment

4.1 Aboriginal health workforce development reporting

4.1.1 Implementation of Aboriginal workforce strategy (46) 4  0
4.1.2 LHN KPI for Aboriginal employment (47) 4  0
4.1.3 Number of Aboriginal health practitioners, health workers and liaison officers (48) 3  0
4.1.4 Number of identified Aboriginal positions (49) 3  0
4.1.5 Number of salary bands occupied by Aboriginal employees (50) 3  0
4.1.6 Number of long-term Aboriginal employees (51) 3  0

4.2 Aboriginal participation in the health workforce

4.2.1 Administrative (52) 3  0
4.2.2 Medical Professionals (53) 4  0
4.2.3 Nurses/Midwives (54) 4  0
4.2.4 Operational Services (55) 3  0
4.2.5 Allied Health/Scientific/Technical (56) 3  0
4.2.6 Other (57)

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5. Financial Accountability and Reporting: Closing the Gap Funding

5.1 Commonwealth contributions for Aboriginal health programs to LHN

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<tr>
<th>Commonwealth contributions for Aboriginal health programs to LHN (58)</th>
<th>Total out of 10</th>
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<tbody>
<tr>
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</table>

5.2 South Australian contributions to Aboriginal specific health services and programs including activity-based funding loading for Aboriginal patients

<table>
<thead>
<tr>
<th>Reporting on contributions for Aboriginal specific health services and programs (59)</th>
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<tr>
<th><strong>TOTAL</strong></th>
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<table>
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<tr>
<th><strong>Total Score</strong></th>
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Institutional Rating scored against criteria

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<th>120-159</th>
<th>80-119</th>
<th>40-79</th>
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<tr>
<td>Evidence of Inst. Racism:</td>
<td>Very Low</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
<td>Very High</td>
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Notes:

1. **Barossa Hills Fleurieu Local Health Network (BHFLHN)**

The BHFLHN is responsible for delivering core health services to around 205,000 people living within the Adelaide Hills, Barossa Valley, Fleurieu Peninsula and Kangaroo Island. Core health services are provided by four medium health units and supported by several smaller sites and a range of community-based facilities. The four medium health units are: Mount Barker District Soldiers’ Memorial Hospital; Gawler Health Service; Barossa Health Service; and Southern Fleurieu Health Service (BHFLHN SLA 2019-2020, p. 21). BHFLHN is the host LHN of the Rural and Remote Mental Health Service for country SA. Based on 2011 Census data, Aboriginal people constitute about 1.0% of the total population of the BHFLHN region (CHSALHN 2015a, p. 19). Assuming that that percentage remains roughly the same, currently there would be about 2,000 Aboriginal people in the BHFLHN region (cf 1,729 - 2011 Census).

The BHFLHN operates on the lands of the Ngadjuri (Kapunda and Tanunda), Peramangk (Angaston, Mount Barker), Ngarrindjeri (Victor Harbour), and Kaurna (Adelaide Plains) First Peoples. There are no ACCHOs operating within the BHFLHN region. As at January 2018, the region now served by the BHFLHN had 28 Aboriginal Experts by Experience (HPCSA, 2019, p. 25).

Aboriginal Health is included among the range of inpatient health services available at two of five the BHFLHN medium site facilities at Gawler and South Coast (Southern Fleurieu Health Service (BHFLHN Service Agreement 2019-2020, p. 50).

Because the BHFLHN came into effect as an LHN in its own right on 1 July 2019, many key documents relied upon for the conduct of this audit, such as the BHFLHN Strategic Plan, the Clinicians and Workforce Engagement Strategy, and the Consumers and Community Engagement Strategy are still under development. Another key document, the BHFLHN annual report for 2019-2020 will not be available until after 30 September 2020. In the absence of these documents, the audit relies primarily on the BHFLHN Governing Board meeting agenda and minutes, the 2018-2019 annual reports of the LHN’s six HACs, and information gained from the BHFLHN page and portals.
located on the SA Health website. Scores have been adjusted to reflect the availability of relevant documents.

**INDICATOR 1: PARTICIPATION IN LHN GOVERNANCE**

**Criterion: Good governance**

The following chart provides an overview of the BHFLHNB references to and discussion concerning Aboriginal health and related matters. In addition to the listed sub-criteria, other headings have been included to cover information not readily assigned to the listed sub-criteria. Where Aboriginal health matters have been discussed, the Agenda item numbers have been indicated in the monthly columns. Also note that the Acknowledgement of Country is a standing item under Agenda Item 1.1 in all meetings, and is not included in the chart below.

**Legend:**
- x = no information relevant to the sub-criterion heading was provided.
- ? = minutes were not uploaded onto SA Health website at the time of this analysis (30 May 2020).
- AHEMGB – Aboriginal Health Expert Member of Governing Board (this person may/may not be an Aboriginal person)
- Tier 1 committee = a Board committee which reports to the Board
- Tier 2 committee = an internal LHN committee which reports to the CEO
- Tier 3 committee = a community-based committee established in accordance with, for example, a LHN consumer and community engagement plan/framework/strategy and which can provide input to, or respond to the LHNB or LHN CEO.

### BHFLHN Board meetings: good governance sub-criteria summary for July 2019 – April 2020

<table>
<thead>
<tr>
<th>Meeting:</th>
<th>July 3rd</th>
<th>Aug. 22nd</th>
<th>Sept. 26th</th>
<th>Oct. 23rd</th>
<th>Nov. 20th</th>
<th>Dec. 18th</th>
<th>Feb. 26th</th>
<th>Mar 27th</th>
<th>April 24th (V)</th>
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<tbody>
<tr>
<td><strong>Sub-criteria:</strong></td>
<td></td>
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<td></td>
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<tr>
<td>1.1.1 LHNB inter. With Aboriginal Com.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>1.1.2 AHPI on Mtg Agenda</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>1.1.3 ACCC direct input to LHNB</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>1.1.4 LHNB educ’d re Aboriginal Health</td>
<td>X</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>1.1.5 LHNB Receives CCT</td>
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<td>3.1</td>
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<td><strong>Additional sub-criteria</strong></td>
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<td>Aboriginal Membership of Brd Committees</td>
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**Summary of matters addressed:**

**July 3rd:**
**Agenda Item 3.1:** Committees of the Governing Board. In relation to the Community and Consumer Engagement Committee, the AHEMGB was to be involved in formulating a recommendation to the Board, based on further investigation and consultation with the six BHFLHN HACs.

**Agenda Item 3.2:** Clinical Due Diligence and Transition Arrangements. The Board noted an update on the Clinical Due Diligence and transition arrangements for the dissolution of Country Health SA Local Health Network and realignment of functions to new Local Health Networks and the Rural Support Services. The Board Resolved: To facilitate continuation of business, the Barossa Hills Fleurieu Local Health Network Governing Board approve the following:

1. Adoption of all policy and procedure documents developed and approved by the previous Country Health SA Local Health Network for use within the Barossa Hills Fleurieu LHN from 1 July 2019.
2. That the term policy and procedure documents includes any policy, procedure, guideline, protocol, manual, work instruction, and governance framework.
3. That the documents are approved for use in their current form with advice provided to staff on the interpretation requirements for any reference within the documents to the entity CHSALHN and/or CHSA LHN positions that no longer exist.

All policy and procedure documents will be subject to review over time.

**Aug. 22nd Agenda Item 4.1:** CEO Report. Among topics covered as a strategic priority was an Aboriginal Health Committee. [No indication whether this is to be a Board Committee or a Tier 2 committee]

**Oct. 23rd Agenda Item 3.1:** Cultural Safety Training. The Board agreed to that Governing Board Members undertaking 1 day Cultural Safety Training in March 2020.

**Feb. 26th Agenda Item 2.2:** Aboriginal Health Community Consultation. The Board supported the Aboriginal Health Team and Aboriginal Community in hosting three Community Forums / Consultations in Gawler, Mount Barker and Victor Harbour.

**March 27th:**

**Agenda Item 3.4:** Cultural Safety Training. The Board supported the facilitation of Cultural Safety Training with the Governing Board, to be undertaken at a later date [due of COVID-19 pandemic]

**Agenda Item 4.3:** Board Review – Composition / Succession Planning. The Board noted the current composition and board member terms and discussed the appointment of a person with Indigenous health knowledge and experience. [Note that AHEMGB was listed on the Agenda sheet, but not on the Minutes sheet]

**April 24th Agenda Item 3.4:** Aboriginal Maternal Infant Care Funding. The Board approved: 1. the CEO to convene a meeting with the other two affected regional LHNs with the Aboriginal Health Directorate within DHW; 2. The CEO to write to the DHW, Commissioning and Performance seeking a 12 month extension of total funding; 3. Discuss with the DHW the adjustment of the Commissioning limit to reflect the transition from Country Health SA LHN to six regional LHNs; and 4. If options 1-3 are not successful, approve a funding commitment annually of $82,000 to the Aboriginal Family Birthing Program at Gawler Health Service.

2. **Board interaction with Aboriginal community**

   Based on the information provided in the Agenda and the Minutes, there is no evidence of BHFLHN interaction with the Aboriginal community/ies within the LHN region [refer PSAHMT Note 4]. **Score = 0 / 2**

3. **LHN Aboriginal Health performance indicators on Board agenda for every meeting**
Based on the information provided in the Agenda and the Minutes, there is no evidence of Aboriginal Health performance indicators being provided to or being discussed at BHFLHNB meetings [refer PSAHMT Note 5]. **Score = 0 / 2**

4. **Direct input to Board by LHN Aboriginal Community Consultative Committee or Aboriginal Experts by Experience**

Based on the information provided in the Agenda and the Minutes, there is no evidence of the Aboriginal Community Consultative Committee (a Tier 3 committee) providing input at BHFLHNB meetings. It is noted that the BHFLHN Board, at its August 22nd meeting discussed, as a strategic priority, the establishment of an Aboriginal Health Committee. However, it is not clear whether this would be a Tier 1, 2 or 3 committee [refer SAHMT Note 6]. The fact that the matter of an Aboriginal Health Committee was raised is balanced against the lack of evidence of any direct input to the board by an Aboriginal community-based consultative committee or an Aboriginal Expert by Experience. **Score = 1 / 2**

5. **LHN Board members are educated about Aboriginal health in their LHN**

Based on the information provided in the Agenda and the Minutes, there is no evidence of BHFLHNB members being educated/informed of the health status and range of health concerns of the Aboriginal community/ies within the LHN via, for example, a presentation from the LHN’s E/D Aboriginal Health [refer PSAHMT Note 7]. **Score = 0 / 2**

6. **LHN Board members receive cultural learning training**

Based on the information provided in the Agenda and the Minutes, at its August 23rd meeting the Board agreed that its members should undertake a one day of Cultural Safety Training in March 2020. However, as recorded in the March 27th Minutes, the training had to be postponed to a later date due to the COVID-19 pandemic. Based on clear intent, full points. **Score = 2 / 2**

**Criterion: Aboriginal representation at board level**

7. **Aboriginal representation at board level**

The 6 member BHFLHNB appointed by the Minister included a member with very significant expertise, knowledge and experience in relation to Aboriginal health - the AHEMGB. However, it is not known at this point whether that person identifies as an Aboriginal person. It is also noted that, as at 6th June 2020, the BHFLHNB had no AHEMGB – see: https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+local+health+networks/barossa+hills+fleurieu+local+health+network/the+barossa+hills+fleurieu+local+health+network+board

This situation appears to have persisted since March 2020, and was of concern to the BHFLHN in its March 27th meeting which included a Board review regarding composition / succession planning. The Board noted the current composition and board member terms and discussed the appointment of a person with Indigenous health knowledge and experience. Given that the Aboriginal status of the original board appointee is currently unknown, and that there currently is no AHEMGB, no points are awarded. **Score = 0 / 10**

**Criterion: Inclusion in Executive Management Structure**

8. **A stand-alone Aboriginal Health Division**

Based on the Regional LHN Leadership Structure provided in the Establishment of Regional Local Health Networks: Detailed Design Proposal – Consultation Paper (CHSALHN 2019, p. 6) the Division of Aboriginal Health exists as a stand-alone division within the BHFLHN organisational structure. **Score = 5 / 5**
9. **Aboriginal LHN lead directly reports to the LHN CEO**

According to the Regional LHN Leadership Structure (see Note 8), the Director of Aboriginal Health reports directly to the BHFLHN CEO. However, the BHFLHN page on the SA Health website provides no links to information (brief bios) concerning the members of the executive management group, as there is for the BHFLHN Board members. Thus there is no information confirming whether the Director of Aboriginal Health is an Aboriginal person or not. Given the emphasis placed on the importance of the Director of Aboriginal Health being an Aboriginal person by the Expert Workshop, failure to provide this information via the BHFLHN page on the SA Health website results in a penalty score.  

**Score = 0 / 5**

**INDICATOR 2: POLICY IMPLEMENTATION**

**Criterion: Improving Aboriginal Health Outcomes**

10. **Explicitly identified as a strategic priority in LHN Strategic Plan**

The BHFLHN Strategic Plan is under development and is still to be published [see BHFLHN 24th April meeting Minute 2.3 in which the Board endorsed the engagement of LeadershipHP Pty Ltd to develop a BHFLHN Strategic Intent document with a draft to be presented at its June meeting]. While information is not currently available regarding the extent to which Aboriginal health outcomes are identified as a strategic priority in the BHFLHN strategic plan, and given the priorities given to and delays caused by the COVID-19 pandemic, a discretionary score is awarded.  

**Score = 5 / 10**

11. **Aboriginal health outcome KPIs reflective of LHN key responsibilities identified in LHN Service Agreement**

The BHFLHN *Service Agreement 2019-2020*, in Schedule 5: Performance Monitoring contains two Aboriginal health-related KPIs also included in the regional LHN Service Agreements, namely the Tier 2 KPIs: DAMA and Aboriginal Employee Participation Rate (pp. 43-45).

The purpose of the following two sub-criteria is to suggest additional Aboriginal Health related KPIs to the existing two. Given the excess burden of disease within the Aboriginal community, and particularly in relation to cancer, heart and stroke, diabetes, kidney disease and mental health, there should be a range of both Tier 1 and 2 KPIs to address these health crises. The basis for scoring is that, given the excess burden of disease among Aboriginal people and the health crises faced by many Aboriginal communities, these KPIs (with Aboriginal people constituting a KPI sub-set), should already be included in the current SA. The fact that they are not results in a penalty score.

12. **Tier 1 KPIs**

* Elective Surgery: Tier 1 – Timely Admissions: % of elective surgery patients admitted within clinically recommended times; % of Aboriginal patients admitted for elective surgery within clinically recommended times. Target 100%.

* Elective Surgery: Tier 1 – Overdue Patients: # of Category 1, 2 and 3 patients; # of Category 1, 2 and 3 Aboriginal patients. Target 0

* Emergency Department: Tier 1 – Seen on Time: % of patients attending ED who commenced treatment within clinically accepted timeframes; % of Aboriginal patients attending ED who commenced treatment within clinically accepted timeframes. Target varies from 100% for Category 1 patients to >=70% for Category 5 patients.

* Mental Health: Tier 1 – Mental Health - Adult/Older Persons Acute 28 Day Readmission Rate: % of patients who had a readmission within 28 days of discharge (non-short stay); % of Aboriginal patients who had a readmission within 28 days of discharge (non-short stay). Target <=12%
* Mental Health: Tier 1 – Suicide of persons in Inpatient Mental Health Units: # of suicides that occur in admitted patient specialised mental health services; # of Aboriginal suicides that occur in admitted patient specialised mental health services. Target - Monitor

**Score = 0 / 5**

13. Tier 2 KPIs

* Aboriginal Health: Tier 2 – Indigenous status reporting: % ‘not stated’ on admission. Target: ?
* Mental Health: Tier 2 - Post Discharge Community Follow Up Rate: % of people receiving one or more mental health service contacts while in the community within 7 days post discharge; % of Aboriginal people receiving one or more mental health service contacts while in the community within 7 days post discharge. Target >=70%.
* Quality and Effectiveness: Tier 2 Potentially Preventable Admissions: % of total separations; % of total Aboriginal separations. <=8%.
* Clinical Pathways: Tier 2 - Rehabilitation: Individual Care Plan: % of rehabilitation patients who leave hospital with an individualised care plan; % of Aboriginal rehabilitation patients who leave hospital with an individualised care plan. Target >=90%.
* Occupancy: Tier 2 – Discharge Summary Transmission Rate: % of discharge summaries transmitted with 48 hours of separation; % of Aboriginal patient discharge summaries transmitted with 48 hours of separation. Target >=80%

**Score = 0 / 5**

**Criterion: Community Engagement**

14. Aboriginal community consultative body

Based on the information provided in the Agenda and the Minutes, the BHFLHN Board, at its August 22nd meeting discussed, as a strategic priority, the establishment of an Aboriginal Health Committee. However, it is not clear whether this would be a Tier 1, 2 or 3 committee. However, there has been no further discussion by the Board in relation to the Aboriginal Health Committee so whether it exists or not, or its Tier level, are not known. **Score = 1 / 4**

15. Aboriginal community engagement embedded within overall community engagement strategy

The Aboriginal community has two avenues to engage with the BHFLHN: through the BHFLHN’s own consumer and community engagement strategy which is currently under development [see BHFLHN 27th March meeting Minute 2.2 in which the Board notes the progress of, inter alia, the BHFLHN Consumer and Community Engagement Strategy]; and through the BHFLHN’s six Health Advisory Councils (HACs), all of which were established in 2008, and therefore have a long association with their respective communities. These are separate entities from the BHFLHNB, but nevertheless work closely with the Board on matters of community engagement. In the absence of the BFHLN’s own Consumer and Community Engagement Strategy, the score for Aboriginal community engagement with the newly established BHFLHN is based on an analysis of the 2018-19 annual reports of the six HACs. The HACs are: Barossa and Districts Health Advisory Council Inc. (BDHAC); Eudunda, Kapunda Health Advisory Council Inc. (EKHAC); Gawler District Health Advisory Council Inc. (GDHAC); Hills Area Health Advisory Council (HAHAC); Kangaroo Island Health Advisory Council Inc. (KIHAC); and Southern Fleurieu Health Advisory Council Inc. (SFHAC).

**BHFLHN HACs’ Annual Reports for 2018-19 – Evidence of Aboriginal Community Engagement**

<table>
<thead>
<tr>
<th>Acknowledgement of country</th>
<th>BDHAC</th>
<th>EKHAC</th>
<th>GDHAC</th>
<th>HAHAC</th>
<th>KIHAC</th>
<th>SFHAC@</th>
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</thead>
<tbody>
<tr>
<td>Evidence of Aboriginal community engagement</td>
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<td>X</td>
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<td>0/7</td>
<td>0/7</td>
<td>0/6</td>
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</tr>
</tbody>
</table>
Based on performance against the indicators, overall there is a very low level of engagement with the Aboriginal community within their respective regions, and only two of the six HACs have registered some form of engagement. **Score = 0.5 / 4**

16. **LHN Aboriginal community newsletter/e-letter/social media**
No discussion has taken place within the BHFLHN meetings regarding publication of an Aboriginal community newsletter, or whether important Aboriginal health information could be conveyed to the LHN’s Aboriginal communities using other platforms such as an e-newsletter, or via a social media platform such as Facebook and Twitter. However, BHFLHN does have a Facebook page: BHFLHN Facebook page - @BHFLHN and posts Aboriginal health related information. **Score = 1 / 3**

17. **At least one Aboriginal community forum/meeting per year convened by the LHN chief executive officer**
At its 26th February meeting the BHFLHN, at Item 2.2, discussed the matter of Aboriginal Health Community Consultation, and supported the Aboriginal Health Team and Aboriginal Community in hosting three Community Forums / Consultations in Gawler, Mount Barker and Victor Harbour. It would be expected that the CEO, in conjunction with the Director of Aboriginal Health, would play a lead role in organising these forums/consultations. **Score = 3 / 3**

18. **Reconciliation Action Plan**
CHSA (aka Country Health SA) developed the Country Health SA Reconciliation Action Plan 2018-2020 (CHSA, 2018). In reference to the BHFLHN resolution of the 3rd July [Item 3.2], and quoted in full above, this RAP is still presumably current [note that the second paragraph of the Board’s resolution does not mention “plan”], however, it is also noted that the RAP has not been discussed in any subsequent meetings of the Board or in any of the meetings of the BHFLHN’s six HACs (see the table below at Note 13). **Score = 1 / 3**

19. **Aboriginal health professionals caring for patients included within clinical engagement strategy**
According to Minute 2.2 of the 27th March meeting of the BFLHN, the Clinician and Workforce Engagement Strategy is still being developed. While information is not currently available regarding the extent to which Aboriginal health professionals are included in the BHFLHN clinical engagement strategy, and given the priorities given to and delays caused by the COVID-19 pandemic, a discretionary score is awarded. **Score = 1.5 / 3**

**Criterion: Public Reporting and Accountability (via LHN website or annual report)**

20. The BHFLHN, in effect, does not have its own website. An internet search for “Barossa Hills Fleurieu Local Health Network” will lead to the SA Health website (www.sahealth.sa.gov.au) which provides a link to BHFLHN:
The BHFLHN page contains a number of portals. As at 7th June 2020, there are six BHFLHN portals: (i) the BHFLHN’s response to COVID-19; (ii) Freedom of Information; (iii) the Barossa Hospital Business Case; (iv) Engagement with consumers & community; (v) the BHFLHN Board; and (vi) BHFLHN hospitals. Each portal provides links to enable access to additional information. For example, the Engagement with Consumers & Community portal provides links for expressions of interest in Consumer and Community Engagement Committees, and links to each of the BHFLHN’s six HACs. The HAC links will provide access to their annual reports and constitutions/rules. Similarly, information regarding the Board membership, meetings (agenda and minutes), and travel and entertainment expenses is available through the BHFLHN Board portal.

There is no portal presenting a snapshot of the BHFLHN, providing basic information about population demographics (including the Aboriginal population and Traditional Owners), geographic region served by the LHN, health workforce characteristics, a resident health profile/dashboard, and summary of services provided. None of the information sought below is readily available on the BHFLHN page (including its portals and their links) (“the BHFLHN page”) on the SA Health website.

Information regarding, for example, Aboriginal employment in the health workforce, cultural competency training completion rates, and Aboriginal health outcome KPIs must be sought via other portals and links on the SA Health website.

This audit took place before the BHFLHN annual report for 2019-2020 was released and therefore the information contained on the BHFLHN page is relied on to provide scores for the following sub-criteria.

21. Traditional Owner acknowledgement While there are a number of First Peoples in the region, the BHFLHN page does not acknowledge them. **Score = 0 / 2**

22. Improving Aboriginal health outcomes: (i) Separate section on website or in annual report devoted to Aboriginal health The BHFLHN page does not have a portal specifically dedicated to Aboriginal health information and data. **Score = 0 / 3**

23. Improving Aboriginal health outcomes: (ii) Reporting on KPIs contained in current service level agreement (SLA) The BHFLHN Service Agreement 2019-2020 contains two Tier 2 KPIs relevant to Aboriginal Health: DAMA (p. 44) and Aboriginal and Torres Strait Islander employment (p. 45). The BHFLHN page does not report on either. **Score = 0 / 3**

24. Improving Aboriginal health outcomes: (iii) Report on Aboriginal community engagement The BHFLHN page “Engagement with consumers & community” portal provides links to the six HACs and Regional Health Advisory Council resources, which includes links to, for example, membership forms and the Aboriginal Health Impact Statement Policy Guidelines. However, the page does not contain information on Aboriginal community engagement activities, such as, meetings that may have taken place with BHFLHN executives, community forums, LHN NAIDOC and Reconciliation Week events, or how engagement is taking place with its rural Aboriginal communities, and the outcomes of these activities. **Score = 0 / 3**

25. Improving Aboriginal health outcomes: (iv) Report on Aboriginal specific National Safety and Quality Health Service Standards assessment The BHFLHN page does not provide links to the six Aboriginal specific National Safety and Quality Health Service Standards (see Table 2), and how the LHN is implementing them and meeting their goals. **Score = 0 / 3**

26. Improving Aboriginal health outcomes: (v) Chronic Disease management and care planning The BHFLHN SA 2019-2020 (p. 25) identifies as one of its three principal areas of services and
accountabilities: “A requirement to participate in the South Australian Aboriginal Chronic Disease Consortium to progress implementation of the three statewide plans [regarding cancer control, heart and stroke, and diabetes] and consider opportunities to reorientate or reform services aligned with these plans.” The BHFLHN page does not provide links to information regarding how the LHN is progressing implementation of the three statewide plans and putting in place chronic disease management and care plans for Aboriginal patients.  

27. **Cultural learning completion rates** The BHFLHN SA 2019-2020 (p. 25) identifies as one of its principal areas of services and accountabilities: “The DHW will work with the BHFLHN to increase the cultural competence of our whole workforce through the implementation of the SA Health Aboriginal Cultural Learning Framework which is a significant strategy for SA Health to meet the accreditation requirements of the NSQHS.” However, the BHFLHN page does not provide links to data on non-Aboriginal staff completion rates for the Cultural Learning Program for the three levels, the mode of delivery, and participant feedback.  

28. **Aboriginal health division/unit placement on LHN organisational structure/chart** The BHFLHN page does not provide a link to information about, or a diagram of the organisational structure of the LHN.  

29. **Data on Aboriginal access to and delivery of services** The BHFLHN is funded to deliver an Aboriginal Family Birthing Program. Aboriginal Health is included among the range of inpatient health services available at two of five the BHFLHN medium site facilities at Gawler and South Coast (Southern Fleurieu Health Service) (BHFLHN Service Agreement 2019-2020, p. 50). However, the BHFLHN page does not provide links to data on the level of access to and use of these services.  

30. **Aboriginal employment: (i) Aboriginal Workforce Framework (planning, recruitment, etc.)** The BHFLHN SA 2019-2020 (p. 25) identifies as one of its principal areas of services and accountabilities: “Build the capacity and capability of the BHFLHN workforce to deliver quality care to Aboriginal people, whereby the DHW’s Workforce Services will work collaboratively with, and support the BHFLHN to implement the SA Health Aboriginal Workforce Framework 2017-2022 which identifies key strategies to attract, retain and develop Aboriginal staff, and consequently increase the number of Aboriginal people working across our organisation.” However, the BHFLHN page does not provide links to information on how it is progressing with the implementation of the Aboriginal Workforce Framework.  

31. **Aboriginal employment: (ii) Data on Aboriginal employment** The BHFLHN page does not provide links to data on Aboriginal employment, either as basic statistics on the proportion of its workforce who identify as Aboriginal employees, or for their participation rate in the various health workforce employment categories.  

32. **Other recognition (e.g., awards, scholarships, etc.)** The BHFLHN page does not provide links to information regarding staff awards, achievements, etc., including for Aboriginal staff.  

**INDICATOR 3: SERVICE DELIVERY AND PARTNERSHIPS**

Criterion: Aboriginal LHN Plan

33. **Co-designed in partnership with ACCHO(s), or other Aboriginal organisations, or Aboriginal Experts by Experience in LHN region** The CHSALHN SLA , with regard to LHN accountabilities, holds that the LHN CEO is responsible for, *inter alia*, “Developing effective and working partnerships with Aboriginal Community Health and
ensuring health needs of Aboriginal people are considered in all health plans, programs and models of care developed by the LHN. “ (CHSALHN SLA 2018-2019, p. 10). While there are no ACCHOs in BHFLHN region, and based on the BHFLHNB meeting minutes, the 2018-2019 annual reports of the six HACs, and lack of information on the SA Health website BHFLHN page (and portals and their links), there is no evidence of any negotiations taking place to develop an Aboriginal Health Plan specifically with the Aboriginal communities in the region. Score = 0 / 2

34. **Partnership with ACCHO(s) in LHN region**  
Refer Note 33. Score = 0 / 2

35. **Commitment to Continuous Quality Improvement**  
Refer Note 33 Score = 0 / 2

36. **Co-designed KPIs**  
Refer Note 33 Score = 0 / 2

37. **Clear statement of ACCHO and LHN responsibilities and conflicts**  
Refer Note 33 Score = 0 / 2

**Criterion: Cultural Safety**

38. **Implementation of cultural safety policy/strategy**  
The BHFLHN SA 2019-2020 (p. 25) identifies as one of its principal areas of services and accountabilities: “The DHW will work with the BHFLHN to increase the cultural competence of our whole workforce through the implementation of the SA Health Aboriginal Cultural Learning Framework which is a significant strategy for SA Health to meet the accreditation requirements of the NSQHSS.” Based on information provided in the BHFLHNB meetings (agenda and minutes), the six HAC annual reports for 2018-19, and SA Health’s website BHFLHN page, no mention is made of the development of, or existence of an LHN-specific cultural safety policy or strategy. Score = 0 / 5

39. **Proportion of staff trained**  
Schedule 5: Performance and Monitoring of the BHFLHN SLA 2019-2020 outlines the performance indicators and associated reporting arrangements that apply to the LHN. Unlike in the CHSALHN SLA 2018-2019 (p. 65) there is no KPI for the percentage of employees who have completed Aboriginal cultural competency training, with a target of 100%. This would also appear to breach NSQHSS Aboriginal and Torres Strait Islander specific standard 1.21 in relation to Clinical Governance safety and quality training whereby the health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients (see Table 2). While Cultural Safety Training for the Governing Board was discussed in by the BHFLHNB at its October 23rd and March 27th meetings, no mention of this in relation to the health workforce staff has been made in either Governing Board meetings, or in the 2018-2019 annual reports of the six HACs. Also there is no information available on the BHFLHN page of the SA Health website. Score = 0 / 5

**Criterion: Selected LHN health performance indicators reported publicly**

40. **Estimated level of completion of Indigenous status – specifically the reporting of ‘not stated’ on admission**  
Schedule 5: Performance and Monitoring of the BHFLHN SLA 2019-2020 outlines the performance indicators and associated reporting arrangements that apply to the LHN. The CHSALHN SLA 2018-2019, in Schedule 4: Performance Indicators and Targets, includes a statement in relation to supporting the delivery of the Closing the Gap agenda and citing the NSQHSS, that: “The LHN should
implement processes to identify patients as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems” (CHSALHN, SLA 2018—19, p. 59). Schedule 5: Performance and Monitoring of the BHFLHN SLA 2019-2020 contains no KPI for addressing the estimated level of completion of Indigenous status. This would also appear to breach NSQHSS Aboriginal and Torres Strait Islander specific standard 5.8 in relation to planning for comprehensive care (see Table 2).  

**Score = 0 / 3**

### 41. Discharges against medical advice (DAMA)

Schedule 5: Performance and Monitoring of the BHFLHN SLA 2019-2020 contains a Tier 2 KPI: % of Aboriginal Patients Who Left Hospital Against Medical Advice, with the measure: % of overnight Aboriginal and/or Torres Strait Islander separations. The 2019-20 target is: <=4.5%, with the following performance ranges: Performing - <=4.5%; Performance Concern - >4.5% and <=6.5%; and Under Performing - >6.5%. This target is the same as in the CHSALHN SLA for 2018-2019 Schedule 4: Performance Indicators and Targets, in relation to Safe and Effective Care in terms of Aboriginal Health (CHSALHN, SLA 2018—19, p. 65). In the Access and Flow performance domain with regard to the Emergency Department, there is also a Tier 2 KPI: Left at Own Risk, with the Measure which includes percentages of (i) all ED presentations, (ii) Aboriginal presentations, and (iii) Mental Health presentations, with the target for all three categories: <=3% (CHSALHN, SLA 2018—19, p. 62). The SA Health website BHFLHN page (including portals and their links), contains no data on how BHFLHN is progressing against the performance ranges contained in its SLA.  

**Score = 0 / 4**

### 42. Potentially preventable hospital admissions (PPHA)

Schedule 5: Performance and Monitoring of the BHFLHN SLA 2019-2020 does not contain a KPI regarding potentially preventable hospital admission for Aboriginal people.  

**Score = 0 / 3**

### 43. Access to mental health services as reported at service level agreement

As noted above, BHFLHN is the host LHN of the Rural and Remote Mental Health Service for country SA. Schedule 5: Performance and Monitoring of the BHFLHN SLA 2019-2020 does not contain a KPI regarding Aboriginal access to mental health services. The SA Health website BHFLHN page (including portals and their links), contains no data on Aboriginal access to mental health services.  

**Score = 0 / 3**

### 44. Low birth-weight babies

While Aboriginal Maternal Infant Care funding is a matter discussed by the BHFLHN at its April 24th meeting, Schedule 5: Performance and Monitoring of the BHFLHN SLA 2019-2020 does not contain a KPI regarding low birth-weight Aboriginal babies. The SA Health website BHFLHN page (including portals and their links), contains no data on low birth-weight Aboriginal babies.  

**Score = 0 / 3**

### 45. Healthcare outcome differential measures (eg, discharge summary timeliness)

Schedule 5: Performance and Monitoring of the BHFLHN SLA 2019-2020 does not contain a KPI regarding Aboriginal healthcare outcome differential measures, and is not a matter discussed at BHFLHN at meetings and in the six HAC annual reports for 2018-19.  

**Score = 0 / 4**

**INDICATOR 4: RECRUITMENT AND EMPLOYMENT**

**Criterion: Aboriginal health workforce development reporting**

### 46. Implementation of Aboriginal workforce strategy

The BHFLHN SA 2019-2020 (p. 25) identifies as one of its principal areas of services and accountabilities: “Build the capacity and capability of the BHFLHN workforce to deliver quality care to Aboriginal people, whereby the DHW’s Workforce Services will work collaboratively with, and support the BHFLHN to implement the SA Health Aboriginal Workforce Framework 2017-2022 which
identifies key strategies to attract, retain and develop Aboriginal staff, and consequently increase the number of Aboriginal people working across our organisation.” The development and implementation of an BHFLHN Aboriginal workforce strategy has not been raised by the BHFLHN at its meetings, or mentioned in the six HAC annual reports for 2018-2019. Similarly, there is no reference to a BHFLHN Aboriginal workforce strategy on the SA Health website BHFLHN page. **Score = 0 / 4**

47. LHN KPI for Aboriginal employment
Schedule 5: Performance and Monitoring of the BHFLHN SLA 2019-2020 contains a Tier 2 KPI: Aboriginal Employment Rate, with the measure: % of employees who identified as being of Aboriginal or Torres Strait Islander origin. The 2019-20 target is: >=4%, with the following performance ranges: Performing - >=4.0%; Performance Concern - <4.0% and >=1.5%; and Under Performing - <1.5%. No data regarding the BHFLHN’s progress against the SLA performance ranges on the SA Health website BHFLHN page. **Score = 0 / 4**

48. Number of Aboriginal health practitioners, health workers and liaison officers
No Aboriginal health practitioners, health workers and liaison officers are listed with the BHFLHN. Refer: https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/services/health+services+for/aboriginal+health+services/aboriginal+health+workers
Data regarding the number of Aboriginal health practitioners, health workers and liaison officers in BHFLHN’s workforce is not provided on the SA Health website BHFLHN page (including portals and their links). **Score = 0 / 3**

49. Number of identified Aboriginal positions
Data regarding the number of identified Aboriginal positions in BHFLHN’s workforce is not provided on the SA Health website BHFLHN page (including portals and their links). **Score = 0 / 3**

50. Number of salary bands occupied by Aboriginal employees
Data regarding the number of salary bands occupied by Aboriginal employees in BHFLHN’s workforce is not provided on the SA Health website BHFLHN page (including portals and their links). **Score = 0 / 3**

51. Number of long term Aboriginal employees
Data regarding the number of long term Aboriginal employees in BHFLHN’s workforce is not provided on the SA Health website BHFLHN page (including portals and their links). **Score = 0 / 3**

Criterion: Aboriginal participation in the health workforce

52. Administrative
Data regarding the number of Aboriginal people working in administration in BHFLHN’s workforce is not provided on the SA Health website BHFLHN page (including portals and their links). **Score = 0/3**

53. Medical Professional
Data regarding the number of Aboriginal medical professionals in BHFLHN’s workforce is not provided on the SA Health website BHFLHN page (including portals and their links). **Score = 0 / 4**

54. Nurses/Midwives
Data regarding the number of Aboriginal nurses and midwives in BHFLHN’s workforce is not provided on the SA Health website BHFLHN page (including portals and their links). **Score = 0 / 4**

55. Operational Services
Data regarding the number of Aboriginal providing operational services in the BHFLHN is not provided on the SA Health website BHFLHN page (including portals and their links). **Score = 0 / 3**

56. **Allied Health/Scientific/Technical**
Data regarding the number of Aboriginal employed to provide allied health/scientific and technical services in the BHFLHN is not provided on the SA Health website BHFLHN page (including portals and their links). **Score = 0 / 3**

57. **Other**
Data regarding other roles occupied and services offered by Aboriginal people in BHFLHN’s workforce (for example, as cultural consultants, and experts by experience) is not provided on the SA Health website BHFLHN page (including portals and their links). **Score = 0 / 3**

**INDICATOR 5: FINANCIAL ACCOUNTABILITY AND REPORTING – CLOSING THE GAP FUNDING**

The BHFLHN Service Agreement 01 July 2019 – 30 June 2020 (BHFLHN SA) in Schedule 3: Local Health Network – Services and Accountabilities, under Section 4. Services for Priority Population Groups, in sub-section 4.1 Aboriginal Health Services, states that:

The LHN will work collaboratively with DHW’s Aboriginal Health other relevant health services, support organisations and Aboriginal community-controlled health services to continue to implement the regional Aboriginal Health Improvement Plan to support services meeting the needs of the local Aboriginal population.

In recognition of the need to ensure appropriate resource allocation for Aboriginal Health Programs, the LHN should maintain or increase their relative funding allocation to these programs commensurate with their total funding allocation (p. 25).

The BHFLHN SA identifies three principal areas of services and accountabilities:

- A requirement to participate in the South Australian Aboriginal Chronic Disease Consortium to progress implementation of the three statewide plans [regarding cancer control, heart and stroke, and diabetes] and consider opportunities to reorientate or reform services aligned with these plans;
- Build the capacity and capability of the BHFLHN workforce to deliver quality care to Aboriginal people, whereby the DHW’s Workforce Services will work collaboratively with, and support the BHFLHN to implement the SA Health Aboriginal Workforce Framework 2017-2022 which identifies key strategies to attract, retain and develop Aboriginal staff, and consequently increase the number of Aboriginal people working across our organisation; and
- The DHW will work with the BHFLHN to increase the cultural competence of our whole workforce through the implementation of the SA Health Aboriginal Cultural Learning Framework which is a significant strategy for SA Health to meet the accreditation requirements of the NSQHS (p. 25).

In Schedule 4: Funding and Commissioned Activity of the BHFLHN SA, in Section 6: Specific Commissioning/Funding Commitments (p. 39), nine services and programs are identified:

- Transition Care Program (TCP)
- Renal Dialysis
- Aboriginal Family Birthing Program
- CHSALHN Cancer Services
- Older persons mental health – Rapid Access Services
- Aged Care Assessment Program (ACAP)
- Country Home Link (CHL)
- Community Support Scheme Program (CSS)
- Multi-Purpose Services (MPS).
While the Aboriginal Family Birthing Program has been allocated $145,987, no funding allocations within the other eight programs/services have been specified for Aboriginal Health services/needs. With regard to Older Persons Mental Health Services, the BHFLHN is expected to work collaboratively with the Office of Ageing Well, Adult Safeguarding Unit to support Aboriginal and Torres Strait Islander people aged 50 years or over (p. 15). The BHFLHN is also responsible for developing the Rural Health Workforce Strategy broad services plan and workforce plan under the guidance of the Rural Health Workforce Strategy Steering Committee to support recruitment, retention and training of, *inter alia*, Aboriginal health workers (p. 18).

The BHFLHN SA has not identified any specific funding allocations (Commonwealth, State, or other) for Aboriginal Health Services, and incorporates only two Tier 2 KPIs relevant to Aboriginal Health: DAMA (p. 44) and Aboriginal and Torres Strait Islander employment (p. 45).

