NSW Health

# Local Health Committees

**Strengthening Local Health Committees across Hunter New England Local Health District**

**June 2024**

*Endorsed by HNE LHD Board 21 August 2024*

*Barrington Tops*

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# Acknowledgments

## Acknowledgment of Traditional Custodians

Hunter New England Local Health District respectfully acknowledges Aboriginal people as the traditional custodians of the land on which our health facilities are located. We recognise and respect the continuing connection to land, water, and culture of Aboriginal and Torres Strait Islander people and its interconnectedness to health and wellbeing.

We pay our respects to the Elders who hold and share the cultural knowledge, heritage, beliefs and the relationship with the land.

We acknowledge the many Aboriginal and Torres Strait Islander communities across the District, the staff who work with us, and the Aboriginal services and organisations who partner with us to improve health outcomes for Aboriginal and Torres Strait Islander people across our footprint. We celebrate the strength, diversity, resilience, and cultural beliefs of Aboriginal and Torres Strait Islander people.

## Acknowledgment of Lived Experience

HNE Health recognises and appreciates consumers, patients, carers, supporters and loved ones. The voices of lived experience are powerful. Their contributions are vital to enable decision making for change to the health system.

# Glossary of abbreviations

| Abbreviation | Definition |
|---|---|
| ACI | Agency for Clinical Innovation |
| ACSQHS | Australian Commission on Safety & Quality in Health Care |
| APM | Annual Public Meeting |
| CE | Chief Executive |
| ELT | Executive Leadership Team |
| HNE | Hunter New England |
| HNELHD | Hunter New England Local Health District |
| HSM | Health Service Manager |
| IAP2 | International Association of Public Participation |
| LGBTQ+ | Lesbian, Gay, Bisexual, Transgender, Queer, and/or Questioning |
| LHC | Local Health Committee |
| LHD | Local Health District |
| MM | Modified Monash |
| MMM | Modified Monash Model |
| MPS | Multipurpose Service |
| NSQHS | National Safety and Quality Health Service |
| SRC | Strategic Relations and Communications |

# Executive Summary

Hunter New England Local Health District (HNELHD) is committed to providing comprehensive care and support across a large geographical area, encompassing hospitals, multipurpose services, and community health facilities. Hunter New England (HNE) covers areas assessed as Modified Monash (MM) categories MM1 to MM7, representing a wide spectrum from major cities to very remote locations.

Community engagement is a multifaceted process that involves various approaches such as informing, consulting, collaborating, co-designing and empowering communities. Local Health Committees (LHC) is a universal term used to describe the health service managed community group or local community engagement and health advocacy. LHCs provide formal opportunities for the community to provide input into local health services and serves as a crucial avenue for health services to engage with communities. It is imperative to ensure that these committees are adequately supported and empowered to effectively engage with their local diverse regional communities. In regional areas, community engagement plays a pivotal role in strengthening relationships with local health services and improving health literacy and the services we deliver. This, in turn, contributes to the development of community resilience and overall wellbeing.

There are currently 18 LHCs operating across the Local Health District (LHD), leaving a significant number of communities without the opportunity to participate in engagement activities aligned with health. It is recommended that comprehensive support be provided to existing LHCs to ensure their long-term sustainability, and that new LHCs be established to guarantee representation for communities assessed as MM3 – MM7.

Through consultations conducted across the LHD, strengths and areas for improvement were identified to support and enhance LHCs. These include the need for a designated position and administrative officer to assist Health Service Managers (HSM) and consumers. This is primarily due to HSMs having conflicting priorities and regularly being required to complete clinical activities resulting in them not consistently being able to prioritise LHCs. This recommended support includes assistance to establish new and sustain existing LHCs, implementing governance processes for LHCs, facilitating the onboarding and orientation of new LHC consumers, implementing strategies to ensure LHCs have meaning and purpose, ensuring consumers feel valued and connected, and developing processes to improve communication with communities.

Community engagement through LHCs will be enhanced and sustained across the LHD through the implementation of the recommendations identified through consultation.

# Introduction

## Hunter New England Local Health District

HNELHD covers the Hunter, New England and Lower Mid North Coast regions of New South Wales, a region of 131,785 square kilometres. Care and support are provided across twenty-seven hospitals; eleven multipurpose services; and forty-three community health centres, as well as mental health, children, oral health, and drug and alcohol services.

In 2021 the estimated population across HNE was 962,390 residents, and over the decade to 2031, the overall population is projected to increase to 1,038,920.

HNE has a diverse population, which covers a significant geographical area. The Modified Monash Model (MMM) considers an area according to geographical remoteness and town size, and defines whether a location is metropolitan, regional, rural, remote, or very remote. The MMM measures remoteness and population size on a scale of Modified Monash (MM) categories MM1 to MM7. MM1 is a metropolitan and MM7 is very remote.

HNE has MM categories 1 (major city) to 6 (remote community).

## Supporting documents

### Future Health: Guiding the next decade of care in NSW 2022 -2032

Future Health: Guiding the next decade of care in NSW 2022 -2032 [1] provides the overarching plan for how NSW Health delivers services over the coming decade. It aims to detail the vision for a sustainable health system that delivers outcomes that matter most to patients and the community, is personalised, invests in wellness and is digitally enabled. The Future Health Report sets the scene for the Future Health Strategic Framework [2] and provides an overview of how the strategy will be turned into action over the next ten years.

The Framework [1, 2] outlines the six Strategic Outcomes that are the cornerstone of delivering Future Health. Of relevance, these include:

| Strategic outcomes | Key objectives |
|---|---|
| Patients and carers have positive experiences and outcomes that matter | 1.1 Partner with patients and communities to make decisions about their own care |
| | 1.3 Drive greater health literacy and access to information |
| | 1.4 Partner with consumers in co-design and implementation of models of care |
| Safe care is delivered across all settings | 2.4 Strengthen equitable outcomes and access for care for rural, regional and priority populations |

### NSW Aboriginal Health Plan 2013 – 2023

NSW Aboriginal Health Plan 2013 – 2023 PD2012_066 is a framework using six key strategic directions to Close the Gap in Aboriginal health outcomes by spreading responsibility for achieving health equity for Aboriginal people in NSW, across all NSW Health operations. The Plan details the six strategic directions which aim to drive change in the health system. The following strategic directions

1. Building trust through local partnerships.
5. Ensuring culturally safe work environments and health services.

6. Strengthening performance monitoring, management and accountability.

As a policy directive, compliance of the policy is considered mandatory.

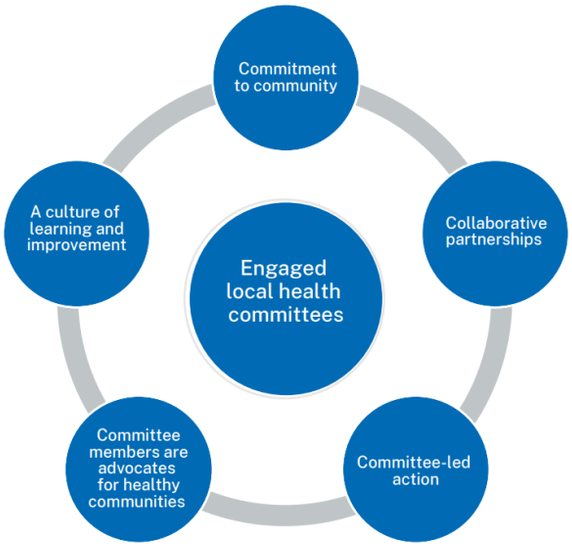
## Strengthening Local Health Committees in Regional NSW

A NSW Government Parliamentary Inquiry into Health outcomes and access to health and hospital services in rural, regional and remote NSW report made 44 recommendations to improve the healthcare system in rural, regional, and remote areas across NSW. The report was published in 2022 and included recommendation 42, which specifically stated:

"That the rural and regional Local Health Districts:

- review, reinvigorate and promote the role of Local Health Advisory Committees to ensure genuine community consultation on local health and hospital service outcomes, and health service planning,
- investigate methods of better informing communities about the services that are available to them, and publish additional data such as wait times and minimum service standards for the facilities within their remit" [3]

In response, the Regional Health Division of NSW Health completed significant consultation with LHDs and LHC across NSW, which is detailed in Strengthening local health committees in regional NSW Addendum [4]. The results from this consultation informed Strengthening local health committees in regional NSW Report [5], which was published in 2023. It presents the findings of the consultation and includes the five guiding principles, which underpin the recommended actions and commitment required by LHDs to strengthen LHCs. It is these five guiding principles that need to be implemented to ensure the success and sustainability of LHCs moving into the future.




Five Guiding Principles [5]

## NSW Regional Health Strategic Plan 2022 - 2032

NSW Regional Health Strategic Plan 2022 – 2032 provides a blueprint for priorities for regional NSW Health moving towards 2032. Priority 4 in the NSW Regional Health Strategic Plan 2022 – 2032 is to "Keep communities informed, build engagement and seek feedback" [5], which acknowledges that community engagement is essential to ensure that healthcare meets local needs, to identify gaps in service delivery and to set priorities. The plan specifically acknowledges the important role that LHCs play in keeping communities informed and engaged. Objective 4.2 of the NSW Regional Health Strategic Plan 2022 – 2032 focuses on "Engage communities through genuine consultation and shared decision-making in design of services and sustainable local health service

development" and recommends "Improve and expand engagement models: review local engagement models including the Local Health Advisory Committees; implement recommendations and monitor impact"[5].

### Towards Excellence – every person, every time. Strategic Plan 2021 – 2026

The Hunter New England Local Health District Strategic Plan 2021 to 2026 defines HNE strategic priorities towards 2026. The Strategic Plan is reviewed annually and revised to reflect HNE priorities. The plan is designed to be a roadmap that ensures HNE delivers high-quality care to communities, support staff, and position the organisation for the future.

The Strategic Plan reflects the health priorities of the NSW State Plan, and aligns with the Service Agreement between HNE and the NSW Ministry of Health. It also supports the principle of Excellence. Every patient. Every time.

Strategic Focus Area One is Community: The people we serve. Within this focus area, multiple priorities and strategic actions are supporting why LHCs need to be strengthened. This includes:

| Priority | Strategic actions |
|---|---|
| Empower communities to engage as partners in health. | Work with other providers, partners and communities to improve access, health literacy and reduce barriers between healthcare settings.<br><br>Work with volunteers to understand their needs and embrace their contribution to patient experience.<br><br>Recruit and support patient and consumer leaders (consumer representatives) to actively participate across all levels of engagement and governance.<br><br>Co-design models of care with consumers to foster patient-centred care. |

### National Safety and Quality Health Service Standards (NSQHS Standards)

The primary aims of the Australian Commission on Safety & Quality in Health Care (ACSQHC) NSQHS Standards are to protect the public from harm and to improve the quality of health service provision.

The Clinical Governance Standard and the Partnering with Consumers Standard set the overarching system requirements for the effective implementation of the remaining six standards, which consider specific high-risk clinical areas of patient care.

NSQHS Standard 2, Partnering with Consumers, aims to ensure that consumers are partners in the design, delivery, and evaluation of healthcare systems and services, and that patients are given the opportunity to be partners in their care. Within the NSQHS Standards, there are many references to engaging with the community. As a mechanism to engage with consumers and the wider community, LHCs are an example of how HNE works towards meeting Standard 2.

# Exclusions

## Volunteers

Volunteering is defined as 'activities taking place for the benefit of communities and the volunteer, and is conducted of the volunteer's own free will for no financial payment in designated volunteer positions'. Volunteers - Engaging, Supporting and Managing Volunteers (nsw.gov.au). Volunteers have significant scope and can participate at kiosks, concierge services, auxiliaries or Pink Ladies.

It is acknowledged that LHC members have historically not been paid for their time to participate in meetings and they could be considered volunteers. For this report, consultation and recommendations are being made specifically relating to LHCs, where committee members are considered as consumers and not volunteers. This is consistent with PD2011_033 Volunteers - Engaging, Supporting and Managing Volunteers where “Members of NSW Health consumer and clinician engagement councils and committees” are excluded.

# Engagement Methodology

## Engagement overview

A variety of electronic surveys, virtual meetings and face-to-face meetings were completed. These were facilitated by the Manager Community Engagement and Partnerships.

## Stakeholders consulted

### NSW LHDs

As strengthening LHCs across regional NSW is a priority across the state, consultation was completed with delegates from multiple LHDs. This was to identify any key learnings that could be considered relevant for HNE.

### HNE Rural and Regional General Managers

An initial survey was distributed to General Managers (or delegate) for completion. This identified LHCs (if they were still functioning), a local delegate from the LHC, and identification of any other key stakeholders recommended to be included in the consultation.

### Delegate from LHCs

A virtual meeting was completed with LHC delegates to discuss the practicalities of LHC meetings. This was generally with the HSM aligned with the LHC.

Consultation with LHC delegates that had recently folded (e.g., 2023), but had expressed an interest in reestablishing an LHC was also completed.

### LHCs

Manager Community Engagement and Partnerships attended LHC meetings face-to-face where a brief overview of the review was provided. Consultation was completed with LHC members. This primarily focused on why consumers were LHC members, and what could be done to make being engaged with a LHC more rewarding and meaningful.

Appendix A: Consultation with LHCs provides additional information about this.

### Stakeholders

Throughout the consultation process, key internal and external stakeholders were identified. Consultation was completed with these individuals either face-to-face or virtually.

Appendix B: Consultation with key stakeholders provides additional information about those involved.

### Electronic survey for LHCs

An electronic survey was distributed by HSMs aligned with a LHC to committee members via email. This included committee members who were staff. The survey allowed for committee members who were not able to attend the face-to-face consultation, or who had thought of additional feedback with the opportunity to provide this.

### Virtual consultation

Virtual consultation was offered to LHCs who were still regularly meeting, but where committee members were not able to attend the face-to-face consultation. The invitation was distributed via the HSM aligned with each committee. Three virtual meetings were offered over three different days (e.g., Monday, Tuesday and Wednesday), and at differing times (e.g., 7 am, 12 pm, 5 pm).

### Opportunity for follow-up

Throughout the process, the contact details for the Manager Community Engagement and Partnerships were provided, with stakeholders encouraged to initiate contact if they were more comfortable providing feedback one-on-one or thought of details after being involved in the consultation. These details were provided in a variety of ways including:

- Hard copy to all LHCs.
- Soft copy distributed with LHC meeting minutes.
- Flyer promoting the survey and virtual consultation.
- Electronic survey including the option to discuss any other items with the Manager Community Engagement and Partnerships.

# Engagement Participation Summary

| Activity | |
|---|---|
| Survey General Manager (delegate) | 28 surveys completed. |
| Meeting with LHC delegates | 24 virtual and face-to-face meetings completed. |
| Consultation with LHCs | 16 face-to-face meetings including:<br>• 57 consumers from a reported total of 104 consumers (55%).<br>• 47 staff members from a reported 61 total staff (77%).<br>• 104 LHC members from a total of 1165 (63%).<br>3 virtual meetings with 0 consumers and 1 staff member. |
| LHC survey | 1 response. |
| Consultation with key stakeholders | 20 internal HNE stakeholders and 27 external HNE stakeholders.<br>1 internal HNE stakeholder and 7 external stakeholders declined to be involved or did not respond to requests. |

# Consultation limitations

## Completion of consultation

Face-to-face consultation was completed with LHCs to coincide with planned LHC meetings. On two occasions (Murrurundi and Tenterfield), face-to-face consultation could not be completed and committee members were provided with the option of completing a virtual consultation or an electronic survey.

For varying reasons, many LHCs ceased meeting during the COVID-19 pandemic (e.g., prior to 2022). It is acknowledged that there are potentially key learnings that could be gathered from these LHCs, but consultation was not completed with these individuals/committees due to not being able to contact them (e.g., HSM had changed, LHC member has passed or no longer able/wanted to be involved).

There are locations across HNE where LHCs have been discontinued and replaced with Partnering with Consumer Committees (e.g., Lower Hunter Sector (MM1 – MM5), Belmont Hospital (MM1), Tamworth Hospital (MM3), John

Hunter Hospital (MM1)). Although consultation was completed with a delegate from some of these committees, consultation was not completed with the Partnering with Consumer Committees. This was primarily due to the changing prioritisation of LHCs at these sites.

### Number of people involved in consultation

The number of people who participated in the consultation could be considered small. Consultation was offered to 18 LHCs and completed face-to-face with 16 LHCs (89%). The LHC delegate reported the number of consumers and staff on each LHC, but it is acknowledged that this may have changed between when this was reported in late 2023, to committees reconvening in early 2024.

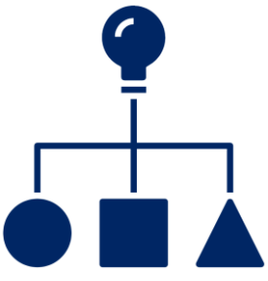
# Engagement Findings and Recommendations

## Overall findings

Through consultation with stakeholders including LHC delegates, LHC members and other key stakeholders, numerous opportunities for improvement were identified to assist in meeting the five guiding principles as outlined in the '*Strengthening local health committees in regional NSW report'*, and hence work towards strengthening LHCs across the LHD. These focused on:

**1. LHC establishment and sustainability**

**2. Resourcing LHCs**



**3. Governance of LHCs**

**4. Recruitment and onboarding of LHC members**

**5. Orientation for new LHC members**

**6. LHCs have meaning and purpose and consumers feel valued and connected**

**7. Supporting HSMs and services**

**8. Communicating with the community**

It is acknowledged that many opportunities for development and potential strategies to strengthen LHCs could be considered appropriate for multiple themes, but these have only been documented once.

# Recommendation 1: LHC establishment and sustainability

## Strengthening LHCs - Guiding Principles

- Commitment to community.
- Collaborative partnerships.
- Committee-led action.
- Committee members are advocates for health communities.
- A culture of learning and improvement.

## Literature

Community engagement is a crucial aspect of local health decision-making, especially for those residing in regional, rural and remote areas of NSW [5]. The relationship between rural communities and their health services is significant, and it is essential to acknowledge this longstanding connection, taking into account the unique cultural context of each community [6]. Moreover, recognising the existing strengths within the community and taking individual and collective actions for the benefit of the broader community are equally important [7].

At the heart of community engagement lies the act of listening to and learning from communities, understanding the issues and topics that hold significance for them. The primary goal of community engagement is to facilitate equitable, meaningful, and active community participation, while also highlighting the strengths of the community [8]. By understanding the expectations of the communities they serve, health services can better cater to their needs. Effective community engagement fosters trust, builds alliances, mediates relationships, and ultimately improves health outcomes within the target community [9]. LHCs serve as one conduit for health services to engage with communities, providing formal opportunities for community input into local health services [5].

Meaningful community engagement at multiple levels in the realm of health should lead to a system that recognises and responds to community needs, while aligning with the norms and values of both the community and the health system. This approach not only helps develop the capacity of community and health professionals, but also enables the appropriate utilisation of community resources. In rural areas, where consumers are more likely to actively engage in their healthcare, such a system proves to be effective and efficient [10].

In Australia, community participation is deeply ingrained in the legislative and policy frameworks that govern health services. Compliance with the NSQHS standards is a requirement for health services, necessitating cooperation with the community, which in turn, relies on the health service for care [6].

To ensure adherence to the NSQHS standards, HNE has implemented Partnering with Consumers Framework (HNELHD Pol 22_07). This framework outlines the essential components necessary to support partnering with consumers at patient, service and organisational levels. Additionally, Implementing the Partnering with Consumers Framework (HNELHD Pol 22_07:PCP 1) provides information, tools and resources to effectively implement the core components of the framework, and manage Partnering with Consumer committees within HNE Health. These committees place significant emphasis on NSQHS Standard 2 to ensure systems are designed and used to support patients, carers, families and consumers to be partners in healthcare planning, design, measurement and evaluation. It is important to note that their focus differs from that of LHCs, as LHCs primarily aim to engage with consumers to address community needs.

## Consultation

- There are 18 LHCs who report to have regularly met in 2023 and continue to have meetings in 2024. Appendix C: Location of LHCs across HNELHD provides more details.
- During the consultation period, eight communities or HSMs initiated contact with Manager community Engagement and Partnerships seeking assistance to re-establish LHCs for their community.
- LHCs stated that they did not want their LHC to merge with another LHC. This was for a variety of reasons including the differences between services, the uniqueness of their local community and a fear of the

community not being heard. It is not anticipated that the pending organisation changes will have an impact on this.

- LHC members consider the committee to be important in assisting with advocacy for the community and sharing information. They also value what the LHC can achieve and are committed to implementing recommendations to ensure the long-term sustainability of LHCs as a form of community engagement.

***"I want to be part of it, I want to give back to community".***

(LHC member)

## Opportunities for improvement

While completing consultation, it identified that across the LHD there are currently 18 LHCs which continue to meet in 2024. During this time a further 8 locations requested support to re-establish the LHCs in their area. This includes Armidale (MM3), Cessnock (MM3), Muswellbrook (MM4), Glen Innes (MM4), Guyra (MM4), Denman (MM5), Kurri Kurri (MM1) and Tingha (MM5) (Appendix D). This leaves a significant number of communities across the LHD who are not represented at a LHC and are subsequently not able to experience the benefits from them.

At this time, it is recognised the roles and functions of the District and Sector Partnering with Consumer Committees and LHCs are different. It is unrealistic to consider that the Partnering with Consumers Committees can implement the 5 guiding principles and fulfil the function of LHCs and that LHCs can complete all the priorities of Partnering with Consumers Committees.

***"The Local Health Committee is a good vital committee who is committed to overall health in the district".***

(LHC member)

## Recommendations

1. The existing 18 LHCs are supported to ensure they are sustained moving into the future.
2. The additional 8 locations (Armidale (MM3), Cessnock (MM3), Muswellbrook (MM4), Glen Innes (MM4), Guyra (MM5), Denman (MM5), Kurri Kurri (MM1) and Tingha (MM5)) who have requested support to re-establish their LHC are assisted and are provided with ongoing support to ensure they are sustainable moving into the future.
3. Where there is a HNE service with staff located geographically (e.g., not outreach) within MM3 to MM6, the community is represented at a LHC. This may be achieved through:
    - Sustaining an existing LHC.
    - Combining with an existing LHC.
    - Re-establishing a LHC, either as a sole community or jointly with another community.
    - For locations with MM1 to MM2, services need to ensure that there is active community engagement. This can be completed through a LHC or another means.

    Appendix D: Proposed LHC considering Modified Monash categories provides more details regarding this.
4. Manager Community Engagement and Partnerships to continue to advocate with HNE Clinical Governance for recognition of LHCs and community engagement to be provided with adequate space and significance in the HNE Consumer Engagement and Framework Strategy.

# Recommendation 2: Resourcing LHCs

## Strengthening LHCs - Guiding Principles

- Commitment to community.
- Collaborative partnerships.

## Literature

The small rural health services in Australia are burdened with significant administrative challenges due to the need to meet various accreditation, accountability and reporting requirements with limited resources. This results in limited capacity to customise service delivery and funding programs to fit specific rural and community characteristics, ultimately leading to barriers to access and equity [6]. External pressures often lead staff to prioritise clinical duties over involving users in community engagement and decision-making processes [6].

Effective consumer engagement requires adequate resources, organisational commitment, support, and funding. Consumer representatives should receive direct remuneration, access to organisational resources, and staff time for administrative support [11]. Training and ongoing support for consumer representatives are also crucial for their effective participation [11].

Providing adequate resources to consumer representatives maximises their contribution and ensures that they are recognised as individuals with expert skills and knowledge. Effective recruitment, orientation and ongoing support for consumers are essential for successful consumer engagement [11]. However, in practice, recruiting community members and developing collaborative partnerships can be challenging without proper training and resource [6].

## Consultation

- From the 18 LHCs meeting in 2024, 10 (56%) HSMs regularly complete clinical shifts.
- A reoccurring theme identified the need to appropriately resource LHCs, as local HSMs do not have the capacity to prioritise LHCs due to competing demands (e.g., completing clinical shifts).
- The role of secretary on LHCs is completed by an administration officer 78% of the time, and the HSM 17% of the time.
- Throughout consultation, LHCs were regularly cancelled within a couple of days of the planned meeting. This was due to the HSM being on leave or not being able to prioritise the meeting, which resulted in delays in completing the consultation and outstanding actions from previous LHC meetings progressing.
- All LHCs reported to prefer meeting face-to-face as this allowed for greater connection with others.
- Verbal feedback from LHC consumers indicated they appreciated the Manager Community Engagement and Partnerships taking the time to attend their LHC meeting in person. This also allowed for a greater rapport to be developed.
- In rural locations where there have been multiple HSMs over the last few years, LHCs consistently recommended that there should be a consistent person to contact, as this will allow for a relationship to be developed and allow the LHC to continue to function effectively.
- When liaising with other LHDs, it was identified that there is generally one person who oversees LHCs and is the point of contact for consumers.

***"Changing HSM impacts on the Local Health Committee and accountability".***

(LHC member)

## Opportunities for improvement

LHCs require significant administrative processes and support. The local HSM aligned with the LHC is generally responsible for completing and/or overseeing these. These tasks include the components required for onboarding consumers, room bookings, distributing meeting appointments, completing meeting minutes, distributing meeting

documents, being a point of contact for consumers and arranging refreshments (as applicable). It is anticipated that these responsibilities will increase when consumers are remunerated in alignment with GL2023_016 Consumer, carer, and community member remuneration.

LHCs cannot always be consistently prioritised or supported locally by HSMs. This is due to a variety of reasons including:

- HSMs have competing demands (e.g., competing clinical shifts, rostering, and a significant workload to ensure safe and appropriate clinical care is provided, and NQSHS standards are met).
- Planned and/or unplanned leave.
- Retention of HSMs in rural areas can be difficult, resulting in acting HSMs who are not familiar with the role or function of a LHC and do not always have a relationship with LHC consumers.

When LHCs are not provided with sufficient support from the local HSM, this can result in:

- Consumers not having anyone to contact in the event they have any questions, concerns or feedback from the community.
- LHC meetings being cancelled at the last minute as the HSM is not able to attend.
- Information not being shared by the HSM with consumers in a timely manner.
- Disengagement by consumers, which can result in LHC meeting quorums not being met and ultimately the LHC ceasing to function.

LHCs also benefit and require other practical support and resources to ensure that they can operate optimally and allow members to feel valued. These resources include:

- Stationery and printing of resources (e.g., meeting documents).
- Refreshments for the LHC meeting (e.g., tea, coffee, food type depending on the time of meeting).
- Travel and accommodation for LHC consumers if they attend any face-to-face annual meetings/forums.
- Resources in meeting rooms to allow for hybrid meetings (e.g., webcam, microphones, speakers).
- Welcome pack for new LHC consumers (e.g., notebook, pen and orientation materials)
- Acknowledgement of significant events and for recognition of contribution. This includes end-of-year celebrations (e.g., lunch), written acknowledgements/thank you cards, and cake for significant birthdays/milestones for LHC consumers.
- Manager Community Engagement and Partnerships accessing a HNE fleet car to allow for face-to-face meeting attendance when practical.
- Potential remuneration of consumers pending recommendations from HNE Clinical Governance on the implementation of GL2023_016 Consumer, carer and community member remuneration.

Appendix E: Approximate costing for facilitating LHCs provides more information regarding this.

**Recommendations**

5. The Manager Community Engagement and Partnerships is currently employed temporarily as 1.0FTE Level 3 HSM. (Appendix F: Current Manager Community Engagement and Partnerships Position Description). Consultation has identified a significant number of strategies (e.g., both initially to assist with establishment, review, and also ongoing) to strengthen LHCs to ensure their sustainability into the future. On top of an already busy workload, it is considered unrealistic that a HSM responsible for a clinical service can implement the recommended strategies or provide the level of support required to ensure the sustainability of LHCs.

   It is recommended that 1.0 FTE Manager Community Engagement and Partnerships (HSM 3) is made permanent ($160 491). The primary purpose of the position will focus on community engagement, with a focus on strengthening LHCs through implementing strategies identified during consultation as detailed through the report. This will ensure that LHCs and HSMs are provided with sufficient support and practical

assistance now and into the future to ensure the sustainability of LHCs. The position does not replace the role of the site HSM at a LHC, rather provides support and practical assistance to the local HSM.

Strengthening local health committees in regional NSW Report also references a 'District local health committee coordinator' and the responsibilities the position is required to complete. Within HNE, the Manager Community Engagement and Partnerships will be responsible for completing these tasks.

Depending on the recommended key accountabilities of the Manager Community Engagement and Partnerships, it is recommended that the position description and grading be reviewed and updated as required.

6. 1.0 FTE administration officer (targeted) assists with tasks associated with facilitating LHCs. As it is anticipated tasks would include completing minutes for LHC meetings, it is recommended that this be graded as A04 position ($78 614) in alignment with HNE Education Framework: Administration and Executive Assistant Curriculum.
7. The Manager Community Engagement and Partnerships will ensure that documents relating to the LHCs are accessible to relevant managers and quality coordinators in the event they are required as evidence for short notice assessment.
8. The Manager Community Engagement and Partnerships becomes the alternate contact for LHC consumers. This could reduce the responsibilities for the local HSM. It will also ensure that consumers have a key contact if there is an Acting HSM. The relationship with LHCs will be developed and maintained through regular attendance at LHC meetings. The Manager Community Engagement and Partnerships would maintain two-way communication with the local HSM regarding the relevant LHC.
9. Manager Community Engagement and Partnerships is currently managed by the HNE Chief of Staff, Strategic Relations and Communications (SRC). It is recommended that the position remains in SRC as the collaboration within the team allows the Manager Community Engagement and Partnerships to be strategically connected and engaged in any contentious topics that may be acknowledged by consumers at LHCs. It also allows for LHCs to have a working relationship with the SRC team to assist them to promote and celebrate the successes of the LHC and the local community. This includes improving the pathway for feedback for local communication (e.g., items for local newsletters and social media).
10. One central cost centre to be responsible for ongoing costs aligned with facilitating and supporting LHCs. If LHCs are centrally managed, one central cost centre will allow for easier management and monitoring especially considering consumer remuneration.
11. LHC meetings are to be scheduled in conjunction with LHC members to allow for the Manager Community Engagement and Partnerships to easily attend face-to-face, while minimising the need for accommodation and risk associated with excessive driving in a short period.
12. Manager Community Engagement and Partnerships has access to a HNE fleet car.
13. An audit is to be completed for each meeting room where LHCs are held to review what resources are required to allow for effective hybrid meetings to be facilitated. This is to ensure that all members who are attending the meeting face-to-face can be viewed and heard by those members attending virtually. The outcome of these audits will allow for options to be explored on how the recommended equipment is procured.

# Recommendation 3: Governance of LHCs

## Strengthening LHCs - Guiding Principles

- A culture of learning and improvement.
- Collaborative partnerships.

## Literature

The concept of governance revolves around the interactions among managers, directors and shareholders [12]. It is grounded in decision-making, stakeholder engagement, transparency, oversight and coherence [13].

Governance is regarded as a critical focus in the journey towards attaining universal healthcare and enhancing the quality, efficiency, effectiveness and responsiveness of the health system [13]. Effective communication among key stakeholders further strengthens this endeavour [14].

## Consultation

- Across HNE, 18 LHCs are meeting regularly in 2024. Partnering with Consumer meetings are also occurring at sites and across Sectors, which have incorporated the concept of engaging with consumers.
- 94% of LHCs do not regularly evaluate their committee.
- 72% of committees do not have a formal reporting mechanism currently in place.
- LHCs occur regularly:
    - 28% monthly
    - 67% bi-monthly
    - 5% quarterly
- 78% of LHCs are chaired by a consumer.
- All the LHCs requested updated terms of reference for their committees, which clearly detailed the purpose and accountabilities.
- LHCs expressed the need to have a way to escalate concerns when they arose, and to have clear and defined communication methods between LHCs, HNE executives and Board.

***"We value the connection with the ELT and the board".***

(LHC member)

## Opportunities for improvement

The Manager Community Engagement and Partnerships is currently responsible for reporting annually to the District Partnering with Consumers Committee, and quarterly to HNE Community and Patient Partnership Committee meeting, aboard subcommittee. This reporting currently provides an update on the work occurring in regard to reviewing and strengthening LHCs.

Across the LHD, the principles and processes used to support, govern and communicate with LHCs is inconsistent. This can be partially attributed to outdated supporting documents and a lack of resources to support LHCs.

For the majority of LHCs, there is no formal communication or reporting process between LHCs and HNE Executive or committees (e.g., General Manager or Partnering with Consumers Committee). This has resulted in a lack of accountability, reduced transparency and information not always being shared. There is also no formal evaluation of LHCs regularly completed therefore, not allowing for continual improvement to enhance LHCs.

The draft HNE Consumer Engagement and Framework Strategy has LHCs reporting to Sector Partnering with Consumer Committees, yet this does not consistently occur across the LHD. It is acknowledged that this reporting line will be impacted by pending organisational restructure effective 1/7/2024.

## Recommendations

14. Manager Community Engagement and Partnerships to draft a HNELHD Guideline and Procedure, that clearly defines the minimum requirements to support and govern LHCs. This will also include considerations allowing for LHCs to have some degree of flexibility in response to differing community needs.
15. Aboriginal Health Impact Statement PD2017_034 states an Aboriginal Health Impact Statement is recommended when initiatives are revised. To work with HNE Aboriginal Health to complete this as appropriate.
16. The LHCs report (a minimum of annually) to the HNE Community and Patient Partnership Committee meeting, a sub-board committee. Reporting is to be coordinated and completed by the Manager Community Engagement and Partnerships.

The same reporting template can also be provided to relevant Partnering with Consumer Committees for their information. This reporting line can be displayed on any relevant organisation charts through a dotted line.

17. Manager Community Engagement and Partnerships to continue to report annually to the District Partnering with Consumers Committee, as detailed in the committees' action plan.
18. Manager Community Engagement and Partnerships to draft an evaluation tool and assist with implementation of this across all LHCs. This is to be timed in alignment with the frequency of other meetings being evaluated at the service (e.g., February).

    The evaluation tool to explore participation considering the International Association of Public Participation (IAP2).
19. Formal reporting requirements with senior HNE Managers and General Managers to be refined, reviewed and developed as organisational restructure continues to evolve.

# Recommendation 4: Recruitment and onboarding of LHC consumers

## Strengthening LHCs - Guiding Principles

- Committee members are advocates for health communities.

## Literature

When recruiting consumers, it is important to ensure a diverse range of participants, including individuals who have direct experience with the service, as well as carers, family members, and people from the local community. Other methods of identifying potential participants include identifying those who have used the complaints feedback mechanisms [15].

Recruitment often involves a narrow group of individuals, with just one or two 'appropriate' or 'acquiescent' patient representatives being handpicked to be involved in committees or projects. Patient representatives are less commonly drawn from cultural and minority ethnic groups and are often from middle-class backgrounds. In most healthcare systems, it is acknowledged that cultural and minority ethnic populations have historically experienced poorer health and faced barriers in accessing certain services. Many other different groups are also excluded from the involvement processes. These groups may have particular or even greater healthcare needs than the wider population, yet their views are seldom heard or listened to. The ability to be successfully involved is significantly affected by education level, income, cognitive skills and cultural differences, which can affect patients' health beliefs and ability to use health services. The consequences of narrow selection processes mean that those with the most to gain are often excluded from healthcare decision-making [16] and community engagement.

Challenges in the application process, concerns about the formality of committee meetings, and health service assumptions that community members understand community participation are further complicated by ambiguity about the committee member's role and decision-making processes [6].

## Consultation

- 72% of LHCs experience difficulty recruiting new members.
- 94% of LHCs have a rolling tenure due to the difficulties in recruiting new committee members.
- Recruitment of new members can be difficult, and there is currently limited diversity in LHCs.
- All LHCs acknowledged they would benefit from assistance with recruiting new members from diverse backgrounds to ensure that their community is represented.

***"…diversity is essential to represent our community".***

(LHC member)

- The majority of LHCs recruit new members by 'tapping' identified people on the shoulder and encouraging them to become a LHC member. This is often built on existing relationships. Examples of this working well have included local schools where there is the opportunity for representation of young people to be LHC members.
- LHCs are comprised of between 2-7 HNE staff and between 3-9 consumers. On average, a LHC has three HNE staff and six consumers.
- The majority of LHCs reported that the paperwork required to be onboarded in Stafflink is a barrier and has resulted in potential new members disengaging from being a LHC member.

***"Paperwork is a barrier and prevents people from joining".***

(LHC member)

- Some LHDs (Western LHD) have removed the requirement for LHC consumers to complete National Criminal Record Checks as part of onboarding. This is because it was found to be a barrier for engaging with consumers as not everyone has the required 100 points of identification. It was assessed that as LHC consumers only meet in the company of staff in a designated meeting room and do not go onto the hospital wards, they were considered to be the same risk as any other community members (e.g., visitors) accessing health services.
- LHDs across the state use a variety of methods to recruit LHC consumers. This includes media releases, tapping on shoulders, social media and expressions of interest on Social Pinpoint, a community engagement online platform.

## Opportunities for improvement

Recruitment for LHCs has previously been completed in a variety of ways. This has varied from 'tapping on the shoulder' to advertising in local newspapers or newsletters and guided by Consumer and Community Representative Selection GL2005_042 and HNELHD GandP 20_11 Recruitment, Onboarding and Orientation of Consumers.

In reviewing LHC membership, the majority of LHCs are not diverse or reflect the local community. In recent years, LHCs have also experienced difficulty recruiting new members.

A recent recommendation has been that all consumers working within HNE are to be registered with Consumer Connect, which is managed by NSW Regional Health Partners. This is due to HNE contributing financially and Consumer Connect maintain a central register for all HNE consumers. Registration is completed by an online application form and applies to all new and existing HNE consumers.

To be able to complete the Consumer Connect registration form, consumers need to:

- Be able to know where to find the Consumer Connect registration form.
- Have an appropriate device and data to be able to find and complete the Consumer Connect application form.
- Have the appropriate level of literacy and health literacy.
- Be motivated to complete the registration form which takes approximately 20 minutes to complete.

On occasions when a service or committee (e.g., LHC) requires a consumer, they are to initiate contact with Consumer Connect by completing the online form. If Consumer Connect has a consumer who may be interested, they will seek the consumer's consent to provide their contact details to the requesting HNE delegate.

The number of consumers who can be registered for Consumer Connect is restricted to approximately 100 consumers across the 3 LHDs (HNE, Central Coast LHD and Mid North Coast LHD), and other organisations that Regional Health Partners works with. This is due to the capacity and being able to manage, support and engage appropriately with consumers.

In April 2024, Consumer Connect confirmed there were 40 consumers registered across the three LHDs, with the majority of consumers being aligned to Central Coast LHD. It was also acknowledged that of those registered, there was limited diversity and geographical spread. This is problematic due to the goal of LHCs to have increased diversity and that LHCs are spread across the LHD. There is currently no clear process if a consumer is required, but Consumer Connect does not have a consumer registered who is assessed as being appropriate.

There are currently 104 consumers across the existing 18 LHCs, with the number of consumers anticipated to increase. This exceeds the 100 cap of consumers able to be registered with Consumer Connect. This is problematic due to the number of other consumers engaged in other capacities across the LHD, and consumers engaged with other LHDs and organisations which Consumer Connect is aligned to. In April 2024, Consumer Connect were unable to clarify how this will be managed.

All consumers (including LHC members) need to be onboarded into Stafflink and oriented to their role. This is outlined in HNELHD GandP 20_11 Recruitment, Onboarding and Orientation of Consumers, which details the paperwork that consumers are required to complete (e.g., dependent on if they are Band A, B or C, and Category A or B), which all have different requirements that require monitoring (e.g., Working With Children Checks and Aged Care Checks, which both need to be regularly renewed and immunisation status). All LHCs are currently operating differently, with some being Category A and others Category B.

The Consumer Representatives intranet page also details the required paperwork including:

- Cover sheet – Consumer Representative
- LHC Application Form
- Confidentiality Agreement for Consumers
- Identification Checklist
- National Police Check
- Working with Children Checks (dependent on role)
- Aged Care Statutory Declaration (dependent on role)

The onboarding process is time consuming to complete for both the HSM and the consumer. The consumer is required to complete all the paperwork and provide the supporting evidence, which is overall considered a potential barrier (e.g., not everyone has a birth certificate) and the HSM is required to provide the documents, assist with the completion of documents and save various documents (e.g., confidentiality agreement). This creates a risk of documents being misplaced or saved in different locations or methods with constantly changing HSMs who have different ways of doing things.

Across the LHD, there are approximately 1200 ‘contingent workers – volunteers’ who have been onboarded in Stafflink. LHC members have traditionally been recommended to be set up as a category ‘contingent worker’, position classification as ‘volunteer’ and position role title of ‘consumer representative’.

On reviewing Stafflink reporting:

a) It appears there are only three LHC members across the LHD who have been onboarded following the recommended classification. This subsequently makes monitoring of mandatory tasks difficult for HSMs and the potential remuneration for consumers.

b) It does not appear that any consumers have been given multiple position numbers when they are completing multiple consumer roles, which may have different documentation requirements (e.g., LHCs could be assessed as being Category B and the Hospital Auxiliary could be assessed to be Category A).

## Recommendations

20. As Consumer Connect continues to evolve, await advice on their strategies to address concerns regarding increasing diversity, having a geographical spread and managing all HNE consumers, which exceeds their cap of 100 registered consumers.

21. To support local HSMs, the Manager Community Engagement and Partnerships coordinates the completion of required paperwork for recruiting and onboarding of LHC members. This is saved in a consistent format and in a secure place.

    The paperwork to be available for HSMs to easily access as required (e.g. evidence for Short Notice Accreditation Assessment).

22. Ensure that the relevant documents (e.g. HNELHD GandP 20_11 Recruitment, Onboarding and Orientation of Consumers) are referenced on the HNE intranet Consumer Representatives for ease of HSMs to refer to as required. Although it is acknowledged that the Manager Community Engagement and Partnerships is primarily liaising with consumers to complete the required paperwork, the HSMs will need to know the process in the event they are asked questions.

23. HNE Clinical Governance and the HNE Consumer Engagement Working Party are reviewing HNELHD GandP 20_11 Recruitment, Onboarding and Orientation of Consumers.

    Await further advice and recommendations.

24. In consultation with HNE Clinical Governance and HNE Workforce Operations People and Culture, review how volunteers are onboarded to Stafflink. This is to include the different types of consumers, considering position classification, position name and position title. This will assist in determining if specific labels (e.g., Local Health Committee) are required to allow for ease of reporting and monitoring. It is acknowledged that HNE Consumer Engagement Working Party may make recommendations relating to this when they update HNELHD GandP 20_11 Recruitment, Onboarding and Orientation of Consumers.

    Recommendations will need to then be actioned as appropriate.

25. Manager Community Engagement and Partnerships to work collaboratively with local HSMs to review all existing LHC consumers to identify:

    - Who has been onboarded correctly into Stafflink with the recommended classification.
    - Who has been onboarded to Stafflink incorrectly considering the recommended classification.
    - Which LHC members are yet to be onboarded to Stafflink.
    - Which LHC members are onboarded into Stafflink but are no longer committee members and need to be separated.

    In consultation with HSMs and HNE Workforce Operations People and Culture, LHC members will need to be added, updated, or separated in Stafflink as required. A process will need to be developed and implemented to ensure currency as this will allow for Stafflink reporting to be regularly completed and monitored.

26. Manager Community Engagement and Partnerships to develop and implement a process for monitoring of mandatory tasks required by a consumer (e.g., mandatory training and immunisation and required checks).

27. The role and function of each LHC is to be reviewed in accordance with Occupational Assessment, Screening and Vaccination Against Specified Infectious Diseases (nsw.gov.au) to ensure they are assessed correctly (e.g., Category A or Category B). It is anticipated that this may require updates to LHC position numbers, to allow for ease of monitoring and reporting.

    This may include consultation with Staff Health services to ensure the appropriate classification.

28. Manager Community Engagement and Partnerships to consult with HNE Workforce Operations People and Culture to develop a position description for LHC members. This is to include a clear descriptor of a consumer's role and responsibilities.

# Recommendation 5: Orientation for new LHC members

## Strengthening LHCs - Guiding Principles

- Commitment to community.
- Collaborative partnerships.
- A culture of learning and improvement.

## Literature

The outcome of effective orientation results in a more positive attitude, as well as improved performance for new recruits. Orientation is typically a very time-limited process, but the effects of effective orientation can impact on work attitudes and performance over an extended period (e.g., months to even years). The favourable ratio between a short-term input and potentially a much longer term of benefits should encourage the investment of resources into this crucial process [15].

To ensure that orientation is meaningful, orientation needs to include information about the health service's structure, the role of the committee, and the role of the consumer at a minimum [15]. Moving forward, to maintain engagement, communication is also a vital part of the process and should be open and regular [9]. A component of orientation is education and/or training. These are required to improve and broaden the knowledge, expertise, and competence of an individual or group. These are recommended based on the premise that skills and knowledge are required to allow for growth and efficiencies [17].

Meaningful involvement and collaboration can be enhanced through systematic training of all members, which can occur during orientation. Training could include topics such as responsibilities (e.g., coming prepared to the meetings and arriving on time, actively participating in the consultation discussion, asking questions and maintaining confidentiality) [8].

Training is considered most effective when it is interactive, uses a variety of methods and is delivered in a sequence involving multiple exposures over a time that is focused on outcomes considered important by the individual [18]. It is also recognised that training should be tailored to the needs of the audience as this contributes to better learning outcomes [19]. This concept is also applied to Cultural Respect training where learning and understanding Aboriginal culture is recognised as a continual learning process [19].

In working towards diversity, learning opportunities should be offered to consumers who feel they lack the skills and confidence to engage. Without being offered the opportunity to learn the required skills and capabilities, many more seldom heard consumers will likely feel unable to effectively engage [20].

Although logical in theory, without proper training and resources, recruiting community members and developing collaborative partnerships can be challenging in practice. Ambiguity about roles and processes is problematic at both individual and strategic levels, and is likely to lead to delayed decision-making and add to tensions that could undermine collaboration efforts [6].

## Consultation

- Comprehensive orientation is not consistently implemented for new LHCs. One sector has established a consumer orientation package, but this is not specific for LHCs.

- Regular education is provided to 67% of LHCs, and LHCs report to value this as they can share learnings with their community.
- A common comment from LHC members was they wanted to have a better understanding of their role and the function of their LHC.

***"…you need to know who does what and what to do".***

(LHC member)

## Opportunities for improvement

Orientation for new LHC consumers is not consistent across the LHD. When consumers are not familiar with their responsibilities of being a committee member, the purpose of the meeting or familiarity with health, a new consumer can find it daunting and overwhelming when they attend their first meeting. This can result in reduced engagement and input by the consumer.

HSMs are able to access the HNE Orientation Guide for Consumer Representatives, which was developed in 2020 to support this. This document has a strong focus on partnering with consumers (NSHQS Standard 2) with little reference to LHCs. HNE Clinical Governance is coordinating a review to update this document through the HNE Consumer Engagement Working Party.

Consumer Connect reports to be developing an orientation package to support consumers who are registered on Consumer Connect. The timeframe until completion and content are unknown. In acknowledging the multiple LHDs and services aligned with Consumer Connect, it is anticipated that the orientation package will be generic to remain relevant to all.

A key component of orientation is mandatory training. HNE Orientation Guide for Consumer Representatives and HNELHD GandP 20_11 Recruitment, Onboarding and Orientation of Consumers outline that the NSW Health Code of Conduct and Aboriginal Culture – Respecting the Difference training modules are mandatory for all consumers to complete, and that other training modules may be recommended depending on the activities being completed.

Cultural respect training is referenced in HNELHD GandP 20_11 Recruitment, Onboarding and Orientation of Consumers referring to an online module, but it does not include a course code. Respecting the Difference: Know the Difference (eLearning) Course Code: 39988681 takes 2 hours to complete and Respecting the Difference: Be the Difference (face-to-face training) Course Code: 428003510 takes 4 hours to complete. Both modules are considered mandatory for "all NSW Health staff on 19 August 2022, including all medical officers and all staff at Local Health Districts, Specialty Networks and Health Agencies".

Consumer Connect report to be developing training to support new consumers, which includes virtual modules focusing on the implementation of medical research, the use of technology, and opportunities as a consumer. The timeframe for these being available is not currently known.

Other training that consumers can access is through Health Consumers NSW who offer "Introduction to Consumer Representation". This is an online 30-minute free course. Health Consumers NSW also offer more comprehensive training where there is a cost, Training for community and health consumer representatives - Health Consumers NSW (hcnsw.org.au).

## Recommendations

29. Manager Community Engagement and Partnerships to work collaboratively with Consumer Connect and HNE Clinical Governance in reviewing and/or developing an orientation package to support consumers.

In consultation with LHC consumers, determine if any specific orientation documents are required to support LHCs considering updated orientation documents from Consumer Connect and HNE Clinical Governance. Supplementary LHC orientation documents are to be developed as recommended by LHC consumers.

30. Consumers are provided with a 'welcome pack', which is coordinated by Manager Community Engagement and Partnerships. An example of this includes a notebook, pen, handwritten welcome note etc.

    It is acknowledged that this has been implemented at Singleton LHC for an extended period and has been well received.

31. Local orientation to LHCs needs to include a walk around the local facility as there are buildings and/or services that are often referenced in LHC meetings or by community members, and the LHC member would benefit from being familiar with these. Local orientation also needs to ensure that the consumer feels welcomed, has the opportunity to become familiar with health system processes, and has questions answered (e.g., meeting with the consumer to explain the documents, answer any questions and build rapport with them). Local orientation would be completed by the local HSM and supported by the Manager Community Engagement and Partnerships.

    It is acknowledged that a Checklist for secretariats or similar could be used to support consumers during their orientation phase.

32. LHCs can be supported (e.g., catering and room use) to facilitate a pre-meeting catch-up where consumers can meet, welcome new members and build relationships with other members.

33. The Manager Community Engagement and Partnerships completes a 30 and 90 day conversation with all new LHC members and continues to regularly round with them. This is to be completed on a specific consumer focused template considering health literacy and relevant questions for consumers.

    The Manager Community Engagement and Partnerships to complete any actions, and ensure feedback is provided to the relevant HSMs. The documentation would also be saved in an accessible location for the local HSMs to easily access.

34. When position numbers are reviewed, explore the opportunity to have mandatory training requirements (e.g., NSW Health Code of Conduct and any other recommended training) 'pinned' to LHC consumer position numbers. This recognises the different responsibilities and requirements for different positions and will allow for easy monitoring of compliance.

35. Manager Community Engagement and Partnerships to work with consumers to support them to complete mandatory training.

36. In attempts to improve cultural safety at LHCs, it is recommended that consumers complete Cultural Respect training, which is relevant and meaningful to their role as consumers. The recommended Cultural Respect training module is to be determined in consultation with HNE Organisational Development and Learning and HNE Aboriginal Health.

37. Manager Community Engagement and Partnerships to explore opportunities for appropriate training to support consumers (e.g., participating in virtual meetings). The potential training is to complement the orientation packages being developed/updated by HNE Clinical Governance and Consumer Connect and in response to consumer needs.

    If a training module is recommended, this is to be developed in consultation with HNE Organisational Development and Learning, HNE Clinical Governance and LHC consumers.

# Recommendation 6: LHCs have meaning and purpose and consumers feel valued and connected

## Strengthening LHCs - Guiding Principles

- A culture of learning and improvement.
- Committee-led action.
- Commitment to community.
- Collaborative partnerships.

- Committee members are advocates for health communities.

## Literature

The quality of meetings can significantly impact performance, satisfaction, attendance, behaviour and outcomes. Factors that determine whether a meeting is considered "good" or "bad" include the use of an agenda, keeping minutes, punctuality, an appropriate meeting environment and having a meeting chair. Research in organisational behaviour management has shown that elements like goal setting, task clarification, and performance feedback can improve meeting outcomes and overall performance [21].

Conducting the meeting effectively requires the chair to manage the agenda and provide prompts and consequences for behaviour, as well as for the participants to contribute productively and stay on task [20]. It is also important to schedule meetings and related activities at times convenient to consumers while considering their language needs, such as health literacy [19].

Meetings need to have clear objectives encouraging action, avoiding tokenism, identifying local solutions to health priorities and improving coordination between local health services [7]. This is assisted by consumers focusing on activities and projects that truly interest and motivate them [20], and are meaningful and relevant to the local community [7]. To ensure that consumers have a voice on a committee, it is recommended that consumers hold a minimum of 50% of positions, with the remainder of the committee being comprised of health representatives and service providers [22].

Meetings need to be held in spaces that are safe and accessible, as this assists with engaging people who are often seldom heard. Individuals and communities who face the most barriers to engaging in health may include those who are racialised, are disabled, are LGBTQ2S+, are homeless, have low health literacy and/or use communication aids [23]. A lack of inclusion of certain populations in authentic patient engagement runs the risk of developing and evaluating healthcare services based on the concerns and priorities of the dominant population, which may further entrench health inequities and preclude the ability to surface ideas that challenge dominant conceptualisations of health and healthcare, thereby reinforcing the status quo rather than promoting healthcare transformation [23].

Consumers who do not receive sufficient social rewards (non-monetary acknowledgement) from others may perceive engaging as a stress rather than a positive experience. In turn, they may be more likely to drop out [24]. Social rewards contribute to participants feeling respected and valued. Those who feel a greater level of respect are more likely to continue to engage, and enjoy an enhanced experience and higher levels of wellbeing [24]. Various strategies primarily focused on communication need to be considered to ensure continued success. This includes regular communication via phone and email (e.g., meeting appointments, meeting preparation materials, thank you cards) [7].

Beyond the meetings, each committee member has a role. Health service providers are responsible for implementing recommendations from meetings in a timely manner and community members are expected to disseminate information to their networks [7].

## Consultation

- The majority of LHCs (67%) either complete consumer engagement activities as a LHC member, or as a HNE consumer (e.g., other committees, recruitment, wayfinding, reviewing documents).
- Of the 18 LHCs continuing to meet, no LHCs report having difficulty with the retention of committee members. It is acknowledged that the LHCs who have experienced difficulty with retention have folded.
- Support provided by HNE to LHCs includes:
    - Printing of documents (83% of LHCs)
    - Light refreshments (67% of LHCs)
- The majority of LHCs identified the need for a simple agenda template that is easy to follow.

- The majority of LHCs acknowledged the importance of having a committee where there is trust, respect and transparency, because “you need to have a cohesive team to achieve goals and see outcomes for the community”.
- All LHCs provided feedback acknowledging how much they valued and appreciated having a connection with the ELT and Board. This previously occurred at the HNE Community Partnership Forums but has been lost as they no longer occur. The majority of LHCs recommended that HNE Community Partnership Forums or something similar be re-established.
- All LHCs stressed the importance of the LHC having a clear function and purpose that produces outcomes for the community.

***“Our 3 priorities are communication, consultation and information”.***

(LHC member)

- The need for health literacy to be considered was identified by a LHC who expressed the need to “translate health jargon into language that can be understood”.
- The majority of LHDs maintain standalone LHC and Partnering with Consumer meetings (or equivariant) due to the differing priorities and purpose of each meeting.
- The majority of LHC in other LHDs have a two-way communication between the committee and LHD executive. This includes having ELT or board members being part on LHC or clear reporting mechanisms.
- The majority of LHDs facilitate a face-to-face forum for LHC to network, celebrate successes and share ideas. The frequency of these varied between once to twice a year.

## Opportunities for improvement

Staff are not always aware or have the skills to engage with consumers to ensure a consumer’s experience is meaningful (e.g., there may be assumed knowledge for a new consumer or unexplained acronyms used). This can have a detrimental impact on the meaningfulness experienced by the consumer and result in disengagement.

There are currently various training opportunities available for staff to support their skill development for engaging with consumers. This includes:

- Health Consumers NSW offers “Introduction to Consumer and Community Engagement in Health Care” which is a free 30 minute online course. Health Consumers NSW also offers other more comprehensive training where there is a cost. Training for community and health consumer representatives - Health Consumers NSW (hcnsw.org.au)
- Mental Health clinicians have an extensive online learning package available through My Health Learning to support staff learning. This focuses on lived experience and collaborating with consumers.
- All of Us: An introduction to our guide to engaging consumers, carers and communities across NSW Health has been developed, and is being implemented across NSW Health. All of Us is a guide to respectful consumer, carer and community engagement across NSW Health, and includes the “Six ways of working” and “five tools”.

LHCs report that meetings do not always have meaning and purpose. This can be partially attributed to the documents currently available to support LHCs (e.g., terms of reference and agenda template) are over 5 years old and not always relevant, and actions not being progressed. The current templates also require a high health literacy to read (e.g., the current terms of reference template have a readability of 13).

## Recommendations

38. Manager Community Engagement and Partnerships is to form and engage with the LHC working party to develop appropriate templates to be used at LHC meetings. This is to include a minimum of agenda, terms of reference and code of care. Templates are to detail the minimum requirements and expectations but allow for sufficient flexibility to meet the needs of each differing community.

39. Templates are easily accessible and are regularly updated considering the changing needs of LHCs.

40. Terms of reference to:

    - Promote diversity across committee membership.
    - Ensure that the majority of committee members are consumers.
    - Ensure staff representation from hospital and community health.
    - Promote representation from mental health as practical.
    - Include clear scope so that committee members are aware of their role (e.g., local health committee and not a hospital board).

41. Ensure that all documents drafted to support LHCs, have a readability level of no higher than eight.

    This is in alignment with HNELHD GandP 20_08 Development/Review and Approval of Written Consumer Information Resources.

    It is acknowledged that work is being completed by the HNE Health Literacy Working Group to increase health literacy across the LHD.

42. LHC members who are staff are encouraged to complete the online module Working with consumers and communities (course code 41749567)

43. As practical and relevant, LHCs to be supported to implement components of All of Us.

    It is acknowledged that the All of Us Core Ingredients underpin the recommendations required to strengthen LHCs.

44. Promote All of Us education to LHC members.

    HNE staff who are LHC members have been provided with the opportunity to attend All of Us training specifically related to LHCs. At the time, there was limited take up of this.

    HNE staff have also been encouraged by HNE Clinical Governance to complete virtual and face-to-face All of Us training during April, May and June 2024.

45. All of Us training is relevant to consumers and has been implemented at some LHCs. This is to continue to be accessible for consumers.

46. Ensure that each LHC is provided with a hard copy of All of Us resources. These have been ordered by the Manager Community Engagement and Partnerships and will be distributed once received.

47. Consumers are currently not remunerated considering GL2023_016 Consumer, carer and community member remuneration.

    HNE Clinical Governance is currently reviewing GL2023_016 to make recommendations for implementation across the LHD. Once finalised, the Manager Community Engagement and Partnerships will work with local HSMs to implement this across all LHCs.

48. LHC working party to explore what additional information LHC members would like to receive (e.g., Language Matters, Hunter New England Local Health District's newsletter).

    Recommended documents are to be discussed with HNE Internal Audit and Corporate Services to ensure recommended information is appropriate to be routinely shared with consumers.

49. Manager Community Engagement and Partnerships to share any recommended and approved documents with LHCs and carbon copy to HSMs so they are aware. This will support the HSMs as they will not be required to complete this, while still being aware of the information being shared.

50. The HNE Annual Public Meeting (APM) is generally held at the end of the calendar year. The APM is the opportunity to summarise the achievements, outcomes and challenges experienced by the LHD, and is jointly presented by the HNE Chief Executive and HNE Board Chair.

    It is recommended that a face-to-face consumer forum aligned with when the APM is held, which includes LHC Chairs and/or delegates. This will allow for LHC representatives to hear directly from HNE Executive Leadership Team (ELT) and the HNE Board, while also hearing from other LHCs and having the opportunity to network with peers.

The APM will be coordinated by the SRC team.

51. Considering pending changes to HNE Executive, it is recommended that opportunities for LHC consumers to meet with HNE senior managers, HNE ELT, and/or HNE Board (a minimum of once annually) be explored. This could be achieved through a variety of ways (e.g., supporting LHC consumers to meet virtually, or inviting LHCs to meet with Chief Executive (CE) or ELT when they are visiting a site).
52. Manager Community Engagement and Partnerships to work collaboratively with local HSMs to ensure that consumers are nominated for awards (e.g., HNE Excellence awards, Sector awards, state awards and local awards) as relevant and appropriate.
53. Ensure that consumers are celebrated. This could include being provided with a Christmas card signed by the relevant ELT, or a cake for significant birthdays/milestones. Consideration also needs to be given to when a consumer passes and how this is acknowledged.

    These are to be coordinated by the Manager Community Engagement and Partnerships in conjunction with local HSMs.
54. LHC members are to be invited to an end-of-year celebration (e.g., lunch) and could potentially include other consumers who work collaboratively with the service.

    This is to be coordinated by the Manager Community Engagement and Partnerships in conjunction with the local HSMs.
55. LHCs to be offered light refreshments when they attend meetings.
56. Development and maintenance of a training register for LHCs, including topics and presenters. This is to be accessible between LHCs and will allow learnings, training and ideas to be easily shared.

    The training register is to be developed and maintained by the Manager Community Engagement and Partnerships and saved in a location for all LHCs to easily access (e.g., LHC SharePoint).
57. All buildings and rooms where LHCs are held are reviewed considering cultural safety, with recommendations as appropriate to assist in increasing cultural safety. Considerations could include:

    - displaying the Aboriginal flag.
    - copy of the HNE Health Sorry Statement and an Acknowledgement of Country in the LHC meeting room.
    - having culturally appropriate artwork and Aboriginal language on directional signage visible within the building/facility.

    Further clarification and advice are required from HNE Aboriginal Health.

    Review to be completed in consultation with HNE Aboriginal Health.
58. All buildings and rooms where LHCs are held are reviewed considering diversity. This is to ensure that the environment is welcoming. Some considerations could include wheelchair and pram-accessible facilities, breastfeeding rooms and unisex toilets.

    Further clarification and advice is required from the various HNE Disability and Inclusion sub-committees.

    Review to be completed in consultation with relevant HNE Disability and Inclusion committees.

# Recommendation 7: Supporting HSMs and services

## Strengthening LHCs - Guiding Principles

- Commitment to community.
- Collaborative partnerships.

## Literature

Managers in small health facilities are primarily nurses who have complex and multifaceted roles, requiring an intertwining of their clinical and managerial responsibilities [25]. This results in managers often being required to

prioritise clinical responsibilities over management tasks. This is often due to staffing issues, which can contribute to vacancies that have not been filled, and planned and unplanned leave.

According to the World Health Organisation, it was estimated that there will be a shortage of 7.2 million health workers to deliver healthcare services worldwide, and by 2035, the demand for nursing will reach 12.9 million. The inadequate supply of nurses has notably created many negative impacts on patients' health-related outcomes as well as challenges to fight diseases and improve health. This causes increased workload and stress levels on nurses, resulting in decreasing the quality of nursing care, threatening the safety of patients and increasing the patient mortality rate [26]. Considering this prediction, staff need support to not only ensure that services can continue to be provided, but to minimise the risk of "burn-out."

## Consultation

- The majority of HSM positions across HNE are registered nurses and/or midwives.
- Local HSMs do not have the capacity to prioritise LHCs due to competing demands (e.g., completing clinical shifts). Of the LHC delegates consulted where the LHC is continuing to meet, 56% of HSMs have recently completed clinical shifts due to not being able to fill the roster for shifts considered essential.

***"The Local Health Committee has been difficult to maintain with varying managers coming through".***

(LHC member)

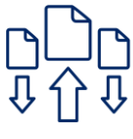
- HSMs report to value LHCs and attempt to prioritise actions relating to them.
- LHC members consistently acknowledged the significant workload that HSMs are responsible for completing and that the operation of clinical services is the priority for the HSM.

## Opportunities for improvement

- HSMs are often time-poor (e.g., completing clinical duties or filling rosters) and can find it difficult to support LHCs. This can result in:
    - HSMs experiencing difficulty coordinating and attending a meeting with the LHC chair to provide support to develop the meeting agenda.
    - LHC meeting documents are not routinely distributed with sufficient notice.
    - LHC meeting outstanding actions not being completed in a timely manner by the HSM.
    - LHC meetings being cancelled by the HSM with short notice (e.g., the day before or the morning of).
    - Difficulty or delay in scheduling meetings is resulting in members being provided with insufficient notice, or meetings not occurring.

***"Managers need to be accountable and follow through with actions".***

(LHC member)



### Recommendations

59. Manager Community Engagement and Partnerships to work with LHC chairs to develop the agenda and distribute this and the meeting documents in a timely manner to committee members.
60. Committees need to be supplied with all the meeting documents a minimum of 1 week in advance. This is to include the details of any guest speakers and their presentations, or the focus of the discussion. This will allow for the committee to have time to reflect and be able to engage in a meaningful discussion at the meeting.
61. Manager Community Engagement and Partnerships to support the local HSM and administration officer with the practicalities and any actions generated at the LHC meeting.

62. Manager Community Engagement and Partnerships regularly attends the LHC meeting to support the chair and therefore, allow LHC meetings to proceed if the local HSM is unable to attend.
63. Manager Community Engagement and Partnerships or Administration Officer to assist with the completion of minutes where there is no AO4 or consumer to complete. When the Administration Office is assisting with this, it may occur virtually.
64. As not all consumers have access to a computer and/or printer, the Manager Community Engagement and Partnerships or Administration Officer can assist with the coordination of printing documents for LHCs and ensure that committee members have access to these.

# Recommendation 8: Communicating with the community

## Strengthening LHCs - Guiding Principles

- Commitment to community.
- Collaborative partnerships.
- Committee members are advocates for health communities.

## Literature

Community engagement is founded on the relationships between the service and the community, and is based on effective two-way communication involving clear messages [27]. Engagement entails listening to local communities, and recognising the expertise in every community member and leader representing the community [28].

In addition to building relationships, it is essential to use strategies tailored to diverse audiences and shared by trusted individuals. Community groups can offer advice on appropriate messaging platforms and modes of communication relevant to their community, taking into account cultural preferences (e.g., various social media platforms, noticeboards, or newsletters). They can also provide guidance on the framing and tone of messages [27] [28] [29].

## Consultation

- All LHCs had consumers who were actively involved in other committees within their local community (e.g., Lions, Rotary, Red Cross, Pink Ladies, Hospital Auxiliary, Country Women's Association). This allows for easy information exchange between committees and across a community.

***"Committee members have tentacles in many places".***

(LHC member)

- All LHCs expressed the importance of knowing what services are available at their local hospital and community health service and how to access these. This information needs to be available in a variety of formats reflecting the varying needs across communities (e.g., brochure, flyer, social media). It was felt by LHCs that through the promotion and knowledge of services, that it would result in services being maintained due to referrals being continuously generated (e.g., "awareness of local services to ensure referrals so we don't lose it").
- The majority of LHCs hope that a process could be put in place with the SRC team, to allow LHCs to be promoted, positive stories from the community can be shared, and to assist with social media.
- The majority of LHCs acknowledged that they need to have a greater presence in the community and require assistance in promoting who they are, what they do, and how to contact them.
- In numerous rural communities, the local paper has ceased operating. Where this has occurred, LHCs consistently identified the need to have other ways to communicate with their community, and that this needs to occur "widely and broadly". In these communities, there is often a newsletter that is developed and distributed by the local community and in these communities, it is hoped that the LHC can regularly contribute.

- Numerous LHCs expressed frustration at the perceived inconsistencies in the approval process required by SRC for items to be circulated locally (e.g., newspaper, newsletter or social media), which is resulting in this not occurring. LHCs suggested that they "Need timely and consistent rules for approval" from SRC and "Need an easier process for approval of content".
- Some LHCs felt that since there had been no local newspaper that regularly included photos and stories of the hospital, there was limited promotion of the local health service in the community. The LHCs felt that this had resulted in a decrease in donations to the hospital.
- LHDs across the state are starting to use platforms external to health to assist with community engagement. This assists with ensuring diversity and allowing easier access for seldom heard community members.

***"…let people know about programs on what may assist their health and wellbeing".***

(LHC member)

## Opportunities for improvement

LHCs are a conjunct with their local community where they can facilitate two-way communication between health services and the community. This can be problematic due to community members not always knowing who the LHC are, or how to contact them. Likewise, LHCs can experience difficulty communicating with the community due to:

- Not all health services have their own social media accounts. LHCs aligned to a service without a social media account report to not be able to effectively communicate with their community. This is resulting in either communities not being informed, or committee members being creative in their use of social media. It is however acknowledged, that social media accounts can be time-consuming and at times, difficult to manage depending on what is occurring. It is acknowledged that HSMs are already time-poor and do not have the capacity to manage service specific accounts. It is also not considered appropriate for administration officers to be responsible for managing service social media accounts.
- When LHCs seek approval from SRC for documents to be shared within their community, LHCs report they can experience difficulty obtaining approval within a timely manner. This results in the item not being shared with the community due to losing relevance, or the LHC potentially not seeking approval due to past poor experience. Overall, it results in less information being shared with the community and the LHC and/or the HNE service not being promoted.
- Different communities have different needs regarding communication style. To ensure that the diverse needs of a community are heard, a multifaceted approach is required.

LHCs report that communities are not familiar with what services are available in their town, or how these are accessed (e.g., how to refer). This information is not readily available locally (e.g., leaflet or brochure) or on the HNE website. It is acknowledged that HealthPathways is an online platform providing localised clinical guidance for patient management and referral processes specific to a patient's journey within HNELHD. Although health professionals can access HealthPathways, the detailed information is not accessible to community members.

Consumers also find it difficult to know how to become involved in their local service (e.g., a LHC consumer). This is due to limited information locally or on the HNE website and consumers are not aware to look for Consumer Connect when searching the internet. Consumer Connect is also the last item on the page when 'consumer + HNE health' is searched in Google.

***"... building relationships and sharing information".***

(LHC member)

## Recommendations

65. Manager Community Engagement and Partnerships to work with LHC working party to develop and implement an updated report template that is easy to complete and includes photos. This is to be completed by each LHC at a minimum of annually, with an increase to frequency to be considered after consultation with LHCs.

    Reporting template to be easily adapted for various modes (e.g., social media, leaflet, newsletter, internet). This will allow for the report to be easily shared with the local community in the relevant and recommended mode.

    Manager Community Engagement and Partnerships to ensure that when reporting is being completed, the required processes are followed (e.g., completion and appropriate storage of NSW Health Consent Form: Video, Audio and Photography).

66. Development of a generic LHC email address. This email to be the primary means for contacting LHCs, which can be shared with communities. Any emails can be directed to the relevant LHC or service, without breaching the privacy of LHC consumers and sharing their personal email addresses. The generic email is to be monitored and actioned by the Manager Community Engagement and Partnerships.

67. Update details of LHCs on HNE website to include a photo of the committee.

    This to also includes the generic email to allow for LHCs to be contacted.

68. Manager Community Engagement and Partnerships can act as a conjunct with SRC to ensure approval is provided within a timely manner for information to be shared between LHCs and the community.

69. Manager Community Engagement and Partnerships to work collaboratively with SRC and LHCs to ensure communication with community is in a variety of modes (e.g., social media, flyer, newsletter), reflective of differing community needs.

70. In reviewing existing HNE service specific Facebook pages, it is evident that these are not regularly used (Appendix G: Facebook accounts aligned with HNE services/facilities). Creation of additional service specific social media accounts is not recommended. This is due to the additional administration requirements in to managing individual social media accounts so that the page has appropriate posts, and that posts are acknowledged appropriately.

    LHCs to utilise existing HNE social media accounts. This is to be done through a roster system where promotion for each LHC can be regularly completed, with additional use as appropriate. As required, targeting of specific social media posts to specific geographical areas can coordinated. This is to be coordinated by the Manager Community Engagement and Partnerships working in partnership with LHCs, HSMs and SRC.

71. HNE website is to be updated to include available services at each service. This includes referral pathways and contact details.

    SRC and HNE Recruitment to work collaboratively with services to complete this.

72. Local HNE services are to be guided by the community on the optimal way to communicate service specific information including referral pathways. It is acknowledged that this may need to be in a variety of modes (e.g., HNE website, flyers, televisions in waiting rooms) and may vary between communities.

73. To consider innovative ways of interacting with community that encourages engagement from a diverse population. An example of this is using a community engagement platform that includes an array of tools that consumers can connect with. Social Pinpoint is the Ministry of Health's preferred platform and has an approximate annual cost $30 000. