IMPROVING HEALTH
AND WELLBEING
IN SOUTH EAST SYDNEY

COMMUNITY PARTNERSHIPS STRATEGY

NOVEMBER 2015

NSW GOVERNMENT Health
South Eastern Sydney
Local Health District

South Eastern Sydney Local Health District Partnerships Strategy

Further copies of this document can be downloaded from the NSW Government's Health website: http://www.health.nsw.gov.au/seslhd/index.asp

Prepared by the Directorate of Planning, Population Health and Equity (T15/38725)

STRATEGY AT A GLANCE

Our vision at SESLHD is to build effective and enduring partnerships to improve community health and wellbeing.

Effective and enduring community partnerships are crucial for our District to achieve an effective and sustainable health system for the future. We should not and cannot design and deliver our health services without them. Across our entire organisation, community partnerships are those that we forge with patients, their families and carers, volunteers, community members and other organisations that represent or serve them. Throughout this document, we will use the term "community" in this broadest sense.

The *SESLHD Community Partnerships Strategy* describes how we intend to achieve this vision.

Our goals and the strategic directions to deliver them are shown above and explored further in this document. We will do so with principles that reflect empathy, respect, responsiveness, co-production, diversity, equity, best practice, innovation, two-way communication and accountability. We will evaluate the effectiveness of our efforts by seeking evidence that people were engaged and did participate, that they were listened to and heard, and that there was real influence and change as a result. And through all this, we aspire to see improvements in the empowerment and resilience of the communities that we serve, and their increased satisfaction with the services that we provide.

Foreword

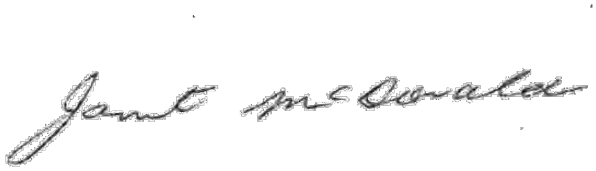
Effective and enduring community partnerships are crucial for our District to achieve an effective and sustainable health system for the future. We should not and cannot design and deliver our health services without them.

We are proud of our track record so far in building partnerships with our communities, which includes patients, their families and carers, volunteers, community members and other organisations that represent or provide services to them. We value their input, and have endeavoured to put it into practice.

But we also recognise that we can and must do more. We must move beyond a top-down consultation approach, towards a genuine and equal partnership between health services and communities. We must place equal value on the professional training of our health workers and the lived experience of those that we serve. We must more directly and proactively seek out, acknowledge and draw upon the assets that individuals and communities can bring to these endeavours.

In doing so, we aim to build a better public health system in partnership with our communities. We aim to empower people, to ensure that they feel listened to, give them a greater sense of power and ownership of their services, and a greater sense of belonging within their community. We aim to deliver better services as a result, with less preventable emergency and hospital admissions, greater satisfaction with and trust of services, and greater patient and community resilience and capacity. We aim to improve the health and wellbeing of all within our District.

The SESLHD Community Partnerships Strategy outlines what we will do to achieve these things. We look forward to working with you to implement it.



Mrs Janet McDonald
Chair, SESLHD Community Partnership Committee

Gerry Marr
Chief Executive, SESLHD

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THE IMPORTANCE OF PARTNERSHIPS

The South Eastern Sydney Local Health District (SESLHD) *Road Map to Excellence* acknowledges that whilst our District has considerable experience and success in delivering high quality health care to the community, there is much work yet to do, and that partnerships are fundamental to this[1]. Giving our communities a stronger voice is vital. Giving them greater control of their own health and wellbeing is essential. When we speak of "communities" in this Strategy, we include patients, their families and carers ("consumers" or people that use or could use our services), volunteers, individual community members and those from other organisations that represent or serve them.

This is more than a principle. We know that partnerships work. We cannot do this alone: we need our communities to be more involved, for mutual benefit including the following[2-6].

BENEFITS FOR COMMUNITIES

- Better health and wellbeing outcomes: decreased mortality, decreased readmission rates, decreased rates of healthcare acquired infections, reduced length of stay, improved adherence to treatment plans and improved resilience.
- An empowering opportunity to be involved and to be heard.
- An opportunity to contribute to and benefit from improved programs and services that are more relevant and appropriate to their needs and also to the assets they can bring to the process.
- A greater sense of control over one's own options and decisions affecting health and well-being.
- A greater sense of belonging to the wider community.

BENEFITS FOR HEALTH SERVICES

- A clearer understanding of what matters *to* patients – not just what is the matter *with* them.
- Improvements in the way that services and programs can meet those needs, and particularly the needs of specific groups, such as people from disadvantaged backgrounds.
- Earlier awareness of and attention to emerging issues, creating better opportunities to respond appropriately, efficiently and positively.
- Improved workforce skills and organisational capacity to meet community needs.
- Increased respect and trust from patients, their families and carers, organisations and communities that we work with.

AND BECAUSE IT IS, QUITE SIMPLY, THE RIGHT THING TO DO

- Local communities have a right to a say in the way public services are designed and delivered.
- Local communities have a right to a say in the activities that affect their health and wellbeing.
- A partnership approach supports social justice. Many health issues, notably those experienced by those among us who are most disadvantaged, are the result of society, not biology. Just as they are socially produced, they can and must be socially remedied. Communities have a right to be involved in that process, not peripherally, nor as recipients, but as equal partners.
- Patients, their families and carers, volunteers, community members and organisations that represent or serve them know the most about local conditions and context. Their involvement is crucial in identifying or advocating for the right solutions.

We are making a stronger commitment to community partnerships across SESLHD. This is informed by input from our communities, our accreditation responsibilities and the values of our staff.

OUR COMMUNITIES WANT THIS

Community feedback

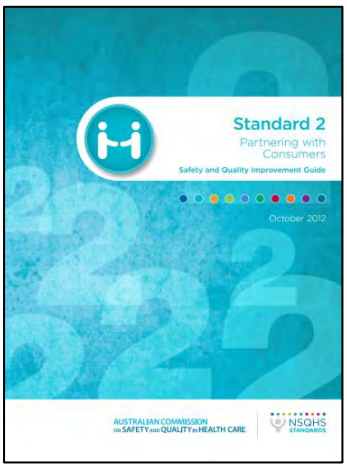
We consistently hear from our communities that they want to be more involved in their local services. For example, feedback collected through the NSW Patient Survey Program and accreditation processes such as Consumer Satisfaction Surveys indicate that whilst SESLHD is performing well and on par with other Districts, there is more work to be done in involving our communities more effectively.

OUR SYSTEM REQUIRES THIS

Accreditation Standards

Our health services are subject to The National Safety and Quality Health Service (NSQHS) Standards as developed and administered by the Australian Commission on Safety and Quality in Health Care[6].

Standard 2 requires leaders of a health service organisation to implement systems to support partnering with patients, their families and carers to improve the safety and quality of care. This standard applies to practice by all across the organisation and is intended to create a health service that is responsive input from patients, families and carers.



OUR STAFF SUPPORT THIS

The Big Conversation:

EVERYONE MATTERS

As part of the *Journey to Excellence*, 'The Big Conversation' was undertaken in November 2014 to engage with employees across SESLHD to gauge a sense of the current state and culture within the District. The aim of The Big Conversation was to have simple, short and engaging conversations with employees to demonstrate a genuine intent to start a dialogue, to see what mattered to people in their day-to-day roles, what was working well, and what people would change if they were able to. Community engagement and partnerships were important themes to emerge from these conversations, reflected in statements as to the importance of:

- Providing a quality service that is patient-centred in that care is provided in such a way that it meets the preferences, needs and values of patients, their families and carers.
- Engaging with our community to ensure that services are designed, implemented and run in such a way that their needs are met.
- Developing and fostering strong partnerships with external services to help ensure that the holistic needs of patients, families and carers are met.
- Developing and fostering partnerships that will ensure continuity of care and for future service improvement.

What works?

Partnerships are important yet complex, and can also be very different depending on the context. What we do understand is that there are some key elements that underpin successful engagement, community participation and partnership strategies across many contexts[2, 4] These include:

- ☑ Making sure that adequate financial and human resources are available to support the process.
- ☑ Communicating effectively, openly and often, both logistically within the health service and in terms of building open and trusting partnerships beyond it.
- ☑ Building strong intersectoral partnerships with other organisations working at the community level.
- ☑ Having strong planning and project management processes in place, to ensure clarity and maintain focus.
- ☑ Including relatively small and well clarified actions that will collectively contribute to a larger goal.

We also know that there are certain things that we must be particularly attentive to when working with different groups in our community. For example, when working with Aboriginal communities, we must ensure that there is[7, 8]:

- ☑ Respect and value for culture beliefs and practices.
- ☑ Widespread community involvement – no one person can speak for a whole community.
- ☑ Ongoing and open communication throughout the process, not just a consultation process at the beginning.
- ☑ Involvement of Aboriginal health workers.

We are committed to these best practice approaches described above. In keeping with this evidence and also with the local priorities identified in key documents such as the *SESLHD Road Map to Excellence*[1] and the *SESLHD Equity Strategy*[9], we will pay particular attention to three key concepts as follows:

Co-production

Working in partnership with communities is a common enough principle across the health sector. But are we really doing it well enough? We need to move beyond doing things *for* communities to a model where we genuinely work *with* them (see right[10]). Known as **co-production**, the responsibility for this rests not just with a select few managers, leaders or committees, but across the whole organisation. Co-production is relevant from the very top of governance and planning, through community-based strategies and programs, and across every single individual clinical interaction.

Adapted from http://www.sigeneration.ca/co-production/

Co-production shifts the power dynamic between the service provider and the patients, families and carers, placing equal value on professional training and lived experience[10]. To achieve that, an **asset-based approach** directly seeks out, acknowledges and draws upon the assets that individuals and communities can bring to these endeavours. This isn't just about addressing needs, or filling gaps. Asset-based approaches take a positive perspective in terms of recognising and building upon the assets of individuals and communities, such as their lived experiences, skills and social networks. What can our communities bring to these partnerships? And how can we *all* benefit from that?

IS YOUR SERVICE CO-PRODUCED?

- **An asset-based approach**: Does your service acknowledge and celebrate the assets of users and the community, rather than focussing only on needs?
- **Working on capabilities**: Does your service build the skills of those involved?
- **Developing mutuality**: Does your service broker a true partnership and shared responsibility between professionals and users?
- **Growing networks**: Does your service support, connect with, learn with, and reflect with a wide range of individuals? Does your service provide forums for users and professionals to connect and share expertise?
- **Blurring roles**: Are professionals and users of services viewed as crucial to delivery?
- **Acting as catalysts**: Does your service provide professionals with the opportunity to act as coaches and facilitators to service users?

Adapted from: http://www.sigeneration.ca/co-production/

We have always taken pride in our consultation processes. When services are delivered, we seek feedback from patients, their families and carers as to their quality. Before a plan is released, we share a draft of it with the community and seek their comments. When a community program is developed, we invite community representatives to sit on our advisory groups. But as the figure above demonstrates, this kind of consultation and engagement is only part-way there on the continuum to co-production. Across our entire organisation, we must therefore ask:

← Are our services co-produced?

Equity

Despite most people within our District enjoying very good health, some do not. Recognising differences is an essential first step addressing inequities, and some of the groups that we know experience inequities in health and wellbeing include (but are not limited to) [11, 12]:

- People from low socioeconomic backgrounds, including people who are homeless, long-term unemployed, or living in public housing or households in rental stress
- Aboriginal people
- People living in single parent households with dependent children
- Socially isolated, disengaged people (eg elderly, young not working or studying)
- People who experience mental illness, particularly moderate to severe mental illness
- People affected by long term conditions
- People from some culturally and linguistically diverse backgrounds, particularly refugees
- Lesbian, gay, bisexual, transgender, and intersex people

We also see the impact on our health system in terms of[9]:

- More preventable presentations to emergency departments
- More complications associated with hospital admissions
- Longer lengths of stay
- More avoidable long-term conditions
- Poorer self-management leading to compounded poor outcomes
- Over-representation of disadvantaged people in virtually every measure of health and wellbeing.

As a health system, we must respond to these inequities. We must develop a better understanding of and response right across our system to the determinants of health, particularly the social and economic influences on individuals and communities[11, 12]. We also need to develop strategies to better identify and address the many different needs across our communities, such as (but not limited to) social isolation, trauma history, cultural needs, the different needs of younger and older people, and socioeconomic disadvantage.

From a partnerships perspective, it is important to realise that **those people in our communities who experience the greatest disadvantage are too often the very same people that we fail to effectively reach or hear in our consultation, engagement and partnership efforts. Our commitment to equity must include a greater focus on building more effective partnerships with those in our communities who need it the most.**

The newly-released *SESLHD Equity Strategy* describes our District-wide commitment to reducing health inequities within a generation[9]. A central theme of that document is that community engagement and partnerships are vital to address inequities[2, 3, 5].

Organisational capacity

In developing this Strategy, it is important to acknowledge that it is not just about determining what we must do, but building the capacity of our organisation to do so.

In this context, we consider the capacity in terms of our systems and structure. This includes concepts such as:

- Governance
- Policies and procedures
- Resourcing

We must also build the capacity of our workforce to deliver this Strategy. When we talk about our workforce, this includes our dedicated team of over 10,000 people. Within this, we have a valuable "peer workforce" (such as peer support workers or peer educators) who are paid employees that draw upon their own personal lived experience to support others. We also have a large number of volunteers who make an important contribution to our health services (see below).

We will build the capacity of our workforce with a focus on:

- Leadership, both in recognised senior positions but also through natural leaders throughout the organisation, at all levels and in all services
- Workforce knowledge and skills
- And the commitment of our entire team

This Strategy is therefore not just about what we will do, but changing our own culture in order to achieve that. The first of our three goals (to be explored later in the document) will focus on this.

Our Volunteers

There are over 900 volunteers serving in our health service. These volunteers have a range of functions such as provision of social and practical elements of care, fundraising and providing community member input into the design, implementation and evaluation of services via committees, working groups and discussion forums. Particular areas of support include assisting feeding, falls prevention, "ward grannies", emergency department hostesses, the patient newspaper and library service, administration work and "wayfinding".

The benefits of volunteering to the individual, the community and organisations such as health services are well known and documented. Volunteers generally enjoy better physical and mental health, a greater understanding and connection to community as well as a sense of achievement and fulfilment. The skills and experience that volunteers bring to health settings is a mutually beneficial relationship that enhances health outcomes for all involved[13, 14].

Our volunteers provide outstanding services and support. They contribute in many different ways and are highly valued and appreciated for the positive difference they make to the daily running of our health system.

OUR PARTNERSHIP PRINCIPLES

Empathy

- We will work to understand what it may be like to "walk in the community's shoes".
- We will respect their lived experiences, skills, perspective and cultures.
- We will ask, listen and validate when communicating with the community.

Respect

- We will show respect to the community.
- We will earn the respect of our communities through open, genuine engagement and partnerships.

Responsiveness

- We will listen, and will do better to truly understand what we are being told.
- We will respond appropriately.
- We will demonstrate our commitment from the Board level down throughout the whole organisation.
- We will build this commitment into our organisational systems and how we measure our performance.

Co-production

- We will shift the focus of our community engagement, consultation and partnerships to a co-productive approach.
- We will shift the power dynamic between the service providers and the patients, families, and carers placing equal value on professional training and lived experience.
- We will take asset-based approach to seek out, acknowledge and draw upon the assets that individuals and communities can bring to these endeavours.

Diversity

- We will respect diversity and encourage fair participation by all.
- We will ensure engagement processes are culturally safe.

Equity

- We will include a strong focus on those disadvantaged individuals, groups and communities that need it the most.
- We will consider the needs of **marginalised** people and communities that experience discrimination and exclusion (social, political, economic) because of unequal power relationships across economic, political, social and cultural dimensions.
- We will consider the needs of **vulnerable** people and communities who are at higher risk for poor health as a result of barriers they experience to social, economic, political and environmental resources, as well as limitations due to illness or disability.

Best practice

- We will be guided by the evidence of what we know will provide the best outcomes for our communities.

Innovation

- We will also foster a culture of innovation. We will be open to new ideas and new approaches, and undertake them with professionalism and accountability.

Two-way communication

- We will communicate openly and often.
- We will ensure that all our partners have timely access to information in appropriate forms and through appropriate channels.
- Communication will be a two-way process.

Accountability

- We will ensure communities have access to health related information including performance data.
- We will use public resources appropriately and responsibly.
- We will measure what matters, and report back to our communities.

WHAT WE WILL DO

Vision and goals

In the simplest terms, we must find better ways to engage the community, be sure that we truly listen to and understand what is being said, and then do something about it. These **three goals** demonstrate a sequence of important steps towards achieving our **vision** of working together to build effective and enduring partnerships to improve community health and wellbeing. In the following pages, we will also describe a set of **strategic directions** for collective action across the District that will enable us to achieve that vision.

When we speak of "communities" in this Strategy, we include patients, their families and carers ("consumers" or people that use or could use our services), volunteers, individual community members and those from other organisations that represent or serve them.

The VISION and GOALS describe what we want to achieve. Later in the document, our STRATEGIC DIRECTIONS describe what we will do to get there, in terms of themes of action. This is all ultimately part of our larger vision for our whole organisation and the communities that we serve.

VISION

To build effective and enduring partnerships to improve community health and wellbeing.

GOALS	EVALUATION
GOAL 1. **First, we must increase community participation and engagement. As noted earlier, the scope of this is broad, including patients, their families and carers, volunteers, community members and other organisations that represent or serve them. We must also pay particular attention to vulnerable and marginalised populations that are often poorly represented in such endeavours.**	**We will collect evidence that people were engaged and did participate**, such as: • Evidence of increased community participation in advisory groups, consultation processes, service planning processes and community initiatives. • Evidence of input being sought and received from patients, their families and carers at the individual care level. • Evidence of proactive strategies to reach out into communities to engage people, particularly those that are not well reached through other means. • Evidence that more people from different backgrounds were involved, including vulnerable and marginalised populations in particular.
GOAL 2. **We must then ensure that community voices are genuinely heard and understood. It isn't enough to simply invite the input of our communities – they must be properly involved in the process, and to achieve that, we must increase our understanding of and attention to the input they provide.**	**We will collect evidence of increased understanding of and attention to their input**, such as: • Feedback from community participants, notably around whether they felt the engagement was genuine and that their opinions had been heard and understood. • Feedback from staff regarding process and outcomes. • Evidence that our workforce has increased its skills (gauged through performance management systems). • Evidence that our organisational systems include appropriate principles and practices that enable and support this goal (gauged through organisational auditing). • Clear documentation of feedback from communities regarding policies, service design and delivery. • Evidence that vulnerable and marginalised populations in particular have been heard.
GOAL 3. **We must finally ensure that we improve our responsiveness to community input and a shift to co-production of health services. This is where we truly demonstrate our commitment to community partnerships, by shifting to a model whereby we do not do things *for* communities, but *with* them.**	**We will collect evidence of real influence and change**, such as: • Evidence of co-production in terms of practical examples of community-driven changes to policy, service design and delivery. • Feedback from communities regarding process and outcomes. • Evidence that that vulnerable and marginalised populations in particular have been heard. • Feedback from staff regarding process and outcomes.

And through all this, we aspire to see improvements in the empowerment and resilience of the communities that we serve, and their increased satisfaction with the services that we provide.

Translating this into action: Strategic Directions

Actions rarely stand in isolation from others – and nor should they. Each action that we undertake will form part of a diverse but connected matrix that considers what we are trying to achieve, and who we will work with to do so. But for the purposes of planning and governance, it is useful to describe our planned actions within distinct strategic directions.

The three strategic directions reflect a settings approach as follows:

Strategic Direction 1: Build the organisational capacity of SESLHD to foster better community engagement.

This has an organisational focus – as described earlier, it reflects investments that will be made to build our organisational capacity to create lasting change.

Strategic Direction 2: Reshape our health services to enable more meaningful community involvement.

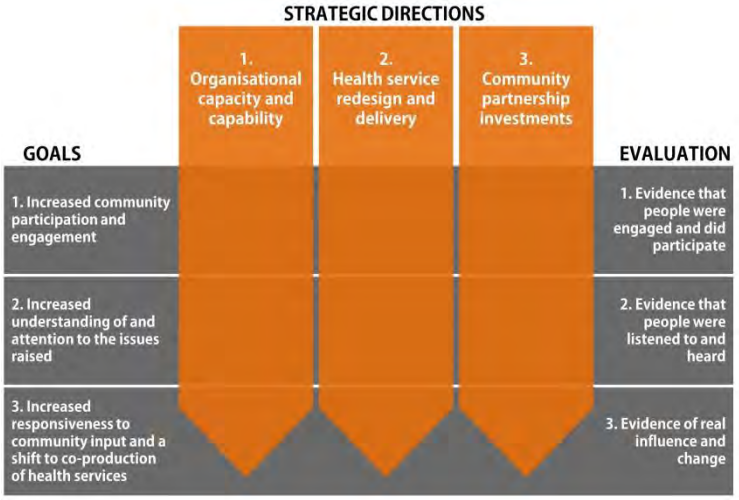
This relates more directly to the design and delivery of health services, notably (though not exclusively) across the clinical sector.

Strategic Direction 3: Make specific and significant investments in community partnership initiatives.

The final area of work will be delivered predominantly in community settings and asks: beyond organisational governance and actions at the immediate service level, how else can we more proactively reach out into our communities to engage people more effectively?

The scope of these three strategic directions is explored more fully in the following pages, as well as examples of specific actions. It is important to understand that:

- The strategic directions extend across the 3 goals, in a matrix fashion (see right).
- As already shown on the previous page, and again at the right, we will evaluate this Strategy in terms of achievement of the goals rather than at the strategic direction level, in order to maintain our focus on the appropriate "big picture" outcomes. Indicators for specific actions will be discussed separately.



STRATEGIC DIRECTION 1
Build the organisational capacity of SESLHD to foster better community engagement.

SCOPE

The focus here is on our organisation itself, and the capacity that we have to deliver the vision described in this plan. That includes a strong focus on our governance, as well as structure, resourcing, workforce development, policy and procedures, commitment and leadership. Whilst direct responsibility for many of the actions will lie at high levels within the organisational hierarchy, their impact and influence will be wide-reaching. Just as we engage the community, we must also engage each other effectively in order for these organisational strategies to be effective.

WHAT WE WILL DO

Actions will emerge and evolve over time, so a simple annual action plan will be written to direct short term actions towards our long term goals. We expect actions to include the following:

1.1 Maintain a dedicated position to centrally coordinate and support implementation of this Strategy across the District.

1.2 Facilitate opportunities for communication and partnerships across internal and external services and programs to foster two-way information sharing and shared problem-solving.

1.3 Create innovative platforms (such as use of websites and social media) in addition to traditional community forums to more effectively engage communities.

1.4 Ensure that leadership and public support of this Strategy are demonstrated across the organisation from key people including the Board and Executive.

1.5 Incorporate principles and priorities from this Strategy into governance, policies, procedures and quality systems.

1.6 Integrate principles and priorities from this Strategy into workforce development strategies such as mandatory training.

1.7 Ensure that volunteers and our peer workforce receive appropriate training and support.

1.8 Reward and promote best practice in partnerships.

1.9 Allocate specific resources to partnership actions, including relevant investment in our information technology infrastructure.

EVALUATION

Pages 13-15 give context for the overall evaluation of this Strategy. Additional action-specific indicators will be included in the annual action plan.

ADDITIONAL ASPIRATIONS

The following are additional aspirations – things that are difficult to measure, and not necessarily the exclusive product of the actions described in this Strategy. But we hope that these actions will contribute in some way to:

- A more positive workplace environment, where staff, patients, their families and carers have better relationships and a shared sense of outcomes.
- Increased empathy of our staff.
- Health and wellbeing benefits for volunteers.

STRATEGIC DIRECTION 2
Reshape our health services to enable more meaningful community involvement.

SCOPE

The second strategic direction is more directly associated with the design and delivery of health services, notably (though not exclusively) across the clinical sector. How can service managers ensure that patients, their families and carers, volunteers, communities and the organisations that represent them are appropriately involved in that process? And how can individual health professionals ensure that the voices of patients, their families and carers they care for are being heard?

WHAT WE WILL DO

Actions will emerge and evolve over time, so a simple annual action plan will be written to direct short term actions towards our long term goals. We expect actions to include the following:

2.1 Introduce governance and accountability mechanisms at the service level to improve community involvement in service design and delivery.
2.2 Introduce governance and accountability mechanisms at the service level to improve community involvement in quality assurance processes.
2.3 Ensure that health service managers are appropriately trained and supported to fully implement this Strategy.
2.4 Develop strategies to better identify and address the many different needs across our communities, such as (but not limited to) social isolation, trauma history, cultural needs, the different needs of younger and older people, and socioeconomic disadvantage.
2.5 Develop systems, resources and training to ensure information resources meet health literacy and consumer testing standards.
2.6 Develop specific strategies to enhance engagement and support of volunteers in service settings.

EVALUATION

Pages 13-15 give context for the overall evaluation of this Strategy. Additional action-specific indicators will be included in the annual action plan.

ADDITIONAL ASPIRATIONS

The following are additional aspirations – things that are difficult to measure, and not necessarily the exclusive product of the actions described in this Strategy. But we hope that these actions will contribute in some way to:

- Improved service outcomes including improved self-care.
- Improved resilience of patients, their families and carers.
- Earlier awareness of and attention to emerging issues, creating better opportunities to respond appropriately.
- Integrated person centred care with seamless movement between services.
- Better health and wellbeing outcomes: decreased mortality, decreased readmission rates, decreased rates of healthcare acquired infections, reduced length of stay and improved adherence to treatment plans.

STRATEGIC DIRECTION 3
Make specific and significant investments in community partnership initiatives.

SCOPE

The final area of work will be delivered predominantly in community settings. Beyond organisational governance and involvement at the service level, how else can we more proactively reach out into our communities to engage people more effectively? This is particularly important when considering the needs of marginalised or disadvantaged groups that we may not otherwise effectively reach. Specific investments are required, and concrete actions delivered in partnership with other community-based services and organisations. This is essential to shift the focus of control back into the communities that we serve.

WHAT WE WILL DO

Actions will emerge and evolve over time, so a simple annual action plan will be written to direct short term actions towards our long term goals. We expect actions to include the following:

3.1 Build strong intersectoral working partnerships with a strong focus on two-way communication and shared problem-solving.

3.2 Ensure that our partners have timely access to information in appropriate forms and through appropriate channels.

3.3 Invest in specific partnership initiatives such as community-focussed, long-term intersectoral projects to address the social determinants of health and wellbeing.

3.4 Incorporate the principles and priorities from this Strategy into all other community-based services, prevention and wellness programs.

EVALUATION

Pages 13-15 give context for the overall evaluation of this Strategy. Additional action-specific indicators will be included in the annual action plan.

ADDITIONAL ASPIRATIONS

The following are additional aspirations – things that are difficult to measure, and not necessarily the exclusive product of the actions described in this Strategy. But we hope that these actions will contribute in some way to:

- Increased resilience of individuals and communities.
- Increased respect and trust from patients, their families and carers, organisations and communities.
- An empowering opportunity for communities to be involved and to be heard.
- An opportunity for communities to contribute to and benefit from improved programs and services that more directly meet their needs.
- A greater sense of control over one's own options and decisions affecting health and well-being.
- A greater sense of belonging to the community.
- Streamlined wellness and prevention programs using partnerships to deliver the best possible programs.
- Better health and wellbeing: decreased mortality, decreased readmission rates, decreased rates of healthcare acquired infections, reduced length of stay and improved adherence to treatment plans.

DELIVERING THE STRATEGY

Governance and accountability

SCOPE OF IMPLEMENTATION

SESLHD has a high concentration of specialised services, Centres of Excellence and a comprehensive range of local hospitals, ambulatory care, community health services, and population health and primary health care programs and services. These programs and services are provided from five major hospital and health service campuses, and a number of other sub-acute and community facilities with support from a wide range of collaborators. This Strategy will be implemented across the entire organisation, with relevance for all services and teams.

The Directorate of Planning, Population Health and Equity will oversee implementation of this Strategy on behalf of the SESLHD Board. Within the Directorate, the SESLHD Community Partnerships Coordinator position will be responsible for providing leadership and coordinated support for implementation across the organisation.

THE ROLE OF KEY GROUPS WITHIN THE SESLHD GOVERNANCE STRUCTURE

The role of the SESLHD Board is to lead, direct and monitor activities and to drive overall performance. This includes ensuring that District resources are applied equitably to meet the needs of the community, and determining those needs in partnership with local communities is something that the Board is strongly committed to. This includes a specific responsibility (under the NSW Health Corporate Governance & Accountability Compendium[15]) to seek the views of providers and consumers of health services and of other members of the community served by SESLHD, as to the District's policies, plans and initiatives for the provision of health services, and to confer with the SESLHD Chief Executive on how to support, encourage and facilitate community and clinician involvement in the planning of district services, and to advise providers and consumers of health services and other members of the community served by the local health district, as to the district's policies, plans and initiatives for the provision of health services. The Board therefore strongly supports and endorses this important *SESLHD Community Partnerships Strategy*.

The SESLHD Community Partnerships Committee (CPC) is an intersectoral Board committee that is community focused, enabling some "ground up" as well as "top down" engagement. Support for this committee is provided by the Directorate of Planning, Population Health and Equity. The CPC:

- Provides a strategic, effective and coordinated approach across the organisation to engage and partner with communities to improve health and wellbeing.
- Includes a strong focus on intersectoral partnerships, recognising that the scope of this undertaking is more than we can achieve alone.
- Promotes health equity through ensuring vulnerable and marginalised communities are engaged and genuine community partnerships are formed across all health programs and services.

The SESLHD Consumer and Community Council (CCC) will provide advice to the organisation's peak committees on strategies to enhance and promote consumer and community participation. It is proposed for this new Council to be formed in 2016 and that support will be provided by the Directorate of Planning, Population Health and Equity. It is proposed that the CCC will:

- Ascertain, co-ordinate and reflect the views of consumers and local community groups that it represents, and act as a link between these stakeholders and the organisation on relevant issues.
- Advocate on behalf of and bring to the attention of the District's peak committees, consumer and community perspectives in relation to service and policy planning, development, delivery and evaluation.
- Identify opportunities and initiatives to promote the wellbeing of the community and foster community spirit.
- Identify ways to identify the health related community assets and needs.
- Participate in the development, implementation and monitoring of the *SESLHD Community Partnerships Strategy* and Annual Action plans.
- Disseminate and communicate information to community interest groups and other stakeholders on the proceedings of the Council.

The SESLHD Volunteer Managers Committee (VMC) is an operational committee that promotes sound leadership, coordination and collaboration of the volunteer program across the District. Support is provided by the Directorate of Planning, Population Health and Equity. The VMC:

- Provides strategic and operational advice regarding volunteer issues including service integration.
- Promotes effective coordination of all volunteering work undertaken across the District.
- Provides a forum for reviewing requirements and legislation necessary to ensure an appropriate, structured and consistent volunteer program that adds value to recipient of care, health facility and volunteer.
- Shares information and receive updates/presentations about achievements, innovative practice, models and lessons learnt that enhance the volunteering program.
- Increases the efficiency of the existing systems and processes relating to volunteering across the District, ensuring adherence to best practice and National Standards for Volunteers as determined by Volunteering Australia.
- Identifies ways/mechanisms and processes that enhance the existing and future volunteering efforts across the organisation.
- Identifies opportunities to enhance and strengthen the volunteering program.

Additional committees/groups. There are long-standing consumer/community committees across our organisation, such as consumer/community advisory committees at local hospitals and other committees that support service planning for priority populations such as Aboriginal people and people from culturally and linguistically diverse backgrounds. These groups will continue to play an important local role, and will be linked into and supported by the governance described above.

REFERENCES

1. SESLHD Board. Road Map to the Delivery of Excellence 2014-2017. South Eastern Sydney Local Health District; 2014.
2. Sarrami Foroushani P TJ, Eikli M, Braithwaite J,. Consumer and Community Engagement: A review of the literature. Sydney: The Centre for Clinical Governance Research, Australian Institute of Health Innovation, Faculty of Medicine, University of New South Wales, and the Agency for Clinical Innovation, New South Wales; 2012.
3. Health Consumers Queensland. Consumer and Community Engagement Framework. Brisbane: Queensland Government; 2012.
4. Tempfer CB, Nowak P. Consumer participation and organizational development in health care: a systematic review. Wien Klin Wochenschr. 2011 Jul;123(13-14):408-14. PubMed PMID: 21739200.
5. The Community Engagement Network Resource and Regional Services Division - Victorian Government Department of Sustainability and Environment. Effective Engagement: building relationships with community and other stakeholders. Book 1: An introduction to engagement. Melbourne: State of Victoria; 2005.
6. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards, September 2012. Sydney: Commonwealth of Australia; 2012.
7. Osborne K, Baum F, Brown L. What works? A review of actions addressing the social and economic determinants of Indigenous health. Issues Paper no. 7 produced for the Closing the Gap Clearinghouse. Canberra: AIHW; 2013.
8. Huffman MD, Galloway JM. Cardiovascular health in indigenous communities: successful programs. Heart Lung Circ. 2010 May-Jun;19(5-6):351-60. PubMed PMID: 20359950.
9. South Eastern Sydney Local Health District. SESLHD Equity Strategy. Sutherland: SESLHD; 2015.
10. Social Innovation Generation. Co-production 2014 [1/9/2015]. Available from: www.coproductionscotland.org.uk\about\what-is-co-production.
11. WHO Commission on Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva: World Health Organization; 2008.
12. World Health Organization. Social determinants of health: the solid facts (2nd edition). Denmark: WHO; 2003.
13. Gray E, Khoo SE, Reimondos A. Participation in different types of volunteering at young, middle and older adulthood. Journal of Population Research. 2012;29(4):373-98.
14. Cattan M, Hogg E, Hardill I. Improving quality of life in ageing populations: What can volunteering do? . Maturitas. 2011;70(4):328-32.
15. NSW Ministry of Health. Corporate Governance & Accountability Compendium for NSW health. Sydney: NSW Ministry of Health; 2012.