**Criterion: Commonwealth contributions for Aboriginal health programs to LHN**

58. **Commonwealth contributions for Aboriginal health programs to LHN**

A search of the SA Health website, including the BHFLHN page (including portals and their links) did not produce any information concerning Commonwealth contributions for Aboriginal health programs to the BHFLHN. **Score = 0 / 10**

**Criterion: South Australian contributions to Aboriginal specific services and programs including activity-based funding loading for Aboriginal patients**

59. **Reporting on contributions for Aboriginal specific health services and programs including activity-based funding loading**

A search of the SA Health website, including the BHFLHN page, did not produce any information on State funding contributions for Aboriginal specific health services and programs at the BHFLHN including for activity-based funding loadings for Aboriginal patients. **Score = 0 / 10**

**BHFLHN documents consulted**

- **Governing Board Meetings:**
  - Agenda: 3 July 2019 / Minutes: 3 July 2019
  - “” “” “” 26 Sept. 2019 / “” 26 Sept. 2019
  - “” “” “” 20 Nov. 2019 / “” 20 Nov. 2019
  - “” “” “” 26 Feb. 2020 / “” 26 Feb. 2020
  - “” “” “” 27 Mar. 2020 / “” 27 Mar. 2020
  - “” “” “” 24 April 2020 / “” 24 April 2020
- **Service Agreement** (1 July 2019 – 30 June 2020)
- **BHFLHN Facebook page** - @BHFLHN

**HACs Annual Report 2018 – 2019**

- Barossa and Districts Health Advisory Council Inc. [BDHAC] *Annual Report 2018 – 2019*
- Gawler District Health Advisory Council Inc. [GDHAC] *Annual Report 2018 – 2019*
- Kangaroo Island Health Advisory Council Inc. [KIHAC] *Annual Report 2018 – 2019*
- Southern Fleurieu Health Advisory Council Inc. [SFHAC] *Annual Report 2018 – 2019*

**BHFLHN documents not sighted**
• BHFLHN Strategic Plan (see BHFLHNB mtg 18 Dec. Al 2.1)
• BHFLHN Consumer and Community Engagement Strategy (see BHFLHNB mtg 18 Dec. Al 2.1)
• BHFLHN Clinician and Workforce Engagement Strategy (see BHFLHNB mtg 18 Dec. Al 2.1)
## 1.14.2 Eyre & Far North Local Health Network (EFNLHN)

### EYRE & FAR NORTH LOCAL HEALTH NETWORK (EFNLHN) MATRIX AUDIT FY2019-June 2020 (1)

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<th>Key Indicators and Criteria</th>
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<td>1.1.4 LHN Board members are educated about Aboriginal health in their LHN (5)</td>
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<td>1.1.5 LHN Board members receive cultural learning training (6)</td>
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<td><strong>1.2 Aboriginal representation at board level</strong></td>
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<td>Aboriginal representation at board level (7)</td>
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<td><strong>1.3 Inclusion in Executive Management Structure</strong></td>
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<td>1.3.1 A stand-alone Aboriginal Health Division (8)</td>
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<tr>
<td>1.3.2 Aboriginal LHN lead directly reports to the LHN CEO (9)</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>30</td>
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</table>

| **2. Policy Implementation** |         |       |
| **2.1 Improving Aboriginal Health Outcomes** |         |       |
| 2.1.1 Explicitly identified as a strategic priority in LHN Strategic Plan (10) | 10 | 5 |
| 2.1.2 Aboriginal health outcome KPIs reflective of LHN key responsibilities identified in LHN Service Agreement (11) |         |       |
| (i) Tier 1 KPIs (12) | 5 | 0 |
| (ii) Tier 2 KPIs (13) | 5 | 0 |
| **2.2 Community engagement** |         |       |
| 2.2.1 Aboriginal community consultative body (14) | 4 | 0 |
| 2.2.2 Aboriginal community engagement embedded within overall community engagement strategy (15) | 4 | 2 |
| 2.2.3 LHN Aboriginal community newsletter/e-letter/social media (16) | 3 | 1 |
| 2.2.4 At least one Aboriginal community forum/meeting/social media convened by the LHN chief executive officer (17) | 3 | 0 |
| 2.2.5 Reconciliation Action Plan (18) | 3 | 1 |
| 2.2.6 Aboriginal health professionals caring for patients included within clinical engagement strategy (19) | 3 | 1.5 |
| **2.3 Public Reporting and Accountability (via LHN website or annual report)** |         |       |
| 2.3.1 Traditional Owner Acknowledgement (21) | 2 | 0 |
| 2.3.2 Improving Aboriginal health outcomes |         |       |
| (i) Separate section in report devoted to Aboriginal health (22) | 3 | 0 |
| (ii) Reporting on KPIs contained in current service level agreement (SLA) (23) | 3 | 0 |
| (iii) Report Aboriginal community engagement (24) | 3 | 0 |
| (iv) Report on Aboriginal specific National Safety and Quality Health Service Standards Assessment (25) | 3 | 0 |
| (v) Chronic disease management and care planning (26) | 3 | 0 |
| 2.3.3 Cultural learning completion rates (27) | 2 | 0 |
2.3.4 Aboriginal health division/unit placement on LHN organisational structure/chart (28) 1 0
2.3.5 Data on Aboriginal access to and delivery of services (29) 3 0
2.3.6 Aboriginal employment
   (i) Aboriginal Workforce Framework (planning, recruitment, etc) (30) 2 0
   (ii) Data on Aboriginal employment (31) 3 0
2.3.7 Other recognition (e.g., awards, scholarships, etc.) (32) 2 0

TOTAL 70 10.5

3. Service delivery and partnerships
3.1 Aboriginal LHN Plan
   3.1.1 Co-designed in partnership with ACCHO(s), or other Aboriginal organisations, or Aboriginal Experts by Experience in LHN region (33) 2 0
   3.1.2 Partnership with ACCHO(s) in LHN region (34) 2 0
   3.1.3 Commitment to Continuous Quality Improvement (35) 2 0
   3.1.4 Co-designed KPIs (36) 2 0
   3.1.5 Clear statement of ACCHO and LHN responsibilities and conflicts (37) 2 0

TOTAL 70 10.5

3.2 Cultural safety
   3.2.1 Implementation of cultural safety policy/strategy (38) 5 0
   3.2.2 Proportion of staff trained (39) 5 0

TOTAL 10 10

3.3 Selected LHN health performance indicators reported publicly
   3.4.1 Estimated level of completion of Indigenous status – specifically the reporting of ‘not stated’ on admission (40) 3 0
   3.4.2 Discharged against medical advice (DAMA) (41) 4 0
   3.4.3 Potentially preventable hospitalisations (PPHA) (42) 3 0
   3.4.4 Access to mental health services as reported at service level agreement (43) 3 0
   3.4.5 Low birth-weight babies (44) 3 0
   3.4.6 Healthcare outcome differential measures (eg. Discharge summary timeliness) (45) 4 0

TOTAL 40 10

4. Recruitment and employment
4.1 Aboriginal health workforce development reporting
   4.1.1 Implementation of Aboriginal workforce strategy (46) 4 0
   4.1.2 LHN KPI for Aboriginal employment (47) 4 0
   4.1.3 Number of Aboriginal health practitioners, health workers and liaison officers (48) 3 2
   4.1.4 Number of identified Aboriginal positions (49) 3 0
   4.1.5 Number of salary bands occupied by Aboriginal employees (50) 3 0
   4.1.6 Number of long-term Aboriginal employees (51) 3 0

TOTAL 40 2

5. Financial Accountability and Reporting: Closing the Gap Funding
5.1 Commonwealth contributions for Aboriginal health programs to LHN
Commonwealth contributions for Aboriginal health programs to LHN (58) 10 0

5.2 South Australian contributions to Aboriginal specific health services and programs including activity-based funding loading for Aboriginal patients
Reporting on contributions for Aboriginal specific health services and programs including activity-based funding loading (59) 10 0

TOTAL 20 0

Total Score 200 22.5

Institutional Rating scored against criteria:

<table>
<thead>
<tr>
<th>Score:</th>
<th>&gt;=160</th>
<th>120-159</th>
<th>80-119</th>
<th>40-79</th>
<th>&lt;=39</th>
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<tbody>
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<td>Very Low</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
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Notes:

1. **Eyre & Far North Local Health Network (EFNLHN)**

   The EFNLHN is responsible for delivering core health services to around 41,000 people living across the western part of SA and north to Coober Pedy. Core health services are provided by a large site (Port Lincoln Hospital and Health Service) and several small sites across the region, supported by a range of community-based facilities. Clinics are located at Lock and Oodnadatta, with a Family Wellbeing Centre situated in Amata. A range of services, including mobile renal dialysis, is also provided to the Anangu Pitjantjatjara Yankunytjatjara (APY Lands) (EFNLHN SLA 2019-2020, p. 20). Based on 2011 Census data, Aboriginal people constitute about 12.1% of the total population of the EFNLHN region (CHSALHN 2015a, p. 19). Assuming that that percentage remains roughly the same, currently there would be about 5,000 Aboriginal people in the EFNLHN region (cf 4,682 - 2011 Census). The EFNLHN region has the state’s largest proportion of Aboriginal people of all the LHNs.

   ACCHOs: Ceduna Koonibba Aboriginal Health Service Aboriginal Corporation; Oak Valley Health Service [Maralinga Tjarutja Lands]; Tullawon Health Service (Yalata); Port Lincoln Aboriginal Health Service Inc.; Umoona Tjutagku Health Service (Coober Pedy). In the APY Lands, the Nganampa Health Council (based in Alice Springs) maintains clinics in the APY communities of Amata, Kaltijiti (Fregon), Iwantja, Mimili, Nyapari, Pipalyatjara and Pukatja (Ernabella), with a service centre located at Umuna, which is about 25kms south of Pukatja and 35km north of Fregon. As at January 2018, the region now served by the EFNLHN had 28 Aboriginal Experts by Experience (HPCSA, 2019, p. 25).

   Aboriginal Health is included among the range of inpatient health services available at the EFNLHN’s large site facility at Port Lincoln (EFNLHN SLA 2019-2020, p. 48).

   Because the EFNLHN came into effect as an LHN in its own right on 1 July 2019, many key documents relied upon for the conduct of this audit, such as the EFNLHN Strategic Plan, the Clinicians and Workforce Engagement Strategy, and the Consumers and Community Engagement Strategy are still under development. Another key document, the EFNLHN annual report for 2019-2020 will not be available until after 30 September 2020. In the absence of these documents, the audit relies primarily on the EFNLHN Governing Board meeting agenda and minutes, and the 2018-2019 annual reports of the LHN’s six HACs. Scores have been adjusted to reflect the availability of relevant documents.

**INDICATOR 1: PARTICIPATION IN LHN GOVERNANCE**

Criterion: Good governance
The following chart provides an overview of the EFNLHNB references to and discussion concerning Aboriginal health and related matters. In addition to the listed sub-criteria, other headings have been included to cover information not readily assigned to the listed sub-criteria. Where Aboriginal health matters have been discussed, the Agenda item numbers have been indicated in the monthly columns. Also note that the Acknowledgement of Country is a standing item under Agenda Item 1.1 in all meetings, and is not included in the chart below.

Legend:

x = no information relevant to the sub-criterion heading was provided.
? = minutes were not uploaded onto SA Health website at the time of this analysis (30 May 2020).

AHEMGB – Aboriginal Health Expert Member of Governing Board (this person may/may not be an Aboriginal person)

Tier 1 committee = a Board committee which reports to the Board
Tier 2 committee = an internal LHN committee which reports to the CEO
Tier 3 committee = a community-based committee established in accordance with, for example, a LHN consumer and community engagement plan/framework/strategy and which can provide input to, or respond to the LHNB or LHN CEO.

### EFNLHNB Board meetings: good governance sub-criteria summary for July 2019 – April 2020

<table>
<thead>
<tr>
<th>Meeting:</th>
<th>July 25th</th>
<th>Aug. 29th (V)</th>
<th>Sept. 26 (V)</th>
<th>Oct. 24 (V)</th>
<th>Nov. 28th (V)</th>
<th>Dec. 19th (V)</th>
<th>Feb. 27 (+V)</th>
<th>March 26 (V)</th>
<th>April 23 (V)</th>
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<tr>
<td><strong>Sub-criteria:</strong></td>
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<tr>
<td>1.1.1 LHNB inter. With Aboriginal Com.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>?</td>
</tr>
<tr>
<td>1.1.2 AHPI on Mtg Agenda</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>?</td>
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<tr>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
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<td>X</td>
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<td>1.1.5 LHNB Receives CCT</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>?</td>
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<tr>
<td><strong>Additional sub-criteria</strong></td>
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<td>Invited Aboriginal Guest</td>
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<td>Y</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>?</td>
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<td>X</td>
<td>X</td>
<td>?</td>
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<tr>
<td>SLA Tier 1 &amp; 2</td>
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<td>X</td>
<td>X</td>
<td>X</td>
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<td>Aboriginal Membership of Brd Committees</td>
<td>4.1.1</td>
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</table>

**Summary of matters addressed:**

**July 25th:**
**Agenda Item 1.2:** Welcome and Apologies. **Discussion:** The Board noted the wording of the Acknowledgement of country and reiterated its commitment to be inclusive of all Aboriginal communities in the Eyre and Far North.

**Agenda Item 4.1.1:** Committees of the Governing Board. The Aboriginal member of the EFNLHNB was appointed to the Clinical Governance Committee and the Consumer, Community and Clinical Engagement Committee.

**Sept. 26th Agenda Item 8.3:** Meeting Evaluation. The Board acknowledged the passing of a Narungga elder and Indigenous advocate [name with-held]; the Chair would attend his funeral and represent the Board.

**Feb. 27th Agenda Item 3.6.1:** Chairperson Update. Aboriginal Health Member Update. The Minutes record at Item 3.6 Chairperson’s Update that the Board noted the update, including correspondence from the Minister about the process for filling a Board vacancy. [There was a Governing Board Special Meeting on 12 February 2020 via teleconference. Agenda not sighted, however, it is noted that the Minutes for that meeting did not list the Aboriginal Health Member originally appointed on 1st July 2019 as a member of the Governing Board]

2. **Board interaction with Aboriginal community**
   While the EFNLHNB, at its 25th July 2019 meeting “reiterated its commitment to be inclusive of all Aboriginal communities in the Eyre and Far North”, based on the information provided in the Agenda and the Minutes, there is no evidence of EFNLHNB interaction with the Aboriginal community/ies within the LHN region. **Score = 0 / 2**

3. **LHN Aboriginal Health performance indicators on Board agenda for every meeting**
   Based on the information provided in the Agenda and the Minutes, there is no evidence of Aboriginal Health performance indicators being provided to or being discussed at EFNLHNB meetings. **Score = 0 / 2**

4. **Direct input to Board by LHN Aboriginal Community Consultative Committee or Aboriginal Expert by Experience**
   Based on the information provided in the Agenda and the Minutes, there is no evidence of the Aboriginal Community Consultative Committee (a Tier 3 committee) or Aboriginal Experts by Experience providing input at EFNLHNB meetings. **Score = 0 / 2**

5. **LHN Board members are educated about Aboriginal health in their LHN**
   Based on the information provided in the Agenda and the Minutes, there is no evidence of EFNLHNB members being educated/informed of the health status and range of health concerns of the Aboriginal communities within the LHN via, for example, a presentation from the LHN’s E/D Aboriginal Health. **Score = 0 / 2**

6. **LHN Board members receive cultural learning training**
   Based on the information provided in the Agenda and the Minutes, no intention has been expressed by the EFNLHN Board Members of organising or participating in Cultural Safety Training. **Score = 0 / 2**

**Criterion: Aboriginal representation at board level**

7. **Aboriginal representation at board level**
   The 7 member EFNLHNB appointed by the Minister included an Aboriginal member with very significant expertise, knowledge and experience in relation to Aboriginal health - the AHEMGB. It is also noted that, as at 9th June 2020, the EFNLHNB had no AHEMGB – see:
This situation appears to have persisted since February 2020, and was of concern to the EFNLHN in its February 27th meeting which included the Chairperson’s Update, including correspondence from the Minister about the process for filling a Board vacancy. Given that that there currently is no AHEMGB after some four months, only half of the available points are awarded. **Score = 5 / 10**

**Criterion: Inclusion in Executive Management Structure**

8. **A stand-alone Aboriginal Health Division**

Based on the Regional LHN Leadership Structure provided in the *Establishment of Regional Local Health Networks: Detailed Design Proposal – Consultation Paper* (CHSALHN 2019, p. 6) the Division of Aboriginal Health exists as a stand-alone division within the EFNLHN organisational structure. **Score = 5 / 5**

9. **Aboriginal LHN lead directly reports to the LHN CEO**

According to the Regional LHN Leadership Structure (see Note 8), the Director of Aboriginal Health reports directly to the EFNLHN CEO. However, the EFNLHN page on the SA Health website provides no links to information (brief bios) concerning the members of the executive management group, as there is for the EFNLHN Board members. Thus there is no information confirming whether the Director of Aboriginal Health is an Aboriginal person or not. Given the emphasis placed on the importance of the Director of Aboriginal Health being an Aboriginal person by the Expert Workshop, failure to provide this information via the EFNLHN page on the SA Health website results in a penalty score. **Score = 0 / 5**

**INDICATOR 2: POLICY IMPLEMENTATION**

**Criterion: Improving Aboriginal Health Outcomes**

10. **Explicitly identified as a strategic priority in LHN Strategic Plan**

FNLHN draft Strategic Plan 2020-2025 was released online for public consultation early in 2020, with public online responses due back in March. The window of opportunity to see the plan was missed. It is expected that the plan will be launched in the second half of 2020. The plan will include the mission, vision, values and key objectives which will be the guideposts for decision making about all aspects of the local health network until 2025. Information accessed 9 June 2020 at [https://www.streakybay.sa.gov.au/your-council/latest-news/eyre-and-far-north-local-health-network-strategy-survey](https://www.streakybay.sa.gov.au/your-council/latest-news/eyre-and-far-north-local-health-network-strategy-survey). While information is not currently available regarding the extent to which Aboriginal health outcomes are identified as a strategic priority in the EFNLHN draft strategic plan, and given the priorities given to and delays caused by the COVID-19 pandemic, a discretionary score is awarded. **Score = 5 / 10**

11. **Aboriginal health outcome KPIs reflective of LHN key responsibilities identified in LHN Service Agreement**

The EFNLHN *Service Agreement 2019-2020*, in Schedule 5: Performance Monitoring contains two Aboriginal health-related KPIs also included in the regional LHN Service Agreements, namely the Tier 2 KPIs: DAMA and Aboriginal Employee Participation Rate (pp. 41-43).

The purpose of the following two sub-criteria is to suggest additional Aboriginal Health related KPIs to the existing two. Given the excess burden of disease within the Aboriginal community, and particularly in relation to cancer, heart and stroke, diabetes, kidney disease and mental health, there should be a range of both Tier 1 and 2 KPIs to address these health crises. The basis for scoring is that, given the excess burden of disease among Aboriginal people and the health crises faced by
many Aboriginal communities, these KPIs (with Aboriginal people constituting a KPI sub-set), should already be included in the current SA. The fact that they are not results in a penalty score.

12. Tier 1 KPIs

* Elective Surgery: Tier 1 – Timely Admissions: % of elective surgery patients admitted within clinically recommended times; % of Aboriginal patients admitted for elective surgery within clinically recommended times. Target 100%.

* Elective Surgery: Tier 1 – Overdue Patients: # of Category 1, 2 and 3 patients; # of Category 1, 2 and 3 Aboriginal patients. Target 0.

* Emergency Department: Tier 1 – Seen on Time: % of patients attending ED who commenced treatment within clinically accepted timeframes; % of Aboriginal patients attending ED who commenced treatment within clinically accepted timeframes. Target varies from 100% for Category 1 patients to >=70% for Category 5 patients.

* Mental Health: Tier 1 – Mental Health - Adult/Older Persons Acute 28 Day Readmission Rate: % of patients who had a readmission within 28 days of discharge (non-short stay); % of Aboriginal patients who had a readmission within 28 days of discharge (non-short stay). Target <=12%

* Mental Health: Tier 1 – Suicide of persons in Inpatient Mental Health Units: # of suicides that occur in admitted patient specialised mental health services; # of Aboriginal suicides that occur in admitted patient specialised mental health services. Target - Monitor.

Score = 0 / 5

13. Tier 2 KPIs

* Aboriginal Health: Tier 2 – Indigenous status reporting: % ‘not stated’ on admission. Target: ?

* Mental Health: Tier 2 - Post Discharge Community Follow Up Rate: % of people receiving one or more mental health service contacts while in the community within 7 days post discharge; % of Aboriginal people receiving one or more mental health service contacts while in the community within 7 days post discharge. Target >=70%.

* People and Culture – Tier 2: Completion of the Aboriginal Cultural Competence Program: % of employees who have completed Aboriginal cultural competence training. Target 100%

* Clinical Pathways: Tier 2 - Rehabilitation: Individual Care Plan: % of rehabilitation patients who leave hospital with an individualised care plan; % of Aboriginal rehabilitation patients who leave hospital with an individualised care plan. Target >=90%.

* Occupancy: Tier 2 – Discharge Summary Transmission Rate: % of discharge summaries transmitted with 48 hours of separation; % of Aboriginal patient discharge summaries transmitted with 48 hours of separation. Target >=80%

Score = 0 / 5

Criterion: Community Engagement

14. Aboriginal community consultative body

Based on the information provided in the Agenda and the Minutes of the EFNLHN Board meetings, no discussion has taken place on the establishment of an Aboriginal community consultative body for the LHN.

Score = 0 / 4

15. Aboriginal community engagement embedded within overall community engagement strategy

The Aboriginal community has two avenues to engage with the EFNLHN: through the EFNLHN’s own consumer and community engagement strategy, and through the EFNLHN’s six Health Advisory Councils (HACs), all of which were established in 2008, and therefore have a long association with their respective communities. These are separate entities from the EFNLHNB, but nevertheless work...
closely with the Board on matters of community engagement. At its 27th March meeting Minute 3.1: “The Governing Board approves the Eyre and Far North Local Health Network (EFNLHN) Consumer and Community Engagement Framework 2020-23, as recommended by the Board Consumer, Community and Clinician Engagement (CCCE) Committee”, however, the CCEF 2020-23 does not appear to have been published as at 9th June 2020. In the absence of the EFNLHN’s own Consumer and Community Engagement Framework, the score for Aboriginal community engagement with the newly established EFNLHN is based on an analysis of the 2018-19 annual reports of the six HACs. The HACs are: Ceduna District Services Health Advisory Council Inc. (CDHAC); Eastern Eyre Health Advisory Council Inc. (EEHAC); Far North Health Advisory Council (FNHAC); Lower Eyre Health Advisory Council Inc. (LEHAC); Mid-West Health Advisory Council (MWHAC); and Port Lincoln Health Advisory Council (PLHAC).

<table>
<thead>
<tr>
<th>EFNLHN HACs’ Annual Reports for 2018-19 – Evidence of Aboriginal Community Engagement</th>
<th>CDHAC</th>
<th>EEHAC</th>
<th>FNHAC</th>
<th>LEHAC</th>
<th>MWHAC</th>
<th>PLHAC</th>
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<td>X</td>
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<td>Evidence of Aboriginal community engagement</td>
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<td>0/7</td>
<td>0/5</td>
<td>0/7</td>
<td>0/7</td>
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<tr>
<td>Contribution by HAC to Aboriginal Community</td>
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<td>X</td>
<td>p. 5</td>
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<td>Participation of HAC in NAIDOC/Reconc. Wk</td>
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<td>X</td>
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<td>X</td>
<td>X</td>
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</tr>
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</table>

# ARRMHAC = Aboriginal Resident Representative Member of HAC

Based on the HAC reports, three of the HACs have not engaged at all with the local Aboriginal community, while the other three have demonstrated some level of engagement. Score = 2 / 4

16. LHN Aboriginal community newsletter/e-letter/social media
No discussion has taken place within the EFNLHN meeting regarding publication of an Aboriginal community newsletter, or whether important Aboriginal health information could be conveyed to the LHN’s Aboriginal communities using other platforms such as an e-newsletter, or via a social media platform such as Facebook and Twitter. However EFNLHN does have its own Facebook page: EFNLHN Facebook page - @EFNLHN - and posts Aboriginal health related information. Score = 1 / 3

17. At least one Aboriginal community forum/meeting per year convened by the LHN chief executive officer
Based on the EFNLHN meeting Minutes no mention has been made about the CEO holding an Aboriginal community forum or meeting. Score = 0 / 3

18. Reconciliation Action Plan
CHSALHN (aka Country Health SA) developed the Country Health SA Reconciliation Action Plan 2018-2020 (CHSA, 2018). In the absence of any reference by the EFNLHN to this RAP it is not known whether it is still current. However, it is noted that the PLHAC has advised that it “…will continue to work with the Reconciliation Action Plan and already there are thoughts for customer service for the Port Lincoln Hospital (PLHAC Annual Report 2018-19, p. 3). Whether this is the CHSALHN RAP or one which the PLHAC has developed with Port Lincoln’s Aboriginal community is not stated. No mention is made of a RAP in any of the 2018-19 annual reports of EFNLHN’s other five HACs (see the table below at Note 13). Score = 1 / 3
19. **Aboriginal health professionals caring for patients included within clinical engagement strategy**

According to Minute 3.3.4 of the 27th February meeting of the EFNLHN, the Board noted “progress to develop a Clinician Engagement Strategy”. It is assumed that the Clinical Engagement Strategy is still under development. While information is not currently available regarding the extent to which Aboriginal health professionals are included in the EFNLHN clinical engagement strategy, and given the priorities given to and delays caused by the COVID-19 pandemic, a discretionary score is awarded. **Score = 1.5 / 3**

**Criterion: Public Reporting and Accountability (via LHN website or annual report)**

20. The EFNLHN, in effect, does not have its own website. An internet search for “Eyre and Far North Local Health Network” will lead to the SA Health website (www.sahealth.sa.gov.au) which provides a link to EFNLHN: https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+local+health+nets/eyre+and+far+north+local+health+network/eyre+and+far+north+local+health+network. The EFNLHN page contains a number of portals. Each portal provides links to enable access to additional information. As at 7th June 2020, there are five EFNLHN portals: (i) the EFNLHN’s response to COVID-19; (ii) Freedom of Information; (iii) Engagement with Consumers & Community; (iv) the EFNLHN Board; (v) EFNLHN Health Services. Each portal provides links to enable access to additional information. For example, the Engagement with Consumers & Community portal provides links to each of the EFNLHN’s six HACs. The HAC links will provide access to their annual reports and constitutions/rules. Similarly, information regarding the Board membership, meetings (agenda and minutes), and travel expenses is available through the EFNLHN Board portal. There is no portal presenting a snap-shot of the EFNLHN, providing basic information about population demographics (including the Aboriginal population and Traditional Owners), geographic region served, brief description of the health workforce, a resident health profile/dashboard, and summary of services provided. None of the information sought below is readily available on the EFNLHN page (including its portals and their links) (“the EFNLHN page”) on the SA Health website. Information regarding, for example, Aboriginal employment in the health workforce, cultural competency training completion rates, and Aboriginal health outcome KPIs must be sought via other portals and links on the SA Health website.

This audit took place before the EFNLHN annual report for 2019-2020 was released and therefore the information contained on the EFNLHN page is relied on to provide scores for the following sub-criteria.

21. **Traditional Owner acknowledgement**

While there are a large number of First Peoples in the region, the EFNLHN page does not acknowledge them. **Score = 0 /2**

22. **Improving Aboriginal health outcomes: (i) Separate section on LHN website and/or in annual report devoted to Aboriginal health**

The EFNLHN page does not have a portal specifically dedicated to Aboriginal health information and data. **Score = 0 /3**

23. **Improving Aboriginal health outcomes: (ii) Reporting on KPIs contained in current service level agreement (SLA)**

The EFNLHN Service Agreement 2019-2020 contains two Tier 2 KPIs relevant to Aboriginal Health: DAMA (p. 44) and Aboriginal and Torres Strait Islander employment (p. 45). The EFNLHN page does not report on either. **Score = 0 /3**

24. **Improving Aboriginal health outcomes: (iii) Report on Aboriginal community engagement**

The EFNLHN page “Engagement with consumers & community” portal provides links to the six HACs and Regional Health Advisory Council resources, which includes links to, for example, membership forms...
and the Aboriginal Health Impact Statement Policy Guidelines. However, the page does not contain information on Aboriginal community engagement activities, such as, meetings that may have taken place with EFNLHN executives, community forums, LHN NAIDOC and Reconciliation Week events, or how engagement is taking place with its rural and remote Aboriginal communities, in the APY Lands, and the outcomes of these activities.  

**Score = 0 /3**

25. **Improving Aboriginal health outcomes: (iv) Report on Aboriginal specific National Safety and Quality Health Service Standards Assessment** The EFNLHN page does not provide links to the six Aboriginal specific National Safety and Quality Health Service Standards (see Table 2), and how the LHN is implementing them and meeting their goals.  

**Score = 0 / 3**

26. **Improving Aboriginal health outcomes: (v) Chronic disease management and care planning** The EFNLHN Service Agreement 2019 – 2020 (p. 24) contains a requirement to participate in the South Australian Aboriginal Chronic Disease Consortium to progress implementation of the three statewide plans [regarding cancer control, heart and stroke, and diabetes] and consider opportunities to reorientate or reform services aligned with these plans. The EFNLHN page does not provide links to information regarding how the LHN is progressing implementation of the three statewide plans and putting in place chronic disease management and care plans for Aboriginal patients.  

**Score = 0 / 3**

27. **Cultural learning completion rates.** The EFNLHN SA 2019-2020 (p. 24) identifies as one of its principal areas of services and accountabilities: “The DHW will work with the EFNLHN to increase the cultural competence of our whole workforce through the implementation of the SA Health Aboriginal Cultural Learning Framework which is a significant strategy for SA Health to meet the accreditation requirements of the NSQHs.” However, the EFNLHN page does not provide links to data on non-Aboriginal staff completion rates for the Cultural Learning Program for the three levels, the mode of delivery, and participant feedback.  

**Score = 0 / 2**

28. **Aboriginal health division/unit placement on LHN organisational structure/chart** The EFNLHN page does not provide a link to information about, or a diagram of the organisational structure of the LHN.  

**Score = 0/1**

29. **Data on Aboriginal access to and delivery of services** Aboriginal Health is included among the range of inpatient health services available at the EFNLHN’s large site facility at Port Lincoln (EFNLHN SLA 2019-2020, p. 48). EFNLHN is also funded to deliver Aboriginal Step-Down Services and the Trachoma Elimination Program, and to employ Aboriginal Patient Pathway Officers (p. 23). However, the EFNLHN page does not provide links to data on the level of access to and use of these services.  

**Score = 0/3**

30. **Aboriginal employment: (i) Aboriginal Workforce Framework (planning, recruitment, etc.)** The EFNLHN SA 2019-2020 (p. 24) identifies as one of its principal areas of services and accountabilities: “Build the capacity and capability of the EFNLHN workforce to deliver quality care to Aboriginal people, whereby the DHW’s Workforce Services will work collaboratively with, and support the EFNLHN to implement the SA Health Aboriginal Workforce Framework 2017-2022 which identifies key strategies to attract, retain and develop Aboriginal staff, and consequently increase the number of Aboriginal people working across our organisation.” However, the EFNLHN page does not provide links to information on how it is progressing with the implementation of the Aboriginal Workforce Framework.  

**Score = 0/2**

31. **Aboriginal employment: (ii) Data on Aboriginal employment** The EFNLHN page does not provide links to data on Aboriginal employment, either as basic statistics on the proportion of its
workforce who identify as Aboriginal employees, or for their participation rate in the various health workforce employment categories. **Score = 0/3**

32. **Other recognition (e.g., awards, scholarships, etc.)** The EFNLHN page does not provide links to information regarding staff awards, achievements, etc., including for Aboriginal staff. **Score = 0/2**

**INDICATOR 3: SERVICE DELIVERY AND PARTNERSHIPS**

**Criterion: Aboriginal LHN Plan**

33. **Co-designed in partnership with ACCHO(s), or Aboriginal organisations, or Aboriginal Experts by Experience in LHN region**

The CHSALHN SLA, with regard to LHN accountabilities, holds that the LHN CEO is responsible for, *inter alia*, “Developing effective and working partnerships with Aboriginal Community Health and ensuring health needs of Aboriginal people are considered in all health plans, programs and models of care developed by the LHN.” (CHSALHN SLA 2018-2019, p. 10). While there are five ACCHOs in EFNLHN region, and based on the EFNLHNB meeting minutes, the 2018-2019 annual reports of the six HACs, and lack of information on the SA Health website EFNLHN page (and portals and their links), there is no evidence of any negotiations taking place to develop an Aboriginal Health Plan specifically with the ACCHOs and/or Aboriginal Experts by Experience in the region. **Score = 0/2**

34. **Partnership with ACCHO(s) in LHN region**

Refer Note 33. **Score = 0/2**

35. **Commitment to Continuous Quality Improvement**

Refer Note 33 **Score = 0/2**

36. **Co-designed KPIs**

Refer Note 33 **Score = 0/2**

37. **Clear statement of ACCHO and LHN responsibilities and conflicts**

Refer Note 33 **Score = 0/2**

**Criterion: Cultural Safety**

38. **Implementation of cultural safety policy/strategy**

The EFNLHN Service Agreement 2019 – 2020 (p. 24) states that the DHW will work with the EFNLHN to increase the cultural competence of our whole workforce through the implementation of the SA Health Aboriginal Cultural Learning Framework which is a significant strategy for SA Health to meet the accreditation requirements of the NSQHS. Based on information provided in the EFNLHNB meetings (agenda and minutes), the six HAC annual reports for 2018-19, and SA Health’s website EFNLHN page, no mention is made of the development of, or existence of an LHN-specific cultural safety policy or strategy. **Score = 0/5**

39. **Proportion of staff trained**

Schedule 5: Performance and Monitoring of the EFNLHN SLA 2019-2020 outlines the performance indicators and associated reporting arrangements that apply to the LHN. Unlike in the CHSALHN SLA 2018-2019 (p. 65) there is no KPI for the percentage of employees who have completed Aboriginal cultural competency training, with a target of 100%. This would also appear to breach NSQHSS Aboriginal and Torres Strait Islander specific standard 1.21 in relation to Clinical Governance safety and quality training whereby the health service organisation has strategies to improve the cultural
awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients (see Table 2). No mention of Cultural Safety Training in relation to the EFNLHN health workforce non-Aboriginal staff has been made in either Governing Board meetings, or in the 2018-2019 annual reports of the six HACs. Also there is no information available on the EFNLHN page of the SA Health website as to the numbers, or proportion of staff trained. Score = 0 / 5

Criterion: Selected LHN health performance indicators reported publicly

40. Estimated level of completion of Indigenous status – specifically the reporting of ‘not stated’ on admission
Schedule 5: Performance and Monitoring of the EFNLHN SLA 2019-2020 outlines the performance indicators and associated reporting arrangements that apply to the LHN. The CHSALHN SLA 2018-2019, in Schedule 4: Performance Indicators and Targets, includes a statement in relation to supporting the delivery of the Closing the Gap agenda and citing the NSQHSS, that: “The LHN should implement processes to identify patients as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems” (CHSALHN, SLA 2018—19, p. 59). Schedule 5: Performance and Monitoring of the EFNLHN SLA 2019-2020 contains no KPI for addressing the estimated level of completion of Indigenous status. This would also appear to breach NSQHSS Aboriginal and Torres Strait Islander specific standard 5.8 in relation to planning for comprehensive care (see Table 2). Score = 0 / 3

41. Discharges against medical advice (DAMA)
Schedule 5: Performance and Monitoring of the EFNLHN SLA 2019-2020 contains a Tier 2 KPI: % of Aboriginal Patients Who Left Hospital Against Medical Advice, with the measure: % of overnight Aboriginal and/or Torres Strait Islander separations. The 2019-20 target is: <=4.5%, with the following performance ranges: Performing - <=4.5%; Performance Concern - >4.5% and <=6.5%; and Under Performing - >6.5%. This target is the same as in the CHSALHN SLA for 2018-2019 Schedule 4: Performance Indicators and Targets, in relation to Safe and Effective Care in terms of Aboriginal Health (CHSALHN, SLA 2018—19, p. 65). In the Access and Flow performance domain with regard to the Emergency Department, there is also a Tier 2 KPI: Left at Own Risk, with the Measure which includes percentages of (i) all ED presentations, (ii) Aboriginal presentations, and (iii) Mental Health presentations, with the target for all three categories: <=3% (CHSALHN, SLA 2018—19, p. 62). The SA Health website EFNLHN page, contains no data on how EFNLHN is progressing against the performance ranges contained in its SLA. Score = 0 / 4

42. Potentially preventable hospital admissions (PPHA)
Schedule 5: Performance and Monitoring of the EFNLHN SLA 2019-2020 does not contain a KPI regarding potentially preventable hospital admission for Aboriginal people. Score = 0 / 3

43. Access to mental health services as reported at service level agreement
Schedule 5: Performance and Monitoring of the EFNLHN SLA 2019-2020 does not contain a KPI regarding Aboriginal access to mental health services. The SA Health website EFNLHN page, contains no data on Aboriginal access to mental health services. Score = 0 / 3

44. Low birth-weight babies
Schedule 5: Performance and Monitoring of the EFNLHN SLA 2019-2020 does not contain a KPI regarding low birth-weight Aboriginal babies. The SA Health website EFNLHN page, contains no data on low birth-weight Aboriginal babies. Score = 0 / 3

45. Healthcare outcome differential measures (eg, discharge summary timeliness)
Schedule 5: Performance and Monitoring of the EFNLHN SLA 2019-2020 does not contain KPIs regarding Aboriginal healthcare outcome differential measures, and is not a matter discussed at EFNLHNB meetings and in the six HAC annual reports for 2018-19. **Score = 0 / 4**

**INDICATOR 4: RECRUITMENT AND EMPLOYMENT**

**Criterion: Aboriginal health workforce development reporting**

46. **Implementation of Aboriginal workforce strategy**

The EFNLHN Service Agreement 2019-2020 (p. 24) under principal services and accountabilities, identifies the need to “build the capacity and capability of the EFNLHN workforce to deliver quality care to Aboriginal people, whereby the DHW’s Workforce Services will work collaboratively with, and support the EFNLHN to implement the **SA Health Aboriginal Workforce Framework 2017-2022** which identifies key strategies to attract, retain and develop Aboriginal staff, and consequently increase the number of Aboriginal people working across our organisation.” The development and implementation of an EFNLHN Aboriginal workforce strategy has not been raised by the EFNLHNB at its meetings, or mentioned in the six HAC annual reports for 2018-2019. Similarly, there is no reference to an EFNLHN Aboriginal workforce strategy on the SA Health website EFNLHN page. **Score = 0 / 4**

47. **LHN KPI for Aboriginal employment**

Schedule 5: Performance and Monitoring of the EFNLHN SLA 2019-2020 contains a Tier 2 KPI: Aboriginal Employment Rate, with the measure: % of employees who identified as being of Aboriginal or Torres Strait Islander origin. The 2019-20 target is: >=4%, with the following performance ranges: Performing - >=4.0%; Performance Concern - <4.0% and >=1.5%; and Under Performing - <1.5%. No data regarding the EFNLHN’s progress against the SLA performance ranges on the SA Health website EFNLHN page. **Score = 0 / 4**

48. **Number of Aboriginal health practitioners, health workers and liaison officers**

According to SA Health, Aboriginal health workers are located at the following EFNLHN health facilities: Ceduna District Hospital, Coober Pedy Hospital, and Port Lincoln Hospital. [https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/services/health+services+for/aboriginal+health+services/aboriginal+health+workers](https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/services/health+services+for/aboriginal+health+services/aboriginal+health+workers). However the number of Aboriginal people employed in these roles is not provided on the SA Health website EFNLHN page. **Score = 2 / 3**

49. **Number of identified Aboriginal positions**

Data regarding the number of identified Aboriginal positions in EFNLHN’s workforce is not provided on the SA Health website EFNLHN page. **Score = 0 / 3**

50. **Number of salary bands occupied by Aboriginal employees**

Data regarding the number of salary bands occupied by Aboriginal employees in EFNLHN’s workforce is not provided on the SA Health website EFNLHN page. **Score = 0/3**

51. **Number of long term Aboriginal employees**

Data regarding the number of long term Aboriginal employees in EFNLHN’s workforce is not provided on the SA Health website EFNLHN page. **Score = 0 / 3**

**Criterion: Aboriginal participation in the health workforce**

52. **Administrative**
Data regarding the number of Aboriginal people working in administration in EFNLHN’s workforce is not provided on the SA Health website EFNLHN page. **Score = 0/3**

53. Medical Professional
Data regarding the number of Aboriginal medical professionals in EFNLHN’s workforce is not provided on the SA Health website EFNLHN page. **Score = 0 / 4**

54. Nurses/Midwives
Data regarding the number of Aboriginal nurses and midwives in EFNLHN’s workforce is not provided on the SA Health website EFNLHN page. **Score = 0 / 4**

55. Operational Services
Data regarding the number of Aboriginal providing operational services in the EFNLHN is not provided on the SA Health website EFNLHN page. **Score = 0 / 3**

56. Allied Health/Scientific/Technical
Data regarding the number of Aboriginal employed to provide allied health/scientific and technical services in the EFNLHN is not provided on the SA Health website EFNLHN page. **Score = 0 / 3**

57. Other
Data regarding other roles occupied and services offered by Aboriginal people in EFNLHN’s workforce (for example, as cultural consultants, and experts by experience) is not provided on the SA Health website EFNLHN page. **Score = 0 / 3**

**INDICATOR 5: FINANCIAL ACCOUNTABILITY AND REPORTING – CLOSING THE GAP FUNDING**

The EFNLHN Service Agreement 01 July 2019 – 30 June 2020 (EFNLHN SA) in Schedule 3: Local Health Network – Services and Accountabilities, under Section 4. Services for Priority Population Groups, in sub-section 4.1 Aboriginal Health Services, states that:

- The LHN will work collaboratively with DHW’s Aboriginal Health other relevant health services, support organisations and Aboriginal community-controlled health services to continue to implement the regional Aboriginal Health Improvement Plan to support services meeting the needs of the local Aboriginal population.
- In recognition of the need to ensure appropriate resource allocation for Aboriginal Health Programs, the LHN should maintain or increase their relative funding allocation to these programs commensurate with their total funding allocation (p. 24).

The EFNLHN SA identifies three principal areas of services and accountabilities:

- A requirement to participate in the South Australian Aboriginal Chronic Disease Consortium to progress implementation of the three statewide plans [regarding cancer control, heart and stroke, and diabetes] and consider opportunities to reorientate or reform services aligned with these plans;
- Build the capacity and capability of the EFNLHN workforce to deliver quality care to Aboriginal people, whereby the DHW’s Workforce Services will work collaboratively with, and support the EFNLHN to implement the SA Health Aboriginal Workforce Framework 2017-2022 which identifies key strategies to attract, retain and develop Aboriginal staff, and consequently increase the number of Aboriginal people working across our organisation; and
- The DHW will work with the EFNLHN to increase the cultural competence of our whole workforce through the implementation of the SA Health Aboriginal Cultural Learning Framework which is a significant strategy for SA Health to meet the accreditation requirements of the NSQHS (p. 24).
In Schedule 4: Funding and Commissioned Activity of the EFNLHN SA, in Section 6: Specific Commissioning/Funding Commitments (p. 37), seven services and programs are identified:

- Aboriginal Patient Pathway Officers
- Transition Care Program (TCP)
- Aboriginal Step-Down Services
- Community Support Scheme Program (CSS)
- Aged Care Assessment Program (ACAP)
- Trachoma Elimination Program
- Multi-Purpose Services (MPS).

While the Aboriginal Patient Pathway Officers program has been allocated $105,840 and the Aboriginal Step-Down Services $333,792, no funding allocations within the other five programs/services have been specified for Aboriginal Health services/needs. With regard to the Trachoma Elimination Program, the EFNLHN will continue to manage the program, and is required to ensure that “there is sufficient organisational and administrative capacity .... to maintain continuous positive trachoma outcomes for Aboriginal people and communities across South Australia” (p. 23). The EFNLHN is expected to work collaboratively with the Office of Ageing Well, Adult Safeguarding Unit to support Aboriginal and Torres Strait Islander people aged 50 years or over (p. 25). The EFNLHN is also responsible for developing the Rural Health Workforce Strategy broad services plan and workforce plan under the guidance of the Rural Health Workforce Strategy Steering Committee to support recruitment, retention and training of, *inter alia*, Aboriginal health workers (p. 18).

The EFNLHN SA has not identified any specific funding allocations (Commonwealth, State, or other) for Aboriginal Health Services, and incorporates only two Tier 2 KPIs relevant to Aboriginal Health: DAMA (p. 42) and Aboriginal and Torres Strait Islander employment (p. 43).

**Criterion: Commonwealth contributions for Aboriginal health programs to LHN**

58. **Commonwealth contributions for Aboriginal health programs to LHN**

A search of the SA Health website, including the EFNLHN page (including portals and their links) did not produce any information concerning Commonwealth contributions for Aboriginal health programs to the EFNLHN.  

*Score = 0 / 10*

**Criterion: South Australian contributions to Aboriginal specific services and programs including activity-based funding loading for Aboriginal patients**

59. **Reporting on contributions for Aboriginal specific health services and programs including activity-based funding loading**

A search of the SA Health website, including the EFNLHN page (including portals and their links), did not produce any information on State funding contributions for Aboriginal specific health services and programs at the EFNLHN including for activity-based funding loadings for Aboriginal patients.  

*Score = 0 / 10*

**EFNLHN documents consulted**

- Governing Board Meetings: *Agenda* 25 July 2019 /  *Minutes* 25 July 2019
  - ““““ 26 Sept. 2019 / ““““ 26 Sept. 2019
  - ““““ 28 Nov. 2019 / ““““ 28 Nov. 2019
  - ““““ 27 Feb. 2020 / ““““ 27 Feb. 2020
  - ““““ 26 Mar. 2020 / ““““ 26 Mar. 2020
23 April 2020 / 23 April 2020

- Service Agreement (1 July 2019 – 30 June 2020)
- EFNLHN Facebook page - @EFNLHN

HACs


EFNLHN documents not sighted
### 1.14.3 Flinders & Upper North Local Health Network (FUNLHN)

**FLINDERS & UPPER NORTH LOCAL HEALTH NETWORK (FUNLHN) MATRIX AUDIT FY2019 - June 2020**

**Key Indicators and Criteria**

<table>
<thead>
<tr>
<th>Category</th>
<th>Indicator</th>
<th>Scoring</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Participation in LHN governance</strong></td>
<td></td>
<td>Total out of 10</td>
<td></td>
</tr>
<tr>
<td><strong>1.1 Good governance</strong></td>
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</tr>
<tr>
<td>1.1.1 Board interaction with Aboriginal community</td>
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<td>1.1.2 LHN Aboriginal health performance indicators on Board agenda for every meeting</td>
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<tr>
<td>1.1.3 Direct input to Board by LHN Aboriginal Community Consultative Committee or Aboriginal Experts by Experience</td>
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<td>1.1.4 LHN Board members are educated about Aboriginal health in their LHN</td>
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<td>2</td>
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<tr>
<td>1.1.5 LHN Board members receive cultural learning training</td>
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<tr>
<td><strong>1.2 Aboriginal representation at board level</strong></td>
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<td></td>
<td>Aboriginal representation at board level</td>
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<td><strong>1.3 Inclusion in Executive Management Structure</strong></td>
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<td>1.3.1 A stand-alone Aboriginal Health Division</td>
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<td>1.3.2 Aboriginal LHN lead directly reports to the LHN CEO</td>
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<td><strong>TOTAL</strong></td>
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<tr>
<td><strong>2. Policy Implementation</strong></td>
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<tr>
<td><strong>2.1 Improving Aboriginal Health Outcomes</strong></td>
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<tr>
<td>2.1.1 Explicitly identified as a strategic priority in LHN Strategic Plan</td>
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<td>2.1.2 Aboriginal health outcome KPIs reflective of LHN key responsibilities identified in LHN Service Agreement</td>
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<tr>
<td>(i) Tier 1 KPIs</td>
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<td><strong>2.2 Community engagement</strong></td>
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<td>2.2.1 Aboriginal community consultative body</td>
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<td>2.2.2 Aboriginal community engagement embedded within overall community engagement strategy</td>
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<td>2.2.4 At least one Aboriginal community forum/meeting per year convened by the LHN chief executive officer</td>
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<td>2.2.5 Reconciliation Action Plan</td>
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<td>2.2.6 Aboriginal health professionals caring for patients included within clinical engagement strategy</td>
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<td><strong>2.3 Public Reporting and Accountability (via LHN website or annual report)</strong></td>
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<td>2.3.2 Improving Aboriginal health outcomes</td>
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<td>(i) Separate section in report devoted to Aboriginal health</td>
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<td>(ii) Reporting on KPIs contained in current service level agreement (SLA)</td>
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<td>(iii) Report Aboriginal community engagement</td>
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<tr>
<td>(iv) Report on Aboriginal specific National Safety and Quality Health Service Standards Assessment</td>
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<tr>
<td>(v) Chronic disease management and care planning</td>
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<tr>
<td>2.3.3 Cultural learning completion rates</td>
<td></td>
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</table>
2.3.4 Aboriginal health division/unit placement on LHN organisational structure/chart (28)  
2.3.5 Data on Aboriginal access to and delivery of services (29)  
2.3.6 Aboriginal employment  
(i) Aboriginal Workforce Framework (planning, recruitment, etc) (30)  
(ii) Data on Aboriginal employment (31)  
2.3.7 Other recognition (e.g., awards, scholarships, etc.) (32)  

TOTAL  70  13.5

3. Service delivery and partnerships

3.1 Aboriginal LHN Plan

3.1.1 Co-designed in partnership with ACCHO(s), or Aboriginal organisations, or Aboriginal Experts by Experience in LHN region (33)  
3.1.2 Partnership with ACCHO(s) in LHN region (34)  
3.1.3 Commitment to Continuous Quality Improvement (35)  
3.1.4 Co-designed KPIs (36)  
3.1.5 Clear statement of ACCHO and LHN responsibilities and conflicts (37)  

3.2 Cultural safety

3.2.1 Implementation of cultural safety policy/strategy (38)  
3.2.2 Proportion of staff trained (39)  

3.3 Selected LHN health performance indicators reported publicly

3.4.1 Estimated level of completion of Indigenous status – specifically the reporting of ‘not stated’ on admission (40)  
3.4.2 Discharged against medical advice (DAMA) (41)  
3.4.3 Potentially preventable hospitalisations (PPHA) (42)  
3.4.4 Access to mental health services as reported at service level agreement (43)  
3.4.5 Low birth-weight babies (44)  
3.4.6 Healthcare outcome differential measures (eg. Discharge summary timeliness) (45)  

TOTAL  40  0

4. Recruitment and employment

4.1 Aboriginal health workforce development reporting

4.1.1 Implementation of Aboriginal workforce strategy (46)  
4.1.2 LHN KPI for Aboriginal employment (47)  
4.1.3 Number of Aboriginal health practitioners, health workers and liaison officers (48)  
4.1.4 Number of identified Aboriginal positions (49)  
4.1.5 Number of salary bands occupied by Aboriginal employees (50)  
4.1.6 Number of long-term Aboriginal employees (51)  

4.2 Aboriginal participation in the health workforce

4.2.1 Administrative (52)  
4.2.2 Medical Professionals (53)  
4.2.3 Nurses/Midwives (54)  
4.2.4 Operational Services (55)  
4.2.5 Allied Health/Scientific/Technical (56)  
4.2.6 Other (57)  

TOTAL  40  2

5. Financial Accountability and Reporting: Closing the Gap Funding
5.1 Commonwealth contributions for Aboriginal health programs to LHN

<table>
<thead>
<tr>
<th>Commonwealth contributions for Aboriginal health programs to LHN (58)</th>
<th>Total out of 10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10 0</td>
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</table>

5.2 South Australian contributions to Aboriginal specific health services and programs including activity-based funding loading for Aboriginal patients

<table>
<thead>
<tr>
<th>Reporting on contributions for Aboriginal specific health services and programs including activity-based funding loading (59)</th>
<th>Total out of 10</th>
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**TOTAL** 20 0

**Total Score** 200 34.5

Institutional Rating scored against criteria

<table>
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<tr>
<th>Score:</th>
<th>&gt;=160</th>
<th>120-159</th>
<th>80-119</th>
<th>40-79</th>
<th>&lt;=39</th>
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</table>

<table>
<thead>
<tr>
<th>Evidence of Inst. Racism:</th>
<th>Very Low</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
<th>Very High</th>
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</thead>
</table>

Notes:

1. **Flinders & Upper North Local Health Network (FUNLHN)**

The FUNLHN is responsible for delivering core health services to approximately 50,000 people living across a large remote region stretching north from Spencer Gulf. Core health services within this region are provided by two large sites (Port Augusta Hospital and Regional Health Service and the Whyalla Hospital and Health Service), a number of smaller sites, and a range of community-based facilities with outreach services to a wider region (FUNHLN SLA 2019-2020, p. 20). Based on 2011 Census data, Aboriginal people constitute about 8.7% of the total population of the FUNLHN region (CHSALHN 2015a, p. 19). Assuming that that percentage remains roughly the same, currently there would be about 4,400 Aboriginal people in the FUNLHN region (cf 3,992 - 2011 Census).

ACCHOs: Pika Wiya Health Service Aboriginal Corporation (Port Augusta); Nunyara Aboriginal Health Service (Whyalla). As at January 2018, the region now served by the FUNLHN had 46 Aboriginal Experts by Experience (HPCSA, 2019, p. 25).

Aboriginal Health is included among the range of inpatient health services available at the FUNLHN’s two large site facilities at Port Augusta and Whyalla (FUNHLN SLA 2019-2020, pp. 48-9).

Because the FUNLHN came into effect as an LHN in its own right on 1 July 2019, many key documents relied upon for the conduct of this audit, such as the FUNLHN Strategic Plan, the Clinicians and Workforce Engagement Strategy, and the Consumers and Community Engagement Strategy are still under development. Another key document, the FUNLHN annual report for 2019-2020 will not be available until after 30 September 2020. In the absence of these documents, the audit relies primarily on the FUNLHN Governing Board meeting agenda and minutes, and the 2018-2019 annual reports of the LHN’s six HACs. Scores have been adjusted to reflect the availability of relevant documents.

**INDICATOR 1: PARTICIPATION IN LHN GOVERNANCE**

**Criterion: Good governance**

The following chart provides an overview of the FUNLHNB references to and discussion concerning Aboriginal health and related matters. In addition to the listed sub-criteria, other headings have been included to cover information not readily assigned to the listed sub-criteria. Where Aboriginal health matters have been discussed, the Agenda item numbers have been indicated in the monthly
columns. Also note that the Acknowledgement of Country is a standing item under Agenda Item 1.1 in all meetings, and is not included in the chart below.

Legend:
x = no information relevant to the sub-criterion heading was provided.
? = minutes were not uploaded onto SA Health website at the time of this analysis (30 May 2020).
AHEMGB – Aboriginal Health Expert Member of Governing Board (this person may/may not be an Aboriginal person)
Tier 1 committee = a Board committee which reports to the Board
Tier 2 committee = an internal LHN committee which reports to the CEO
Tier 3 committee = a community-based committee established in accordance with, for example, a LHN consumer and community engagement plan/framework/strategy and which can provide input to, or respond to the LHNB or LHN CEO.

**FUNLHN Board meetings: good governance sub-criteria summary for July 2019 – April 2020**

<table>
<thead>
<tr>
<th>Meeting:</th>
<th>July 26th</th>
<th>Aug. 23rd</th>
<th>Sept. 27th</th>
<th>Oct. 31st</th>
<th>Nov. 22nd</th>
<th>Dec. 20th</th>
<th>Jan. 31st</th>
<th>Mar. 6th</th>
<th>Mar. 27 (V)</th>
<th>Apr. 24 (V)</th>
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<tbody>
<tr>
<td><strong>Sub-criteria:</strong></td>
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<td>1.1.1 LHNB inter. With Aboriginal Com.</td>
<td>X</td>
<td>4.11</td>
<td>X</td>
<td>3.1</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>1.1.2 AHPI on Mtg Agenda</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>1.1.3 ACCC direct input to LHNB</td>
<td>X</td>
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<td>X</td>
<td>X</td>
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<td>X</td>
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<td>4.17</td>
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<td>X</td>
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<tr>
<td>1.1.5 LHNB Receives CCT</td>
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<td><strong>Additional sub-criteria</strong></td>
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<td>Invited Aboriginal Guest</td>
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**Summary of matters addressed:**
July 26th Agenda Item 3.1.3: Community and Consumer Engagement Committee. ToR provided for discussion. (Updated ToR sent July 24 July 2019). Action: Board Member – [AHEMGB]

August 23rd:
Agenda Item 4.11: Briefing to the Board – Aboriginal Cultural Competency and development options. Briefing paper discussed including supporting information regarding the Iga Warta cultural immersion program. Resolution that the Board explore further options available in the FUNLHN region for cultural immersion.
Agenda Item 4.14: Special Financial delegation to CEO – Circular Resolution to approve Pika Wiya quarterly grant payment. Noted. Board approved by circular resolution.
Agenda Item 4.17: Annual Public Meeting. Discussion that the SA Health Aboriginal Health Community Forum in the LHN with Board Members and request a preferred date to hold this. Action: The Board requested further information regarding the agenda and meeting length for the Aboriginal Community Forum.

Sept. 27th Agenda Item 5.4: Clinical Governance Committee. Recommendation that the ToR be amended to include the Director of Mental Health and Director of Aboriginal Health in the Membership. Action: The Board endorsed that the ToR be amended to include the Director of MH and Director of AH.

Oct. 31st Agenda Item 3.1: CEO Report (For information). Acknowledgement to [Director of Aboriginal Health] regarding Flinders Fun Day event. Action: Invite [Director of Aboriginal Health] to board meeting to present Flinders Fun Day event.

November 22nd:
Agenda Item 2.1: [Agenda not uploaded to SA Health website FUNLHN portal]. Minutes: 2.1 [Director of Aboriginal Health] presentation to the Board from the recent Flinders Fun Day.
Agenda Item 5.1: Consumer and Community Engagement Committee. [Committee Board Member] & [AHEMGB] have and will continue to make presentations on Board CCE Governance and links to operational CCE.
Agenda Item 7.1.1: Chairs Meeting with the Minister. Indigenous Leadership – Department wish to identify potential leadership candidates.

January 31st:
Agenda Item 5.2: Finance & Performance Committee. Third Party contracts including Pika Wiya and RFDS Contract.
Agenda Item 6.8: Health Performance Council Tully to FUNLHN Aboriginal Community and Consumer Engagement Strategy. Tabled for information.
Agenda Item 7.1: CEO Recruitment. Discussed in Camera session recruitment of CEO. Board members on panel of selection includes the [AHEMGB].

March 6th:
Agenda Item 3.2: [Agenda not uploaded to SA Health website FUNLHN portal]. Minute 3.2: Aboriginal Cultural Competency. Date decided as 20th to 22nd April. Action: Obtain program information from the [Director of Aboriginal Health] and provide out of session to the board for information.
Agenda Item 3.6: A1837841 Draft CE Minute to CEO FUNLHN & EFNLHN – Closing the Gap Funding. Discussed in detail. Procurement process discussed. Options and advice to be explored. Action: Acting CEO to explore authority re options for external funding.
Agenda Item 6.12: Letter to Board Member, Regional Doctor and Director Aboriginal Health – Australia Day Awards.

March 27th:
Agenda Item 1.4: Conflicts of interest disclosure. [Board Member] recorded working with Aboriginal Health Council for COVID-19. Nil identified conflicts for recording.
Agenda Item 2.1: COVID-19. Discussion:
   o EFNLHN working with APY lands, RFDS providing tele med services and have available staff to put on ground if required. APY Lands have approximately 4 days of stock, may see a surge of patients in Port Augusta if APY lands close.
   o Director of Aboriginal Health working with Pika Wiya and K9 unit in Port Augusta.

April 24th Agenda Item 1.6: Actions arising from previous minutes. 2020-016 (Closing the Gap Funding). Discussed future funding, all in agreement, that funding continues for the next twelve months and acknowledge cost pressure associated with this. Investigations to occur for external funding potential OZ minerals, BHP. Action: Meeting to be arranged 1/5 between [AHEMGB], [Chair], another identified board member, CEO and Director Aboriginal Health to discuss.

2. Board interaction with Aboriginal community
At its August 23rd 2019 meeting, at Agenda Item 4.11, the FUNLHNB discussed Aboriginal Cultural Competency, however, framed the discussion more in terms of cultural immersion with some reference to the Iga Warta cultural immersion program. The view taken here is that cultural immersion is more in keeping with an activity which promotes interaction with the Aboriginal community, rather than undertaking a cultural competency program as described in the SA Health Aboriginal Cultural Learning Framework (SA Health 2017a). Also the FUNLHNB, at its 31st October 2019 meeting, the CEO in her report acknowledged the [Director of Aboriginal Health] regarding Flinders Fun Day event and invited the [Director] to [the next] board meeting to present on the Flinders Fun Day event. Based on the information provided in the Minutes of the two meetings, this provides some evidence of possible FUNLHNB interaction with the Aboriginal community within the LHN region. **Score = 2 / 2**

3. LHN Aboriginal Health performance indicators on Board agenda for every meeting
Based on the information provided in the Agenda and the Minutes, there is no evidence of Aboriginal Health performance indicators being provided to or being discussed at FUNLHNB meetings. **Score = 0 / 2**

4. Direct input to Board by LHN Aboriginal Community Consultative Committee or Aboriginal Expert by Experience
Based on the information provided in the Agenda and the Minutes, there is no evidence of the Aboriginal Community Consultative Committee (a Tier 3 committee) or Aboriginal Experts by Experience providing input at FUNLHNB meetings. **Score = 0 / 2**

5. LHN Board members are educated about Aboriginal health in their LHN
At its August 23rd 2019 meeting, at Agenda Item 4.17, the FUNLHNB discussed the possibility that a SA Health Aboriginal Community Forum could take place with the LHN and to confirm a possible date. However, no further discussion regarding the Forum is recorded in the minutes of subsequent meetings. It is assumed here that such a Forum would be an opportunity to have FUNLHNB members educated about the health issues of the Aboriginal community. Based on intention, half points are awarded. **Score = 1 / 2**
6. **LHN Board members receive cultural learning training**

See Note 2. The view here is that cultural immersion is not synonymous with Cultural learning Training, although at its March 6th 2020 meeting the Board did raise the matter of Aboriginal Cultural Competency with dates set for between 20th and 22nd April. The Minutes of the April 24th meeting make no reference to Aboriginal Cultural Competency, although it was most likely deferred to another date due to COVID-19. Based on intention, half points are awarded. **Score = 1 / 2**

**Criterion: Aboriginal representation at board level**

7. **Aboriginal representation at board level**

The seven members of the FUNLHN Governing Board includes an Aboriginal member as the AHEMGB. **Score = 10 / 10**

**Criterion: Inclusion in Executive Management Structure**

8. **A stand-alone Aboriginal Health Division**

Based on the Regional LHN Leadership Structure provided in the *Establishment of Regional Local Health Networks: Detailed Design Proposal – Consultation Paper* (CHSALHN 2019, p. 6) the Division of Aboriginal Health exists as a stand-alone division within the FUNLHN organisational structure. **Score = 5 / 5**

9. **Aboriginal LHN lead directly reports to the LHN CEO**

According to the Regional LHN Leadership Structure (see Note 8), the Director of Aboriginal Health reports directly to the FUNLHN CEO. However, the FUNLHN page on the SA Health website provides no links to information (brief bios) concerning the members of the executive management group, as there is for the FUNLHN Board members. Thus there is no information confirming whether the Director of Aboriginal Health is an Aboriginal person or not. Given the emphasis placed on the importance of the Director of Aboriginal Health being an Aboriginal person by the Expert Workshop, failure to provide this information via the FUNLHN page on the SA Health website results in a penalty score. **Score = 0 / 5**

**INDICATOR 2: POLICY IMPLEMENTATION**

**Criterion: Improving Aboriginal Health Outcomes**

10. **Explicitly identified as a strategic priority in LHN Strategic Plan**

The FUNLHN Strategic Plan is under development and is still to be published. While information is not currently available regarding the extent to which Aboriginal health outcomes are identified as a strategic priority in the FUNLHN strategic plan, and given the priorities given to and delays caused by the COVID-19 pandemic, a discretionary score is awarded. **Score = 5 / 10**

11. **Aboriginal health outcome KPIs reflective of LHN key responsibilities identified in LHN Service Agreement**

The FUNLHN *Service Agreement 2019-2020*, in Schedule 5: Performance Monitoring contains two Aboriginal health-related KPIs also included in the regional LHN Service Agreements, namely the Tier 2 KPIs: DAMA and Aboriginal Employee Participation Rate (pp. 41-43).

The purpose of the following two sub-criteria is to suggest additional Aboriginal Health related KPIs to the existing two. Given the excess burden of disease within the Aboriginal community, and particularly in relation to cancer, heart and stroke, diabetes, kidney disease and mental health, there should be a range of both Tier 1 and 2 KPIs to address these health crises. The basis for scoring is that, given the excess burden of disease among Aboriginal people and the health crises faced by many Aboriginal communities, these KPIs (with Aboriginal people constituting a KPI sub-set), should already be included in the current SA. The fact that they are not results in a penalty score.
12. Tier 1 KPIs
* Elective Surgery: Tier 1 – Timely Admissions: % of elective surgery patients admitted within clinically recommended times; % of Aboriginal patients admitted for elective surgery within clinically recommended times. Target 100%.
* Elective Surgery: Tier 1 – Overdue Patients: # of Category 1, 2 and 3 patients; # of Category 1, 2 and 3 Aboriginal patients. Target 0
* Emergency Department: Tier 1 – Seen on Time: % of patients attending ED who commenced treatment within clinically accepted timeframes; % of Aboriginal patients attending ED who commenced treatment within clinically accepted timeframes. Target varies from 100% for Category 1 patients to >=70% for Category 5 patients.
* Mental Health: Tier 1 – Mental Health - Adult/Older Persons Acute 28 Day Readmission Rate: % of patients who had a readmission within 28 days of discharge (non-short stay); % of Aboriginal patients who had a readmission within 28 days of discharge (non-short stay). Target <=12%
* Mental Health: Tier 1 – Suicide of persons in Inpatient Mental Health Units: # of suicides that occur in admitted patient specialised mental health services; # of Aboriginal suicides that occur in admitted patient specialised mental health services. Target - Monitor

Score = 0 / 5

13. Tier 2 KPIs
* Aboriginal Health: Tier 2 – Indigenous status reporting: % ‘not stated’ on admission. Target: ?
* Mental Health: Tier 2 - Post Discharge Community Follow Up Rate: % of people receiving one or more mental health service contacts while in the community within 7 days post discharge; % of Aboriginal people receiving one or more mental health service contacts while in the community within 7 days post discharge. Target >=70%.
* People and Culture – Tier 2: Completion of the Aboriginal Cultural Competence Program: % of employees who have completed Aboriginal cultural competence training. Target 100%
* Clinical Pathways: Tier 2 - Rehabilitation: Individual Care Plan: % of rehabilitation patients who leave hospital with an individualised care plan; % of Aboriginal rehabilitation patients who leave hospital with an individualised care plan. Target >=90%.
* Occupancy: Tier 2 – Discharge Summary Transmission Rate: % of discharge summaries transmitted with 48 hours of separation; % of Aboriginal patient discharge summaries transmitted with 48 hours of separation. Target >=80%

Score = 0 / 5

Criterion: Community Engagement

14. Aboriginal community consultative body
Based on the information provided in the Agenda and the Minutes of the FUNLHN Board meetings, no discussion has taken place on the establishment of an Aboriginal community consultative body for the LHN.

Score = 0 / 4

15. Aboriginal community engagement embedded within overall community engagement strategy
The Aboriginal community has two avenues to engage with the FUNLHN: through the FUNLHN’s own consumer and community engagement strategy which is currently under development and had not been released as at 10 June 2020 [refer: https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+local+health+networks/flinders+and+upper+north+local+health+network/engagement+with+consumers+and+the+community++flinders+and+upper+north+lhn], and through the FUNLHN’s five
Health Advisory Councils (HACs). The HACs were all established in 2008, and therefore have a long association with their respective communities. These are separate entities from the FUNLHN, but nevertheless work closely with the Board on matters of community engagement. In the absence of the FUNLHN’s own Consumer and Community Engagement Strategy, the score for Aboriginal community engagement with the newly established FUNLHN is based on an analysis of the 2018-19 annual reports of the five HACs. The HACs are: Hawker District Memorial Health Advisory Council (HDMHAC); Leigh Creek Health Services Health Advisory Council (LCSHAC); Port Augusta, Roxby Downs Woomera Health Advisory Council (PARDWHAC); Quorn Health Services Health Advisory Council (QHSHAC); and Whyalla Hospital and Health Services Health Advisory Council (WHSHAC).

### FUNLHN HACs’ Annual Reports for 2018-19 – Evidence of Aboriginal Community Engagement

<table>
<thead>
<tr>
<th></th>
<th>HDMHAC</th>
<th>LCSHAC</th>
<th>PARDWHAC</th>
<th>QHSHAC</th>
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<td>X</td>
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<tr>
<td>Evidence of Aboriginal community engagement</td>
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<td>p. 3</td>
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# ARRMHAC = Aboriginal Resident Representative Member of HAC
& The Presiding Member reports that: “A position has been reserved and the utilisation of the ‘special member’ of clause of the rules will be utilised for an Aboriginal representative. The inability to recruit an Aboriginal person to the Port Augusta Roxby Downs Woomera Health Advisory (HAC) is a disappointment and an ongoing issue. Many strategies have been tried and extensive consultation has been conducted with the Aboriginal Directorate and will continue” (p. 3). Membership of the HAC is at 20 April 2020, but no ARRMHAC is identified.

Two of the HACs provide no information regarding their engagement with local Aboriginal communities in the FUNLHN region, while two others [one by virtue of the ARRMHAC] have indicated some level of engagement. The PARDWHAC is clearly seeking an Aboriginal person to become their HAC’s Aboriginal resident representative member. **Score = 2.5 / 4**

16. **LHN Aboriginal community newsletter/e-letter/social media**

No discussion has taken place within the FUNLHN meetings regarding publication of an Aboriginal community newsletter, or whether important Aboriginal health information could be conveyed to the LHN’s Aboriginal communities using other platforms such as an e-newsletter, or via a social media platform such as Facebook and Twitter. However, FUNLHN does have a Facebook page - @FUNLHN - and posts Aboriginal health related information. **Score = 1 / 3**

17. **At least one Aboriginal community forum/meeting per year convened by the LHN chief executive officer**

At its August 23rd meeting, the FUNLHN discussed the holding of an Aboriginal Health Community Forum with a preferred date to be indicated. No further discussion has occurred in ensuing meetings. It is assumed that the CEO in conjunction with the Director of Aboriginal Health would
take the lead role in organising such a Forum. Based on intention, half points are awarded. **Score = 1.5 / 3**

18. **Reconciliation Action Plan**

CHSALHN (aka Country Health SA) developed the *Country Health SA Reconciliation Action Plan 2018-2020* (CHSA, 2018). At its 31st January 2020 meeting (Agenda Item 3.6), the FUNLHN referred to the Board Reconciliation Statement, which was endorsed. Whether this is in reference to the CHSALHN RAP is not stated. No mention is made of a RAP in any of the 2018-19 annual reports of FUNLHN’s HACs (see the table at Note 15). **Score = 2 / 3**

19. **Aboriginal health professionals caring for patients included within clinical engagement strategy**

In the absence of any information on the SA Health website FUNLHN page (and portals and their links), it is assumed that the Clinical Engagement Strategy is still under development. While information is not currently available regarding the extent to which Aboriginal health professionals are included in the FUNLHN clinical engagement strategy, and given the priorities given to and delays caused by the COVID-19 pandemic, a discretionary half score is awarded. **Score = 1.5 / 3**

**Criterion: Public Reporting and Accountability (via LHN website or annual report)**

20. The FUNLHN, in effect, does not have its own website. An internet search for “Flinders and Upper North Local Health Network” will lead to the SA Health website ([www.sahealth.sa.gov.au](http://www.sahealth.sa.gov.au)) which provides a link to FUNLHN: [https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+local+health+networks/flinders+and+upper+north+local+health+network/flinders+and+upper+north+local+health+network](https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+local+health+networks/flinders+and+upper+north+local+health+network/flinders+and+upper+north+local+health+network). The FUNLHN page contains a number of portals. Each portal provides links to enable access to additional information. As at 7th June 2020, there are four FUNLHN portals: (i) Engagement with Consumers & Community; (ii) Flinders and Upper North Services; (iii) the FUNLHN’s response to COVID-19; and (iv) Freedom of Information. Each portal provides links to enable access to additional information. For example, the Engagement with Consumers & Community portal provides links to each of the FUNLHN’s five HACs. The HAC links will provide access to their annual reports and constitutions/rules. Similarly, information regarding the services available at the FUNLHN’s sites is available through the Flinders and Upper North Services portal. There is no portal presenting a snap-shot of the FUNLHN, providing basic information about population demographics (including the Aboriginal population and Traditional Owners), geographic region served, brief description of the health workforce, a resident health profile/dashboard, and summary of services provided. None of the information sought below is readily available on the FUNLHN page (including its portals and their links) (“the FUNLHN page”) on the SA Health website. Information regarding, for example, Aboriginal employment in the health workforce, cultural competency training completion rates, and Aboriginal health outcome KPIs must be sought via other portals and links on the SA Health website.

This audit took place before the FUNLHN annual report for 2019-2020 was released and therefore the information contained on the FUNLHN page is relied on to provide scores for the following sub-criteria.

21. **Traditional Owner acknowledgement** While there are a large number of First Peoples in the region, the FUNLHN page does not acknowledge them. **Score = 0 / 2**

22. **Improving Aboriginal health outcomes: (i) Separate section in report devoted to Aboriginal health** The FUNLHN page does not have a portal specifically dedicated to Aboriginal health information and data. **Score = 0 / 3**
23. **Improving Aboriginal health outcomes: (ii) Reporting on KPIs contained in current service level agreement (SLA)** The FUNLHN Service Agreement 2019-2020 contains two Tier 2 KPIs relevant to Aboriginal Health: DAMA (p. 44) and Aboriginal and Torres Strait Islander employment (p. 45). The FUNLHN page does not report on either.  **Score = 0 / 3**

24. **Improving Aboriginal health outcomes: (iii) Report on Aboriginal community engagement** The FUNLHN page “Engagement with consumers & community” portal provides links to the five HACs and Regional Health Advisory Council resources, which includes links to, for example, membership forms and the Aboriginal Health Impact Statement Policy Guidelines. However, the page does not contain information on Aboriginal community engagement activities, such as, meetings that may have taken place with FUNLHN executives, community forums, LHN NAIDOC and Reconciliation Week events, or how engagement is taking place with its rural and remote Aboriginal communities, and the outcomes of these activities.  **Score = 0 / 3**

25. **Improving Aboriginal health outcomes: (iv) Report on Aboriginal specific National Safety and Quality Health Service Standards assessment** The FUNLHN page does not provide links to the six Aboriginal specific National Safety and Quality Health Service Standards (see Table 2), and how the LHN is implementing them and meeting their goals.  **Score = 0 / 3**

26. **Improving Aboriginal health outcomes: (v) Chronic disease management and care planning** The FUNLHN SA 2019-2020 (p. 24) identifies as one of its three principal areas of services and accountabilities: “A requirement to participate in the South Australian Aboriginal Chronic Disease Consortium to progress implementation of the three statewide plans [regarding cancer control, heart and stroke, and diabetes] and consider opportunities to reorientate or reform services aligned with these plans.” The FUNLHN page does not provide links to information regarding how the LHN is progressing implementation of the three statewide plans and putting in place chronic disease management and care plans for Aboriginal patients.  **Score = 0 / 3**

27. **Cultural learning completion rates** The FUNLHN SA 2019-2020 (p. 24) identifies as one of its principal areas of services and accountabilities: “The DHW will work with the FUNLHN to increase the cultural competence of our whole workforce through the implementation of the SA Health Aboriginal Cultural Learning Framework which is a significant strategy for SA Health to meet the accreditation requirements of the NSQHS.” However, the FUNLHN page does not provide links to data on non-Aboriginal staff completion rates for the Cultural Learning Program for the three levels, the mode of delivery, and participant feedback.  **Score = 0 / 2**

28. **Aboriginal health division/unit placement on LHN organisational structure/chart** The FUNLHN page does not provide a link to information about, or a diagram of the organisational structure of the LHN.  **Score = 0 / 1**

29. **Data on Aboriginal access to and delivery of services** Aboriginal Health is included among the range of inpatient health services available at the FUNLHN’s two large site facilities at Port Augusta and Whyalla (FUNLHN SLA 2019-2020, pp. 48-9). FUNLHN is funded to provide an Aboriginal Patient Pathway Officers program Aboriginal Step-Down Services (p. 24). However, the FUNLHN page does not provide links to data on the level of access to and use of these services.  **Score = 0 / 3**

30. **Aboriginal employment: (i) Aboriginal Workforce Framework (planning, recruitment, etc.)** The FUNLHN SA 2019-2020 (p. 24) identifies as one of its principal areas of services and accountabilities: “Build the capacity and capability of the FUNLHN workforce to deliver quality care to Aboriginal people, whereby the DHW’s Workforce Services will work collaboratively with, and support the
FUNLHN to implement the SA Health Aboriginal Workforce Framework 2017-2022 which identifies key strategies to attract, retain and develop Aboriginal staff, and consequently increase the number of Aboriginal people working across our organisation.” However, the FUNLHN page does not provide links to information on how it is progressing with the implementation of the Aboriginal Workforce Framework. Score = 0 / 2

31. **Aboriginal employment: (ii) Data on Aboriginal employment**  The FUNLHN page does not provide links to data on Aboriginal employment, either as basic statistics on the proportion of its workforce who identify as Aboriginal employees, or for their participation rate in the various health workforce employment categories. Score = 0 / 3

32. **Other recognition (e.g., awards, scholarships, etc.)**  The FUNLHN page does not provide links to information regarding staff awards, achievements, etc., including for Aboriginal staff. Score = 0 / 2

**INDICATOR 3: SERVICE DELIVERY AND PARTNERSHIPS**

**Criterion: Aboriginal LHN Plan**

33. **Co-designed in partnership with ACCHO(s), or Aboriginal organisations, or Aboriginal Experts by Experience in LHN region**  The CHSALHN SLA, with regard to LHN accountabilities, holds that the LHN CEO is responsible for, *inter alia*, “Developing effective and working partnerships with Aboriginal Community Health and ensuring health needs of Aboriginal people are considered in all health plans, programs and models of care developed by the LHN.” (CHSALHN SLA 2018-2019, p. 10). While there are two ACCHOs in FUNLHN region, and based on the FUNLHN meeting minutes, the 2018-2019 annual reports of the six HACs, and lack of information on the SA Health website FUNLHN page (and portals and their links), there is no evidence of any negotiations taking place to develop an Aboriginal Health Plan specifically with the ACCHOs or the Aboriginal Experts by Experience in the region. Score = 0 / 2

34. **Partnership with ACCHO(s) in LHN region**  Refer Note 33. Score = 0 / 2

35. **Commitment to Continuous Quality Improvement**  Refer Note 33 Score = 0 / 2

36. **Co-designed KPIs**  Refer Note 33 Score = 0 / 2

37. **Clear statement of ACCHO and LHN responsibilities and conflicts**  Refer Note 33 Score = 0 / 2

**Criterion: Cultural Safety**

38. **Implementation of cultural safety policy/strategy**  The FUNLHN SA 2019-2020 (p. 24) identifies as one of its principal areas of services and accountabilities: “The DHW will work with the FUNLHN to increase the cultural competence of our whole workforce through the implementation of the SA Health Aboriginal Cultural Learning Framework which is a significant strategy for SA Health to meet the accreditation requirements of the NSQHS.” While the matter of Aboriginal Cultural Competency was raised by the FUNLHN at its August 23rd (Minute 4.11) and March 6th (Minute 3.2) meetings this was in relation to the Board and not the LHN workforce. Based on information provided in the FUNLHN meetings (agenda and minutes), the five HAC annual reports for 2018-19, and SA Health’s website FUNLHN page, no
mention is made of the development of, or existence of an LHN-specific cultural safety policy or strategy. Score = 0 / 5

39. Proportion of staff trained
Schedule 5: Performance and Monitoring of the FUNLHN SLA 2019-2020 outlines the performance indicators and associated reporting arrangements that apply to the LHN. Unlike in the CHSALHN SLA 2018-2019 (p. 65) there is no KPI for the percentage of employees who have completed Aboriginal cultural competency training, with a target of 100%. This would also appear to breach NSQHSS Aboriginal and Torres Strait Islander specific standard 1.21 in relation to Clinical Governance safety and quality training whereby the health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients (see Table 2). No mention of Cultural Safety Training in relation to the FUNLHN health workforce non-Aboriginal staff has been made in either Governing Board meetings, or in the 2018-2019 annual reports of the six HACs. Also there is no information available on the FUNLHN page of the SA Health website as to the numbers, or proportion of staff trained. Score = 0 / 5

Criterion: Selected LHN health performance indicators reported publicly

40. Estimated level of completion of Indigenous status – specifically the reporting of ‘not stated’ on admission
Schedule 5: Performance and Monitoring of the FUNLHN SLA 2019-2020 outlines the performance indicators and associated reporting arrangements that apply to the LHN. The CHSALHN SLA 2018-2019, in Schedule 4: Performance Indicators and Targets, includes a statement in relation to supporting the delivery of the Closing the Gap agenda and citing the NSQHSS, that: “The LHN should implement processes to identify patients as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems” (CHSALHN, SLA 2018—19, p. 59). Schedule 5: Performance and Monitoring of the FUNLHN SLA 2019-2020 contains no KPI for addressing the estimated level of completion of Indigenous status. This would also appear to breach NSQHSS Aboriginal and Torres Strait Islander specific standard 5.8 in relation to planning for comprehensive care (see Table 2). Score = 0 / 3

41. Discharges against medical advice (DAMA)
Schedule 5: Performance and Monitoring of the FUNLHN SLA 2019-2020 contains a Tier 2 KPI: % of Aboriginal Patients Who Left Hospital Against Medical Advice, with the measure: % of overnight Aboriginal and/or Torres Strait Islander separations. The 2019-20 target is: <=4.5%, with the following performance ranges: Performing - <=4.5%; Performance Concern - >4.5% and <=6.5%; and Under Performing - >6.5%. This target is the same as in the CHSALHN SLA for 2018-2019 Schedule 4: Performance Indicators and Targets, in relation to Safe and Effective Care in terms of Aboriginal Health (CHSALHN, SLA 2018—19, p. 65). In the Access and Flow performance domain with regard to the Emergency Department, there is also a Tier 2 KPI: Left at Own Risk, with the Measure which includes percentages of (i) all ED presentations, (ii) ABORIGINAL presentations, and (iii) Mental Health presentations, with the target for all three categories: <=3% (CHSALHN, SLA 2018—19, p. 62). The SA Health website FUNLHN page contains no data on how FUNLHN is progressing against the performance ranges contained in its SLA. Score = 0 / 4

42. Potentially preventable hospital admissions (PPHA)
Schedule 5: Performance and Monitoring of the FUNLHN SLA 2019-2020 does not contain a KPI regarding potentially preventable hospital admission for Aboriginal people. Score = 0 / 3

43. Access to mental health services as reported at service level agreement
Schedule 5: Performance and Monitoring of the FUNLHN SLA 2019-2020 does not contain a KPI regarding Aboriginal access to mental health services. The SA Health website FUNLHN page contains no data on Aboriginal access to mental health services. **Score = 0 / 3**

44. **Low birth-weight babies**
Schedule 5: Performance and Monitoring of the FUNLHN SLA 2019-2020 does not contain a KPI regarding low birth-weight Aboriginal babies. The SA Health website FUNLHN page contains no data on low birth-weight Aboriginal babies. **Score = 0 / 3**

45. **Healthcare outcome differential measures (eg, discharge summary timeliness)**
Schedule 5: Performance and Monitoring of the FUNLHN SLA 2019-2020 does not contain KPIs regarding Aboriginal healthcare outcome differential measures, and is not a matter discussed at FUNLHNFB meetings and in the HAC annual reports for 2018-19. **Score = 0 / 4**

**INDICATOR 4: RECRUITMENT AND EMPLOYMENT**

**Criterion: Aboriginal health workforce development reporting**

46. **Implementation of Aboriginal workforce strategy**
The FUNLHN SA 2019-2020 (p. 24) identifies as one of its principal areas of services and accountabilities: “Build the capacity and capability of the FUNLHN workforce to deliver quality care to Aboriginal people, whereby the DHW’s Workforce Services will work collaboratively with, and support the FUNLHN to implement the SA Health Aboriginal Workforce Framework 2017-2022 which identifies key strategies to attract, retain and develop Aboriginal staff, and consequently increase the number of Aboriginal people working across our organisation.” The development and implementation of an FUNLHN Aboriginal workforce strategy has not been raised by the FUNLHNFB at its meetings, or mentioned in the five HAC annual reports for 2018-2019. Similarly, there is no reference to a FUNLHN Aboriginal workforce strategy on the SA Health website FUNLHN page. **Score = 0 / 4**

47. **LHN KPI for Aboriginal employment**
Schedule 5: Performance and Monitoring of the FUNLHN SLA 2019-2020 contains a Tier 2 KPI: Aboriginal Employment Rate, with the measure: % of employees who identified as being of Aboriginal or Torres Strait Islander origin. The 2019-20 target is: >=4%, with the following performance ranges: Performing - >=4.0%; Performance Concern - <4.0% and >=1.5%; and Under Performing - <1.5%. No data regarding the FUNLHN’s progress against the SLA performance ranges on the SA Health website FUNLHN page. **Score = 0 / 4**

48. **Number of Aboriginal health practitioners, health workers and liaison officers**
According to SA Health, Aboriginal health workers are located at the following FUNLHN health facilities: Port Augusta Regional Health Service, and Whyalla Hospital and Health Service. [https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/services/health+services+for/aboriginal+health+services/aboriginal+health+workers](https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/services/health+services+for/aboriginal+health+services/aboriginal+health+workers). However the number of Aboriginal people employed in these roles is not provided on the SA Health website EFNLHN page. **Score = 2 / 3**

49. **Number of identified Aboriginal positions**
Data regarding the number of identified Aboriginal positions in FUNLHN’s workforce is not provided on the SA Health website FUNLHN page. **Score = 0 / 3**

50. **Number of salary bands occupied by Aboriginal employees**
Data regarding the number of salary bands occupied by Aboriginal employees in FUNLHN’s workforce is not provided on the SA Health website FUNLHN page. **Score = 0 / 3**

51. **Number of long term Aboriginal employees**
Data regarding the number of long term Aboriginal employees in FUNLHN’s workforce is not provided on the SA Health website FUNLHN page. **Score = 0 / 3**

**Criterion: Aboriginal participation in the health workforce**

52. **Administrative**
Data regarding the number of Aboriginal people working in administration in FUNLHN’s workforce is not provided on the SA Health website FUNLHN page. **Score = 0 / 3**

53. **Medical Professional**
Data regarding the number of Aboriginal medical professionals in FUNLHN’s workforce is not provided on the SA Health website FUNLHN page. **Score = 0 / 4**

54. **Nurses/Midwives**
Data regarding the number of Aboriginal nurses and midwives in FUNLHN’s workforce is not provided on the SA Health website FUNLHN page. **Score = 0 / 4**

55. **Operational Services**
Data regarding the number of Aboriginal providing operational services in the FUNLHN is not provided on the SA Health website FUNLHN page. **Score = 0 / 3**

56. **Allied Health/Scientific/Technical**
Data regarding the number of Aboriginal employed to provide allied health/scientific and technical services in the FUNLHN is not provided on the SA Health website FUNLHN page. **Score = 0 / 3**

57. **Other**
Data regarding other roles occupied and services offered by Aboriginal people in FUNLHN’s workforce (for example, as cultural consultants, and experts by experience) is not provided on the SA Health website FUNLHN page. **Score = 0 / 3**

**INDICATOR 5: FINANCIAL ACCOUNTABILITY AND REPORTING – CLOSING THE GAP FUNDING**
The FUNLHN Service Agreement 01 July 2019 – 30 June 2020 (FUNLHN SA) in Schedule 3: Local Health Network – Services and Accountabilities, under Section 4. Services for Priority Population Groups, in sub-section 4.1 Aboriginal Health Services, states that:

- The LHN will work collaboratively with DHW’s Aboriginal Health other relevant health services, support organisations and Aboriginal community-controlled health services to continue to implement the regional Aboriginal Health Improvement Plan to support services meeting the needs of the local Aboriginal population.
- In recognition of the need to ensure appropriate resource allocation for Aboriginal Health Programs, the LHN should maintain or increase their relative funding allocation to these programs commensurate with their total funding allocation (p. 24).

The FUNLHN SA identifies three principal areas of services and accountabilities:

- A requirement to participate in the South Australian Aboriginal Chronic Disease Consortium to progress implementation of the three statewide plans [regarding cancer control, heart and stroke, and diabetes] and consider opportunities to reorientate or reform services aligned with these plans;
- Build the capacity and capability of the FUNLHN workforce to deliver quality care to Aboriginal people, whereby the DHW’s Workforce Services will work collaboratively
with, and support the FUNLHN to implement the *SA Health Aboriginal Workforce Framework 2017-2022* which identifies key strategies to attract, retain and develop Aboriginal staff, and consequently increase the number of Aboriginal people working across our organisation; and

- The DHW will work with the FUNLHN to increase the cultural competence of our whole workforce through the implementation of the *SA Health Aboriginal Cultural Learning Framework* which is a significant strategy for SA Health to meet the accreditation requirements of the NSQHS (p. 24).

In Schedule 4: Funding and Commissioned Activity of the FUNLHN SA, in Section 6: Specific Commissioning/Funding Commitments (p. 39), eight services and programs are identified:

- Aboriginal Patient Pathway Officers
- Aboriginal Step-Down Services
- CHSALHN Cancer Services
- Transition Care Program (TCP)
- Community Support Scheme Program (CSS)
- Chronic Pain Model of Care
- Aged Care Assessment Program (ACAP)
- Multi-Purpose Services (MPS).

While the Aboriginal Patient Pathway Officers program has been allocated $63,504 and the Aboriginal Step-Down Services $236,264, no funding allocations within the other six programs/services have been specified for Aboriginal Health services/needs. The FUNLHN is expected to work collaboratively with the Office of Ageing Well, Adult Safeguarding Unit to support Aboriginal and Torres Strait Islander people aged 50 years or over (p. 25). The FUNLHN is also responsible for developing the Rural Health Workforce Strategy broad services plan and workforce plan under the guidance of the Rural Health Workforce Strategy Steering Committee to support recruitment, retention and training of, *inter alia*, Aboriginal health workers (p. 18). Aboriginal Health is included among the range of inpatient health services available at the FUNLHN’s two large site facilities at Port Augusta and Whyalla (p. 48-9).

The FUNLHN SA has not identified any specific funding allocations (Commonwealth, State, or other) for Aboriginal Health Services, and incorporates only two Tier 2 KPIs relevant to Aboriginal Health: DAMA (p. 44) and Aboriginal and Torres Strait Islander employment (p. 45).

**Criterion: Commonwealth contributions for Aboriginal health programs to LHN**

58. **Commonwealth contributions for Aboriginal health programs to LHN**

A search of the SA Health website, including the FUNLHN page (including portals and their links) did not produce any information concerning Commonwealth contributions for Aboriginal health programs to the FUNLHN. **Score = 0 / 10**

**Criterion: South Australian contributions to Aboriginal specific services and programs including activity-based funding loading for Aboriginal patients**

59. **Reporting on contributions for Aboriginal specific health services and programs including activity-based funding loading**

A search of the SA Health website, including the FUNLHN page (including portals and their links), did not produce any information on State funding contributions for Aboriginal specific health services and programs at the FUNLHN including for activity-based funding loadings for Aboriginal patients. **Score = 0 / 10**

**FUNLHN documents consulted**
• Governing Board Meetings: Agenda 26 July 2019 / Minutes 26 July 2019

• Service Level Agreement (1 July 2019 – 30 June 2020)

• FUNLHN Facebook page - @FUNLHN

HACs
• Hawker District Memorial Health Advisory Council [HDMHAC] Annual Report 2018 - 2019
• Leigh Creek Health Services Health Advisory Council [LCSHAC] Annual Report 2018 - 2019
• Quorn Health Services Health Advisory Council [QHSHAC] Annual Report 2018 - 2019
• Whyalla Hospital and Health Services Health Advisory Council [WHSHAC] Annual Report 2017 - 2018

FUNLHN documents not sighted
## 1.14.4 Limestone Coast Local Health Network (LCLHN)

### LIMESTONE COAST LOCAL HEALTH NETWORK (LCLHN) MATRIX AUDIT FY2019 – June 2020 (1)

<table>
<thead>
<tr>
<th>Key Indicators and Criteria</th>
<th>Scoring</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Participation in LHN governance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1.1 Good governance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1.1 Board interaction with Aboriginal community (2)</td>
<td>2</td>
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<tr>
<td>1.1.2 LHN Aboriginal health performance indicators on Board agenda for every meeting (3)</td>
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<tr>
<td>1.1.3 Direct input to Board by LHN Aboriginal Community Consultative Committee or Aboriginal Experts by Experience (4)</td>
<td>2</td>
<td>0</td>
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<tr>
<td>1.1.4 LHN Board members are educated about Aboriginal health in their LHN (5)</td>
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<td>2</td>
</tr>
<tr>
<td>1.1.5 LHN Board members receive cultural learning training (6)</td>
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<tr>
<td><strong>1.2 Aboriginal representation at board level</strong></td>
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<td></td>
</tr>
<tr>
<td>Aboriginal representation at board level (7)</td>
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<tr>
<td><strong>1.3 Inclusion in Executive Management Structure</strong></td>
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<tr>
<td>1.3.1 A stand-alone Aboriginal Health Division (8)</td>
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<td>1.3.2 Aboriginal LHN lead directly reports to the LHN CEO (9)</td>
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</table>

### 2. Policy Implementation

#### 2.1 Improving Aboriginal Health Outcomes

2.1.1 Explicitly identified as a strategic priority in LHN Strategic Plan (10) | 10 | 5 |

2.1.2 Aboriginal health outcome KPIs reflective of LHN key responsibilities identified in LHN Service Agreement (11) |

(i) Tier 1 KPIs (12) | 5 | 0 |

(ii) Tier 2 KPIs (13) | 5 | 0 |

#### 2.2 Community engagement

2.2.1 Aboriginal community consultative body (14) | 4 | 0 |

2.2.2 Aboriginal community engagement embedded within overall community engagement strategy (15) | 4 | 0 |

2.2.3 LHN Aboriginal community newsletter/e-letter/social media (16) | 3 | 1 |

2.2.4 At least one Aboriginal community forum/meeting per year convened by the LHN chief executive officer (17) | 3 | 3 |

2.2.5 Reconciliation Action Plan (18) | 3 | 0 |

2.2.6 Aboriginal health professionals caring for patients included within clinical engagement strategy (19) | 3 | 1.5 |

#### 2.3 Public Reporting and Accountability (via LHN website or annual report)

2.3.1 Traditional Owner Acknowledgement (21) | 2 | 0 |

2.3.2 Improving Aboriginal health outcomes |

(i) Separate section in report devoted to Aboriginal health (22) | 3 | 0 |

(ii) Reporting on KPIs contained in current service level agreement (SLA) (23) | 3 | 0 |

(iii) Report Aboriginal community engagement (24) | 3 | 0 |

(iv) Report on Aboriginal specific National Safety and Quality Health Service Standards Assessment (25) | 3 | 0 |

(v) Chronic disease management and care planning (26) | 3 | 0 |

2.3.3 Cultural learning completion rates (27) | 2 | 0 |
<table>
<thead>
<tr>
<th>Section</th>
<th>Requirement</th>
<th>Score</th>
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<tr>
<td>2.3.4</td>
<td>Aboriginal health division/unit placement on LHN organisational structure/chart (28)</td>
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<tr>
<td>2.3.5</td>
<td>Data on Aboriginal access to and delivery of services (29)</td>
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<tr>
<td>2.3.6</td>
<td>Aboriginal employment (i) Aboriginal Workforce Framework (planning, recruitment, etc) (30)</td>
<td>2</td>
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<td></td>
<td>(ii) Data on Aboriginal employment (31)</td>
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<td>2.3.7</td>
<td>Other recognition (e.g., awards, scholarships, etc.) (32)</td>
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<td><strong>TOTAL</strong></td>
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### 3. Service delivery and partnerships

#### 3.1 Aboriginal LHN Plan

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Score</th>
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<tbody>
<tr>
<td>3.1.1. Co-designed in partnership with ACCHO(s), or Aboriginal organisations, or Aboriginal Experts by Experience in LHN region (33)</td>
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<tr>
<td>3.1.2 Partnership with ACCHO(s) in LHN region (34)</td>
<td>2</td>
</tr>
<tr>
<td>3.1.3 Commitment to Continuous Quality Improvement (35)</td>
<td>2</td>
</tr>
<tr>
<td>3.1.4 Co-designed KPIs (36)</td>
<td>2</td>
</tr>
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<td>3.1.5 Clear statement of ACCHO and LHN responsibilities and conflicts (37)</td>
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<td><strong>TOTAL</strong></td>
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#### 3.2 Cultural safety

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.2.1 Implementation of cultural safety policy/strategy (38)</td>
<td>5</td>
</tr>
<tr>
<td>3.2.2 Proportion of staff trained (39)</td>
<td>5</td>
</tr>
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<td><strong>TOTAL</strong></td>
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#### 3.3 Selected LHN health performance indicators reported publicly

<table>
<thead>
<tr>
<th>Requirement</th>
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<tbody>
<tr>
<td>3.4.1 Estimated level of completion of Indigenous status – specifically the reporting of ‘not stated’ on admission (40)</td>
<td>3</td>
</tr>
<tr>
<td>3.4.2 Discharged against medical advice (DAMA) (41)</td>
<td>4</td>
</tr>
<tr>
<td>3.4.3 Potentially preventable hospitalisations (PPHA) (42)</td>
<td>3</td>
</tr>
<tr>
<td>3.4.4 Access to mental health services as reported at service level agreement (43)</td>
<td>3</td>
</tr>
<tr>
<td>3.4.5 Low birth-weight babies (44)</td>
<td>3</td>
</tr>
<tr>
<td>3.4.6 Healthcare outcome differential measures (eg. Discharge summary timeliness) (45)</td>
<td>4</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>20</strong></td>
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</table>

### 4. Recruitment and employment

#### 4.1 Aboriginal health workforce development reporting

<table>
<thead>
<tr>
<th>Requirement</th>
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<tbody>
<tr>
<td>4.1.1 Implementation of Aboriginal workforce strategy (46)</td>
<td>4</td>
</tr>
<tr>
<td>4.1.2 LHN KPI for Aboriginal employment (47)</td>
<td>4</td>
</tr>
<tr>
<td>4.1.3 Number of Aboriginal health practitioners, health workers and liaison officers (48)</td>
<td>3</td>
</tr>
<tr>
<td>4.1.4 Number of identified Aboriginal positions (49)</td>
<td>3</td>
</tr>
<tr>
<td>4.1.5 Number of salary bands occupied by Aboriginal employees (50)</td>
<td>3</td>
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<tr>
<td>4.1.6 Number of long-term Aboriginal employees (51)</td>
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#### 4.2 Aboriginal participation in the health workforce

<table>
<thead>
<tr>
<th>Requirement</th>
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<tbody>
<tr>
<td>4.2.1 Administrative (52)</td>
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<tr>
<td>4.2.2 Medical Professionals (53)</td>
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<tr>
<td>4.2.3 Nurses/Midwives (54)</td>
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<tr>
<td>4.2.4 Operational Services (55)</td>
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</tr>
<tr>
<td>4.2.5 Allied Health/Scientific/Technical (56)</td>
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<tr>
<td>4.2.6 Other (57)</td>
<td>3</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td><strong>20</strong></td>
</tr>
</tbody>
</table>

### 5. Financial Accountability and Reporting: Closing the Gap Funding

#### 5.1 Commonwealth contributions for Aboriginal health programs to LHN

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>10</strong></td>
</tr>
</tbody>
</table>
COMMONWEALTH CONTRIBUTIONS FOR ABORIGINAL HEALTH PROGRAMS TO LHN (58)

5.2 South Australian contributions to Aboriginal specific health services and programs including activity-based funding loading for Aboriginal patients

<table>
<thead>
<tr>
<th>Reporting on contributions for Aboriginal specific health services and programs including activity-based funding loading (59)</th>
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</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td>20</td>
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</tr>
</tbody>
</table>

TOTAL Score: 200

INSTITUTIONAL RATING SCORED AGAINST CRITERIA

Score: 

- >=160
- 120-159
- 80-119
- 40-79
- <=39

Evidence of Inst. Racism:

- Very Low
- Low
- Moderate
- High
- Very High

NOTES:

1. Limestone Coast Local Health Network (LCLHN)

The LCLHN is responsible for providing core health services to around 66,000 people living within the Limestone Coast region. Services are provided by one large site (Mount Gambier and Districts Health Service) and two medium sites and supported by several smaller sites and a range of community-based facilities (LCLHN SLA 2019-2020, p. 20). Based on 2011 Census data, Aboriginal people constitute about 1.7% of the total population of the LCLHN region (CHSALHN 2015a, p. 19). Assuming that that percentage remains roughly the same, currently there would be about 1,150 Aboriginal people in the LCLHN region (cf 1,092 - 2011 Census).

ACHHOs: Pangula Mannamurna Inc (Mount Gambier). LCLHN also maintains the Limestone Coast Aboriginal Experts by Experience network. As at January 2018, the region now served by the LCLHN had 13 Aboriginal Experts by Experience (HPCSA, 2019, p. 25)

Aboriginal Health is not included among the range of inpatient health services available at the LCLHN’s large and medium site facilities at Mount Gambier, Millicent and Naracoorte (LCLHN SLA 2019-2020, p. 48).

Because the LCLHN came into effect as an LHN in its own right on 1 July 2019, many key documents relied upon for the conduct of this audit, such as the LCLHN Strategic Plan, the Clinicians and Workforce Engagement Strategy, and the Consumers and Community Engagement Strategy are still under development. Another key document, the LCLHN annual report for 2019-2020 will not be available until after 30 September 2020. In the absence of these documents, the audit relies primarily on the LCLHN Governing Board meeting agenda and minutes, and the 2018-2019 annual reports of the LHN’s six HACs. Scores have been adjusted to reflect the availability of relevant documents.

INDICATOR 1: PARTICIPATION IN LHN GOVERNANCE

Criterion: Good governance

The following chart provides an overview of the LCLHN references to and discussion concerning Aboriginal health and related matters. In addition to the listed sub-criteria, other headings have been included to cover information not readily assigned to the listed sub-criteria. Where Aboriginal health matters have been discussed, the Agenda item numbers have been indicated in the monthly
columns. Also note that the Acknowledgement of Country of the Kaurna people is a standing item under Agenda Item 1.1 in all meetings and is not included in the chart below.

Legend:
x = no information relevant to the sub-criterion heading was provided.
? = minutes were not uploaded onto SA Health website at the time of this analysis (30 May 2020).
AHEMGB – Aboriginal Health Expert Member of Governing Board (this person may/may not be an Aboriginal person)
Tier 1 committee = a Board committee which reports to the Board
Tier 2 committee = an internal LHN committee which reports to the CEO
Tier 3 committee = a community-based committee established in accordance with, for example, a
LHN consumer and community engagement plan/framework/strategy and which can provide input
or respond to the LHNB or LHN CEO.

**LCLHN Board meetings: good governance sub-criteria summary for July 2019 – April 2020**

<table>
<thead>
<tr>
<th>Meeting:</th>
<th>July 29th</th>
<th>Sept. 30th</th>
<th>Oct. 28th</th>
<th>Nov. 25th</th>
<th>Jan. 20th</th>
<th>Feb 24th</th>
<th>Mar 30th (+V)</th>
<th>April 27th (+V)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sub-criteria:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 1.1.1 LHNB inter. | X | X | X | X | X | X | X | X | ?
| With Aboriginal Com. | | | | | | | | | |
| 1.1.2 AHPI on Mtg Agenda | X | X | X | X | X | X | X | X | ?
| 1.1.3 ACCC direct input to LHNB Educ’d re Aboriginal Health | X | X | X | X | X | X | X | X | ?
| 1.1.4 LHNB Receives CCT | X | X | X | X | X | X | X | X | ?
| **Additional sub-criteria** |           |           |           |           |           |         |               |                |
| Invited Aboriginal Guest | Y | X | Y | X | X | X | X | X | ?
| Aboriginal Health Agenda Item | X | X | 2.1.2 b) | 7.1.2 | X | X | X | X | X |
| Aboriginal Health Discussed | 1.3.4 | 3.1.1.1 | 3.1.1 b) | 7.1.1 | 3.1 c) | 1.3/ | 3.1 | 4.1/5.1 | 3.1 a) | X | ?
| 6.1.1/8.1.2 | 7.1.1 | 4.1 | 7.1 | 7.1/11.2 | 2.11.13 |
| SLA Tier 1 & 2 Aboriginal Health KPIs Discussed | X | X | X | X | X | X | X | X | ?
| Aboriginal Membership of Brd Committees | 3.1.2 | | | | | | | | |

**Summary of matters addressed:**

**July 29th:**

*Agenda Item 1.3.4 d)*: Letter of Agreement – Recognition of CHSA Credentials were noted as approved on July 1 2019 by CEO. **Action:** [Executive Director of Nursing & Midwifery, LCLHN] to
confirm credentialing process for the Aboriginal and Torres Strait Islander (ATSI) workforce, specifically the ATSI Health Practitioner role.

**Agenda Item 3.1.2 c):** Appointment of Board Committees – c) Clinical Governance. Members include an AHEMGB, who identifies as an Aboriginal person. A working party to support the development of the Consumer and Community Engagement and the Clinician Engagement Strategies will be formed with representation by the following Board Members and LCLHN roles – includes the AHEMGB, and the Director of Aboriginal Health.

### September 2nd:

**Agenda Item 1.3.1:** Minutes of Previous Meeting. Minutes of 29 July meeting accepted with an adjustment being made to Item 1.3.4 Recognition of CHSSA Credentials and confirmation of the credentialing process for the Aboriginal and Torres Strait Islander (ATSI) workforce, specifically the ATSI Health Practitioner role.

**Agenda Item 2.1.1 a):** CEO Report a) General Update. Three strategies are to be presented at the Board meeting to be held on 30 September including People & Culture, Aboriginal Health and Communications.

**Agenda Item 3.1.1 b):** Strategic Planning b) Limestone Coast LHN Engagement Strategies. An update on the Aboriginal Health Community Forum on 25 September was provided.

**Agenda Item 6.1.1:** Smoke-Free Transition for Country Health Aged Care. **Action:** The specific impact on Aboriginal Health and the existing strategies to be further considered.

**Agenda Item 8.1.2:** Matters for Noting – Escalation Matrix. **Action:** Escalation Matrix to be reviewed and refined and to include where the need for an Aboriginal Consultant is required.

### September 30th:

**Agenda Item 2.1.2 b):** Aboriginal Health Operational Strategic Plan. The Aboriginal Health Operational Strategic Plan was presented to the Board by the Director Aboriginal Health, supporting the feedback and outcomes of the Aboriginal Health Community Forum held on 25 September at Pangula Mannamurna. The Corka Mob was confirmed as being the Elders consultation group within the Limestone Coast. **Action:** The Aboriginal Health Operational Strategic Plan to be presented to Regional Leadership for feedback before final approval from the Governing Board. **Action:** Budget allocation for Aboriginal Health to be confirmed.

**Agenda Item 7.1.1:** Matters for Noting - Escalation Matrix. The Escalation Matrix was noted – **Action:** Director Aboriginal Health to discuss the involvement of an Aboriginal Consultant with Aboriginal member of the LCLHN.

**Agenda Item 7.1.2:** Matters for Noting – Minute – Aboriginal Health System Priorities. The minute relating to Aboriginal Health System Priorities was noted.

### October 28th:

**Agenda Item 3.1 c):** Finance – Letter from CE DHW to LCLHN re 2019-20 budget authorisation. Additional funding for Aboriginal & Torres Strait Islander identifiers was noted and the Road Map for Action – SA Aboriginal Chronic Disease Consortium was referenced.

**Agenda Item 4.1:** Engagement Strategy Update. Existing engagement strategies for Townsville and the Women’s & Children’s Hospital were referenced along with the positive outcomes of the Aboriginal Health Community Forum.

### November 25th:

**Agenda Item 1.3:** Meeting Opening – Introduction. **Discussion:** The Aged Care model and the work of the Board Chairs in response to the Aged Care report, the need to identify future leaders in Aboriginal Health and the Rural Medical Workforce Plan. **Action:** A Board Chair Report to be added as a recurring agenda item.
Agenda Item 7.1: Rural Health Workforce Strategy Planning. Discussion: Opportunities for collaboration with other LHNs, SA Ambulance Service, Pangula Mannamurna, universities, ..... were discussed.

January 20th:
Agenda Item 4.1: Engagement Strategy & Governance Update [in relation to the Clinician & Staff and the Consumer, Community & Carer Engagement Strategies]. Further noted was the statewide planning being undertaken by SA Health and the ‘mapping’ exercise of this planning to ensure the incorporation of Aboriginal Health.

Agenda Item 5.1: Country SA Primary Health Network. CEO of CSAPHN confirmed support in relation to Aboriginal Health by way of integrated team care funded by PHN and have a health navigator/care coordinator role noting alcohol and drug programs were also included. Direct work with Pangula Mannamurna was highlighted noting the changes in CEO and leadership and the potential impact on funding submission during this time.

Agenda Item 7.1: LCLHN Specialist Palliative Care Services & the ‘Donna Project’. The Aboriginal LCLHNB member highlighted the high instance of kidney failure and late diagnosis of cancer for Aboriginal and Torres Strait Islander communities and further highlighted the issues related to dying at home stating that ideas culturally would be different in communities. It was confirmed that work was being done in consultation with Pangula Mannamurna, an Aboriginal Community Health Service, targeting renal care for Aboriginal people noting that Aboriginal guidelines for providing culturally appropriate, safe care was to be revised and redeveloped.

Agenda Item 11.12: Matters for Noting – Health Performance Council Correspondence. The correspondence relating to the HPC was discussed noting the strategic action to respect regional diversity of Aboriginal people and training to be considered for the Governing Board, Executive and staff.

Agenda Item 11.13: Matters for Noting – CE, DHW Correspondence re Commissioning & Funding Model Review. Discussed with the following Action: Membership relating to Aboriginal Health Commissioning to be confirmed with the Aboriginal LCLHNB member. Also Action List: Meeting 20 January 2019 [year presumably should be 2020]: 11.13 – membership relating to Aboriginal Health Commissioning to be confirmed with the Aboriginal LCLHNB member.

Feb. 24th Agenda Item 3.1 a): CEO Report a) General Update. A further update was provided on the planning and commissioning proposals for 2020-21 including: Aboriginal Workforce funding.

Mar. 30th Agenda Item 1.2: Apologies. An apology was noted for the Aboriginal Board Member due to involvement in the Incident Management Team for COVID-19.

April 27th Agenda Item 1.7: Correspondence to the Minister for Health & Wellbeing - Resignation of the Aboriginal Board Member. [Minutes for April 27th LCLHNB meeting not up-loaded to SA Health website at 27the May]

2. Board interaction with Aboriginal community
Based on the information provided in the Agenda and the Minutes, there is no evidence of LCLHNB interaction with the Aboriginal community/ies within the LHN region. Score = 0 / 2

3. LHN Aboriginal Health performance indicators on Board agenda for every meeting
Based on the information provided in the Agenda and the Minutes, there is no evidence of Aboriginal Health performance indicators being provided to or being discussed at LCLHNB meetings [refer PSAHMT Note 5]. Score = 0 / 2
4. **Direct input to Board by LHN Aboriginal Community Consultative Committee or Aboriginal Expert by Experience**
   Based on the information provided in the Agenda and the Minutes, there is no evidence of an Aboriginal Community Consultative Committee (a Tier 3 committee) or Aboriginal Experts by Experience providing input at LCLHNB meetings. **Score = 0 / 2**

5. **LHN Board members are educated about Aboriginal health in their LHN**
   At its September 2nd 2019 meeting, at Agenda Item 3.1.1b, the LCLHNB discussed the Aboriginal Health Community Forum to take place on September 25th, and which was held at Pangula Mannamurna (Mount Gambier) (Sept. 30th meeting Minute 2.1.2b). It is assumed that some, if not all LCLHNB members would have attended this Forum. **Score = 2 / 2**

6. **LHN Board members receive cultural learning training**
   Based on the information provided in the Agenda and the Minutes, no intention has been expressed by the LCLHN Board Members of organising or participating in Cultural Safety Training. **Score = 0 / 2**

**Criterion: Aboriginal representation at board level**

7. **Aboriginal representation at board level**
   The 6 member LCLHNB appointed by the Minister includes an Aboriginal member with very significant expertise, knowledge and experience in relation to Aboriginal health - the AHEMGB. However this Board member resigned in April because of involvement in the Incident Management Team for COVID-19. **Score = 10 / 10**

**Criterion: Inclusion in Executive Management Structure**

8. **A stand-alone Aboriginal Health Division**
   Based on the Regional LHN Leadership Structure provided in the *Establishment of Regional Local Health Networks: Detailed Design Proposal – Consultation Paper* (CHSALHN 2019, p. 6) the Division of Aboriginal Health exists as a stand-alone division within the LCLHN organisational structure. **Score = 5 / 5**

9. **Aboriginal LHN lead directly reports to the LHN CEO**
   According to the Regional LHN Leadership Structure (see Note 8), the Director of Aboriginal Health reports directly to the LCLHN CEO. However, the LCLHNB page on the SA Health website provides no links to information (brief bios) concerning the members of the executive management group, as there is for the LCLHN Board members. Thus there is no information confirming whether the Director of Aboriginal Health is an Aboriginal person or not. Given the emphasis placed on the importance of the Director of Aboriginal Health being an Aboriginal person by the Expert Workshop, failure to provide this information via the LCLHNB page on the SA Health website results in a penalty score. **Score = 0 / 5**

**INDICATOR 2: POLICY IMPLEMENTATION**

**Criterion: Improving Aboriginal Health Outcomes**

10. **Explicitly identified as a strategic priority in LHN Strategic Plan**
   Attempts to locate the LCLHN Strategic plan, or a consultation draft, on the SA Health website have been unsuccessful as at 10 June 2020. It is therefore assumed to still be under development. While information is not currently available regarding the extent to which Aboriginal health outcomes are identified as a strategic priority in the LCLHN strategic plan, and given the priorities given to and delays caused by the COVID-19 pandemic, a discretionary half score is awarded. **Score = 5 / 10**
11. Aboriginal health outcome KPIs reflective of LHN key responsibilities identified in LHN Service Agreement  

The LCLHN Service Agreement 2019-2020, in Schedule 5: Performance Monitoring contains two Aboriginal health-related KPIs also included in the regional LHN Service Agreements, namely the Tier 2 KPIs: DAMA and Aboriginal Employee Participation Rate (pp. 41-43).

The purpose of the following two sub-criteria is to suggest additional Aboriginal Health related KPIs to the existing two. Given the excess burden of disease within the Aboriginal community, and particularly in relation to cancer, heart and stroke, diabetes, kidney disease and mental health, there should be a range of both Tier 1 and 2 KPIs to address these health crises. The basis for scoring is that, given the excess burden of disease among Aboriginal people and the health crises faced by many Aboriginal communities, these KPIs (with Aboriginal people constituting a KPI sub-set), should already be included in the current SA. The fact that they are not results in a penalty score.

12. Tier 1 KPIs

* Elective Surgery: Tier 1 – Timely Admissions: % of elective surgery patients admitted within clinically recommended times; % of Aboriginal patients admitted for elective surgery within clinically recommended times. Target 100%.
* Elective Surgery: Tier 1 – Overdue Patients: # of Category 1, 2 and 3 patients; # of Category 1, 2 and 3 Aboriginal patients. Target 0
* Emergency Department: Tier 1 – Seen on Time: % of patients attending ED who commenced treatment within clinically accepted timeframes; % of Aboriginal patients attending ED who commenced treatment within clinically accepted timeframes. Target varies from 100% for Category 1 patients to >=70% for Category 5 patients.
* Mental Health: Tier 1 – Mental Health - Adult/Older Persons Acute 28 Day Readmission Rate: % of patients who had a readmission within 28 days of discharge (non-short stay); % of Aboriginal patients who had a readmission within 28 days of discharge (non-short stay). Target <=12%
* Mental Health: Tier 1 – Suicide of persons in Inpatient Mental Health Units: # of suicides that occur in admitted patient specialised mental health services; # of Aboriginal suicides that occur in admitted patient specialised mental health services. Target - Monitor

Score = 0 / 5

13. Tier 2 KPIs

* Aboriginal Health: Tier 2 – Indigenous status reporting: % ‘not stated’ on admission. Target: ?
* Mental Health: Tier 2 - Post Discharge Community Follow Up Rate: % of people receiving one or more mental health service contacts while in the community within 7 days post discharge; % of Aboriginal people receiving one or more mental health service contacts while in the community within 7 days post discharge. Target >=70%.
* People and Culture – Tier 2: Completion of the Aboriginal Cultural Competence Program: % of employees who have completed Aboriginal cultural competence training. Target 100%
* Clinical Pathways: Tier 2 - Rehabilitation: Individual Care Plan: % of rehabilitation patients who leave hospital with an individualised care plan; % of Aboriginal rehabilitation patients who leave hospital with an individualised care plan. Target >=90%.
* Occupancy: Tier 2 – Discharge Summary Transmission Rate: % of discharge summaries transmitted with 48 hours of separation; % of Aboriginal patient discharge summaries transmitted with 48 hours of separation. Target >=80%

Score = 0 / 5

Criterion: Community Engagement

14. Aboriginal community consultative body
Based on the information provided in the LCLHNB Agenda and the Minutes, there is no evidence of an Aboriginal Community Consultative Committee (a Tier 3 committee) having been formed, however the LCLHN maintains the Limestone Coast Aboriginal Experts by Experience network. **Score = 4 / 4**

15. **Aboriginal community engagement embedded within overall community engagement strategy**
The Aboriginal community has two avenues to engage with the LCLHN: through the LCLHN’s own consumer and community engagement strategy which is currently under development [as at 10 June 2020, refer: https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+local+health+networks/limestone+coast+local+health+network/engagement+with+consumers+and+the+community++,+limestone+coast+local+health+network], and through the LCLHN’s six Health Advisory Councils (HACs). The HACs were established in 2008, and therefore have a long association with their respective communities. These are separate entities from the LCLHNB, but nevertheless work closely with the Board on matters of community engagement. In the absence of the LCLHN’s own Consumer and Community Engagement Strategy, the score for Aboriginal community engagement with the newly established LCLHN is based on an analysis of the 2018-19 annual reports of the six HACs. The HACs are: Bordertown and District Health Advisory Council Inc. (BDHAC); Kingston/Robe Health Advisory Council Inc. (KRHAC); Millicent and Districts Health Advisory Council Inc. (MDHAC); Mount Gambier and Districts Health Advisory Council Inc. (MGHAC); Naracoorte Area Health Advisory Council Inc. (NAHAC); and Penola and Districts Health Advisory Council Inc. (PDHAC).

### LCLHN HACs’ Annual Reports for 2018-19 – Evidence of Aboriginal Community Engagement

<table>
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<tr>
<th></th>
<th>BDHAC</th>
<th>KRHAC</th>
<th>MDHAC</th>
<th>MGHAC</th>
<th>NAHAC</th>
<th>PDHAC</th>
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<td>Evidence of Aboriginal community engagement</td>
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# ARRMHAC = Aboriginal Resident Representative Member of HAC

Based on performance against the indicators, there has been a complete lack of engagement with the Aboriginal community within the respective HAC regions. **Score = 0 / 4**

16. **LHN Aboriginal community newsletter/e-letter/social media**
Based on the Agenda and Minutes of LCLHNB meetings to April 2020, the HAC reports, and a search of the SA Health website LCLHN page, no evidence has emerged regarding a LCLHN Aboriginal community newsletter, or whether important Aboriginal health information could be conveyed to the LHN’s Aboriginal communities using other platforms such as an e-letter, or via social media platforms such as Facebook and Twitter. However, LCLHN has a Facebook page - @LimestoneCoastLHN - on which it posts Aboriginal health related information. **Score = 1 / 3**

17. **At least one Aboriginal community forum/meeting per year convened by the LHN chief executive officer**
At its September 2nd 2019 meeting, at Agenda Item 3.1.1b, the LCLHNB discussed the Aboriginal Health Community Forum to take place on September 25th, and which was held at Pangula Mannamurna (Mount Gambier) (Sept. 30th meeting Minute 2.1.2b). It is assumed that the CEO together with the Director of Aboriginal Health would have been instrumental in helping to organise this Forum. **Score = 3 / 3**

18. **Reconciliation Action Plan**

CHSALHN (aka Country Health SA) has the *Country Health SA Reconciliation Action Plan 2018-2020* (CHSA, 2018). No discussion has taken place with regard to a RAP either in LCLHNB meetings or in the HAC 2018-2019 annual reports. **Score = 0 / 3**

19. **Aboriginal health professionals caring for patients included within clinical engagement strategy**

A search of the SA Health website, and particularly the LCLHN page (and its portals and their links), did not find the LCLHN Clinical Engagement strategy, or a consultation draft, so it is therefore assumed that it is not yet available. While information is not currently available regarding the extent to which Aboriginal health professionals are included in the LCLHN (draft) clinical engagement strategy, and given the priorities given to and delays caused by the COVID-19 pandemic, a discretionary half score is awarded. **Score = 1.5 / 3**

**Criterion: Public Reporting and Accountability (via LHN website or annual report)**

20. The LCLHN, in effect, does not have its own website. An internet search for “Limestone Coast Local Health Network” will lead to the SA Health website (www.sahealth.sa.gov.au) which provides a link to LCLHN: https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+local+health+networks/limestone+coast+local+health+network/limestone+coast+local+health+n etwork. The LCLHN page contains a number of portals. Each portal provides links to enable access to additional information. As at 7th June 2020, there are five LCLHN portals: (i) Engagement with Consumers & Community; (ii) The Board; (iii) Freedom of Information; (iv) Limestone Coast LHN; and (v) the LCLHN’s response to COVID-19. Each portal provides links to enable access to additional information. For example, the Engagement with Consumers & Community portal provides links to each of the LCLHN’s six HACs. The HAC links will provide access to their annual reports and constitutions/rules. Similarly, information regarding the services available at the LCLHN’s sites is available through the Limestone Coast LHN portal. There is no portal presenting a snap-shot of the LCLHN, providing basic information about population demographics (including the Aboriginal population and Traditional Owners), geographic region served, brief description of the health workforce, a resident health profile/dashboard, and summary of services provided. None of the information sought below is readily available on the LCLHN page (including its portals and their links) (“the LCLHN page”) on the SA Health website. Information regarding, for example, Aboriginal employment in the health workforce, cultural competency training completion rates, and Aboriginal health outcome KPIs must be sought via other portals and links on the SA Health website.

This audit took place before the LCLHN annual report for 2019-2020 was released and therefore the information contained on the LCLHN page is relied on to provide scores for the following sub-criteria.

21. **Traditional Owner acknowledgement.** While there are a number of First Peoples in the region, the LCLHN page does not acknowledge them. **Score = 0 / 2**

22. **Improving Aboriginal health outcomes: (i) Separate section in report devoted to Aboriginal health**

The LCLHN page does not have a portal specifically dedicated to Aboriginal health information and data. **Score = 0/3**
23. Improving Aboriginal health outcomes: (ii) Reporting on KPIs contained in current service level agreement (SLA) The LCLHN Service Agreement 2019-2020 contains two Tier 2 KPIs relevant to Aboriginal Health: DAMA (p. 44) and Aboriginal and Torres Strait Islander employment (p. 45). The LCLHN page does not report on either. **Score = 0/3**

24. Improving Aboriginal health outcomes: (iii) Report on Aboriginal community engagement The LCLHN page “Engagement with consumers & community” portal provides links to the six HACs and Regional Health Advisory Council resources, which includes links to, for example, membership forms and the Aboriginal Health Impact Statement Policy Guidelines. However, the page does not contain information on Aboriginal community engagement activities, such as, meetings that may have taken place with LCLHN executives, community forums, LHN NAIDOC and Reconciliation Week events, or how engagement is taking place with its rural Aboriginal communities, and the outcomes of these activities. **Score = 0/3**

25. Improving Aboriginal health outcomes: (iv) Report on Aboriginal specific National Safety and Quality Health Service Standards assessment The LCLHN page does not provide links to the six Aboriginal specific National Safety and Quality Health Service Standards (see Table 2), and how the LHN is implementing them and meeting their goals. **Score = 0/3**

26. Improving Aboriginal health outcomes: (v) Chronic disease management and care planning The LCLHN SA 2019-2020 (p. 24) identifies as one of its principal areas of services and accountabilities: “A requirement to participate in the South Australian Aboriginal Chronic Disease Consortium to progress implementation of the three statewide plans [regarding cancer control, heart and stroke, and diabetes] and consider opportunities to reorientate or reform services aligned with these plans.” The LCLHN page does not provide links to information regarding how the LHN is progressing implementation of the three statewide plans and putting in place chronic disease management and care plans for Aboriginal patients. **Score = 0 /3**

27. Cultural learning completion rates The LCLHN SA 2019-2020 (p. 24) identifies as one of its principal areas of services and accountabilities: “The DHW will work with the LCLHN to increase the cultural competence of our whole workforce through the implementation of the SA Health Aboriginal Cultural Learning Framework which is a significant strategy for SA Health to meet the accreditation requirements of the NSQHs.” However, the LCLHN page does not provide links to data on non-Aboriginal staff completion rates for the Cultural Learning Program for the three levels, the mode of delivery, and participant feedback. **Score = 0 /2**

28. Aboriginal health division/unit placement on LHN organisational structure/chart The LCLHN page does not provide a link to information about, or a diagram of the organisational structure of the LHN. **Score = 0 /1**

29. Data on Aboriginal access to and delivery of services The LCLHN page does not provide links to data on the level of access to and use of the health services by Aboriginal people within its region. **Score = 0 /3**

30. Aboriginal employment: (i) Aboriginal Workforce Framework (planning, recruitment, etc.) The LCLHN SA 2019-2020 (p. 24) identifies as one of its principal areas of services and accountabilities: “Build the capacity and capability of the LCLHN workforce to deliver quality care to Aboriginal people, whereby the DHW’s Workforce Services will work collaboratively with, and support the LCLHN to implement the SA Health Aboriginal Workforce Framework 2017-2022 which identifies key strategies to attract, retain and develop Aboriginal staff, and consequently increase the number of Aboriginal people working across our organisation.” However, the LCLHN page does not provide links
to information on how it is progressing with the implementation of the Aboriginal Workforce Framework.  **Score = 0 /2**

31. **Aboriginal employment: (ii) Data on Aboriginal employment** The LCLHN page does not provide links to data on Aboriginal employment, either as basic statistics on the proportion of its workforce who identify as Aboriginal employees, or for their participation rate in the various health workforce employment categories. **Score = 0 /3**

32. **Other recognition (e.g., awards, scholarships, etc.)** The LCLHN page does not provide links to information regarding staff awards, achievements, etc., including for Aboriginal staff. **Score = 0 /2**

**INDICATOR 3: SERVICE DELIVERY AND PARTNERSHIPS**

**Criterion: Aboriginal LHN Plan**

33. **Co-designed in partnership with ACCHO(s), or Aboriginal organisations, or Aboriginal Experts by Experience in LHN region**

The CHSALHN SLA, with regard to LHN accountabilities, holds that the LHN CEO is responsible for, *inter alia*, “Developing effective and working partnerships with Aboriginal Community Health and ensuring health needs of Aboriginal people are considered in all health plans, programs and models of care developed by the LHN.” (CHSALHN SLA 2018-2019, p. 10). At its Sept. 30th meeting of the LCLHNB (Agenda Item 2.1.2b), the Aboriginal Health Operational Strategic Plan was presented to the Board by the Director Aboriginal Health, supporting the feedback and outcomes of the Aboriginal Health Community Forum held on 25 September at Pangula Mannamurna. The Corka Mob was confirmed as being the Elders consultation group within the Limestone Coast. The Aboriginal Health Operational Strategic Plan was also to be presented to Regional Leadership for feedback before final approval from the Governing Board. It is assumed here that Pangula Mannamurna, as the region’s only ACCHO, together with the Corka Mob, would play core roles within the implementation of Aboriginal Health Operational Strategic Plan. **Score = 2 /2**

34. **Partnership with ACCHO(s) in LHN region** Refer Note 33 At this point no details regarding a partnership approach are known. **Score = 0 /2**

35. **Commitment to Continuous Quality Improvement** Refer Note 33. At this point no details regarding a commitment to Continuous Quality Improvement are known. **Score = 0 /2**

36. **Co-designed KPIs** Refer Note 33. At this point no details regarding whether there is a process for co-designing of KPIs are known. **Score = 0 /2**

37. **Clear statement of ACCHO and LHN responsibilities and conflicts** Refer Note 33. At this point no details regarding Pangula Mannamurna and LHN responsibilities and conflicts are to be addressed are known. **Score = 0 /2**

**Criterion: Cultural Safety**

38. **Implementation of cultural safety policy/strategy**

The LCLHN SA 2019-2020 (p. 24) identifies as one of its principal areas of services and accountabilities: “The DHW will work with the LCLHN to increase the cultural competence of our whole workforce through the implementation of the SA Health Aboriginal Cultural Learning Framework which is a significant strategy for SA Health to meet the accreditation requirements of the NSQHS.” Based on information provided in the LCLHNB meetings (agenda and minutes), the six
HAC annual reports for 2018-19, and SA Health’s website LCLHN page, no mention is made of the development of, or existence of an LHN-specific cultural safety policy or strategy.  

**Score = 0 / 5**

**39. Proportion of staff trained**

Schedule 5: Performance and Monitoring of the LCLHN SLA 2019-2020 outlines the performance indicators and associated reporting arrangements that apply to the LHN. Unlike in the CHSALHN SLA 2018-2019 (p. 65) there is no KPI for the percentage of employees who have completed Aboriginal cultural competency training, with a target of 100%. This would also appear to breach NSQHSS Aboriginal and Torres Strait Islander specific standard 1.21 in relation to Clinical Governance safety and quality training whereby the health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients (see Table 2). No mention of Cultural Safety Training in relation to the LCLHN health workforce non-Aboriginal staff has been made in either Governing Board meetings, or in the 2018-2019 annual reports of the six HACs. Also there is no information available on the FUNLHN page of the SA Health website as to the numbers, or proportion of staff trained.  

**Score = 0 / 5**

**Criterion: Selected LHN health performance indicators reported publicly**

**40. Estimated level of completion of Indigenous status – specifically the reporting of ‘not stated’ on admission**

Schedule 5: Performance and Monitoring of the LCLHN SLA 2019-2020 outlines the performance indicators and associated reporting arrangements that apply to the LHN. The CHSALHN SLA 2018-2019, in Schedule 4: Performance Indicators and Targets, includes a statement in relation to supporting the delivery of the Closing the Gap agenda and citing the NSQHSS, that: “The LHN should implement processes to identify patients as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems” (CHSALHN, SLA 2018—19, p. 59). Schedule 5: Performance and Monitoring of the LCLHN SLA 2019-2020 contains no KPI for addressing the estimated level of completion of Indigenous status. This would also appear to breach NSQHSS Aboriginal and Torres Strait Islander specific standard 5.8 in relation to planning for comprehensive care (see Table 2).  

**Score = 0 / 3**

**41. Discharges against medical advice (DAMA)**

Schedule 5: Performance and Monitoring of the LCLHN SLA 2019-2020 contains a Tier 2 KPI: % of Aboriginal Patients Who Left Hospital Against Medical Advice, with the measure: % of overnight Aboriginal and/or Torres Strait Islander separations. The 2019-20 target is: <=4.5%, with the following performance ranges: Performing - <=4.5%; Performance Concern - >4.5% and <=6.5%; and Under Performing - >6.5%. This target is the same as in the CHSALHN SLA for 2018-2019 Schedule 4: Performance Indicators and Targets, in relation to Safe and Effective Care in terms of Aboriginal Health (CHSALHN, SLA 2018—19, p. 65). In the Access and Flow performance domain with regard to the Emergency Department, there is also a Tier 2 KPI: Left at Own Risk, with the Measure which includes percentages of (i) all ED presentations, (ii) Aboriginal presentations, and (iii) Mental Health presentations, with the target for all three categories: <=3% (CHSALHN, SLA 2018—19, p. 62). The SA Health website LCLHN page contains no data on how LCLHN is progressing against the performance ranges contained in its SLA.  

**Score = 0 / 4**

**42. Potentially preventable hospital admissions (PPHA)**

Schedule 5: Performance and Monitoring of the LCLHN SLA 2019-2020 does not contain a KPI regarding potentially preventable hospital admission for Aboriginal people.  

**Score = 0 / 3**

**43. Access to mental health services as reported at service level agreement**
Schedule 5: Performance and Monitoring of the LCLHN SLA 2019-2020 does not contain a KPI regarding Aboriginal access to mental health services. The SA Health website LCLHN page contains no data on Aboriginal access to mental health services. **Score = 0/3**

44. **Low birth-weight babies**
Schedule 5: Performance and Monitoring of the LCLHN SLA 2019-2020 does not contain a KPI regarding low birth-weight Aboriginal babies. The SA Health website LCLHN page contains no data on low birth-weight Aboriginal babies. **Score = 0/3**

45. **Healthcare outcome differential measures (eg, discharge summary timeliness)**
Schedule 5: Performance and Monitoring of the LCLHN SLA 2019-2020 does not contain KPIs regarding Aboriginal healthcare outcome differential measures, and is not a matter discussed at LCLHNB meetings and in the six HAC annual reports for 2018-19. **Score = 0/4**

**INDICATOR 4: RECRUITMENT AND EMPLOYMENT**

Criterion: Aboriginal health workforce development reporting

46. **Implementation of Aboriginal workforce strategy**
At its September 2nd 2019 meeting at Minute 1.3.1, the LCLHNB referred to the recognition of CHSSA Credentials and confirmation of the credentialing process for the Aboriginal and Torres Strait Islander workforce. At the Nov. 25th meeting, in regard to Rural Health Workforce Strategy Planning (Agenda Item 7.1) opportunities for collaboration with, *inter alia*, other LHNs and Pangula Mannamurna, were discussed.

At its February 24th meeting (Minute 3.1a), the CEO reported on the planning and commissioning proposals for 2020-21 including Aboriginal Workforce funding. However, while there is no reference to a LCLHN Aboriginal workforce strategy on the SA Health website LCLHN page it is clearly on the LCLHNB agenda. **Score = 3/4**

47. **LHN KPI for Aboriginal employment**
Schedule 5: Performance and Monitoring of the LCLHN SLA 2019-2020 contains a Tier 2 KPI: Aboriginal Employment Rate, with the measure: % of employees who identified as being of Aboriginal or Torres Strait Islander origin. The 2019-20 target is: >=4%, with the following performance ranges: Performing - >=4.0%; Performance Concern - <4.0% and >=1.5%; and Under Performing - <1.5%. No data regarding the LCLHN’s progress against the SLA performance ranges on the SA Health website LCLHN page. **Score = 0/4**

48. **Number of Aboriginal health practitioners, health workers and liaison officers**
According to SA Health, Aboriginal health workers are located at the LCLHN health facility at Mount Gambier [https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/services/health+services+for/aboriginal+health+services/aboriginal+health+workers](https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/services/health+services+for/aboriginal+health+services/aboriginal+health+workers). At its September 2nd 2019 meeting at Minute 1.3.1, the LCLHNB referred to the recognition of CHSSA Credentials and confirmation of the credentialing process for the Aboriginal and Torres Strait Islander workforce, and specifically regarding the health practitioner role. However the number of Aboriginal people employed in the health practitioner, health worker and liaison officer roles is not provided on the SA Health website LCLHN page. **Score = 2/3**

49. **Number of identified Aboriginal positions**
Data regarding the number of identified Aboriginal positions in LCLHN’s workforce is not provided on the SA Health website LCLHN page. **Score = 0/3**
50. **Number of salary bands occupied by Aboriginal employees**
Data regarding the number of salary bands occupied by Aboriginal employees in LCLHN’s workforce is not provided on the SA Health website LCLHN page. **Score = 0/3**

51. **Number of long term Aboriginal employees**
Data regarding the number of long term Aboriginal employees in LCLHN’s workforce is not provided on the SA Health website LCLHN page. **Score = 0/3**

**Criterion: Aboriginal participation in the health workforce**

52. **Administrative**
Data regarding the number of Aboriginal people working in administration in LCLHN’s workforce is not provided on the SA Health website LCLHN page. **Score = 0/3**

53. **Medical Professional**
Data regarding the number of Aboriginal medical professionals in LCLHN’s workforce is not provided on the SA Health website LCLHN page. **Score = 0/4**

54. **Nurses/Midwives**
Data regarding the number of Aboriginal nurses and midwives in LCLHN’s workforce is not provided on the SA Health website LCLHN page. **Score = 0/4**

55. **Operational Services**
Data regarding the number of Aboriginal providing operational services in the LCLHN is not provided on the SA Health website LCLHN page. **Score = 0/3**

56. **Allied Health/Scientific/Technical**
Data regarding the number of Aboriginal employed to provide allied health/scientific and technical services in the LCLHN is not provided on the SA Health website LCLHN page. **Score = 0/3**

57. **Other**
Data regarding other roles occupied and services offered by Aboriginal people in LCLHN’s workforce (for example, as cultural consultants, and experts by experience) is not provided on the SA Health website LCLHN page. **Score = 0/3**

**INDICATOR 5: FINANCIAL ACCOUNTABILITY AND REPORTING – CLOSING THE GAP FUNDING**

The LCLHN Service Agreement 01 July 2019 – 30 June 2020 (LCLHN SA) in Schedule 3: Local Health Network – Services and Accountabilities, under Section 4. Services for Priority Population Groups, in sub-section 4.1 Aboriginal Health Services, states that:

- The LHN will work collaboratively with DHW’s Aboriginal Health other relevant health services, support organisations and Aboriginal community-controlled health services to continue to implement the regional Aboriginal Health Improvement Plan to support services meeting the needs of the local Aboriginal population.

In recognition of the need to ensure appropriate resource allocation for Aboriginal Health Programs, the LHN should maintain or increase their relative funding allocation to these programs commensurate with their total funding allocation (pp. 23-24).

The LCLHN SA identifies three principal areas of services and accountabilities:

- A requirement to participate in the South Australian Aboriginal Chronic Disease Consortium to progress implementation of the three statewide plans [regarding cancer control, heart and stroke, and diabetes] and consider opportunities to reorientate or reform services aligned with these plans;
• Build the capacity and capability of the LCLHN workforce to deliver quality care to Aboriginal people, whereby the DHW’s Workforce Services will work collaboratively with, and support the LCLHN to implement the SA Health Aboriginal Workforce Framework 2017-2022 which identifies key strategies to attract, retain and develop Aboriginal staff, and consequently increase the number of Aboriginal people working across our organisation; and

• The DHW will work with the LCLHN to increase the cultural competence of our whole workforce through the implementation of the SA Health Aboriginal Cultural Learning Framework which is a significant strategy for SA Health to meet the accreditation requirements of the NSQHS (p. 24).

In Schedule 4: Funding and Commissioned Activity of the LCLHN SA, in Section 6: Specific Commissioning/Funding Commitments (p. 37), five services and programs are identified:

• Transition Care Program (TCP)
• Community Support Scheme Program (CSS)
• Chronic Pain Model of Care
• Aged Care Assessment Program (ACAP)
• Multi-Purpose Services (MPS).

No funding allocations within the five programs/services have been specified for Aboriginal Health services/needs. The LCLHN is expected to work collaboratively with the Office of Ageing Well, Adult Safeguarding Unit to support Aboriginal and Torres Strait Islander people aged 50 years or over (pp. 24-25). The LCLHN is also responsible for developing the Rural Health Workforce Strategy broad services plan and workforce plan under the guidance of the Rural Health Workforce Strategy Steering Committee to support recruitment, retention and training of, inter alia, Aboriginal health workers (p. 18). Aboriginal Health is not included among the range of inpatient health services available at the LCLHN’s large and medium site facilities at Mount Gambier, Millicent and Naracoorte (p. 48).

The LCLHN SA has not identified any specific funding allocations (Commonwealth, State, or other) for Aboriginal Health Services, and incorporates only two Tier 2 KPIs relevant to Aboriginal Health: DAMA (p. 42) and Aboriginal and Torres Strait Islander employment (p. 43).

Criterion: Commonwealth contributions for Aboriginal health programs to LHN

58. Commonwealth contributions for Aboriginal health programs to LHN
A search of the SA Health website, including the LCLHN page (including portals and their links) did not produce any information concerning Commonwealth contributions for Aboriginal health programs to the LCLHN. **Score = 0 / 10**

Criterion: South Australian contributions to Aboriginal specific services and programs including activity-based funding loading for Aboriginal patients

59. Reporting on contributions for Aboriginal specific health services and programs including activity-based funding loading
A search of the SA Health website, including the LCLHN page (including portals and their links), did not produce any information on State funding contributions for Aboriginal specific health services and programs at the LCLHN including for activity-based funding loadings for Aboriginal patients. **Score = 0 / 10**

LCLHN documents consulted

• Governing Board Meetings: Agenda 29 July 2019 / Minutes 29 July 2019
<table>
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<th>Date</th>
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<td>24 Feb. 2020</td>
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<td>27 Apr. 2020</td>
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- **Service Agreement** (1 July 2019 – 30 June 2020)
- LCLHN Facebook page - @LimestoneCoastLHN

**HACs**
- Penola and Districts Health Advisory Council Inc. [PDHAC] Annual Report 2018-2019

LCLHN documents not sighted
### RIVERLAND MALLEE COORONG LOCAL HEALTH NETWORK (RMCLHN) MATRIX AUDIT FY2019 – June 2020 (1)

#### Key Indicators and Criteria

<table>
<thead>
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<th>1. Participation in LHN governance</th>
<th>Scoring</th>
<th>Score</th>
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<tr>
<td><strong>1.1 Good governance</strong></td>
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<td>1.1.1 Board interaction with Aboriginal community (2)</td>
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<td>1.1.2 LHN Aboriginal health performance indicators on Board agenda for every meeting (3)</td>
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<td>1.1.3 Direct input to Board by LHN Aboriginal Community Consultative Committee or Aboriginal Experts by Experience (4)</td>
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<td>1.1.4 LHN Board members are educated about Aboriginal health in their LHN (5)</td>
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<td>2</td>
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<tr>
<td>1.1.5 LHN Board members receive cultural learning training (6)</td>
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<th>1.2 Aboriginal representation at board level</th>
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<tr>
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<td>Aboriginal representation at board level (7)</td>
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<thead>
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<th>1.3 Inclusion in Executive Management Structure</th>
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<tr>
<td>Total out of 10</td>
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<tr>
<td>A stand-alone Aboriginal Health Division (8)</td>
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<td>Aboriginal LHN lead directly reports to the LHN CEO (9)</td>
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<td><strong>TOTAL</strong></td>
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#### 2. Policy Implementation

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<th>2.1 Improving Aboriginal Health Outcomes</th>
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<tr>
<td>Total out of 20</td>
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<tr>
<td>Explicitly identified as a strategic priority in LHN Strategic Plan (10)</td>
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<tr>
<td>Aboriginal community consultative body (14)</td>
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<td>Aboriginal community engagement embedded within overall community engagement strategy (15)</td>
<td>4</td>
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<td>LHN Aboriginal community newsletter/e-letter/social media (16)</td>
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<td>At least one Aboriginal community forum/meeting per year convened by the LHN chief executive officer (17)</td>
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<td>Reconciliation Action Plan (18)</td>
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<td>Aboriginal health professionals caring for patients included within clinical engagement strategy (19)</td>
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<tr>
<th>2.3 Public Reporting and Accountability (via LHN website or annual report)</th>
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<th>Score</th>
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<tr>
<td>Traditional Owner Acknowledgement (21)</td>
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<tr>
<td>Improving Aboriginal health outcomes</td>
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<tr>
<td>(i) Separate section in report devoted to Aboriginal health (22)</td>
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<td>(ii) Reporting on KPIs contained in current service level agreement (SLA) (23)</td>
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<td>(iii) Report Aboriginal community engagement (24)</td>
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<td>(iv) Report on Aboriginal specific National Safety and Quality Health Service Standards Assessment (25)</td>
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<td>(v) Chronic disease management and care planning (26)</td>
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<td>Cultural learning completion rates (27)</td>
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</table>
2.3.4 Aboriginal health division/unit placement on LHN organisational structure/chart (28) 1 0
2.3.5 Data on Aboriginal access to and delivery of services (29) 3 0
2.3.6 Aboriginal employment
(i) Aboriginal Workforce Framework (planning, recruitment, etc.) (30) 2 0
(ii) Data on Aboriginal employment (31) 3 0
2.3.7 Other recognition (e.g., awards, scholarships, etc.) (32) 2 0

TOTAL 70 11.5

3. Service delivery and partnerships

3.1 Aboriginal LHN Plan
3.1.1 Co-designed in partnership with ACCHO(s), or Aboriginal organisations, or Aboriginal Experts by Experience in LHN region (33) 2 0
3.1.2 Partnership with ACCHO(s) in LHN region (34) 2 0
3.1.3 Commitment to Continuous Quality Improvement (35) 2 0
3.1.4 Co-designed KPIs (36) 2 0
3.1.5 Clear statement of ACCHO and LHN responsibilities and conflicts (37) 2 0

Total out of 10

3.2 Cultural safety
3.2.1 Implementation of cultural safety policy/strategy (38) 5 0
3.2.2 Proportion of staff trained (39) 5 0

Total out of 10

3.3 Selected LHN health performance indicators reported publicly
3.4.1 Estimated level of completion of Indigenous status – specifically the reporting of ‘not stated’ on admission (40) 3 0
3.4.2 Discharged against medical advice (DAMA) (41) 4 0
3.4.3 Potentially preventable hospitalisations (PPHA) (42) 3 0
3.4.4 Access to mental health services as reported at service level agreement (43) 3 0
3.4.5 Low birth-weight babies (44) 3 0
3.4.6 Healthcare outcome differential measures (eg. Discharge summary timeliness) (45) 4 0

TOTAL 40 2

4. Recruitment and employment

4.1 Aboriginal health workforce development reporting
4.1.1 Implementation of Aboriginal workforce strategy (46) 4 0
4.1.2 LHN KPI for Aboriginal employment (47) 4 0
4.1.3 Number of Aboriginal health practitioners, health workers and liaison officers (48) 3 2
4.1.4 Number of identified Aboriginal positions (49) 3 0
4.1.5 Number of salary bands occupied by Aboriginal employees (50) 3 0
4.1.6 Number of long-term Aboriginal employees (51) 3 0

Total out of 20

4.2 Aboriginal participation in the health workforce
4.2.1 Administrative (52) 3 0
4.2.2 Medical Professionals (53) 4 0
4.2.3 Nurses/Midwives (54) 4 0
4.2.4 Operational Services (55) 3 0
4.2.5 Allied Health/Scientific/Technical (56) 3 0
4.2.6 Other (57) 3 0

Total out of 20

5. Financial Accountability and Reporting: Closing the Gap Funding
5.1 Commonwealth contributions for Aboriginal health programs to LHN

<table>
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<tr>
<th>Commonwealth contributions for Aboriginal health programs to LHN (58)</th>
<th>Total out of 10</th>
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5.2 South Australian contributions to Aboriginal specific health services and programs including activity-based funding loading for Aboriginal patients

<table>
<thead>
<tr>
<th>Reporting on contributions for Aboriginal specific health services and programs including activity-based funding loading (59)</th>
<th>Total out of 10</th>
</tr>
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<tr>
<td></td>
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| TOTAL                                                                 | 20             |

Total Score

| 200 | 30.5 |

Institutional Rating scored against criteria

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<th>Score:</th>
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<th>120-159</th>
<th>80-119</th>
<th>40-79</th>
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<tr>
<td>Evidence of Inst. Racism:</td>
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<td>Low</td>
<td>Moderate</td>
<td>High</td>
<td>Very High</td>
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</tbody>
</table>

Notes:

1. **Riverland Mallee Coorong Local Health Network (RMCLHN)**
   The RMCLHN is responsible for delivering core health services to around 70,000 people living within this region. Services are provided by two large sites (the Riverland General Hospital in Berri and the Murray Bridge Soldiers’ Memorial Hospital), and several smaller sites, supported by a range of community-based facilities (RMCLHN SLA 2019-2020, p. 20). Based on 2011 Census data, Aboriginal people constitute about 3.5% of the total population of the RMCLHN region (CHSALHN 2015a, p. 19). Assuming that that percentage remains roughly the same, currently there would be about 2,500 Aboriginal people in the RMCLHN region (cf 2,398 - 2011 Census).

   ACCHOs: Moorundi Aboriginal Community Controlled Health Service Inc. (Murray Bridge); Tumake Yande Elders House in Murray Bridge.

   Aboriginal Health is included among the range of inpatient health services available at the RMCLHN’s medium site facility at Murray Bridge (Murray Bridge Soldiers’ Memorial Hospital) (RMCLHN SLA 2019-2020, p. 48).

   As at January 2018, the region now served by the RMCLHN had 37 Aboriginal Experts by Experience (HPCSA, 2019, p. 25)

   Because the RMCLHN came into effect as an LHN in its own right on 1 July 2019, many key documents relied upon for the conduct of this audit, such as the RMCLHN Strategic Plan, the Clinicians and Workforce Engagement Strategy, and the Consumers and Community Engagement Strategy are still under development. Another key document, the RMCLHN annual report for 2019-2020 will not be available until after 30 September 2020. In the absence of these documents, the audit relies primarily on the RMCLHN Governing Board meeting agenda and minutes, and the 2018-2019 annual reports of the LHN’s eight HACs. Scores have been adjusted to reflect the availability of relevant documents.

**INDICATOR 1: PARTICIPATION IN LHN GOVERNANCE**

**Criterion: Good governance**

The following chart provides an overview of the RMCLHN’s references to and discussion concerning Aboriginal health and related matters. In addition to the listed sub-criteria, other headings have been included to cover information not readily assigned to the listed sub-criteria. Where Aboriginal
health matters have been discussed, the Agenda item numbers have been indicated in the monthly columns. Also note that the Acknowledgement of Country is a standing item under Agenda Item 1.1 in all meetings, and is not included in the chart below.

Legend:
x = no information relevant to the sub-criterion heading was provided.
? = minutes were not uploaded onto SA Health website at the time of this analysis (30 May 2020).
AHEMGB – Aboriginal Health Expert Member of Governing Board (this person may/may not be an Aboriginal person)
Tier 1 committee = a Board committee which reports to the Board
Tier 2 committee = an internal LHN committee which reports to the CEO
Tier 3 committee = a community-based committee established in accordance with, for example, a LHN consumer and community engagement plan/framework/strategy and which can provide input to, or respond to the LHNB or LHN CEO.

RMCLHN Board meetings: good governance sub-criteria summary for July 2019 – April 2020

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<thead>
<tr>
<th>Meeting:</th>
<th>July 25th</th>
<th>Aug. 29th</th>
<th>Sept. 26th</th>
<th>Oct. 31st</th>
<th>Nov. 28th</th>
<th>Jan. 30th</th>
<th>Feb 7th</th>
<th>Mar 27th</th>
<th>April 30th (V)</th>
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Summary of matters addressed:

July 25th:

**Agenda Item 2.2:** Present and apologies. The Chair has met with the [Aboriginal Health Expert Member of the Governing Board – AHEMGB] who has indicated his preference to be on the Clinical Governance Committee. The discussion included Aboriginal engagement and consumer focus and the AHEMGB’s understanding of Board procedures. It was also noted that the AHEMGB is commencing a new role at Flinders University.

**Agenda Item 2.5:** Review Action Log. Engagement with Aboriginal Health – refer agenda item 4.5
**Agenda Item 4.2:** Board Charter volume 1 & 2. Questions raised in relation to the grammar in one section and the definition related to a member with experience in Aboriginal health. Grammar to be checked and the definition to align to the legislation. **Action:** The Board Charter Volume 2 to be amended in relation to the grammar and the definition to align to the legislation.

**Agenda Item 4.5:** Aboriginal Consumer Engagement. **Discussion:** (i) following the Shadow Board meeting of 27 June 2019, the [Chair] followed up with the [AHEMGB] to seek advice regarding the Minister’s wish for an increase in the engagement with Aboriginal consumers; (ii) The context of incorporating Aboriginal engagement within the RMCLHN Consumer and Community Engagement Strategy or developing a separate Aboriginal Consumer and Community Engagement Strategy was raised with further discussion to occur with the [AHEMGB]; (iii) Noted that SA Health Aboriginal Health Directorate have requested that a series of workshops be arranged across regional SA. The request was for one workshop per LHN but feedback has been provided that there would need to be three in RMCLHN to accommodate the distinct communities. These are to be conducted by September – October and involve at least one Board member; (iv) [The Chair] to follow up with the [AHEMGB] regarding his potential involvement in the Aboriginal community forums being organised through SA Health Aboriginal Health Directorate and Director Aboriginal Health RMCLHN; and (v) Discussion about the Elders program in RMCLHN and different ways Aboriginal communities currently engage with services. **Action:** The Board noted the discussions and plans for Aboriginal community engagement forms. [The Chair] to follow up with the [AHEMGB] regarding his involvement in the Aboriginal community forums being organised through SA Health Aboriginal Health Directorate and Director Aboriginal Health RMCLHN.

**Agenda Item 6.2:** Board Committees. Board confirmed membership of the Clinical Governance Committee to include the [AHEMGB]

**August 29th:**

**Agenda Item 4.5:** Aboriginal Community Forums. **Discussion:** (i) The Aboriginal Health Branch, DHW, are conducting forums in each of the regional LHNs in partnership with the LHN. The date for the RMCLHN Forum is 1 November 2019; (ii) The purpose of the forums is to provide Aboriginal communities with an overview of the recent governance changes in SA Health, and highlight the opportunities for partnership and collaboration in improving Aboriginal health outcomes at the local level; (iii) The forums will also provide an opportunity for Aboriginal health partners and communities to meet and talk with key RMCLHN staff, and the Chair and Aboriginal Health expert of the RMCLHN Governing Board. The Board noted the information about the proposed Aboriginal Community Forums.

**Agenda Item 9.6:** Tumake Yande Elders House – Invitation to opening. Invitation received for the opening of the Tumake Yande Elders House in Murray Bridge 29 September 2019. It was noted that the date coincides with the next Board meeting in Lameroo.

**September 26th:**

**Agenda Item 5.1:** Aboriginal Health Forum: 5.1.1 Draft Agenda; 5.1.2 Draft Presentation. **Discussion:** (i) The Aboriginal Health Branch, DHW is conducting forums in each LHN with the RMCLHN Forum scheduled for 1 November 2019; (ii) The purpose of the forums is to provide Aboriginal communities with an overview of the recent governance changes in SA Health, and highlight the opportunities for partnership and collaboration in improving Aboriginal health outcomes at the local level; (iii) The forums will also provide an opportunity for Aboriginal health partners and communities to meet and talk with key RMCLHN staff, and the Chair and Aboriginal Health expert of the LHN Governing Board. The Board noted the information about the RMCLHN Aboriginal Health Community Forum. **Action:** [Secretariat] to check with the [AHEMGB] about any feedback on the draft presentation.

**Agenda Item 10.1:** Correspondence - Minute to LHN Board Chairs re AHEMGB Information Session 11 October. The Board noted the correspondence.
Oct. 31st Agenda Item 2.5: Review Actins Log. Noted that Aboriginal Health Community Forum scheduled for 1 November in Murray Bridge and 7 November in Berri.

Nov. 28th Agenda Item 3.2: CEO Report. The Aboriginal Community Engagement workshops held in Murray Bridge and Berri were noted with a further workshop planned for Meningie.

Feb. 27th Agenda Item 10.2: Correspondence. In – Communique Aboriginal Health Board Member Forum. Minute 10.1.2: All correspondence noted.

March 27th Agenda Item 6.1.5: Performance Report – Other. CEO responded to questions in relation to the KPI Report, People and Culture Report and Quality and Safety report. Action: Specific briefing to be provided about strategies in relation to Aboriginal self-discharges.

April 30th Agenda Item 5.2: no minutes.

2. Board interaction with Aboriginal community
Based on the information provided in the Agenda and Minutes of the RMCLHNB meetings, there is no evidence of Board interaction with the Aboriginal communities within their region. **Score = 0 / 2**

3. LHN Aboriginal Health performance indicators on Board agenda for every meeting
Based on the information provided in the Agenda and the Minutes, there is no evidence of Aboriginal Health performance indicators being provided to or being discussed at RMCLHNB meetings. **Score = 0 / 2**

4. Direct input to Board by LHN Aboriginal Community Consultative Committee or by Aboriginal Expert by Experience
Based on the information provided in the Agenda and the Minutes, there is no evidence of an Aboriginal Community Consultative Committee (a Tier 3 committee) operating within the LHN region. Similarly, no evidence has emerged of the Aboriginal Experts by Experience providing input at RMCLHNB meetings. **Score = 0 / 2**

5. LHN Board members are educated about Aboriginal health in their LHN
Two Aboriginal Health Community Forums were held at Murray Bridge (1 November) and Berri (7th November 2019), and given that one of the purposes of the forums was to “also provide an opportunity for Aboriginal health partners and communities to meet and talk with key RMCLHN staff, and the Chair and Aboriginal Health expert of the LHN Governing Board” (RMCLHNB meeting August 25th at Minute 4.5), it is assumed that at least some members of the Board, including the Chair, will have received information about the health issues of Aboriginal communities within their region. **Score = 2 / 2**

6. LHN Board members receive cultural learning training
Based on the information provided in the Agenda and the Minutes, no intention has been expressed by the RMCLHN Board Members of organising or participating in Cultural Safety Training. **Score = 0 / 2**

**Criterion: Aboriginal representation at board level**

7. Aboriginal representation at board level
The RMCLHN Governing Board comprises six members, one of whom is the Aboriginal Health Expert Member of the Governing Board – AHEMGB. **Score = 10 / 10**

**Criterion: Inclusion in Executive Management Structure**
8. A stand-alone Aboriginal Health Division
Based on the Regional LHN Leadership Structure provided in the Establishment of Regional Local Health Networks: Detailed Design Proposal – Consultation Paper (CHSALHN 2019, p. 6) and the diagram of the governance structure provided on p. 3 of the Draft Consumer and Community Engagement Strategy, which was released for public consultation in April 2020 (see RMCLHN meeting 27th March 2020, at Minute 6.3), the Division of Aboriginal Health exists as a stand-alone division within the RMCLHN organisational structure. Score = 5 / 5

9. Aboriginal LHN lead directly reports to the LHN CEO
According to the Regional LHN Leadership Structure (see Note 8), the Director of Aboriginal Health reports directly to the RMCLHN CEO. However, the RMCLHN page on the SA Health website provides no links to information (brief bios) concerning the members of the executive management group, as there is for the RMCLHN Board members. Thus there is no information confirming whether the Director of Aboriginal Health is an Aboriginal person or not. Given the emphasis placed on the importance of the Director of Aboriginal Health being an Aboriginal person by the Expert Workshop, failure to provide this information via the RMCLHN page on the SA Health website results in a penalty score. Score = 0 / 5

INDICATOR 2: POLICY IMPLEMENTATION

Criterion: Improving Aboriginal Health Outcomes

10. Explicitly identified as a strategic priority in LHN Strategic Plan
In the absence of any information on the SA Health website RMCHLN page (and portals and their links), it is assumed that the LHN’s Strategic Plan is still under development, and therefore not available for review. While information is not currently available regarding the extent to which Aboriginal health outcomes are identified as a strategic priority in the RMCLHN strategic plan, and given the priorities given to and delays caused by the COVID-19 pandemic, a discretionary half score is awarded. Score = 5 / 10

11. Aboriginal health outcome KPIs reflective of LHN key responsibilities identified in LHN Service Agreement
The RMCLHN Service Agreement 2019-2020, in Schedule 5: Performance Monitoring contains two Aboriginal health-related KPIs also included in the regional LHN Service Agreements, namely the Tier 2 KPIs: DAMA and Aboriginal Employee Participation Rate (pp. 41-43).

The purpose of the following two sub-criteria is to suggest additional Aboriginal Health related KPIs to the existing two. Given the excess burden of disease within the Aboriginal community, and particularly in relation to cancer, heart and stroke, diabetes, kidney disease and mental health, there should be a range of both Tier 1 and 2 KPIs to address these health crises. The basis for scoring is that, given the excess burden of disease among Aboriginal people and the health crises faced by many Aboriginal communities, these KPIs (with Aboriginal people constituting a KPI sub-set), should already be included in the current SA. The fact that they are not results in a penalty score.

12. Tier 1 KPIs
  * Elective Surgery: Tier 1 – Timely Admissions: % of elective surgery patients admitted within clinically recommended times; % of Aboriginal patients admitted for elective surgery within clinically recommended times. Target 100%.
  * Elective Surgery: Tier 1 – Overdue Patients: # of Category 1, 2 and 3 patients; # of Category 1, 2 and 3 Aboriginal patients. Target 0
  * Emergency Department: Tier 1 – Seen on Time: % of patients attending ED who commenced treatment within clinically accepted timeframes; % of Aboriginal patients attending ED who
commenced treatment within clinically accepted timeframes. Target varies from 100% for Category 1 patients to >=70% for Category 5 patients.

* Mental Health: Tier 1 – Mental Health - Adult/Older Persons Acute 28 Day Readmission Rate: % of patients who had a readmission within 28 days of discharge (non-short stay); % of Aboriginal patients who had a readmission within 28 days of discharge (non-short stay). Target <=12%.

* Mental Health: Tier 1 – Suicide of persons in Inpatient Mental Health Units: # of suicides that occur in admitted patient specialised mental health services; # of Aboriginal suicides that occur in admitted patient specialised mental health services. Target - Monitor

Score = 0 / 5

13. Tier 2 KPIs

* Aboriginal Health: Tier 2 – Indigenous status reporting: % ‘not stated’ on admission. Target: ?

* Mental Health: Tier 2 - Post Discharge Community Follow Up Rate: % of people receiving one or more mental health service contacts while in the community within 7 days post discharge; % of Aboriginal people receiving one or more mental health service contacts while in the community within 7 days post discharge. Target >=70%.

* People and Culture – Tier 2: Completion of the Aboriginal Cultural Competence Program: % of employees who have completed Aboriginal cultural competence training. Target 100%

* Clinical Pathways: Tier 2 - Rehabilitation: Individual Care Plan: % of rehabilitation patients who leave hospital with an individualised care plan; % of Aboriginal rehabilitation patients who leave hospital with an individualised care plan. Target >=90%.

* Occupancy: Tier 2 – Discharge Summary Transmission Rate: % of discharge summaries transmitted with 48 hours of separation; % of Aboriginal patient discharge summaries transmitted with 48 hours of separation. Target >=80%

Score = 0 / 5

Criterion: Community Engagement

14. Aboriginal community consultative body

Based on the information provided in the Agenda and the Minutes of the RMCLHN Board meetings, no discussion has taken place on the establishment of an Aboriginal community consultative body for the LHN.

Score = 0 / 4

15. Aboriginal community engagement embedded within overall community engagement strategy

The Aboriginal community has two avenues to engage with the RMCLHN: through the RMCLHN’s own consumer and community engagement strategy, and through the RMCLHN’s eight Health Advisory Councils (HACs). The Draft Consumer and Community Engagement Strategy was released for public consultation in April 2020 (see RMCLHN meeting 27th March 2020, at Minute 6.3), however, it is light on detail. Under the heading “Our Plan”, “We will provide comprehensive consumer focussed care”, which will be achieved by, inter alia, respecting “the needs, values and goals of each individual consumer, including those with a lived experience of diversity, including but not limited to those who identify as Aboriginal, LGBTI and CALD communities” (p. 5). The Board noted that the current COVID-19 environment will impact the consultation phase, but determined to proceed and review the Plan in 12 months (and thereafter every three years). For the purpose of the audit, the RMCLHN Consumer and Community Engagement Strategy is considered to be still under development.

The HACs were all established in 2008, and therefore have a long association with their respective communities. These are separate entities from the RMCLHN, but nevertheless work closely with the Board on matters of community engagement. In the absence of the RMCLHN’s formally
endorsed Consumer and Community Engagement Strategy, the score for Aboriginal community engagement with the newly established RMCLHN is based on an analysis of the 2018-19 annual reports of the eight HACs. The HACs are: Berri, Barmera District Health Advisory Council Inc. (BBHAC); Coorong Health Service Health Advisory Council Inc. (CHHAC); Loxton and Districts Health Advisory Council Inc. (LDHAC); Mallee Health Service Health Advisory Council Inc. (MHHAC); Mannum District Hospital Health Advisory Council Inc. (MDHHAC); Murray Bridge Soldiers’ Memorial Hospital Health Advisory Council Inc. (MBSMHAC); Renmark, Paringa District Health Advisory Council Inc. (RPHAC); and Waikerie and Districts Health Advisory Council Inc. (WDHAC).

<table>
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<th>RMCLHN HACs’ Annual Reports for 2018-19 – Evidence of Aboriginal Community Engagement</th>
<th>BBHAC</th>
<th>CHHAC</th>
<th>LDHAC</th>
<th>MHHAC</th>
<th>MDHHAC</th>
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# ARRMHAC = Aboriginal Resident Representative Member of HAC

Based on the indicators of Aboriginal community engagement, only two of the eight HACs record some evidence of such engagement. **Score = 1 / 4**

16. **LHN Aboriginal community newsletter/e-letter/social media**

No discussion has taken place within the RMCLHN meetings regarding publication of an Aboriginal community newsletter, or whether important Aboriginal health information could be conveyed to the LHN’s Aboriginal communities using other platforms such as an e-letter, or via social media platforms such as Facebook and Twitter. However, RMCLHN has a Facebook page - @RMCLHN - on which it post Aboriginal health related information. **Score = 1 / 3**

17. **At least one Aboriginal community forum/meeting per year convened by the LHN chief executive officer**

Two Aboriginal Health Community Forums were held at Murray Bridge (1 November) and Berri (7th November 2019), and given that one of the purposes of the forums was to “also provide an opportunity for Aboriginal health partners and communities to meet and talk with key RMCLHN staff, and the Chair and Aboriginal Health expert of the LHN Governing Board” (RMCLHN meeting August 25th at Minute 4.5), it is assumed that the CEO, together with the Director of Aboriginal Health would have been responsible for convening these meetings. **Score = 3 / 3**
18. **Reconciliation Action Plan**

CHSALHN (aka Country Health SA) has the *Country Health SA Reconciliation Action Plan 2018-2020* (CHSA, 2018). No discussion has taken place with regard to a RAP either in RMCLHNB meetings or in the HAC 2018-2019 annual reports.  **Score = 0 / 3**

19. **Aboriginal health professionals caring for patients included within clinical engagement strategy**

The *Draft Clinician and Workforce Engagement Strategy* was released for public consultation in April 2020 (see RMCLHNB meeting 27th March 2020, at Minute 6.4), however, it is light on detail. Apart from mentioning that the Strategy, in terms of its scope, “will also appropriately involve and engage with other providers of health services, including, *inter alia*, Moorundi Aboriginal Community Controlled Health Services Inc.” (p. 2), no mention is made of Aboriginal health professionals caring for patients within the draft Strategy. The Board noted that the current COVID-19 environment will impact the consultation phase, but determined to proceed and review the Plan in 12 months (and thereafter every three years). For the purpose of the audit, the RMCLHN Clinician and Workforce Engagement Strategy is considered to be still under development. While information is not currently available regarding the extent to which Aboriginal health professionals are included in the RMCLHN clinical engagement strategy, and given the priorities given to and delays caused by the COVID-19 pandemic, a discretionary half score is awarded.  **Score = 1.5 / 3**

**Criterion: Public Reporting and Accountability (via LHN website or annual report)**

20. The RMCLHN, in effect, does not have its own website. An internet search for “Riverland Mallee Coorong Local Health Network” will lead to the SA Health website (www.sahealth.sa.gov.au) which provides a link to RMCLHN: https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+local+health+networks/riverland+mallee+coorong+local+health+network/riverland+mallee+coorong+local+health+network. The RMCLHN page contains a number of portals. Each portal provides links to enable access to additional information. As at 7th June 2020, there are seven RMCLHN portals: (i) About Us; (ii) Riverland Mallee Coorong Services; (iii) RMCLHN Engagement; (iv) the RMCLHN’s response to COVID-19; (v) The Board; (vi) RMCLHN HACs; and (vii) Freedom of Information. Each portal provides links to enable access to additional information. For example, the Board portal provides links to Board membership, meetings (agenda and minutes), and expenses. The HAC portal provides links that will enable access to their annual reports and constitutions/rules. There is no portal presenting a snap-shot of the RMCLHN providing basic information about population demographics (including the Aboriginal population and Traditional Owners), geographic region served, brief description of the health workforce, a resident health profile/dashboard, and summary of services provided. None of the information sought below is readily available on the RMCLHN page (including its portals and their links) on the SA Health website. Information regarding, for example, Aboriginal employment in the health workforce, cultural competency training completion rates, and Aboriginal health outcome KPIs must be sought via other portals and links on the SA Health website.

This audit took place before the RMCLHN annual report for 2019-2020 was released and therefore the information contained on the RMCLHN page is relied on to provide scores for the following sub-criteria.

21. **Traditional Owner acknowledgement** While there are a number of First Peoples in the region, the RMCLHN page does not acknowledge them.  **Score = 0 / 2**
22. **Improving Aboriginal health outcomes: (i) Separate section in report devoted to Aboriginal health** The RMCLHN page does not have a portal specifically dedicated to Aboriginal health information and data. **Score = 0 / 3**

23. **Improving Aboriginal health outcomes: (ii) Reporting on KPIs contained in current service level agreement (SLA)** The RMCLHN Service Agreement 2019-2020 contains two Tier 2 KPIs relevant to Aboriginal Health: DAMA (p. 44) and Aboriginal and Torres Strait Islander employment (p. 45). The RMCLHN page does not report on either. **Score = 0 / 3**

24. **Improving Aboriginal health outcomes: (iii) Report on Aboriginal community engagement** The RMCLHN page “RMCLHN Engagement” portal provides links to the eight HACs and Regional Health Advisory Council resources, which includes links to, for example, membership forms and the Aboriginal Health Impact Statement Policy Guidelines. However, the page does not contain information on Aboriginal community engagement activities, such as, meetings that may have taken place with RMCLHN executives, community forums, LHN NAIDOC and Reconciliation Week events, or how engagement is taking place with its rural Aboriginal communities, and the outcomes of these activities. **Score = 0 / 3**

25. **Improving Aboriginal health outcomes: (iv) Report on Aboriginal specific National Safety and Quality Health Service Standards assessment** The RMCLHN page does not provide links to the six Aboriginal specific National Safety and Quality Health Service Standards (see Table 2), and how the LHN is implementing them or meeting their goals. **Score = 0 / 3**

26. **Improving Aboriginal health outcomes: (v) Chronic disease management and care planning** The RMCLHN SA 2019-2020 (p. 24) identifies as one of its principal areas of services and accountabilities: “A requirement to participate in the South Australian Aboriginal Chronic Disease Consortium to progress implementation of the three statewide plans [regarding cancer control, heart and stroke, and diabetes] and consider opportunities to reorientate or reform services aligned with these plans.” The RMCLHN page does not provide links to information regarding how the LHN is progressing implementation of the three statewide plans and putting in place chronic disease management and care plans for Aboriginal patients. **Score = 0 / 3**

27. **Cultural learning completion rates** The RMCLHN SA 2019-2020 (p. 24) identifies as one of its principal areas of services and accountabilities: “The DHW will work with the RMCLHN to increase the cultural competence of our whole workforce through the implementation of the SA Health Aboriginal Cultural Learning Framework which is a significant strategy for SA Health to meet the accreditation requirements of the NSQHS.” However, the RMCLHN page does not provide links to data on non-Aboriginal staff completion rates for the Cultural Learning Program across the three levels, the mode of delivery, and participant feedback. **Score = 0 / 2**

28. **Aboriginal health division/unit placement on LHN organisational structure/chart** The RMCLHN page does not provide a link to information about, or a diagram of the organisational structure of the LHN. **Score = 0 / 1**

29. **Data on Aboriginal access to and delivery of services** Aboriginal Health is included among the range of inpatient health services available at the RMCLHN’s medium site facility at Murray Bridge (Murray Bridge Soldiers’ Memorial Hospital) (RMCLHN SLA 2019-2020, p. 48). The RMCLHN page does not provide links to data on the level of access to and use of the health services by Aboriginal people within its region. **Score = 0 / 3**
30. **Aboriginal employment: (i) Aboriginal Workforce Framework (planning, recruitment, etc.)** The RMCLHN SA 2019-2020 (p. 24) identifies as one of its principal areas of services and accountabilities: “Build the capacity and capability of the RMCLHN workforce to deliver quality care to Aboriginal people, whereby the DHW’s Workforce Services will work collaboratively with, and support the RMCLHN to implement the SA Health Aboriginal Workforce Framework 2017-2022 which identifies key strategies to attract, retain and develop Aboriginal staff, and consequently increase the number of Aboriginal people working across our organisation.” However, the RMCLHN page does not provide links to information on how it is progressing with the implementation of the Aboriginal Workforce Framework. **Score = 0 / 2**

31. **Aboriginal employment: (ii) Data on Aboriginal employment** The RMCLHN page does not provide links to data on Aboriginal employment, either as basic statistics on the proportion of its workforce who identify as Aboriginal employees, or for their participation rate in the various health workforce employment categories. **Score = 0 / 3**

32. **Other recognition (e.g., awards, scholarships, etc.)** The RMCLHN page does not provide links to information regarding staff awards, achievements, etc., including for Aboriginal staff. **Score = 0 / 2**

### INDICATOR 3: SERVICE DELIVERY AND PARTNERSHIPS

**Criterion: Aboriginal LHN Plan**

33. **Co-designed in partnership with ACCHO(s), or Aboriginal organisations, or Aboriginal Experts by Experience in LHN region**

The CHSALHN SLA, with regard to LHN accountabilities, holds that the LHN CEO is responsible for, *inter alia*, “Developing effective and working partnerships with Aboriginal Community Health and ensuring health needs of Aboriginal people are considered in all health plans, programs and models of care developed by the LHN.” (CHSALHN SLA 2018-2019, p. 10). RMCLHN has one ACCHO within its region, Moorundi Aboriginal Community Controlled Health Service Inc. in Murray Bridge. No reference is made to this health service in the RMCLHN meeting Agenda or Minutes. No evidence has emerged of any intention to develop an Aboriginal health plan involving RMCLHN and Moorundi, or the LHN’s Aboriginal Experts by Experience. **Score = 0 / 2**

34. **Partnership with ACCHO(s) in LHN region**

Refer Note 33. At this point no details regarding a formal agreement are known. **Score = 0 / 2**

35. **Commitment to Continuous Quality Improvement**

Refer Note 33. At this point no details regarding a commitment to Continuous Quality Improvement are known. **Score = 0 / 2**

36. **Co-designed KPIs**

Refer Note 33. At this point no details regarding mutually agreed KPIs are known. **Score = 0 / 2**

37. **Clear statement of ACCHO and LHN responsibilities and conflicts**

Refer Note 33. At this point no details regarding ACCHO and LHN responsibilities and conflicts are to be addressed are known. **Score = 0 / 2**

**Criterion: Cultural Safety**

38. **Implementation of cultural safety policy/strategy**

The RMCLHN SA 2019-2020 (p. 24) identifies as one of its principal areas of services and accountabilities: “The DHW will work with the RMCLHN to increase the cultural competence of our
whole workforce through the implementation of the SA Health Aboriginal Cultural Learning Framework which is a significant strategy for SA Health to meet the accreditation requirements of the NSQHSS.” Based on information provided in the RMCLHN meetings (agenda and minutes), the eight HAC annual reports for 2018-19, and SA Health’s website RMCLHN page, no mention is made of the development of, or existence of an LHN-specific cultural safety policy or strategy. **Score = 0 / 5**

39. **Proportion of staff trained**

Schedule 5: Performance and Monitoring of the RMCLHN SLA 2019-2020 outlines the performance indicators and associated reporting arrangements that apply to the LHN. Unlike in the CHSALHN SLA 2018-2019 (p. 65) there is no KPI for the percentage of employees who have completed Aboriginal cultural competency training, with a target of 100%. This would also appear to breach NSQHSS Aboriginal and Torres Strait Islander specific standard 1.21 in relation to Clinical Governance safety and quality training whereby the health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients (see Table 2). No mention of Cultural Safety Training in relation to the RMCLHN health workforce non-Aboriginal staff has been made in either Governing Board meetings, or in the 2018-2019 annual reports of the eight HACs. Also there is no information available on the RMCLHN page of the SA Health website as to the numbers, or proportion of staff trained. **Score = 0 / 5**

**Criterion: Selected LHN health performance indicators reported publicly**

40. **Estimated level of completion of Indigenous status – specifically the reporting of ‘not stated’ on admission**

Schedule 5: Performance and Monitoring of the RMCLHN SLA 2019-2020 outlines the performance indicators and associated reporting arrangements that apply to the LHN. The CHSALHN SLA 2018-2019, in Schedule 4: Performance Indicators and Targets, includes a statement in relation to supporting the delivery of the Closing the Gap agenda and citing the NSQHSS, that: “The LHN should implement processes to identify patients as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems” (CHSALHN, SLA 2018—19, p. 59). Schedule 5: Performance and Monitoring of the RMCLHN SLA 2019-2020 contains no KPI for addressing the estimated level of completion of Indigenous status. This would also appear to breach NSQHSS Aboriginal and Torres Strait Islander specific standard 5.8 in relation to planning for comprehensive care (see Table 2). **Score = 0 / 3**

41. **Discharges against medical advice (DAMA)**

Schedule 5: Performance and Monitoring of the RMCLHN SLA 2019-2020 contains a Tier 2 KPI: % of Aboriginal Patients Who Left Hospital Against Medical Advice, with the measure: % of overnight Aboriginal and/or Torres Strait Islander separations. The 2019-20 target is: <=4.5%, with the following performance ranges: Performing - <=4.5%; Performance Concern - >4.5% and <=6.5%; and Under Performing - >6.5%. This target is the same as in the CHSALHN SLA for 2018-2019 Schedule 4: Performance Indicators and Targets, in relation to Safe and Effective Care in terms of Aboriginal Health (CHSALHN, SLA 2018—19, p. 65). In the Access and Flow performance domain with regard to the Emergency Department, there is also a Tier 2 KPI: Left at Own Risk, with the Measure which includes percentages of (i) all ED presentations, (ii) Aboriginal presentations, and (iii) Mental Health presentations, with the target for all three categories: <=3% (CHSALHN, SLA 2018—19, p. 62). At the RMCLHN’s March 27th 2020 meeting (Agenda Item 6.1.5), with regard to the LHN’s Performance Report, in response to questions to the CEO in relation to, inter alia, the KPI Report, the Board requested a special briefing about strategies in relation to Aboriginal self-discharges. The SA Health website RMCLHN page contains no data on how RMCLHN is progressing against the performance ranges contained in its SLA. **Score = 0 / 4**
42. **Potentially preventable hospital admissions (PPHA)**
Schedule 5: Performance and Monitoring of the RMCLHN SLA 2019-2020 does not contain a KPI regarding potentially preventable hospital admission for Aboriginal people. **Score = 0 / 3**

43. **Access to mental health services as reported at service level agreement**
Schedule 5: Performance and Monitoring of the RMCLHN SLA 2019-2020 does not contain a KPI regarding Aboriginal access to mental health services. The SA Health website RMCLHN page contains no data on Aboriginal access to mental health services. **Score = 0 / 3**

44. **Low birth-weight babies**
Schedule 5: Performance and Monitoring of the RMCLHN SLA 2019-2020 does not contain a KPI regarding low birth-weight Aboriginal babies. The SA Health website RMCLHN page contains no data on low birth-weight Aboriginal babies. **Score = 0 / 3**

45. **Healthcare outcome differential measures (eg, discharge summary timeliness)**
Schedule 5: Performance and Monitoring of the RMCLHN SLA 2019-2020 does not contain KPIs regarding Aboriginal healthcare outcome differential measures, and is not a matter discussed at RMCLHNB meetings and in the HAC annual reports for 2018-19. **Score = 0 / 4**

**INDICATOR 4: RECRUITMENT AND EMPLOYMENT**

**Criterion: Aboriginal health workforce development reporting**

46. **Implementation of Aboriginal workforce strategy**
The RMCLHN SA 2019-2020 (p. 24) identifies as one of its principal areas of services and accountabilities: “Build the capacity and capability of the RMCLHN workforce to deliver quality care to Aboriginal people, whereby the DHW’s Workforce Services will work collaboratively with, and support the RMCLHN to implement the SA Health Aboriginal Workforce Framework 2017-2022 which identifies key strategies to attract, retain and develop Aboriginal staff, and consequently increase the number of Aboriginal people working across our organisation.” The development and implementation of an RMCLHN Aboriginal workforce strategy has not been raised by the RMCLHN at its meetings, or mentioned in the eight HAC annual reports for 2018-2019. Similarly, there is no reference to a RMCLHN Aboriginal workforce strategy on the SA Health website RMCLHN page. **Score = 0 / 4**

47. **LHN KPI for Aboriginal employment**
Schedule 5: Performance and Monitoring of the RMCLHN SLA 2019-2020 contains a Tier 2 KPI: Aboriginal Employment Rate, with the measure: % of employees who identified as being of Aboriginal or Torres Strait Islander origin. The 2019-20 target is: >=4%, with the following performance ranges: Performing - >=4.0%; Performance Concern - <4.0% and >=1.5%; and Under Performing - <1.5%. No data regarding the RMCLHN’s progress against the SLA performance ranges on the SA Health website RMCLHN page. **Score = 0 / 4**

48. **Number of Aboriginal health practitioners, health workers and liaison officers** According to SA Health, Aboriginal health workers are located at RMCLHN health facilities at Murray Bridge and the Riverland Regional Health Service (Berri Campus). [https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/services/health+services+for/aboriginal+health+services/aboriginal+health+workers](https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/services/health+services+for/aboriginal+health+services/aboriginal+health+workers). However the number of Aboriginal people employed in these roles is not provided on the SA Health website RMCLHN page. **Score = 2 / 3**
49. **Number of identified Aboriginal positions**  
Data regarding the number of identified Aboriginal positions in RMCLHN’s workforce is not provided on the SA Health website RMCLHN page. **Score = 0 / 3**

50. **Number of salary bands occupied by Aboriginal employees**  
Data regarding the number of salary bands occupied by Aboriginal employees in RMCLHN’s workforce is not provided on the SA Health website RMCLHN page. **Score = 0 / 3**

51. **Number of long term Aboriginal employees**  
Data regarding the number of long term Aboriginal employees in RMCLHN’s workforce is not provided on the SA Health website RMCLHN page. **Score = 0 / 3**

**Criterion: Aboriginal participation in the health workforce**

52. **Administrative**  
Data regarding the number of Aboriginal people working in administration in RMCLHN’s workforce is not provided on the SA Health website RMCLHN page. **Score = 0 / 3**

53. **Medical Professional**  
Data regarding the number of Aboriginal medical professionals in RMCLHN’s workforce is not provided on the SA Health website RMCLHN page. **Score = 0 / 4**

54. **Nurses/Midwives**  
Data regarding the number of Aboriginal nurses and midwives in RMCLHN’s workforce is not provided on the SA Health website RMCLHN page. **Score = 0 / 4**

55. **Operational Services**  
Data regarding the number of Aboriginal providing operational services in the RMCLHN is not provided on the SA Health website RMCLHN page. **Score = 0 / 3**

56. **Allied Health/Scientific/Technical**  
Data regarding the number of Aboriginal employed to provide allied health/scientific and technical services in the RMCLHN is not provided on the SA Health website RMCLHN page. **Score = 0 / 3**

57. **Other**  
Data regarding other roles occupied and services offered by Aboriginal people in RMCLHN’s workforce (for example, as cultural consultants, and experts by experience) is not provided on the SA Health website RMCLHN page. **Score = 0 / 3**

**INDICATOR 5: FINANCIAL ACCOUNTABILITY AND REPORTING – CLOSING THE GAP FUNDING**

The RMCLHN Service Agreement 01 July 2019 – 30 June 2020 (RMCLHN SA) in Schedule 3: Local Health Network – Services and Accountabilities, under Section 4. Services for Priority Population Groups, in sub-section 4.1 Aboriginal Health Services, states that:

The LHN will work collaboratively with DHW’s Aboriginal Health other relevant health services, support organisations and Aboriginal community-controlled health services to continue to implement the regional Aboriginal Health Improvement Plan to support services meeting the needs of the local Aboriginal population.

In recognition of the need to ensure appropriate resource allocation for Aboriginal Health Programs, the LHN should maintain or increase their relative funding allocation to these programs commensurate with their total funding allocation (p. 24).

The RMCLHN SA identifies three principal areas of services and accountabilities:
• A requirement to participate in the South Australian Aboriginal Chronic Disease Consortium to progress implementation of the three statewide plans [regarding cancer control, heart and stroke, and diabetes] and consider opportunities to reorientate or reform services aligned with these plans;

• Build the capacity and capability of the RMCLHN workforce to deliver quality care to Aboriginal people, whereby the DHW’s Workforce Services will work collaboratively with, and support the RMCLHN to implement the SA Health Aboriginal Workforce Framework 2017-2022 which identifies key strategies to attract, retain and develop Aboriginal staff, and consequently increase the number of Aboriginal people working across our organisation; and

• The DHW will work with the RMCLHN to increase the cultural competence of our whole workforce through the implementation of the SA Health Aboriginal Cultural Learning Framework which is a significant strategy for SA Health to meet the accreditation requirements of the NSQHS (p. 24).

In Schedule 4: Funding and Commissioned Activity of the RMCLHN SA, in Section 6: Specific Commissioning/Funding Commitments (p. 37), seven services and programs are identified:

• Transition Care Program (TCP)
• Chronic Pain Model of Care
• Care Coordinators – Intensive Home Based Support Services (IBHSS) and other mental health programs
• Community Support Scheme Program (CSS)
• Country Cancer Services
• Aged Care Assessment Program (ACAP)
• Multi-Purpose Services (MPS).

No funding allocations within the seven programs/services have been specified for Aboriginal Health services/needs. The RMCLHN is expected to work collaboratively with the Office of Ageing Well, Adult Safeguarding Unit to support Aboriginal and Torres Strait Islander people aged 50 years or over (pp. 15 and 25). The RMCLHN is also responsible for developing the Rural Health Workforce Strategy broad services plan and workforce plan under the guidance of the Rural Health Workforce Strategy Steering Committee to support recruitment, retention and training of, inter alia, Aboriginal health workers (p. 18).

The RMCLHN SA has not identified any specific funding allocations (Commonwealth, State, or other) for Aboriginal Health Services, and incorporates only two Tier 2 KPIs relevant to Aboriginal Health: DAMA (p. 42) and Aboriginal and Torres Strait Islander employment (p. 43).

**Criterion: Commonwealth contributions for Aboriginal health programs to LHN**

58. Commonwealth contributions for Aboriginal health programs to LHN
A search of the SA Health website, including the RMCLHN page (including portals and their links) did not produce any information concerning Commonwealth contributions for Aboriginal health programs to the RMCLHN. **Score = 0 / 10**

**Criterion: South Australian contributions to Aboriginal specific services and programs including activity-based funding loading for Aboriginal patients**

59. Reporting on contributions for Aboriginal specific health services and programs including activity-based funding loading
A search of the SA Health website, including the RMCLHN page (including portals and their links), did not produce any information on State funding contributions for Aboriginal specific health services
and programs at the RMCLHN including for activity-based funding loadings for Aboriginal patients.

**Score = 0 / 10**

**RMCLHN documents consulted**

- **Governing Board Meetings:**
  - Agenda 25 July 2019 / Minutes 25 July 2019
  - “ “ “ 30 Apr. 2020 / no 30 Apr. 2020

- **Service Agreement** (1 July 2019 – 30 June 2020)

- **Draft Consumer and Community Engagement Strategy** [For public consultation] (RMCLHN, no date)

- **Draft Clinician and Workforce Engagement Strategy** [For public consultation] (RMCLHN, no date)

- **RMCLHN Facebook page - @RMCLHN**

**HACs Annual Report 2018-2019**

- Murray Bridge Soldiers' Memorial Hospital Health Advisory Council Inc. [MBSMHAC]  Annual Report 2018-2019

**RMCLHN documents not sighted**
## Key Indicators and Criteria

### 1. Participation in LHN governance

#### 1.1 Good governance

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<tr>
<th>Indicator</th>
<th>Score</th>
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<tbody>
<tr>
<td>1.1.1 Board interaction with Aboriginal community</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>1.1.2 LHN Aboriginal health performance indicators on Board agenda for every meeting</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>1.1.3 Direct input to Board by LHN Aboriginal Community Consultative Committee or Aboriginal Experts by Experience</td>
<td>2</td>
<td>0</td>
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<tr>
<td>1.1.4 LHN Board members are educated about Aboriginal health in their LHN</td>
<td>2</td>
<td>1</td>
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<tr>
<td>1.1.5 LHN Board members receive cultural learning training</td>
<td>2</td>
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#### 1.2 Aboriginal representation at board level

<table>
<thead>
<tr>
<th>Indicator</th>
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<tbody>
<tr>
<td>Aboriginal representation at board level</td>
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#### 1.3 Inclusion in Executive Management Structure

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<thead>
<tr>
<th>Indicator</th>
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<tbody>
<tr>
<td>A stand-alone Aboriginal Health Division</td>
<td>5</td>
<td>5</td>
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<tr>
<td>Aboriginal LHN lead directly reports to the LHN CEO</td>
<td>5</td>
<td>0</td>
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**TOTAL** 30 17

### 2. Policy Implementation

#### 2.1 Improving Aboriginal Health Outcomes

<table>
<thead>
<tr>
<th>Indicator</th>
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<tbody>
<tr>
<td>Explicitly identified as a strategic priority in LHN Strategic Plan (10)</td>
<td>10</td>
<td>5</td>
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<tr>
<td>Aboriginal health outcome KPIs reflective of LHN key responsibilities identified in LHN Service Agreement (11)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(i) Tier 1 KPIs (12)</td>
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<tr>
<td>(ii) Tier 2 KPIs (13)</td>
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**TOTAL** 20

#### 2.2 Community engagement

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<thead>
<tr>
<th>Indicator</th>
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<tbody>
<tr>
<td>Aboriginal community consultative body (14)</td>
<td>4</td>
<td>2</td>
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<tr>
<td>Aboriginal community engagement embedded within overall community engagement strategy (15)</td>
<td>4</td>
<td>1</td>
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<tr>
<td>LHN Aboriginal community newsletter/e-letter/social media (16)</td>
<td>3</td>
<td>1</td>
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<tr>
<td>At least one Aboriginal community forum/meeting per year convened by the LHN chief executive officer (17)</td>
<td>3</td>
<td>3</td>
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<td>Reconciliation Action Plan (18)</td>
<td>3</td>
<td>3</td>
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<tr>
<td>Aboriginal health professionals caring for patients included within clinical engagement strategy (19)</td>
<td>3</td>
<td>1.5</td>
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**TOTAL** 20

#### 2.3 Public Reporting and Accountability (via LHN website or annual report)

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<tr>
<th>Indicator</th>
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<tr>
<td>Traditional Owner Acknowledgement (21)</td>
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<tr>
<td>Improving Aboriginal health outcomes</td>
<td></td>
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<tr>
<td>(i) Separate section in report devoted to Aboriginal health (22)</td>
<td>3</td>
<td>0</td>
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<tr>
<td>(ii) Reporting on KPIs contained in current service level agreement (SLA) (23)</td>
<td>3</td>
<td>0</td>
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<tr>
<td>(iii) Report Aboriginal community engagement (24)</td>
<td>3</td>
<td>0</td>
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<tr>
<td>(iv) Report on Aboriginal specific National Safety and Quality Health Service Standards Assessment (25)</td>
<td>3</td>
<td>0</td>
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<tr>
<td>(v) Chronic disease management and care planning (26)</td>
<td>3</td>
<td>0</td>
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<tr>
<td>Cultural learning completion rates (27)</td>
<td>2</td>
<td>0</td>
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</table>
2.3.4 Aboriginal health division/unit placement on LHN organisational structure/chart (28)  
2.3.5 Data on Aboriginal access to and delivery of services (29)  
2.3.6 Aboriginal employment  
(i) Aboriginal Workforce Framework (planning, recruitment, etc.) (30)  
(ii) Data on Aboriginal employment (31)  
2.3.7 Other recognition (e.g., awards, scholarships, etc.) (32)  

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TOTAL 70 16.5

3. Service delivery and partnerships  
3.1 Aboriginal LHN Plan  
3.1.1 Co-designed in partnership with ACCHO(s), or Aboriginal organisations, or Aboriginal Experts by Experience in LHN region (33)  
3.1.2 Partnership with ACCHO(s) in LHN region (34)  
3.1.3 Commitment to Continuous Quality Improvement (35)  
3.1.4 Co-designed KPIs (36)  
3.1.5 Clear statement of ACCHO and LHN responsibilities and conflicts (37)  

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Total out of 10 2 1

3.2 Cultural safety  
3.2.1 Implementation of cultural safety policy/strategy (38)  
3.2.2 Proportion of staff trained (39)  

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Total out of 10 5 0

3.3 Selected LHN health performance indicators reported publicly  
3.4.1 Estimated level of completion of Indigenous status – specifically the reporting of ‘not stated’ on admission (40)  
3.4.2 Discharged against medical advice (DAMA) (41)  
3.4.3 Potentially preventable hospitalisations (PPHA) (42)  
3.4.4 Access to mental health services as reported at service level agreement (43)  
3.4.5 Low birth-weight babies (44)  
3.4.6 Healthcare outcome differential measures (e.g. Discharge summary timeliness) (45)  

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Total out of 20 3 0

4. Recruitment and employment  
4.1 Aboriginal health workforce development reporting  
4.1.1 Implementation of Aboriginal workforce strategy (46)  
4.1.2 LHN KPI for Aboriginal employment (47)  
4.1.3 Number of Aboriginal health practitioners, health workers and liaison officers (48)  
4.1.4 Number of identified Aboriginal positions (49)  
4.1.5 Number of salary bands occupied by Aboriginal employees (50)  
4.1.6 Number of long-term Aboriginal employees (51)  

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Total out of 20 4 0

4.2 Aboriginal participation in the health workforce  
4.2.1 Administrative (52)  
4.2.2 Medical Professionals (53)  
4.2.3 Nurses/Midwives (54)  
4.2.4 Operational Services (55)  
4.2.5 Allied Health/Scientific/Technical (56)  
4.2.6 Other (57)  

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Total 40 2

5. Financial Accountability and Reporting: Closing the Gap Funding
5.1 Commonwealth contributions for Aboriginal health programs to LHN
Commonwealth contributions for Aboriginal health programs to LHN (58) 10 0

5.2 South Australian contributions to Aboriginal specific health services and programs including activity-based funding loading for Aboriginal patients
Reporting on contributions for Aboriginal specific health services and programs including activity-based funding loading (59) 10 0

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Institutional Rating scored against criteria

Score:  

<table>
<thead>
<tr>
<th>Score</th>
<th>Evidence of Inst. Racism</th>
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<tr>
<td>&gt;=160</td>
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<tr>
<td>120-159</td>
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<td>80-119</td>
<td>Moderate</td>
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<tr>
<td>40-79</td>
<td>High</td>
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<tr>
<td>&lt;=39</td>
<td>Very High</td>
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Notes:

1. **Yorke & Northern Local Health Network (YNLHN)**
   The YNLHN is responsible for delivering core health services within hospitals and health services to approximately 77,000 people living across the Yorke Peninsula, Southern Flinders and the lower and mid north areas of SA. Core health services within the region are provided by a large site (Port Pirie Regional Health Service), two medium sized sites and several smaller sites, supported by a range of community based facilities (YNLHN SLA 2019-2020, p. 20). Based on 2011 Census data, Aboriginal people constitute about 2.3% of the total population of the YNLHN region (CHSALHN 2015a, p. 19). Assuming that that percentage remains roughly the same, currently there would be about 1,800 Aboriginal people in the YNLHN region (cf 1,664 - 2011 Census).

   The YNLHN has no ACCHOs, however, the Narungga Health Assembly has been established with a view of taking on that role: [https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/news+and+media/all+media+releases/narungga+health+assembly+inaugural+meeting](https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/news+and+media/all+media+releases/narungga+health+assembly+inaugural+meeting)

   As at January 2018, the region now served by the YNLHN had 14 Aboriginal Experts by Experience (HPCSA, 2019, p. 25).

   Aboriginal Health is included among the range of inpatient health services available at the large site facilities at Port Pirie, Clare and Wallaroo (YNLHN SLA 2019-2020, p. 48).

   Because the YNLHN came into effect as an LHN in its own right on 1 July 2019, many key documents relied upon for the conduct of this audit, such as the YNLHN Strategic Plan, the Clinicians and Workforce Engagement Strategy, and the Consumers and Community Engagement Strategy are still under development. Another key document, the YNLHN annual report for 2019-2020 will not be available until after 30 September 2020. In the absence of these documents, the audit relies primarily on the YNLHN Governing Board meeting agenda and minutes, and the 2018-2019 annual reports of the LHN’s six HACs. Scores have been adjusted to reflect the availability of relevant documents.

**INDICATOR 1: PARTICIPATION IN LHN GOVERNANCE**

**Criterion: Good governance**

The following chart provides an overview of the YNLHN’s references to and discussion concerning Aboriginal health and related matters. In addition to the listed sub-criteria, other headings have
been included to cover information not readily assigned to the listed sub-criteria. Where Aboriginal health matters have been discussed, the Agenda item numbers have been indicated in the monthly columns. Also note that the Acknowledgement of Country is a standing item under Agenda Item 1.1 in all meetings, and is not included in the chart below.

Legend:
x = no information relevant to the sub-criterion heading was provided.  
? = minutes were not uploaded onto SA Health website at the time of this analysis (30 May 2020).  
AHEMGB – Aboriginal Health Expert Member of Governing Board (this person may/may not be an Aboriginal person)
Tier 1 committee = a Board committee which reports to the Board
Tier 2 committee = an internal LHN committee which reports to the CEO
Tier 3 committee = a community-based committee established in accordance with, for example, a LHN consumer and community engagement plan/framework/strategy and which can provide input to, or respond to the LHNB or LHN CEO.

YNLHN Board meetings: good governance sub-criteria summary for July 2019 – April 2020

<table>
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<tr>
<th>Meeting:</th>
<th>July 9th</th>
<th>Aug. 27th</th>
<th>Sept. 24th</th>
<th>Oct. 15th</th>
<th>Nov. 28th</th>
<th>Nov. 19th</th>
<th>Jan. 11th</th>
<th>Feb. 4th</th>
<th>March 19th</th>
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Summary of matters addressed:

Aug. 27th Agenda Item 14: General Business.
  o The Board noted the information circulated by email about the requirement for Board members to complete the on line WHS Officer Training. Action: All Board members to complete the on line training. (ALL).
  o The Board noted the dates of the Aboriginal Health Governance Forums being held in the YNLHN: 2 October (Port Pirie) and 9 October (Maitland). [No mention of these two forums in the 15th October Board meeting Agenda or Minutes]
  o The Board noted the request on behalf of the Port Pirie Aboriginal Community Group to meet the Board. This was endorsed by the Board and arrangements will be made for the group to meet the Board over lunch at the Port Pirie Regional Health Service on 24 September 2019. Action: Advice to be provided to the ED Community and Allied Health and the Aboriginal Health Team Leader.
Sept. 24th Agenda Item [9.10]: [No mention made of the meeting with the Port Pirie Aboriginal Community Group on 24th September, even though an un-dated site visit to Port Pirie was recorded in this Minute]

November 19th:
Agenda Item 1: Resignation of original 1 July 2019 AHEMGB appointee and announcement of the replacement AHEMGB.
Agenda Item 10.2: Chair’s Update. Attended Aboriginal Community Forum in Maitland [9th October see 27th Aug. Board Meeting Agenda Item 14]; and Narrunga [sic] Health Assembly update.

December 17th:
Agenda Item 1: New AHEMGB welcomed by Chair.
Agenda Item 9.10: YNHLN Performance Report – October. Discussion occurred about the need for strategies to increase Aboriginal employment. It was identified that the report requires additional work-mitigating strategies are essential where KPIs are at risk or not being met. Action: (i) investigate why ABORIGINAL consumers are leaving against medical advice; (ii) add reporting to Board and Board Committees to next agenda; and (iii) provide information about the forum being held in FUNLHN for Aboriginal employees.
Agenda Item 9.11: Community (Annual Public Meeting) feedback. YNLHN Annual Public Meeting was held at 5.30pm on 21 November 2019 in the main foyer of the Wallaroo Hospital and Health Service. Three members of the public attended. ....]

February 11th:
Agenda Item 6.1: Presentations/Visitors. ED Community and Allied Health Services, YNLHN. ED confirmed the role of the Aboriginal Liaison Officer based in the Central Referral Unit and the potential for this position to support increased capacity for the delivery of TCP services to Aboriginal people.
Agenda Item 8.1: Mid-North HAC Land Purchase. Action: Seek confirmation of the registered and non-cultural heritage sites by asking the Native Title group to provide advice regarding this.
Agenda Item 9.1: YNHLN Governance Structure. Considerable discussion occurred about the governance structure, particularly the role of the Reconciliation Committee, which will lead the development of the YNHLN Reconciliation Action Plan and the work associated with the Standards. Discussion occurred about the future Tier 2 committees, in particular, Aboriginal Health.

March 4th Agenda Item 9.6: Consumer and Community Engagement Board Committee – Meeting Summary and Minutes (19.02.2020). YNLHN HAC Presiding Members are to be asked to nominate 2 representatives for this committee to ensure community feedback is provided. Action: AHEMG to be invited to attend the regular meetings between the HAC Presiding members; CEO and Board Chair.

April 1st Agenda Item 7: COVID-19 Update. Community and Allied Health Services – Specific strategies have been implemented to support Aboriginal people. Medical Service – Discussion occurred about service provision to the Point Pearce Community, which is now in lock down. Advised that on-site health workers are continuing to provide support.

2. Board interaction with Aboriginal community
At its Aug. 27th 2019 meeting (Agenda Item 14), the YNLHN noted the request on behalf of the Port Pirie Aboriginal Community Group to meet the Board. This was endorsed by the Board and arrangements will be made for the group to meet the Board over lunch at the Port Pirie Regional Health Service on 24 September 2019. It is also noted that, at its Sept. 24th meeting (Minute 9.10),
no mention was made of the meeting with the Port Pirie Aboriginal Community Group on 24th September, even though an un-dated site visit to Port Pirie was recorded in this Minute. It is unclear whether the lunch meeting took place. Score = 1 / 2

3. **LHN Aboriginal Health performance indicators on Board agenda for every meeting**
   Based on the information provided in the Agenda and the Minutes, there is no evidence of Aboriginal Health performance indicators being provided to or being discussed at YNLHNB meetings [refer PSAHMT Note 5]. Score = 0 / 2

4. **Direct input to Board by LHN Aboriginal Community Consultative Committee or Aboriginal Expert by Experience**
   Based on the information provided in the Agenda and the Minutes, there is no evidence of an Aboriginal Community Consultative Committee (a Tier 3 committee), or Aboriginal Experts by Experience providing input at YNLHNB meetings. Score = 0 / 2

5. **LHN Board members are educated about Aboriginal health in their LHN**
   At its Aug. 27th 2019 meeting (Agenda Item 14), the YNHLN Board noted the dates of the Aboriginal Health Governance Forums being held in the YNLHN: 2 October (Port Pirie) and 9 October (Maitland). However, no mention was made of these two forums in the 15th October Board meeting Agenda or Minutes. It is unclear whether any of the Board members attended either of these Forums, which would have offered an opportunity for Board members to learn something of the health status and concerns of the Aboriginal communities within their LHN region. Score = 1 / 2

6. **LHN Board members receive cultural learning training**
   Based on the information provided in the Agenda and the Minutes, no intention has been expressed by the YNLHN Board Members of organising or participating in Cultural Safety Training. Score = 0 / 2

**Criterion: Aboriginal representation at board level**

7. **Aboriginal representation at board level**
   The 6 member YNLHNB appointed by the Minister includes an Aboriginal member with very significant expertise, knowledge and experience in relation to Aboriginal health - the AHEMGB. However this Board member resigned in November 2019, and a new AHEMGB was quickly appointed. Score = 10 / 10

**Criterion: Inclusion in Executive Management Structure**

8. **A stand-alone Aboriginal Health Division**
   Based on the Regional LHN Leadership Structure provided in the *Establishment of Regional Local Health Networks: Detailed Design Proposal – Consultation Paper* (CHSALHN 2019, p. 6) the Division of Aboriginal Health exists as a stand-alone division within the YNLHN organisational structure. Score = 5 / 5

9. **Aboriginal LHN lead directly reports to the LHN CEO**
   According to the Regional LHN Leadership Structure (see Note 8), the Director of Aboriginal Health reports directly to the YNLHN CEO. However, the YNLHN page on the SA Health website provides no links to information (brief bios) concerning the members of the executive management group, as there is for the YNLHN Board members. Thus there is no information confirming whether the Director of Aboriginal Health is an Aboriginal person or not. Given the emphasis placed on the importance of the Director of Aboriginal Health being an Aboriginal person by the Expert Workshop, failure to provide this information via the YNLHN page on the SA Health website results in a penalty score. Score = 0 / 5
INDICATOR 2: POLICY IMPLEMENTATION

Criterion: Improving Aboriginal Health Outcomes

10. Explicitly identified as a strategic priority in LHN Strategic Plan
A search of the YNLHN meeting agenda and minutes, and the SA Health website YNLHN page (and portals and their links) did not locate the YNLHN Strategic Plan, and therefore it must be assumed that it is still being developed and not available for review. While information is not currently available regarding the extent to which Aboriginal health outcomes are identified as a strategic priority in the LCLHN strategic plan, and given the priorities given to and delays caused by the COVID-19 pandemic, a discretionary half score is awarded. **Score = 5 / 10**

11. Aboriginal health outcome KPIs reflective of LHN key responsibilities identified in LHN Service Agreement
The YNLHN Service Agreement 2019-2020, in Schedule 5: Performance Monitoring contains two Aboriginal health-related KPIs also included in the regional LHN Service Agreements, namely the Tier 2 KPIs: DAMA and Aboriginal Employee Participation Rate (pp. 41-43).

The purpose of the following two sub-criteria is to suggest additional Aboriginal Health related KPIs to the existing two. Given the excess burden of disease within the Aboriginal community, and particularly in relation to cancer, heart and stroke, diabetes, kidney disease and mental health, there should be a range of both Tier 1 and 2 KPIs to address these health crises. The basis for scoring is that, given the excess burden of disease among Aboriginal people and the health crises faced by many Aboriginal communities, these KPIs (with Aboriginal people constituting a KPI sub-set), should already be included in the current SA. The fact that they are not results in a penalty score.

12. Tier 1 KPIs

* Elective Surgery: Tier 1 – Timely Admissions: % of elective surgery patients admitted within clinically recommended times; % of Aboriginal patients admitted for elective surgery within clinically recommended times. Target 100%.
* Elective Surgery: Tier 1 – Overdue Patients: # of Category 1, 2 and 3 patients; # of Category 1, 2 and 3 Aboriginal patients. Target 0
* Emergency Department: Tier 1 – Seen on Time: % of patients attending ED who commenced treatment within clinically accepted timeframes; % of Aboriginal patients attending ED who commenced treatment within clinically accepted timeframes. Target varies from 100% for Category 1 patients to >=70% for Category 5 patients.
* Mental Health: Tier 1 – Mental Health - Adult/Older Persons Acute 28 Day Readmission Rate: % of patients who had a readmission within 28 days of discharge (non-short stay); % of Aboriginal patients who had a readmission within 28 days of discharge (non-short stay). Target <=12%
* Mental Health: Tier 1 – Suicide of persons in Inpatient Mental Health Units: # of suicides that occur in admitted patient specialised mental health services; # of Aboriginal suicides that occur in admitted patient specialised mental health services. Target - Monitor

**Score = 0 / 5**

13. Tier 2 KPIs

* Aboriginal Health: Tier 2 – Indigenous status reporting: % ‘not stated’ on admission. Target: ?
* Mental Health: Tier 2 - Post Discharge Community Follow Up Rate: % of people receiving one or more mental health service contacts while in the community within 7 days post discharge; % of Aboriginal people receiving one or more mental health service contacts while in the community within 7 days post discharge. Target >=70%.
* People and Culture – Tier 2: Completion of the Aboriginal Cultural Competence Program: % of employees who have completed Aboriginal cultural competence training. Target 100%

* Clinical Pathways: Tier 2 - Rehabilitation: Individual Care Plan: % of rehabilitation patients who leave hospital with an individualised care plan; % of Aboriginal rehabilitation patients who leave hospital with an individualised care plan. Target >=90%.

* Occupancy: Tier 2 – Discharge Summary Transmission Rate: % of discharge summaries transmitted with 48 hours of separation; % of Aboriginal patient discharge summaries transmitted with 48 hours of separation. Target >=80%

Score = 0 / 5

Criterion: Community Engagement

14. Aboriginal community consultative body
The YNLHNB, at its Feb. 11th 2020 meeting (Agenda Item 9.1), considerable discussion occurred about the YNLHN governance structure, particularly the role of the Reconciliation Committee, which will lead the development of the YNLH Reconciliation Action Plan. Discussion also occurred about the future Tier 2 committees, in particular, Aboriginal Health. It is assumed here that the YNLHN is examining the need for some form of Aboriginal Health committee, however, whether this is an internal LHN committee (Tier 2), or whether it might be more community-based is not known. The fact that it is under discussion is worth half points. Score = 2 / 4

15. Aboriginal community engagement embedded within overall community engagement strategy
The Aboriginal community has two avenues to engage with the YNLHN: through the YNLHN’s own consumer and community engagement strategy which is currently under development, and through the YNLHN’s eight Health Advisory Councils (HACs), all of which were established in 2008, and therefore have a long association with their respective communities. These are separate entities from the YNLHNB, but nevertheless work closely with the Board on matters of community engagement. In the absence of a YNLHN’s Consumer and Community Engagement Strategy, the score for Aboriginal community engagement with the newly established YNLHN is based on an analysis of the 2018-19 annual reports of the eight HACs. The HACs are: Balaklava and Riverton Health Advisory Council Inc. (BRHAC); Lower North Health Advisory Council Inc. (LNHAC); Mid North Health Advisory Council Inc. (MNHAC); Northern Yorke Peninsula Health Advisory Council Inc. (NYPHAC); Port Broughton District Hospital and Health Advisory Council Inc. (PBDHAC); Port Pirie Health Advisory Council (PPHAC); Southern Flinders Health Advisory Council (SFHAC); and Yorke Peninsula Health Advisory Council Inc. (YPHAC).

### YNLHN HACs’ Annual Reports for 2018-19 – Evidence of Aboriginal Community Engagement

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# ARRMHAC = Aboriginal Resident Representative Member of HAC
Based on the HAC reports, six of the HACs have not engaged at all with the local Aboriginal community, while the other two have demonstrated some level of engagement, the Mid North Health Advisory Council by virtue of having an ARRMHAC. **Score = 1 / 4**

16. **LHN Aboriginal community newsletter/e-letter/social media**

No discussion has taken place within the YNLHNB meetings regarding publication of an Aboriginal community newsletter, or whether important Aboriginal health information could be conveyed to the LHN’s Aboriginal communities using other platforms such as an e-letter, or via social media platforms such as Facebook and Twitter. However, YNLHN does have its own Facebook page - @YNLHN - on which it posts Aboriginal health related information. **Score = 1 / 3**

17. **At least one Aboriginal community forum/meeting per year convened by the LHN chief executive officer**

At its Aug. 27th 2019 meeting (Agenda Item 14), the YNHLN Board noted the dates of the Aboriginal Health Governance Forums being held in the YNLHN: 2 October (Port Pirie) and 9 October (Maitland). It is assumed that the CEO and the Director of Aboriginal Health would have had key roles in the organisation of these two meetings. **Score = 3 / 3**

18. **Reconciliation Action Plan**

CHSALHN (aka Country Health SA) has the *Country Health SA Reconciliation Action Plan 2018-2020.* (CHSA, 2018). The YNLHNB, at its Feb. 11th 2020 meeting (Agenda Item 9.1), considerable discussion occurred about the YNLHN governance structure, particularly the role of the Reconciliation Committee, which will lead the development of the YNLHN Reconciliation Action Plan and the work associated with the Standards [presumably this is a reference to the NSQHSS Aboriginal and Torres Strait Islander specific standards – see Table 2)]. Indication is that the YNLHNB intends to develop its own RAP. **Score = 3 / 3**

19. **Aboriginal health professionals caring for patients included within clinical engagement strategy**

In the absence of any information on the SA Health website YNHLN page (and portals and their links), it is assumed that the Clinical Engagement Strategy is still under development. While information is not currently available regarding the extent to which Aboriginal health professionals are included in the YNLHN clinical engagement strategy, and given the priorities given to and delays caused by the COVID-19 pandemic, a discretionary half score is awarded. **Score = 1.5 / 3**

**Criterion: Public Reporting and Accountability (via LHN website or annual report)**

20. The YNLHN, in effect, does not have its own website. An internet search for “Yorke and Northern Local Health Network” will lead to the SA Health website ([www.sahealth.sa.gov.au](http://www.sahealth.sa.gov.au)) which provides a link to YNHLN: [https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+local+health+networks/yorke+and+northern+local+health+network/yorke+and+northern+local+health+network](https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+local+health+networks/yorke+and+northern+local+health+network/yorke+and+northern+local+health+network). The YNHLN page contains a number of portals. As at 7th June 2020, there are five YNLHN portals: (i) Freedom of Information; (ii) Engagement with Consumers & Community; (iii) the YNLHN Board; (iv) YNLHN Services; and (v) the YNLHN’s response to COVID-19. Each portal provides links to enable access to additional information. For example, the Engagement with Consumers & Community portal provides links to each of the YNLHN’s eight HACs. The HAC links will provide access to their annual reports and constitutions/rules. Similarly, information regarding the Board membership, meetings (agenda and minutes), and travel expenses is available through the YNLHN Board portal. There is no portal presenting a snap-shot of the YNLHN, providing basic information
about population demographics (including the Aboriginal population and Traditional Owners), geographic region served, brief description of the health workforce, a resident health profile/dashboard, and summary of services provided. None of the information sought below is readily available on the YNLHN page (including its portals and their links) (“the YNLHN page”) on the SA Health website. Information regarding, for example, Aboriginal employment in the health workforce, cultural competency training completion rates, and Aboriginal health outcome KPIs must be sought via other portals and links on the SA Health website.

This audit took place before the YNLHN annual report for 2019-2020 was released and therefore the information contained on the YNLHN page is relied on to provide scores for the following sub-criteria.

21. **Traditional Owner acknowledgement** While there are a number of First Peoples in the region, the YNLHN page does not acknowledge them. **Score = 0 / 2**

22. **Improving Aboriginal health outcomes: (i) Separate section in report devoted to Aboriginal health** The YNLHN page does not have a portal specifically dedicated to Aboriginal health information and data. **Score = 0 / 3**

23. **Improving Aboriginal health outcomes: (ii) Reporting on KPIs contained in current service level agreement (SLA)** The YNLHN Service Agreement 2019-2020 contains two Tier 2 KPIs relevant to Aboriginal Health: DAMA (p. 44) and Aboriginal and Torres Strait Islander employment (p. 45). The YNLHN page does not report on either. **Score = 0 / 3**

24. **Improving Aboriginal health outcomes: (iii) Report on Aboriginal community engagement** The YNLHN page “Engagement with Consumers & Community” portal provides links to the eight HACs and Regional Health Advisory Council resources, which includes links to, for example, membership forms and the Aboriginal Health Impact Statement Policy Guidelines. However, the page does not contain information on Aboriginal community engagement activities, such as, meetings that may have taken place with YNLHN executives, community forums, LHN NAIDOC and Reconciliation Week events, or how engagement is taking place with its rural Aboriginal communities, and the outcomes of these activities. **Score = 0 / 3**

25. **Improving Aboriginal health outcomes: (iv) Report on Aboriginal specific National Safety and Quality Health Service Standards assessment** The YNLHN page does not provide links to the six Aboriginal specific National Safety and Quality Health Service Standards (see Table 2), and how the LHN is implementing them or meeting their goals. **Score = 0 / 3**

26. **Improving Aboriginal health outcomes: (v) Chronic disease management and care planning** The YNLHN SA 2019-2020 (p. 24) identifies as one of its principal areas of services and accountabilities: “A requirement to participate in the South Australian Aboriginal Chronic Disease Consortium to progress implementation of the three statewide plans [regarding cancer control, heart and stroke, and diabetes] and consider opportunities to reorientate or reform services aligned with these plans.” The YNLHN page does not provide links to information regarding how the LHN is progressing implementation of the three statewide plans and putting in place chronic disease management and care plans for Aboriginal patients. **Score = 0 / 3**

27. **Cultural learning completion rates** The YNLHN SA 2019-2020 (p. 24) identifies as one of its principal areas of services and accountabilities: “The DHW will work with the YNLHN to increase the cultural competence of our whole workforce through the implementation of the SA Health Aboriginal Cultural Learning Framework which is a significant strategy for SA Health to meet the accreditation requirements of the NSQHS.” However, the YNLHN page does not provide links to data
on non-Aboriginal staff completion rates for the Cultural Learning Program across the three levels, the mode of delivery, and participant feedback.  

Score = 0 / 2

28. Aboriginal health division/unit placement on LHN organisational structure/chart The YNLHN page does not provide a link to information about, or a diagram of the organisational structure of the LHN.  

Score = 0 / 1

29. Data on Aboriginal access to and delivery of services Aboriginal Health is included among the range of inpatient health services available at the large site facilities at Port Pirie, Clare and Wallaroo (YNLHN SLA 2019-2020, p. 48). The YNLHN page does not provide links to data on the level of access to and use of the health services by Aboriginal people within its region.  

Score = 0 / 3

30. Aboriginal employment: (i) Aboriginal Workforce Framework (planning, recruitment, etc.) The YNLHN SA 2019-2020 (p. 24) identifies as one of its principal areas of services and accountabilities: “Build the capacity and capability of the YNLHN workforce to deliver quality care to Aboriginal people, whereby the DHW’s Workforce Services will work collaboratively with, and support the YNLHN to implement the SA Health Aboriginal Workforce Framework 2017-2022 which identifies key strategies to attract, retain and develop Aboriginal staff, and consequently increase the number of Aboriginal people working across our organisation.” However, the YNLHN page does not provide links to information on how it is progressing with the implementation of the Aboriginal Workforce Framework.  

Score = 0 / 2

31. Aboriginal employment: (ii) Data on Aboriginal employment The YNLHN page does not provide links to data on Aboriginal employment, either as basic statistics on the proportion of its workforce who identify as Aboriginal employees, or for their participation rate in the various health workforce employment categories.  

Score = 0 / 3

32. Other recognition (e.g., awards, scholarships, etc.) The YNLHN page does not provide links to information regarding staff awards, achievements, etc., including for Aboriginal staff.  

Score = 0 / 3

INDICATOR 3: SERVICE DELIVERY AND PARTNERSHIPS

Criterion: Aboriginal LHN Plan

33. Co-designed in partnership with ACCHO(s), or Aboriginal organisations, or Aboriginal experts by Experience in LHN region

The CHSALHN SLA, with regard to LHN accountabilities, holds that the LHN CEO is responsible for, inter alia, “Developing effective and working partnerships with Aboriginal Community Health and ensuring health needs of Aboriginal people are considered in all health plans, programs and models of care developed by the LHN.” (CHSALHN SLA 2018-2019, p. 10). While there are no ACCHOs formerly registered with the AHCSA in YNLHN region, the newly established Narungga Health Assembly may be a likely organisation with which to negotiate an LHN Aboriginal Health Plan given its desire to provide culturally sensitive health services in the near future with the assistance of the YNLHN - see https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/news+and+media/all+media+releases/narungga+health+assembly+inaugural+meeting. However, based on the YNLHNB meeting minutes, the 2018-2019 annual reports of the eight HACs, and lack of information on the SA Health website YNLHN page, other evidence is yet to emerge of any negotiations taking place to develop an Aboriginal Health Plan specifically for the region.  

Score = 1 / 2

34. Partnership with ACCHO(s) in LHN region
Refer Note 33. **Score = 0 / 2**

35. **Commitment to Continuous Quality Improvement**
Refer Note 33 **Score = 0 / 2**

36. **Co-designed KPIs**
Refer Note 33 **Score = 0 / 2**

37. **Clear statement of ACCHO and LHN responsibilities and conflicts**
Refer Note 33 **Score = 0 / 2**

**Criterion: Cultural Safety**

38. **Implementation of cultural safety policy/strategy**
The YNLHN SA 2019-2020 (p. 24) identifies as one of its principal areas of services and accountabilities: “The DHW will work with the YNLHN to increase the cultural competence of our whole workforce through the implementation of the SA Health Aboriginal Cultural Learning Framework which is a significant strategy for SA Health to meet the accreditation requirements of the NSQHSS.” Based on information provided in the YNLHN meetings (agenda and minutes), the eight HAC annual reports for 2018-19, and SA Health’s website YNLHN page, no mention is made of the development of, or existence of an LHN-specific cultural safety policy or strategy. **Score = 0 / 5**

39. **Proportion of staff trained**
Schedule 5: Performance and Monitoring of the YNLHN SLA 2019-2020 outlines the performance indicators and associated reporting arrangements that apply to the LHN. Unlike in the CHSALHN SLA 2018-2019 (p. 65) there is no KPI for the percentage of employees who have completed Aboriginal cultural competency training, with a target of 100%. This would also appear to breach NSQHSS Aboriginal and Torres Strait Islander specific standard 1.21 in relation to Clinical Governance safety and quality training whereby the health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients (see Table 2). No mention of Cultural Safety Training in relation to the YNLHN health workforce non-Aboriginal staff has been made in either Governing Board meetings, or in the 2018-2019 annual reports of the eight HACs. Also there is no information available on the YNLHN page of the SA Health website as to the numbers, or proportion of staff trained. **Score = 0 / 5**

**Criterion: Selected LHN health performance indicators reported publicly**

40. **Estimated level of completion of Indigenous status – specifically the reporting of ‘not stated’ on admission**
Schedule 5: Performance and Monitoring of the YNLHN SLA 2019-2020 outlines the performance indicators and associated reporting arrangements that apply to the LHN. The CHSALHN SLA 2018-2019, in Schedule 4: Performance Indicators and Targets, includes a statement in relation to supporting the delivery of the Closing the Gap agenda and citing the NSQHSS, that: “The LHN should implement processes to identify patients as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems” (CHSALHN, SLA 2018—19, p. 59). Schedule 5: Performance and Monitoring of the YNLHN SLA 2019-2020 contains no KPI for addressing the estimated level of completion of Indigenous status. This would also appear to breach NSQHSS Aboriginal and Torres Strait Islander specific standard 5.8 in relation to planning for comprehensive care (see Table 2). **Score = 0 / 3**

41. **Discharges against medical advice (DAMA)**
Schedule 5: Performance and Monitoring of the YNLHN SLA 2019-2020 contains a Tier 2 KPI: % of Aboriginal Patients Who Left Hospital Against Medical Advice, with the measure: % of overnight Aboriginal and/or Torres Strait Islander separations. The 2019-20 target is: <=4.5%, with the following performance ranges: Performing - <=4.5%; Performance Concern - >4.5% and <=6.5%; and Under Performing - >6.5%. This target is the same as in the CHSALHN SLA for 2018-2019 Schedule 4: Performance Indicators and Targets, in relation to Safe and Effective Care in terms of Aboriginal Health (CHSALHN, SLA 2018—19, p. 65). In the Access and Flow performance domain with regard to the Emergency Department, there is also a Tier 2 KPI: Left at Own Risk, with the Measure which includes percentages of (i) all ED presentations, (ii) Aboriginal presentations, and (iii) Mental Health presentations, with the target for all three categories: <=3% (CHSALHN, SLA 2018—19, p. 62). The YNLHN at its Dec. 17th 2019 meeting (Agenda Item 9.10), in relation to the YNLHN Performance Report for October, it was identified that the report requires additional work-mitigating strategies which are essential where KPIs are at risk or not being met, and identified, as an action, investigation of why Aboriginal consumers are leaving against medical advice. The SA Health website YNLHN page contains no data on how YNLHN is progressing against the performance ranges contained in its SLA. Score = 0 / 4

42. Potentially preventable hospital admissions (PPHA)
Schedule 5: Performance and Monitoring of the YNLHN SLA 2019-2020 does not contain a KPI regarding potentially preventable hospital admission for Aboriginal people. Score = 0 / 3

43. Access to mental health services as reported at service level agreement
Schedule 5: Performance and Monitoring of the YNLHN SLA 2019-2020 does not contain a KPI regarding Aboriginal access to mental health services. The SA Health website YNLHN page contains no data on Aboriginal access to mental health services. Score = 0 / 3

44. Low birth-weight babies
Schedule 5: Performance and Monitoring of the YNLHN SLA 2019-2020 does not contain a KPI regarding low birth-weight Aboriginal babies. The SA Health website YNLHN page contains no data on low birth-weight Aboriginal babies. Score = 0 / 3

45. Healthcare outcome differential measures (eg, discharge summary timeliness)
Schedule 5: Performance and Monitoring of the YNLHN SLA 2019-2020 does not contain KPIs regarding Aboriginal healthcare outcome differential measures, and is not a matter discussed at YNLHN meetings and in the HAC annual reports for 2018-19. Score = 0 / 4

INDICATOR 4: RECRUITMENT AND EMPLOYMENT
Criterion: Aboriginal health workforce development reporting
46. Implementation of Aboriginal workforce strategy
The YNLHN SA 2019-2020 (p. 24) identifies as one of its principal areas of services and accountabilities: “Build the capacity and capability of the YNLHN workforce to deliver quality care to Aboriginal people, whereby the DHW’s Workforce Services will work collaboratively with, and support the YNLHN to implement the SA Health Aboriginal Workforce Framework 2017-2022 which identifies key strategies to attract, retain and develop Aboriginal staff, and consequently increase the number of Aboriginal people working across our organisation.” The development and implementation of an YNLHN Aboriginal workforce strategy has not been raised by the YNLHN at its meetings, or mentioned in the six HAC annual reports for 2018-2019. The YNLHN at its Dec. 17th 2019 meeting (Agenda Item 9.10), in relation to the YNLHN Performance Report for October, discussion did, however, occur about the need for strategies to increase Aboriginal employment.
There is no reference to a YNLHN Aboriginal workforce strategy on the SA Health website YNLHN page. **Score = 0 / 4**

47. **LHN KPI for Aboriginal employment**
Schedule 5: Performance and Monitoring of the YNLHN SLA 2019-2020 contains a Tier 2 KPI: Aboriginal Employment Rate, with the measure: % of employees who identified as being of Aboriginal or Torres Strait Islander origin. The 2019-20 target is: >=4%, with the following performance ranges: Performing - >=4.0%; Performance Concern - <4.0% and >=1.5%; and Under Performing - <1.5%. No data regarding the YNLHN’s progress against the SLA performance ranges on the SA Health website YNLHN page (including portals and their links). **Score = 0 / 4**

48. **Number of Aboriginal health practitioners, health workers and liaison officers**
According to SA Health, Aboriginal health workers are located at the YNLHN health facility at Maitland: [https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/services/health+services+for/aboriginal+health+services/aboriginal+health+workers](https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/services/health+services+for/aboriginal+health+services/aboriginal+health+workers). At its Feb. 11th 2020 meeting (Agenda Item 6.1), a presentation was made by the LHN’s ED Community and Allied Health Services to the YNLHNB during which the role of the Aboriginal Liaison Officer based in the Central Referral Unit was confirmed and the potential for this position to support increased capacity for the delivery of TCP services to Aboriginal people. However, the number of Aboriginal people employed in these roles is not provided on the SA Health website YNLHN page. **Score = 2 / 3**

49. **Number of identified Aboriginal positions**
Data regarding the number of identified Aboriginal positions in YNLHN’s workforce is not provided on the SA Health website YNLHN page. **Score = 0 / 3**

50. **Number of salary bands occupied by Aboriginal employees**
Data regarding the number of salary bands occupied by Aboriginal employees in YNLHN’s workforce is not provided on the SA Health website YNLHN page. **Score = 0 / 3**

51. **Number of long term Aboriginal employees**
Data regarding the number of long term Aboriginal employees in YNLHN’s workforce is not provided on the SA Health website YNLHN page. **Score = 0 / 3**

**Criterion: Aboriginal participation in the health workforce**

52. **Administrative**
Data regarding the number of Aboriginal people working in administration in YNLHN’s workforce is not provided on the SA Health website YNLHN page. **Score = 0 / 3**

53. **Medical Professional**
Data regarding the number of Aboriginal medical professionals in YNLHN’s workforce is not provided on the SA Health website YNLHN page. **Score = 0 / 4**

54. **Nurses/Midwives**
Data regarding the number of Aboriginal nurses and midwives in YLHN’s workforce is not provided on the SA Health website YNLHN page. **Score = 0 / 4**

55. **Operational Services**
Data regarding the number of Aboriginal providing operational services in the YNLHN is not provided on the SA Health website YNLHN page. **Score = 0 / 3**
56. **Allied Health/Scientific/Technical**
Data regarding the number of Aboriginal employed to provide allied health/scientific and technical services in the YNLHN is not provided on the SA Health website YNLHN page.  
Score = 0 / 3

57. **Other**
Data regarding other roles occupied and services offered by Aboriginal people in YNLHN’s workforce (for example, as cultural consultants, and experts by experience) is not provided on the SA Health website YNLHN page.  
Score = 0 / 3

**INDICATOR 5: FINANCIAL ACCOUNTABILITY AND REPORTING – CLOSING THE GAP FUNDING**

The YNLHN *Service Agreement 01 July 2019 – 30 June 2020 (YNLHN SA)* in Schedule 3: Local Health Network – Services and Accountabilities, under Section 4. Services for Priority Population Groups, in sub-section 4.1 Aboriginal Health Services, states that:

- The LHN will work collaboratively with DHW’s Aboriginal Health other relevant health services, support organisations and Aboriginal community-controlled health services to continue to implement the regional Aboriginal Health Improvement Plan to support services meeting the needs of the local Aboriginal population.
- In recognition of the need to ensure appropriate resource allocation for Aboriginal Health Programs, the LHN should maintain or increase their relative funding allocation to these programs commensurate with their total funding allocation (p. 24).

The YNLHN SA identifies three principal areas of services and accountabilities:

- A requirement to participate in the South Australian Aboriginal Chronic Disease Consortium to progress implementation of the three statewide plans [regarding cancer control, heart and stroke, and diabetes] and consider opportunities to reorientate or reform services aligned with these plans;
- Build the capacity and capability of the YNLHN workforce to deliver quality care to Aboriginal people, whereby the DHW’s Workforce Services will work collaboratively with, and support the YNLHN to implement the *SA Health Aboriginal Workforce Framework 2017-2022* which identifies key strategies to attract, retain and develop Aboriginal staff, and consequently increase the number of Aboriginal people working across our organisation; and
- The DHW will work with the YNLHN to increase the cultural competence of our whole workforce through the implementation of the *SA Health Aboriginal Cultural Learning Framework* which is a significant strategy for SA Health to meet the accreditation requirements of the NSQHS (p. 24).

In Schedule 4: Funding and Commissioned Activity of the YNLHN SA, in Section 6: Specific Commissioning/Funding Commitments (p. 37), four services and programs are identified: the Transition Care Program (TCP), the Community Support Scheme Program (CSS), the Aged Care Assessment Program (ACAP) and Multi-Purpose Services (MPS). No funding allocations within these four programs/services have been specified for Aboriginal Health services/needs, and there has been no specific commissioning/funding commitment made to Aboriginal Health, or an area of identified need. The YNLHN is expected to work collaboratively with the Office of Ageing Well, Adult Safeguarding Unit to support Aboriginal and Torres Strait Islander people aged 50 years or over (p. 25). The YNLHN is also responsible for developing the Rural Health Workforce Strategy broad services plan and workforce plan under the guidance of the Rural Health Workforce Strategy Steering Committee to support recruitment, retention and training of, *inter alia*, Aboriginal health workers (p. 18).
The YNLHN SA has not identified any specific funding allocations (Commonwealth, State, or other) for Aboriginal Health Services, and incorporates only two Tier 2 KPIs for relevant to Aboriginal Health: DAMA (p. 42) and Aboriginal and Torres Strait Islander employment (p. 43).

**Criterion: Commonwealth contributions for Aboriginal health programs to LHN**

58. **Commonwealth contributions for Aboriginal health programs to LHN**

A search of the SA Health website, including the YNLHN page did not produce any information concerning Commonwealth contributions for Aboriginal health programs to the YNLHN. **Score = 0 / 10**

**Criterion: South Australian contributions to Aboriginal specific services and programs including activity-based funding loading for Aboriginal patients**

59. **Reporting on contributions for Aboriginal specific health services and programs including activity-based funding loading**

A search of the SA Health website, including the YNLHN page, did not produce any information on State funding contributions for Aboriginal specific health services and programs at the YNLHN including for activity-based funding loadings for Aboriginal patients. **Score = 0 / 10**

**YNLHN documents consulted**

- Governing Board Meetings: *Agenda* 9 July 2019 / *Minutes* 9 July 2019
- “ “ “ “ 1 April 2020 / “ 1 April 2020

- *Service Agreement* (1 July 2019 – 30 June 2020)
- YNLHN Facebook page - @YNLHN

**HAC Annual Reports**

- [Port Broughton District Hospital and Health Advisory Council Inc. [PBDHAC] Annual Report 2018-2019](#)

**YNLHN documents not sighted**
SUMMARY OF THE RESULTS OF THE AUDITS

This part provides an overall summary of the audit results and highlights examples of LHN best practice encountered. It is again emphasised that the assessment process is based on the publicly available information provided by each LHN, which can vary, and that one of the purposes of the Matrix is to promote transparency in policy implementation and accountability. This means that some LHNs may be doing some of the assessable activities but not reporting them therefore incurring a penalty score.

The following sections briefly describe the rationale for each criterion, provide tabulated results of the audits for each criterion and associated sub-criteria for all 10 LHNs, and a commentary on those results.

1.15 **Key Indicator: Participation in LHN governance**

The Expert Workshop, which met in Adelaide on 8th August 2019 to create the prototype customised SA Health Matrix Template, decided on a number of sub-criteria that reflect what Aboriginal people would expect of LHN Boards in terms of extending good LHN governance to include their communities. The Expert Workshop wanted to see evidence of LHNB direct interaction with the local community/ies, that Aboriginal health performance indicators (and not just those KPIs included in the SLA/SAs) would be regularly reviewed, that a community-based Aboriginal consultative body or Aboriginal Expert by Experience would have opportunities to directly address the Board, that the LHNB would make it its business to become thoroughly familiar with the health status and issues of concern to the local community that their LHN served, and that the members of the LHNB would undertake Cultural Competency Training based on the *SA Health Aboriginal Cultural Learning Framework* (SA Health 2017a). Because measurement of these sub-criteria was based solely on the agenda and minutes of LHNB meetings, generally held monthly, on reading these records of meetings it also became apparent that other aspects reflective of good governance could be considered. These included: whether Aboriginal guests (eg, health experts) were invited to make presentations at Board meetings, whether Aboriginal health matters were formally included in the agenda, or as non-agenda items where Aboriginal health matters were raised/discussed, whether in the monthly SLA/SA Performance Reports the Aboriginal specific KPIs were reviewed, and whether the Aboriginal Health Expert Member of the Governing Board (AHEMGB) was also a member of any of the Board committees.

In relying solely on board meeting agenda and minutes to score the sub-criteria for good governance, it is also important to acknowledge the limitations of this method. Most Board meetings last several hours and involve reports and documents tendered (eg, from the CEO, CFO, and Board committees). Board minutes, by nature, only summarise information which the Board considers essential for the record, and the decisions and actions taken by the Board. It is highly likely that in most meetings, matters relating to Aboriginal health were mentioned, perhaps in passing, but at the time were not considered significant enough to record in the minutes.
1.15.1 Criterion: Good governance

One of the principles to be applied in connection with the operation and administration of the HCA is that, in accordance with s. 5(b), “Aboriginal people and Torres Strait Islanders should be recognised as having a special heritage and the health system should, in interacting with Aboriginal people and Torres Strait Islanders, support the values that respect their historical and contemporary cultures.” This criterion and associated sub-criteria are designed to measure the levels of LHN board interaction with the local Aboriginal community including an understanding of their particular health issues, that the board is taking an active interest in improving the health of that community through a particular focus on their LHN’s Closing the Gap performance and initiatives based on selected KPIs, and that the non-Aboriginal board members have significant level of cultural awareness and competence in accordance with the SA Health Aboriginal Cultural Learning Framework (SA Health 2017a).

Table 3: Criterion – Good governance

<table>
<thead>
<tr>
<th>Sub criteria</th>
<th>Barossa Hills Fleurieu LHN</th>
<th>Central Adelaide LHN</th>
<th>Eyre Far North LHN</th>
<th>Flinders Upper North LHN</th>
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<th>Northern Adelaide LHN</th>
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<th>Southern Adelaide LHN</th>
<th>Women’s Children’s LHN</th>
<th>Yorke Northern LHN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board interaction - Aboriginal community</td>
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<td>2/2</td>
<td>0/2</td>
<td>2/2</td>
<td>0/2</td>
<td>2/2</td>
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<td>1/2</td>
</tr>
<tr>
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<td>0/2</td>
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<td>0/2</td>
</tr>
<tr>
<td>Board input Aboriginal Community Consultative</td>
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<td>0/2</td>
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<td>1/2</td>
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<tr>
<td>Board CLT</td>
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</tbody>
</table>
Based on the sub-criteria selected by the Expert Workshop, Table 3 indicates an almost uniformly low level of engagement by LHNBs with the Aboriginal community/ies within their LHN region. While five indicated engagement through, for example, attendance at a NAIDOC event, holding a meeting at an Aboriginal health clinic, or accepting an invitation to meet with an Aboriginal community group, the other five did not record any level of such engagement. Seven LHNBs indicated that they either attended or accepted an invitation to attend an Aboriginal Health forum, hosted by the SA Health Aboriginal Health Division in conjunction with the LHN Board’s AHEMGB, the CEO and Director of Aboriginal Health (remembering that from March 2020 many LHN meetings had to be postponed due to COVID-19). It also became apparent in reviewing the broader range of documents used for the audit, that there were very few Aboriginal community-based consultative bodies established (as distinct from internal LHN Aboriginal committees) with which boards could interact. An outcome of the July 2020 prototype customized matrix validation was to also include Aboriginal Experts by Experience as an alternative if there was no Aboriginal community-based consultative body in the LHN region. However, this option is only available for the six regional LHNs. With regard to Aboriginal health performance indicators, those included as KPIs in the LHN SLAs/SAs [see Table 14: Summary of LHN SLA/SA Tier 2 Aboriginal health related KPIs] may have been brought to the attention of the Board as part of the CEO’s monthly performance reporting. Concerns were raised at WCHNB meetings about the need to introduce other Aboriginal health KPIs regarding, for example, chronic disease, gestational diabetes, smoking and low birth-weight babies. Of particular concern is the absence of evidence that LHN board members have undergone Cultural Competency Training as per the SA Health Aboriginal Cultural Learning Framework.

Table 4, below, reflects the number of Aboriginal health matters discussed by LHN Boards over the period July 2019 to April 2020. For this table, Aboriginal-health-related matters included substantive issues, such as selection of KPIs for the Aboriginal Health Scorecard discussed by the WCHN Board, discussions about RAPs (SALHN Board), concern about SLA/SA performance reports (eg, in relation to Aboriginal self-discharges) (RMCLHN), Aboriginal health workforce matters (LCLHN), opportunities for cultural education programs (FUNLHN, CALHN), AHEMGB appointments to Board committees, to arrangements regarding Aboriginal Health Community Forums (most LHNS) and invitations to attend Aboriginal-hosted events. These findings are based on the minutes of these meetings. In some cases, indicated by #, the minutes were not posted on the SA Health website LHN page when the audit was undertaken (usually April meetings minutes).

<table>
<thead>
<tr>
<th>Sub criteria</th>
<th>Barossa Hills Fleurieu LHN</th>
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<th>Southern Adelaide LHN</th>
<th>Women’s Children’s LHN</th>
<th>Yorke Northern LHN</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of meetings</td>
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<td>10</td>
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<td>22</td>
<td>2</td>
<td>14</td>
<td>9</td>
<td>17</td>
<td>12</td>
</tr>
</tbody>
</table>
1.15.2 Criterion: Aboriginal representation at board level

LHNs are established as incorporated hospitals under Part 5, s. 29 of the HCA. With regard to the composition of governing boards for incorporated hospitals, under s.33B(1) boards can consist of 6 to 8 members, however, “At least 1 member of a governing board must be a person who has expertise, knowledge or experience in relation to Aboriginal health.” [s.33B(4)]. The acronym AHEMGB – Aboriginal Health Expertise Member of the Governing Board is used to indicate the governing board member who has “expertise, knowledge or experience in relation to Aboriginal health”. Because significant weighting is given to Aboriginal representation in the governance structure the score is given on an “all-or-nothing” basis.

Table 5: Criterion – Aboriginal representation on LHN Boards (LHNB)

<table>
<thead>
<tr>
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<th>Southern Adelaide LHN</th>
<th>Women’s Children’s LHN</th>
<th>Yorke Northern LHN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal representation on Board</td>
<td>0/10</td>
<td>10/10</td>
<td>5/10</td>
<td>10/10</td>
<td>10/10</td>
<td>10/10</td>
<td>10/10</td>
<td>10/10</td>
<td>10/10</td>
<td>10/10</td>
</tr>
</tbody>
</table>

As indicated in Table 5, eight of the ten LHNs had AHEMGBs who identified as Aboriginal people. With regard to the BHFLHN it is not known, based on available documentation, whether the AHEMGB identified as an Aboriginal person. Additionally, the BHFLHNB was without an AHEMGB from March 2020, and although of concern to the Board, at the time of writing this report, no new appointment to this position had been made. The EFNLHNB appointed on 1st July 2019 included an AHEMGB who identifies as an Aboriginal person. However, the EFNLHNB was without an AHEMGB from February 2020, and again although of concern to the Board at the time of writing this report, a replacement had not been appointed.
1.15.3 **Criterion: Inclusion in Executive Management Structure**

This criterion responds to the key priority of developing the leadership skills and potential of Aboriginal people whereby, as outlined in the *SA Health Aboriginal Workforce Framework 2017-2022*, SA Health wants to see:

- Strong Aboriginal leadership across SA Health; and
- An increase in the number of Aboriginal people in Executive roles (SA Health 2017b, p. 11).

**Table 6: Criterion – Inclusion in Executive Management Structure (EMS)**

<table>
<thead>
<tr>
<th>Sub criteria</th>
<th>Barossa Hills LHN</th>
<th>Central Adelaide LHN</th>
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<th>Riverland Mallee Coorong LHN</th>
<th>Southern Adelaide LHN</th>
<th>Women’s Children’s LHN</th>
<th>Yorke Northern LHN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal Health Division</td>
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<tr>
<td>Aboriginal Health executive reports to CEO</td>
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<td>0/5</td>
<td>0/5</td>
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<td>0/5</td>
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</tr>
</tbody>
</table>

SALHN is the only LHN that did not meet the two sub-criteria. The six regional LHNs, by virtue of the organisational structure laid out in the *Establishment of Regional Local Health Networks: Detailed Design Proposal* consultation paper (CHSALHN, 2019, p. 6) and their size compared with their three metropolitan counterparts and the WCHN, placed Aboriginal Health at divisional status and headed by a director rather than an executive director. Nevertheless, in accordance with the proposed organisational structure, the Director of Aboriginal Health reports to the LHN CEO and is a member of the LHN executive management group. However, in the absence of an annual report where the make-up of the executive management group is usually indicated, including a short bio for each of its members, the SA Health website LHN page for the six regional LHNs had to be relied on for verification of the identity of the Director of Aboriginal Health – whether or not the Director was an Aboriginal person. Unlike for the LHN board members where each LHN page has a portal for the LHN Governing Board, no such information was available on the LHN page (which includes portals and their links) concerning the members of the executive management group. As with the Governing Board, because significant weighting is given to Aboriginal representation in the governance structure the score is given on an “all-or-nothing” basis. Because the identity of the Director of Aboriginal Health could not be verified – whether the Director was an Aboriginal person or not, no points could be awarded to the six regional LHNs for the second sub-criterion.
1.16 Key Indicator: Policy implementation

The policy environment for this key indicator is linked to the 2008 COAG National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes and The National Indigenous Reform Agreement, and the suite of policies that the agreements have generated at the state level. Unfortunately, the much anticipated Close the Gap Refresh Agreement could not be used as it was not signed off by the COAG in time for consideration for this audit. Community engagement is also fundamental for the successful implementation of Closing the Gap health policy. However, there has to be readily available sources of information for Aboriginal people to access if community engagement is to be effective. Such information, in the first instance, should be made available in the LHN annual reports and websites.

This key indicator examines LHN strategic plans, SLAs/SAs with regard to their Aboriginal health specific Tier 1 and Tier 2 KPIs, and the content and quality of Aboriginal health-related information presented on their websites and annual reports. With regard to the regional LHNs, in the absence of their first annual reports, such information was searched for on their websites.

1.16.1 Criterion: Improving Aboriginal Health Outcomes

One of the Early Actions of the SA Health Strategic Plan 2017-2020 was that by June 2018 each LHN would develop their Local Strategic Management Plan. The first sub-criterion focuses on the necessity of ensuring that Aboriginal health is included as a strategic priority in each LHN strategic plan. The second is concerned with whether or not Aboriginal health related KPIs that will measure progress towards positive health outcomes for Aboriginal people and improve their health status are included in the annual LHN SLAs/SAs.

The parent documents regarding LHN strategic plans are the SA Health Strategic Plan 2017 to 2020 (SA Health, 2017c) and the SA Health Strategic Plan 2017 to 2020: Early Actions (SA Health, 2017d). One of the early actions to respond to the Strategic Plan is: 3. Create strategic and business plan to implement the SA Health strategic plan, whereby “each Local Health Network has their own strategic management plan informed by the SA Health strategic plan” (SA Health, 2017d, p. 6. See also SA Health, 2017c, p. 15). However, at the time of writing up this report the six newly established LHNs were still in the process of finalising their strategic plans, mostly as a result of delays caused by the COVID-19 pandemic. As the completed Strategic Plans of the regional LHNs were not available, it was decided to give each a discretionary score of 5/10 for this sub-criterion.

The metropolitans LHNs and WCHN SLAs contain the same four Tier 2 Aboriginal health related KPIs: Left at Own Risk; DAMA, Aboriginal employment; and Cultural Competency Training completion. The six regional LHNs in their SAs all have Tier 2 KPIs for DAMA and Aboriginal Employment. These KPIs are taken as given and are not included in the scoring here as they are scored against performance in other sub-criteria [see Table 14]. Instead, given the excess burden of chronic disease and the poor mental health status of the Aboriginal community, five Tier 1 and five Tier 2 KPIs, most of which are included in the current LHN SLAs/SAs, have been identified which should also specifically include an Aboriginal sub-set for inclusion for the performance measurement against each KPI. The CALHN Service Level Agreement 2018-2019, for example, in Schedule 4: Performance Indicators and Targets (excluding SA Dental Service KPIs) contains 60 KPIs (22 Tier 1 and 38 Tier 2) (pp. 55-59). The RMCLHN Service Agreement 2019-2020, in Schedule 5: Performance Monitoring, 33
KPIs (15 Tier 1 and 18 Tier 2) are listed (pp. 41-43). Many of these KPIs could include a data sub-set specifically for Aboriginal health. Such is the case in the CALHN SLA, which includes an Emergency Department Tier 2 KPI: Left at Own Risk which measures three data sets: (i) % of All ED presentations; (ii) % of Aboriginal presentations; and (iii) % of Mental Health presentations – all with a target <=3%. A similar approach could be adopted in such health service areas as Mental Health with regard to, for example, Mental Health – Acute Linked Length of Stay (Tier 1), Post Discharge Community Follow Up Rate (Tier 2); Rehabilitation - Individual Care Plan (Tier 2); Stroke – Admission to Stroke Unit (Tier 2); and Emergency Department Unplanned Re-attendances within 48 Hours (Tier 2) [examples taken from the CALHN SLA].

Scoring is based on whether these, and other selected KPIs also include Aboriginal data sub-sets.

Table 7: Criterion – Improving Aboriginal Health Outcomes

<table>
<thead>
<tr>
<th>Sub criteria</th>
<th>Barossa Hills LHN</th>
<th>Central Adelaide LHN</th>
<th>Eyre Far North LHN</th>
<th>Flinders Upper North LHN</th>
<th>Limestone Coast LHN</th>
<th>Northern Adelaide LHN</th>
<th>Riverland Mallee Coorong LHN</th>
<th>Southern Adelaide LHN</th>
<th>Women’s Children’s LHN</th>
<th>Yorke Northern LHN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal Health priority in Strategic Plan</td>
<td>5/10</td>
<td>0/10</td>
<td>5/10</td>
<td>5/10</td>
<td>5/10</td>
<td>5/10</td>
<td>5/10</td>
<td>0/10</td>
<td>10/10</td>
<td>5/10</td>
</tr>
<tr>
<td>Aboriginal Health KPIs in Service (Level) Agreement</td>
<td>0/10</td>
<td>0/10</td>
<td>0/10</td>
<td>0/10</td>
<td>0/10</td>
<td>0/10</td>
<td>0/10</td>
<td>0/10</td>
<td>0/10</td>
<td>0/10</td>
</tr>
</tbody>
</table>

The WCHN established its own Aboriginal Health Plan 2018-2022 as one of the individual strategic priority plans encompassed by the WCHN Local Strategic Management Plan. Only one of the other three established LHNs has shown some indication of incorporating the health needs of Aboriginal people in their strategic planning.

It might be expected that the selection of Aboriginal health KPIs would be carried out in consultation with Aboriginal health experts and their community, and also reflect the fields of clinical expertise and health domains of the major health facilities within the LHN. The fact that all the LHNs did not score for this sub-criterion raises the issue about the process for the selection of Aboriginal health related KPIs for inclusion in SLAs/SAs and the extent that Aboriginal health experts and professionals, ACCHOs and Aboriginal Experts by Experience are involved in this process. Also, given the urgent need to
address the chronic disease and mental health burden of the Aboriginal community, the question has to be asked – why are there no Tier 1 Aboriginal health related KPIs? As pointed out in Note 15 of the SA Health Matrix Template, Tier 1 KPIs are critical system markers which operate as intervention triggers. Underperformance triggers immediate action, analysis of the cause of deviation, and consideration of the need for intervention. This provides an early warning system to enable appropriate intervention as a performance issue arises within critical performance areas.
1.16.2 Criterion: Community engagement

Until recently there were two avenues for consumers and communities to engage with the LHNs: through mechanisms established under a LHN engagement strategy or framework and through LHN Health Advisory Council(s) (HACs). The CALHN, NALHN, SALHN and WCHN HACs were dissolved by Schedule 3A of the Health Care (Governance) Amendment Bill 2019. Since their establishment on 1st July 2019, the six regional LHNs are required to not only have consumer and community engagement and clinician engagement Board committees, but also their own consumer and community engagement and clinician engagement strategies. As at the end of May 2020, the consumer and community engagement and clinician engagement strategies of the six regional LHNs were still under development because of delays substantially caused by the COVID-19 pandemic, although in some cases, consultation drafts for community feedback had been released and were therefore not considered for assessment. To compensate for the absence of completed clinician engagement strategies, each of the regional LHNs has been given a discretionary score of 1.5/3.

The thirty-nine HACs in regional South Australia, which were established in 2008 and which were the principal mechanisms for more locally based consumer and community advocacy and engagement within the former CHSALHN, continue to operate within their new respective LHN regions. Consequently, the assessment of the various sub-criteria for community engagement is based on the 39 regional LHN HAC constitutions/rules and their 2018-19 annual reports, the consumer and community engagement strategies of the three metropolitan LHNs and WCHN, and an analysis of the agenda and minutes of all of the LHNB meetings.

Table 8: Criterion – Community Engagement

<table>
<thead>
<tr>
<th>Sub criteria</th>
<th>Barossa Hills Fleurieu LHN</th>
<th>Central Adelaide LHN</th>
<th>Eyre Far North LHN</th>
<th>Flinders Upper North LHN</th>
<th>Limestone Coast LHN</th>
<th>Northern Adelaide LHN</th>
<th>Riverland Mallee Coorong LHN</th>
<th>Southern Adelaide LHN</th>
<th>Women’s Children’s LHN</th>
<th>Yorke Northern LHN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal community consultative body</td>
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<td>0/4</td>
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<td>0/4</td>
<td>0/4</td>
<td>4/4</td>
<td>2/4</td>
<td>2/4</td>
<td>1/4</td>
</tr>
<tr>
<td>Aboriginal community engagement in overall community engagement strategy</td>
<td>0.5/4</td>
<td>0/4</td>
<td>2/4</td>
<td>2.5/4</td>
<td>0/4</td>
<td>4/4</td>
<td>1/4</td>
<td>4/4</td>
<td>4/4</td>
<td>1/4</td>
</tr>
</tbody>
</table>
All LHNs show evidence of some degree of engagement with the Aboriginal community/ies within their regions. Over half have RAPs or indicate a commitment to developing a RAP, and LHN CEOs (usually in conjunction with the Director of Aboriginal Health), in at least four instances, have convened a meeting with the Aboriginal community. Unfortunately little evidence has emerged of the existence of Aboriginal community-based consultative bodies (although the Aboriginal Experts by Experience in the regional LHNs provide another option for community consultation), and there were no newsletters focused on LHN Aboriginal communities. Given the general lack of important information available to Aboriginal consumers and communities within LHN annual reports and websites [see sections 4.2.3 and 4.2.4 following], newsletters/e-letters and social media platforms could prove to be important vehicles by which to communicate that information and more general news about LHN activities and initiatives. While the non-availability of regional LHN clinical engagement strategies was noted above, there was no evidence of Aboriginal health professionals being included in the clinical engagement strategies of the four established LHNs.

In the absence of regional LHN consumer and community engagement strategies, it was thought necessary to analyse the 39 regional HAC 2018-19 annual reports for evidence of engagement with local Aboriginal communities. This was not factored into the community engagement criterion by the Expert Workshop. It should also be noted that these HAC 2018-2019 annual reports in many cases reflect issues and concerns regarding the transition out of CHSALHN to the six regional LHNs, particularly the working relationships to be established with the new LHN Governing Boards. As Table 8 indicates, of the 39 HACS, less than a third showed evidence of engagement with the local Aboriginal community. This may also reflect the possibility that there may be very few Aboriginal people residing within some of the HAC regions. Table 1 indicates that four of the regional LHNs (BHFLHN, LCLHN, RMCLHN and YNLHN) have less than 3,000 Aboriginal people residing in their regions, while between them they have 28 of the 39 HACS.

<table>
<thead>
<tr>
<th></th>
<th>1/3</th>
<th>1/3</th>
<th>1/3</th>
<th>1/3</th>
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<th>1/3</th>
<th>1/3</th>
<th>1/3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newsletter/e-letters/social media</td>
<td>3/3</td>
<td>0/3</td>
<td>0/3</td>
<td>1.5/3</td>
<td>3/3</td>
<td>0/3</td>
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<tr>
<td>LHN CEO convenes forum</td>
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<td>3/3</td>
<td>3/3</td>
<td>3/3</td>
<td>3/3</td>
</tr>
<tr>
<td>RAP</td>
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<td>0/3</td>
<td>1.5/3</td>
<td>1.5/3</td>
<td>1.5/3</td>
<td>0/3</td>
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<td>0/3</td>
<td>1.5/3</td>
</tr>
</tbody>
</table>
Table 9: Criterion – Regional Health Advisory Council evidence of Aboriginal Community Engagement

<table>
<thead>
<tr>
<th>Sub criteria</th>
<th>Barossa Hills LHN</th>
<th>Central Adelaide LHN</th>
<th>Eyre Far North LHN</th>
<th>Flinders Upper North LHN</th>
<th>Limestone Coast LHN</th>
<th>Northern Adelaide LHN</th>
<th>Riverland Mallee Coorong LHN</th>
<th>Southern Adelaide LHN</th>
<th>Women’s Children’s LHN</th>
<th>Yorke Northern LHN</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of HACs</td>
<td>6</td>
<td>X</td>
<td>6</td>
<td>5</td>
<td>6</td>
<td>X</td>
<td>8</td>
<td>X</td>
<td>X</td>
<td>8</td>
</tr>
<tr>
<td>No. of engaged HACs</td>
<td>2</td>
<td>X</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>X</td>
<td>2</td>
<td>X</td>
<td>X</td>
<td>2</td>
</tr>
</tbody>
</table>

**Total No. of HACs = 39**  
**Total No. of HACs that engaged with Aboriginal Communities = 12**

In analysing the levels of HAC engagement with the local Aboriginal community, one of the sub-criteria concerns whether the advisory council has an identified Aboriginal member [technically: Aboriginal Resident Representative Member of the HAC (ARRMHAC) reflecting the residency requirement governing appointments to Advisory Councils]. The HAC constitutions/rules, in relation to advisory council membership, provide that: “In making appointments to the Advisory Council, regard will be had to ensuring appointees have an appropriate balance of skills, qualifications or experience, as appropriate to the powers and functions of the Advisory Council.” A list of examples of such skills, qualifications or experience is provided which includes, as an example, an appointee with “knowledge or experience of the needs of People of Aboriginal or Torres Strait Islander Descent”. [This example is taken from Barossa and Districts Health Advisory Council Inc. Constitution (and as determined by the Minister for Health in accordance with Section 17(1) of the Health Care Act 2008 on the 6th day of June 2008), Article 10 and 10.5, however this wording is uniform across all HAC constitutions/rules.] Only two of the 39 regional LHN HACs listed an ARRMHAC (Hawker District Memorial Health Advisory Council – FUNLHN; and Mid North Health Advisory Council – YNLHN). Other HACs may well have an Aboriginal Resident Representative member, but they were not identified as such on their respective HAC page of the SA Health website.

In section 4.2.3 following, in relation to Table 9: Criterion – Public Reporting and Accountability (via LHN website or annual report), limitations of the Premier and Cabinet’s Circular PC013: Annual Reporting Requirements 2019-2020 in terms of its “one size fits all”, “tick-a-box” approach are alluded to. HACs and LHNs are required to use the same annual reporting template, even though their focus and responsibilities are very different. There is considerable variation in the amount of information concerning individual HAC consumer and community engagement activities “volunteered” beyond their statutory annual reporting obligations. In some reports the Presiding Member, in introducing their report, took the opportunity to provide a summary of their HAC’s consumer and community engagement activities, or, in responding to the mandatory reporting requirement regarding reporting required under any other act or regulation, provided an expanded account of how their HAC complied with the functions and powers detailed under Part 4 Health Advisory Councils of the HCA 2008 (and as written into their constitution/rules). In other annual reports, the statutory reporting requirements were completed with no additional detail on consumer and community activities, particularly in relation to their core function of advocacy to promote the
interests of the community, undertaken during the year. An example of the former is the Port Augusta, Roxby Downs & Woomera Health Advisory Council Annual Report 2018-2019 (pp. 3-5, 15-16). An example of the latter is the Eastern Eyre Health Advisory Council Inc Annual Report 2018-2019 (pp. 3 and 14).
1.16.3 Criterion: Public Reporting and Accountability (via LHN website or annual report)

Annual reporting requirements are mandated for all South Australian Government agencies and entities in the General Government Sector which are presenting annual reports to the South Australian Parliament. These requirements are set out in the Premier and Cabinet’s Circular PC013: Annual Reporting Requirements 2019-2020. In terms of the principles of annual reporting, annual reports must be:

- Transparent and accountable
- Concise
- Open
- Performance-based
- Factual
- Citizen-centric
- Accessible
- Digital (pp. 2-3).

In the context of this institutional racism audit report, the annual reporting requirements are the same for the LHNs as they are for the regional Health Advisory Councils and are to follow the same template (Premier and Cabinet 2019, pp. 8-9). The following analysis is based on the 2018-2019 annual reports of the three metropolitan LHNs and of the WCHN, and information available on their SA Health website LHN page. As this report predates the release of the first annual reports of the six regional LHNs which will not be available until after September 30th 2020, their SA Health website LHN pages are relied upon for the relevant information.

This criterion is designed to reflect the extent that LHN websites and annual reports also embrace and reflect the Aboriginal community/ies that the LHN serves, that their SA Health website page and report engenders the feeling that the LHN is also “their” LHN, that is, the degree to which it is also “Aboriginal citizen-centric”.

Table 10: Criterion – Public Reporting and Accountability (via LHN website or annual report)

<table>
<thead>
<tr>
<th>Sub criteria</th>
<th>Barossa Hills Fleurieu LHN</th>
<th>Central Adelaide LHN</th>
<th>Eyre Far North LHN</th>
<th>Flinders Upper North LHN</th>
<th>Limestone Coast LHN</th>
<th>Northern Adelaide LHN</th>
<th>Riverland Mallee Coorong LHN</th>
<th>Southern Adelaide LHN</th>
<th>Women’s Children’s LHN</th>
<th>Yorke Northern LHN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional Owner acknowledgement</td>
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<td>0/2</td>
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<td>0/2</td>
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<td>0/2</td>
<td>0/2</td>
</tr>
<tr>
<td>Website or AR section on Aboriginal health</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
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</tr>
<tr>
<td>KPIs in SLA reported</td>
<td>0/3</td>
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<tr>
<td>Report on Aboriginal specific NSQHSS</td>
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<tr>
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<tr>
<td>Cultural learning completion rates</td>
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<td>0/2</td>
<td>0/2</td>
<td>0/2</td>
<td></td>
</tr>
<tr>
<td>Aboriginal Hlth Div. located on org. chart</td>
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<td>0/1</td>
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<td>0/1</td>
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<td></td>
</tr>
<tr>
<td>Aboriginal access to services data</td>
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<td>Aboriginal Workforce Framework</td>
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<tr>
<td>Data on Aboriginal employment</td>
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<td>7</td>
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</tr>
</tbody>
</table>

In an on-line world, this criterion simply reflects the expectation that a range of health-related information, including performance related data should be readily available 24/7 on each individual LHN website. Many members of the Aboriginal community have a vested interest in being able to access this information, such members include those who are LHN members and LHN employees, regional HAC members, ACCHO directors and administrators, health professionals and workers, Aboriginal Experts by Experience, and members of Aboriginal community consultative bodies – all who have a role in providing input into the governance, and clinical and community engagement processes of their LHN.

Information not deemed necessary for inclusion in the annual report should be made available on the agency website. As LHNs are required to submit annual reports, it is taken here that they are agencies in their own right. This means that each should have its own website. Instead, what was found was that effectively each LHN does not have its own dedicated website, that instead, an internet search for any particular LHN invariably leads to the SA Health website, which provides a link or portal for each LHN. A visit to the LHN page enabled access to a range of portals and their links, none of which provided the information sought for the assessment of this criterion.
With particular regard to the low scores of the CALHN, NALHN, SALHN and WCHN annual reports 2018-2019, it is argued that this reflects an annual reporting regime based on a “one size fits all”, “tick-a-box” approach that does not enable LHNs to properly give an account of the range and effectiveness of the services they provide while reflecting the diversity of the community they serve. Annual reporting presents as a bureaucratic “in-house” exercise, not designed to provide a broad array of health-related, and not necessarily performance-based information to the community. As an exercise in “citizen-centric” communication and inclusiveness, the contrast between the annual reports and, for example, LHN Consumer and Community Engagement Strategies/Frameworks could not be more marked.

In the Circular PC013: Annual Reporting Requirements 2019-2020, the principles of transparency and accountability are paramount (p. 3). However, with regard to annual report information, information not required for statutory reporting should not be included in the annual report, instead, it should be placed on the website or on Data SA where it is “more searchable and accessible”. Such information should be included on the agency website, “as appropriate to maintain transparency” and/or Data SA “as appropriate to maintain and improve transparency” (p. 3). With regard to the “citizen-centric” principle, annual reports should have meaning and relevance to the community. This means that, inter alia: “Reports must be comprehensible to community members with nine years of education” (pp. 4-5). Comprehensible to most of the community they may be, but information rich they are not. An example of an Aboriginal “citizen-centric” report is the Torres and Cape Hospital and Health Service Annual report 2018-2019.76

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76 Available at: https://www.publications.qld.gov.au/dataset/0ec4720e-1db9-4429-b8a3-6efa7be38b95/resource/adfd52c3-1183-4606-82c1-2829ff36fb38/fs_download/tchhs-annual-report-2018-19.pdf
1.17 Key Indicator: Service delivery and partnerships

Effective healthcare requires an integrated and coordinated approach between the public health sector and Aboriginal community-controlled health services embodied in the co-design of local level health service plans. Effective healthcare for Aboriginal people depends substantially upon each LHN having a non-Indigenous health workforce capable of delivering culturally safe care. Evidence is sought as to the existence of a cultural safety training plan or strategy, whether the LHN has the capacity to deliver such training, and the number or percentage of the non-Indigenous workforce to have actually completed such training. To assist in the measurement of service delivery a number of Tier 3 Health System Performance Measures (HSPM) have been selected from the Aboriginal and Torres Strait Islander Health Performance Framework endorsed by AWMAC in 2011.

1.17.1 Criterion: Aboriginal LHN Plan

This criterion was designed to reflect the necessity of having LHNs engage with ACCHOs as independent providers of a range of primary health care services to Aboriginal people. ACCHOs have a major role in providing post-hospital care, but also in providing treatments and care that will lessen the need for many Aboriginal patients to go to hospital, that is, in reducing the number of potentially preventable hospitalisations. However, as shown in Table 1, four LHNs (BHFLHN, NALHN, SALHN and YNHLN) do not have ACCHOs within their regions, while EFNLHN has five ACCHOs and with another Alice Springs based ACCHO (Nanampa Health Council) operating several community clinics in the APY Lands. Given this situation, Aboriginal organisations and Aboriginal Experts by Experience within LHN regions could also participate in the co-designing of LHN Aboriginal health plans. As a statewide health network WCHN shares responsibilities for Aboriginal women’s and children’s care with all of the ACCHOs, but particularly those in regional SA. Assessment for this criterion, is based on the desirability of having some form of Aboriginal Health Plan that responds to community health care needs negotiated with local ACCHO(s), or local Aboriginal community organisations, or Aboriginal Experts by Experience.

Table 11: Criterion – Aboriginal LHN Plan

<table>
<thead>
<tr>
<th>Sub criteria</th>
<th>Barossa Hills Fleurieu LHN</th>
<th>Central Adelaide LHN</th>
<th>Eyre Far North LHN</th>
<th>Flinders Upper North LHN</th>
<th>Limestone Coast LHN</th>
<th>Northern Adelaide LHN</th>
<th>Riverland Mallee Coorong LHN</th>
<th>Southern Adelaide LHN</th>
<th>Women's Children's LHN</th>
<th>Yorke Northern LHN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-designed with ACCHO(s), etc.</td>
<td>0/2</td>
<td>0/2</td>
<td>0/2</td>
<td>0/2</td>
<td>2/2</td>
<td>0/2</td>
<td>0/2</td>
<td>0/2</td>
<td>2/2</td>
<td>1/2</td>
</tr>
<tr>
<td>ACCHO/LHN partnership</td>
<td>0/2</td>
<td>0/2</td>
<td>0/2</td>
<td>0/2</td>
<td>2/2</td>
<td>0/2</td>
<td>0/2</td>
<td>0/2</td>
<td>2/2</td>
<td>0/2</td>
</tr>
<tr>
<td>CQI commitment</td>
<td>0/2</td>
<td>0/2</td>
<td>0/2</td>
<td>0/2</td>
<td>2/2</td>
<td>0/2</td>
<td>0/2</td>
<td>0/2</td>
<td>2/2</td>
<td>0/2</td>
</tr>
<tr>
<td>Responsibility &amp; conflict statement</td>
<td>0/2</td>
<td>0/2</td>
<td>0/2</td>
<td>2/2</td>
<td>0/2</td>
<td>0/2</td>
<td>0/2</td>
<td>1/2</td>
<td>0/2</td>
<td></td>
</tr>
<tr>
<td>---</td>
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<td>---</td>
<td>---</td>
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<td></td>
</tr>
</tbody>
</table>

Only the LCLHN, with its Aboriginal Health Operational Strategic Plan (awaiting final Board approval) and the WCHN, with its *Aboriginal Health Plan 2018-2022*, provided evidence of an LHN Aboriginal health plan. The absence of such a plan renders the remaining sub-criteria non-assessable.
1.17.2 Criterion: Cultural Safety

Culturally unsafe healthcare contributes to persistent health inequalities for Aboriginal people. The *SA Health Aboriginal Cultural Learning Framework (SAHACLFW)* (SA Health 2017a) has been developed to enable SA Health to provide a consistent approach to the improvement of the cultural competency within its workforce in order to meet the needs of its Aboriginal consumers (p. 1). The SAHACLFW will also enable LHNs to meet NSQHSS Standard 1: Clinical Governance – Item: Governance, leadership and culture – Action 1.21 The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients (p. 5). The SAHACLFW also aligns with the vision, aims, guiding principles and the six domains of the *Cultural Respect Framework 2016-2023 for Aboriginal and Torres Strait Islander Health* (AHMAC 2016) (p. 5).

Employing Adult Learning Principles, the Aboriginal cultural learning outcomes are organised around three levels of learning:

- Individual level: knowledge and Awareness (Level One)
- Work Practice or System Level (Level Two)
- Organisational Level (Level Three) (pp. 8, 13-19).

How training will be delivered will depend on a number of factors, including the geographical location/distribution of staff, numbers of staff to be trained, availability of suitable staff to develop and deliver in-house training, and resources to outsource training (p. 10). While the four established LHNs have a Tier 2 KPI to measure the Cultural Safety Training completion rates of their non-Indigenous workforce in their 2018-2019 SLA (target 100%), this is not the case for the six regional LHNs in their 2019-2020 Service Agreements. It should be pointed out that this criterion does not address the quality or effectiveness of Cultural Learning programs, or their mode of delivery.

**Table 12: Criterion – Cultural Safety**

<table>
<thead>
<tr>
<th>Sub criteria</th>
<th>Barossa Hills Fleurieu LHN</th>
<th>Central Adelaide LHN</th>
<th>Eyre Far North LHN</th>
<th>Flinders Upper North LHN</th>
<th>Limestone Coast LHN</th>
<th>Northern Adelaide LHN</th>
<th>Riverland Mallee Coorong LHN</th>
<th>Southern Adelaide LHN</th>
<th>Women’s Children’s LHN</th>
<th>Yorke Northern LHN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural safety policy</td>
<td>0/5</td>
<td>0/5</td>
<td>0/5</td>
<td>0/5</td>
<td>0/5</td>
<td>0/5</td>
<td>0/5</td>
<td>0/5</td>
<td>0/5</td>
<td>0/5</td>
</tr>
<tr>
<td>implemented</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of staff trained</td>
<td>0/5</td>
<td>0/5</td>
<td>0/5</td>
<td>0/5</td>
<td>0/5</td>
<td>0/5</td>
<td>0/5</td>
<td>0/5</td>
<td>0/5</td>
<td>4.5/5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Despite the very considerable emphasis on having a trained workforce to provide culturally safe health care to Aboriginal people, only the WCHN has put in place, through its *Aboriginal Health Plan 2018-2022*, a strategy to ensure that its workforce is properly trained. It is the only LHN which has provided evidence that has come anywhere near to meeting the Tier 2 KPI target of 100% of the workforce to have received cultural safety training. The HPCSA
noted in its *Post-Implementation review of Country Health SA’s Aboriginal Community & Consumer Engagement Strategy* that: “... we see that many Country Health staff have not completed what is ostensibly a mandatory cultural learning framework...” (HPCSA 2019, p. 8).
1.17.3 Criterion: Selected LHN health performance indicators reported publicly

The sub-criteria selected by the Expert Workshop include a number of health system performance indicators from the *Aboriginal and Torres Strait Islander Health Performance Framework: Health System Performance* (AHMAC, 2012). The Aboriginal and Torres Strait Islander Health Performance Framework (HPF) was designed to measure the impact of the National Strategic Framework for Aboriginal and Torres Strait Islander Health (NSFATSIH) and was an important tool in the development of the *National Aboriginal and Torres Strait Islander Health Plan 2013-2023*. The HPF monitors progress in Aboriginal and Torres Strait Islander health outcomes, health system performance and the broader determinants of health. The HPF covers the entire health system, including Indigenous-specific services and programs, and mainstream programs.

Table 13: Criterion – Selected health service performance indicators reported publicly

<table>
<thead>
<tr>
<th>Sub criteria</th>
<th>Barossa Hills Fleurieu LHN</th>
<th>Central Adelaide. LHN</th>
<th>Eyre Far North LHN</th>
<th>Flinders Upper North LHN</th>
<th>Limestone Coast LHN</th>
<th>Northern Adelaide LHN</th>
<th>Riverland Mallee Coorong LHN</th>
<th>Southern Adelaide LHN</th>
<th>Women's Children's LHN</th>
<th>Yorke Northern LHN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of Aboriginal status recording</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
</tr>
<tr>
<td>DAMA</td>
<td>0/4</td>
<td>0/4</td>
<td>0/4</td>
<td>0/4</td>
<td>0/4</td>
<td>0/4</td>
<td>0/4</td>
<td>0/4</td>
<td>0/4</td>
<td>0/4</td>
</tr>
<tr>
<td>PPHA</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
</tr>
<tr>
<td>Mental health access</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
</tr>
<tr>
<td>Low birth weight</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
</tr>
<tr>
<td>Healthcare outcome measures</td>
<td>0/4</td>
<td>0/4</td>
<td>0/4</td>
<td>0/4</td>
<td>0/4</td>
<td>0/4</td>
<td>0/4</td>
<td>0/4</td>
<td>0/4</td>
<td>0/4</td>
</tr>
</tbody>
</table>

In terms of the sub-criteria selected by the Expert Workshop, only DAMA is incorporated as a KPI in the SLAs/SAs of all LHNs (see Table 14 below). These sub-criteria are all monitored, to a greater or lesser extent, by all of the LHNs in their reporting on Aboriginal health, the data being provided to SA Health as well as national monitoring agencies like the Australian Institute for Health and Welfare. The reason why the scoring of these sub-criteria is uniformly low is because it is well-nigh impossible to gain access to this data through what should be considered normal channels – LHN websites and annual reports.

Table 14: Summary of LHN SLA/SA Tier 2 Aboriginal health related KPIs
<table>
<thead>
<tr>
<th>Sub criteria</th>
<th>Barossa Hills Fleurieu LHN</th>
<th>Central Adelaide LHN</th>
<th>Eyre Far North LHN</th>
<th>Flinders Upper North LHN</th>
<th>Limestone Coast LHN</th>
<th>Northern Adelaide LHN</th>
<th>Riverland Mallee Coorong LHN</th>
<th>Southern Adelaide LHN</th>
<th>Women’s Children’s LHN</th>
<th>Yorke Northern LHN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal employee participation rate (&gt;=4%)</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Completion of ACCP (100%)</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>DAMA (&lt;=4.5%)</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>ED Aboriginal ‘Left at Own Risk’ (&lt;=3%)</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

These four Tier 2 KPIs represent a very small number from the broad range of clinical and non-clinical performance indicators concerning Aboriginal health and wellbeing which LHNs are required to report on, however, this data concerning these indicators is rarely publicly reported except via national reports generally published by the AIHW. The KPIs selected by the Expert Workshop in Table 13, also represent only a small proportion of KPIs that could be included in SLAs/SAs and subject to the monthly performance reporting as required in the agreements.
1.18 **Key Indicator: Recruitment and employment**

The recruitment and employment indicator measures the existence and effectiveness of employment strategies for recruiting and retaining Aboriginal people into an organisation’s health workforce. The primary policy reference for the Aboriginal health workforce in SA is the *SA Health Aboriginal Workforce Framework 2017-2022* (SA Health 2017b). The implementation of the Framework will assist SA Health to meet the requirements of the NSQHSS for Aboriginal and Torres Strait Islander consumers. In addition, the Framework complements SA Health RAPs, which outline practical action to build strong relationships and enhance respect between Aboriginal people and non-Aboriginal people (SA Health 2017b, p. 3).

This indicator focuses on whether there is a published plan or strategy for Aboriginal health workforce development, who has responsibility for ensuring that the plan or strategy is implemented, and the level of Aboriginal employment assessed against the 4% target set by the DHW in the LHN SLAs/SAs. It is also important to record where Aboriginal people are being employed within an LHN and at what level. While sometimes employment percentages can be impressive, many Aboriginal people are employed in clerical positions and in support services (as cleaners, bed washers, patient transporters, etc) and not in front line services as doctors, nurses and in other (allied) health professions. Aboriginal health practitioners, health workers and liaison officers have important roles within LHNs and should be separately identified.

### 1.18.1 Aboriginal health workforce development reporting

In the context of the key priority Evaluate and Measure of the *SA Health Aboriginal Workforce Framework 2017-2022*, SA Health will: “Develop Aboriginal health workforce action plans in each LHN, SAAS and DHA aligned to the framework in consultation with key Aboriginal stakeholders” (SA Health 2017b, p. 12). The following sub-criteria are all subject of key priorities of the *SA Health Aboriginal Workforce Framework 2017-2022*.

**Table 15: Criterion – Aboriginal health workforce development reporting**

<table>
<thead>
<tr>
<th>Sub criteria</th>
<th>Barossa Hills Fleurieu LHN</th>
<th>Central Adelaide LHN</th>
<th>Eyre Far North LHN</th>
<th>Flinders Upper North LHN</th>
<th>Limestone Coast LHN</th>
<th>Northern Adelaide LHN</th>
<th>Riverland Mallee Coorong LHN</th>
<th>Southern Adelaide LHN</th>
<th>Women’s Children’s LHN</th>
<th>Yorke Northern LHN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal workforce strategy implementation</td>
<td>0/4</td>
<td>0/4</td>
<td>0/4</td>
<td>0/4</td>
<td>0/4</td>
<td>1/4</td>
<td>0/4</td>
<td>1/4</td>
<td>2.5/4</td>
<td>0/4</td>
</tr>
<tr>
<td>LHN KPI for Aboriginal employment</td>
<td>0/4</td>
<td>0/4</td>
<td>0/4</td>
<td>0/4</td>
<td>0/4</td>
<td>1/4</td>
<td>2/4</td>
<td>1/4</td>
<td>2/4</td>
<td>0/4</td>
</tr>
</tbody>
</table>
The WCHN is the only LHN to have established an Aboriginal workforce plan (the WCHN *Aboriginal Workforce Strategy 2018-2022*) in response to SA Health’s 2017-2022 Framework, while the LCLHN board is contemplating the development of some form of plan or strategy. With regard to the LHN KPI for Aboriginal employment, while this is a KPI in all LHN SLAs/SAs, the scores here are based on extrapolations of workforce data for the four established LHNs contained in the OCPSE’s *Workforce Information Report 2018-19*, and assessed against DHW 4% target set in the SLAs/SAs. SA Health maintains a register of Aboriginal health workers and where they are located at various LHN facilities. Their location is reflected in the scores for this sub-criterion. No information has been found in annual reports and LHN websites regarding the numbers of identified Aboriginal positions in LHN workforces, or the salary bands occupied by Aboriginal employees. Only WCHN has provided information regarding length of service, with Aboriginal employees serving approximately half the time of non-Aboriginal employees.
1.18.2 Criterion: Aboriginal participation in the health workforce

Aboriginal health workforce staff are a key and integral part of providing culturally safe health care for Aboriginal clients. Aboriginal people make up 2% of South Australia’s population, with more than half of this population (53.8% living in metropolitan Adelaide (SA Health 2017b, p. 3. Citing ABS 2016 Census Data). The occupational groups, identified in terms of the health services, and as identified in the SA Health Aboriginal Workforce Framework 2017-2022 are: the administrative workforce; medical professionals; nurses and midwives; operational services; allied health, scientific and technical staff; and others (SA Health 2017b, p. 5), and excludes Paramedics and Ambulance Officers, and Dental and Visiting Dental Officers for the purposes of this report. The number or percentage of Aboriginal people employed within each of these occupational groups should be published in each LHN annual report and on their SA Health website LHN page.

Table 16: Criterion - Aboriginal participation in the health workforce

<table>
<thead>
<tr>
<th>Sub criteria</th>
<th>Barossa Hills Fleurieu LHN</th>
<th>Central Adelaide LHN</th>
<th>Eyre Far North LHN</th>
<th>Flinders Upper North LHN</th>
<th>Limestone Coast LHN</th>
<th>Northern Adelaide LHN</th>
<th>Riverland Mallee Coorong LHN</th>
<th>Southern Adelaide LHN</th>
<th>Women’s Children’s LHN</th>
<th>Yorke Northern LHN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>3/3</td>
<td>0/3</td>
<td>0/3</td>
</tr>
<tr>
<td>Medical Professionals</td>
<td>0/4</td>
<td>0/4</td>
<td>0/4</td>
<td>0/4</td>
<td>0/4</td>
<td>0/4</td>
<td>0/4</td>
<td>0/4</td>
<td>0.5/4</td>
<td>0/4</td>
</tr>
<tr>
<td>Nurses &amp; Midwives</td>
<td>0/4</td>
<td>0/4</td>
<td>0/4</td>
<td>0/4</td>
<td>0/4</td>
<td>0/4</td>
<td>0/4</td>
<td>0/4</td>
<td>0.5/4</td>
<td>0/4</td>
</tr>
<tr>
<td>Operational Services</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
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<td>3/3</td>
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<tr>
<td>Allied Health Scientific Technical</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>1/3</td>
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</tr>
<tr>
<td>Other</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
<td>0/3</td>
</tr>
</tbody>
</table>

Except for the WCHN, which provided data on Aboriginal workforce representation in the various employment categories in its Aboriginal Workforce Strategy 2018-2022 no other LHN has provided such information in either their annual reports (the three metropolitan LHNs) or on their websites (effectively their web-page on the SA Health website) including WCHN. The HPCSA noted in its Post-Implementation review of Country Health SA’s Aboriginal Community & Consumer Engagement Strategy that: “... there is an under-representation of Aboriginal staff across Country Health, with every
one of the six country regions bar Barossa/Hills/Fleurieu having an Aboriginal headcount disproportionately low compared to the population makeup” (HPCSA 2019, p. 8).

In the LHN SLAs/SAs DHW has set an aggressive target of 4% of each LHN’s workforce to be comprised of Aboriginal employees – essentially twice the percentage of the South Australian population that identify as Aboriginal. While this is an important target, it also ignores the difference in LHN demographics whereby the percentages of Aboriginal people of the total respective LHN populations varies considerably - 12.1% in the EFNLHN down to 1% in the BHFLHN. Aboriginal people comprise less than the overall State proportion of 2% in 4 of the LHNs (BHFLHN, CALHN, LCLHN and SALHN) – see Table 1. Table 17 provides data on total Aboriginal employment in each of the metropolitan LHNs, WCHN and the former CHSALHN, and what the equity target figure would look like, and what the DHW’s 4% target would look like taking into account the Aboriginal population percentages in each of these LHNs.

Table 17: LHN Aboriginal Employment – Actual, Equitable and SLA 4% target enumerated

<table>
<thead>
<tr>
<th>Data</th>
<th>Barossa Hills Fleurieu LHN</th>
<th>Central Adelaide Health SA*</th>
<th>Country Health SA*</th>
<th>Eyre Far North LHN</th>
<th>Flinders Upper North LHN</th>
<th>Limestone Coast LHN</th>
<th>Northern Adelaide LHN</th>
<th>Riverland Mallee Coorong LHN</th>
<th>Southern Adelaide LHN</th>
<th>Women’s Children’s LHN</th>
<th>Yorke Northern LHN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee numbers FTE</td>
<td>11,597</td>
<td>6046</td>
<td></td>
<td></td>
<td></td>
<td>3,492</td>
<td>5,711</td>
<td>2,762</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee numbers headcount</td>
<td>14,113</td>
<td>8336</td>
<td></td>
<td></td>
<td></td>
<td>4,807</td>
<td>7,232</td>
<td>3,673</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aboriginal employee numbers headcount</td>
<td>85</td>
<td>220</td>
<td></td>
<td></td>
<td></td>
<td>75</td>
<td>59</td>
<td>71</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Aboriginal employment FTE</td>
<td>0.67%</td>
<td>2.70%</td>
<td></td>
<td></td>
<td></td>
<td>1.64%</td>
<td>0.87%</td>
<td>2.28%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Aboriginal employment headcount</td>
<td>0.6%</td>
<td>2.64%</td>
<td></td>
<td></td>
<td></td>
<td>1.56%</td>
<td>0.82%</td>
<td>1.93%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aboriginal % of total LHN populations</td>
<td>1%</td>
<td>1.1%</td>
<td>12.1%</td>
<td>8.7%</td>
<td>1.7%</td>
<td>2.1%</td>
<td>3.5</td>
<td>1.2</td>
<td>2.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equity target for Aboriginal employment FTE</td>
<td></td>
<td></td>
<td>[130]</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equity target for Aboriginal employment headcount</td>
<td>155</td>
<td></td>
<td>101</td>
<td></td>
<td>86</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SLA 4% target FTE</td>
<td></td>
<td>[464]</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SLA 4% target headcount</td>
<td>564</td>
<td></td>
<td>192</td>
<td></td>
<td>290</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Data sources – FTE and HC Number of Aboriginal employees, and FTE and HC percentages:

*Country Health SA transitioned to six new regional local health networks (LHNs) on 1 July 2019.*

Given the critical importance of Aboriginal participation across all employment categories of the health workforce, but particularly in clinical roles, and given the demand for information, not only just for the employment categories but in relation the sub-criteria in Table 15, there is a case for each LHN establishing an Aboriginal employment dashboard or scorecard with information readily available on the SA Health website LHN page. WCHN has established an Aboriginal Health Scorecard. A scorecard could similarly be established to track Aboriginal participation in the health workforce with goals or KPIs set for each employment category, salary band, recruitment, retention, training, promotion etc.

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1.19 Key Indicator: Financial Accountability and Reporting: Closing the Gap Funding

Financial accountability and reporting with regard to money allocated/granted for Aboriginal health is extremely important whether under the Closing the Gap strategy, or in relation to other federal and state allocations. Aboriginal people, as well as the community at large, want, and have a right to know how the money is spent on programs targeted to address Aboriginal health needs. Open and transparent financial accountability is therefore essential. Financial Statements included as annual reporting requirements, should routinely include, as part of their income-expenditure statements, separate statements regarding funding which has been specifically allocated to Aboriginal healthcare and service delivery (either through federal or state allocations) or through special grants programs – for example, for clinical trials, NHMRC grants, allied health services (ATODS, Mental Health, Dialysis), employment and training, or delivery of cultural competency training under Closing the Gap funding. This indicator is based on the premise that both the Aboriginal community and the South Australian public at large have a right to know how the considerable amounts of funding allocated by both the Commonwealth and the SA governments to Closing the Gap in Indigenous Health Outcomes are actually being spent. This indicator is included to promote transparency and accountability in funding arrangements at the local LHN level by including a financial statement in the annual report as the most appropriate reporting vehicle.

The following Table, in two parts, identifies funding allocated to Aboriginal specific health programs and services in the LHN service agreements with the DHW. The SLAs for the three metropolitan LHNs and WCHN are for 2018-2019 (and as at 10 July 2020 remain unchanged) and for the six regional LHNs, their service agreements cover 2019-2020.

Table 18: LHN SLA/SA Specific Purchasing and Funding Commitments – Identified Aboriginal programs and services

a) CALHN, NALHN, SALHN and WCHN Service Level Agreements 2018-2019 Schedule 3: Specific Purchasing/Funding Commitments purchased by the DHW from the LHN – Identified Aboriginal funding programs and services

<table>
<thead>
<tr>
<th>Program/Service</th>
<th>Central Adelaide LHN</th>
<th>Northern Adelaide LHN</th>
<th>Southern Adelaide LHN</th>
<th>Women’s Children’s LHN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal Oral Health Program*</td>
<td>$347,368</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enhancing In Hospital Care*</td>
<td>$829,757</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural Healing-Improving Mental Health Care Access *</td>
<td></td>
<td>$467,590</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 8s Ear Health*</td>
<td>$70,393.13</td>
<td>$110,153.47</td>
<td>$226,850.75</td>
<td></td>
</tr>
<tr>
<td>First 1000 Days</td>
<td>$825,769</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opportunistic Screening</td>
<td>$787,564</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aboriginal Well Health Checks*</td>
<td></td>
<td>$497,299</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quit Smoking Initiative*</td>
<td></td>
<td>$1,128,578</td>
<td></td>
<td>$968,770</td>
</tr>
<tr>
<td>Collaborative Approach Antenatal to 2 Years*</td>
<td></td>
<td></td>
<td></td>
<td>$609,041</td>
</tr>
</tbody>
</table>
KATU (Kunpungku Atunymankunytjaku Tjitji Uwarkara)*  
$907,445

Strengthening Families  
$648,781

Total  
$1,177,125  
$2,151,316.13  
$1,736,030.47  
$3,360,887.75

b) Regional LHN Service Agreements 2019-2020 Schedule 4 Item 6: Specific Commissioning/Funding Commitments commissioned by the DHW from the LHN – Identified Aboriginal Funding programs and services

<table>
<thead>
<tr>
<th>Program/Service</th>
<th>Barossa Hills Fleurieu LHN</th>
<th>Eyre Far North LHN</th>
<th>Flinders Upper North LHN</th>
<th>Limestone Coast LHN</th>
<th>Riverland Mallee Coorong LHN</th>
<th>Yorke Northern LHN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal Family Birthing Program</td>
<td>$145,987</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aboriginal Patient Pathways Officers</td>
<td>$105,840</td>
<td>$63,504</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aboriginal Stepdown Services</td>
<td>$333,792</td>
<td>$236,264</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trachoma Elimination Program</td>
<td>$60,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$145,987</td>
<td>$499,632</td>
<td>$299,768</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

* Closing the Gap program

1.19.1 Criterion: Commonwealth contributions for Aboriginal health programs to LHN

Data on Commonwealth expenditure on Indigenous health within the public health system is exceedingly difficult to find, partly because it is derived from different programs, and is not delivered as a consolidated amount. However, LHNs should be able to identify the programs, the funding sources, and the amounts received.

Table 19: Criterion – Commonwealth contributions for Aboriginal health programs to LHN

<table>
<thead>
<tr>
<th>Sub criteria</th>
<th>Barossa Hills Fleurieu LHN</th>
<th>Central Adelaide LHN</th>
<th>Eyre Far North LHN</th>
<th>Flinders Upper North LHN</th>
<th>Limestone Coast LHN</th>
<th>Northern Adelaide LHN</th>
<th>Riverland Mallee Coorong LHN</th>
<th>Southern Adelaide LHN</th>
<th>Women’s Children’s LHN</th>
<th>Yorke Northern LHN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commonwealth contribution identified</td>
<td>0/10</td>
<td>0/10</td>
<td>0/10</td>
<td>0/10</td>
<td>0/10</td>
<td>0/10</td>
<td>0/10</td>
<td>0/10</td>
<td>0/10</td>
<td>0/10</td>
</tr>
</tbody>
</table>
1.19.2 Criterion: South Australian contributions to Aboriginal specific health services and programs including activity-based funding loading for Aboriginal patients

As with the Commonwealth, there appears to be a reluctance to disclose sources and amounts of funding received for the diverse array of Aboriginal health programs and services.

Table 20: Criterion – South Australian contributions to Aboriginal specific health services and programs including for activity based funding loadings

<table>
<thead>
<tr>
<th>Sub criteria</th>
<th>Barossa Hills LHN</th>
<th>Central Adelaide LHN</th>
<th>Eyre Far North LHN</th>
<th>Flinders Upper North LHN</th>
<th>Limestone Coast LHN</th>
<th>Northern Adelaide LHN</th>
<th>Riverland Mallee Coorong LHN</th>
<th>Southern Adelaide LHN</th>
<th>Women’s Children’s LHN</th>
<th>Yorke Northern LHN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity based funding loading for Aboriginal patients</td>
<td>0/5</td>
<td>0/5</td>
<td>0/5</td>
<td>0/5</td>
<td>0/5</td>
<td>0/5</td>
<td>0/5</td>
<td>0/5</td>
<td>0/5</td>
<td>0/5</td>
</tr>
<tr>
<td>Aboriginal program funding</td>
<td>0/5</td>
<td>0/5</td>
<td>0/5</td>
<td>0/5</td>
<td>0/5</td>
<td>0/5</td>
<td>0/5</td>
<td>0/5</td>
<td>0/5</td>
<td>0/5</td>
</tr>
</tbody>
</table>

There has been a uniform lack of disclosure across all LHNs of the sources and amounts of funding for various Closing the Gap and other programs and services from both the Commonwealth and the State.
1.20 Institutional racism ratings for SA Health’s 10 LHNs for FY2018-June2020

The following Table provides the overall Matrix assessment scores according to the five key indicators. As noted in section 1.5.2, one of the primary purposes of the Matrix audits is to provide a framework for discussion between each LHN and the Aboriginal community/ies, ACCHO(s) and Aboriginal Experts by Experience within its region. From this perspective, the score is less important than the discussion it generates.

Table 21: Institutional racism ratings for SA Health’s 10 LHNs for FY2018-June2020

<table>
<thead>
<tr>
<th>5 key indicators</th>
<th>Barossa Hills Fleurieu LHN</th>
<th>Central Adelaide LHN</th>
<th>Eyre Far North LHN</th>
<th>Flinders Upper North LHN</th>
<th>Limestone Coast LHN</th>
<th>Northern Adelaide LHN</th>
<th>Riverland Mallee Coorong LHN</th>
<th>Southern Adelaide LHN</th>
<th>Women’s Children’s LHN</th>
<th>Yorke Northern LHN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation in Governance (30 points)</td>
<td>8</td>
<td>24</td>
<td>10</td>
<td>19</td>
<td>17</td>
<td>22</td>
<td>17</td>
<td>12</td>
<td>21</td>
<td>17</td>
</tr>
<tr>
<td>Policy implementation (70 points)</td>
<td>13</td>
<td>4</td>
<td>10.5</td>
<td>13.5</td>
<td>10.5</td>
<td>16</td>
<td>11.5</td>
<td>14</td>
<td>26</td>
<td>16.5</td>
</tr>
<tr>
<td>Service delivery (40 points)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>18.5</td>
<td>1</td>
</tr>
<tr>
<td>Employment (40 points)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>1.5</td>
<td>2</td>
<td>2</td>
<td>18.5</td>
<td>2</td>
</tr>
<tr>
<td>Financial accountability &amp; reporting (20 points)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total (200 points)</td>
<td>21</td>
<td>29</td>
<td>22.5</td>
<td>34.5</td>
<td>34.5</td>
<td>39.5</td>
<td>30.5</td>
<td>28</td>
<td>84</td>
<td>36.5</td>
</tr>
</tbody>
</table>
LHN rating based on the total score across the five key indicators:

Institutional Rating scored against criteria

<table>
<thead>
<tr>
<th>Score:</th>
<th>&gt;=160</th>
<th>120-159</th>
<th>80-119</th>
<th>40-79</th>
<th>&lt;=39</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence of Institutional Racism</td>
<td>Very Low</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
<td>Very High</td>
</tr>
</tbody>
</table>

BHFLHN  Rating = Very High
CALHN  Rating = Very High
EFNLHN  Rating = Very High
FUNLHN  Rating = Very High
LCLHN  Rating = Very High
NALHN  Rating = Very High
RMCLHN  Rating = Very High
SALHN  Rating = Very High
WCHN  Rating = Moderate
YNLHN  Rating = Very High

The results of the audit indicate that nine of the 10 LHNs rate within the very high range of institutional racism, and one in the moderate range, although the Northern Adelaide LHN is on the borderline of being rated as high. The scores ranged from 21 to 84 out of a possible 200 points.

1.2.1 Examples of best practice

In concluding this report, some examples of LHN best practice should be highlighted. The audit uncovered a number of examples of LHN best practice which could perhaps be emulated by other LHNs. The following is a brief list of these highlights mostly drawn from LHN and HAC annual reports for the period FY2018-June 2020:

- Both the Hawker District Memorial Health Advisory Council (FUNLHN region) and the Mid North Health Advisory Council (YNLHN region) identified the Aboriginal Resident Representative Member among the members of their respective Advisory Councils on their SA Health website HAC page.
• WCHN has established an Aboriginal Health Steering Committee, a Tier One B (1B) Committee chaired by the CEO and reporting directly to the WCHN Strategic Executive Committee. WCHN claimed in 2018 that it was the only LHN to have embedded an Aboriginal Health Committee to assist it to fulfil its key role of corporate and clinical governance of the WCHN (WCHN 2018, p. 10).
• WCHN published its *Aboriginal Workforce Strategy 2018-2022*, with oversight of the strategy provided by the Aboriginal Workforce Sub-committee. The strategy also contained information on the deployment of the Aboriginal workforce across the five health employment categories (p. 11).
• WCHN also published an *Aboriginal Health Plan 2018-2022* in which tackling racism and discrimination has been made its first strategic priority.
• Based on WCHN Board meeting discussions, WCHN is also in the process of establishing an Aboriginal Health Scorecard that looks likely to contain a broader range of Aboriginal health-related KPIs than is currently contained in the WCHN SLA 2018-2019.
• SALHN has established an Aboriginal and Torres Strait Islander Consumer and Community Group within the consumer engagement governance and management structure under its *Consumer Engagement Framework and Plan 2019-2021*.
• Three LHNs have established or are in the process of establishing RAPs (SALHN, WCHN and YNLHN). With regard to SALHN’s *Innovate Reconciliation Action Plan 2019 – 2022*, the SALHN’s Board has indicated the importance of the RAP in providing an important framework supporting the improvement of health care to Aboriginal and Torres Strait Islander people within its region.
• While limitations in the Premier and Cabinet’s *Circular PC013: Annual Reporting Requirements 2019-2020* have been alluded to in terms of its standardised reporting requirements for all General Government Sector agencies, some regional HACs have provided reasonably detailed summaries of their consumer and community engagement and advocacy activities. One such example is the Port Augusta, Roxby Downs & Woomera Health Advisory Council in its *Annual report 2018-2019*.
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ABOUT THE AUTHORS

**Adrian Marrie** holds a BA with 1st Class Honours from the Elder Conservatorium, Adelaide University, a BA with 1st Class Honours from Flinders University (and a Flinders University Medal), and a Grad. Dip. of Arts from the University of South Australia. He is a director of Bukal Consultancy Services P/L, a company he founded with his wife, Henrietta in 1994, and also serves as company secretary. He has worked privately as a consultant with organisations such as the Foundation for Aboriginal and Islander Research Action (FAIRA) in Brisbane, Bama Wabu Rainforest Aboriginal Corporation in Cairns, and the Yarrabah Aboriginal Community Council, essentially advising on cultural heritage policy and issues, community development plans and the development of reference manuals and guides. As a director of Bukal Consultancy Services, he has been involved in a number of consultancy projects which include cultural impact assessments regarding major local and regional development projects, Indigenous tourism development, and repatriation of cultural property and ancestral remains. Consultancies have also included working with the Great Barrier Reef Marine Park Authority and the CSIRO. Most recently, as a freelance researcher, he has also been extensively involved with Henrietta in researching the Indigenous charities and non-profit sector, advocating for changes to Australian charity law. In 2017 Adrian wrote a report for the Anti-Discrimination Queensland Commissioner Addressing Institutional Barriers to Health Equity for Aboriginal and Torres Strait Islander People in Queensland’s Hospital and Health Services. During 2019 he researched and co-authored a report on Great Barrier Reef Indigenous tourism funded by the National Environmental Science Program. In 2018 he was appointed Adjunct Associate Professor, School of Human Health and Social Sciences, Central Queensland University. A keen classical guitarist, he and his wife live near Cairns.

**Dr Chris Bourke** is Strategic Programs Director for the Australian Healthcare and Hospitals Association (AHHA) where he was the Project Lead for Phase 3 of the Lighthouse Hospital Project that aimed to drive better care in hospitals for Aboriginal and Torres Strait Islander people experiencing coronary heart disease. He leads AHHA’s work in Aboriginal and Torres Strait Islander health particularly in ameliorating institutional racism in healthcare organisations and supporting the Close the Gap Campaign for Indigenous health equality. Chris is a Gamilaroi man and Australia’s first Indigenous dentist. From 2011 to 2016, Chris was a Member of the ACT Legislative Assembly, where he had various ministerial portfolios including Aboriginal and Torres Strait Islander Affairs and Education. Chris has held clinical positions in the private and public sector including his own private dental practice, Aboriginal Medical Services, public hospitals and state/territory health departments in New South Wales, Victoria, South Australian, Queensland, the Australian Capital Territory and the Northern Territory. He is an Honorary Clinical Associate Professor with the University of Melbourne and Adjunct Associate Professor at Griffith University. He is a member of the National Health Leadership Forum and is Co-Chair ACT Reconciliation Council. Chris’ board appointments include the Australian Dental Council and the Remote Area Health Corps. In addition to his dental degree Chris has postgraduate diplomas in Public Health and Clinical Dentistry (Oral Implants) and an MBA.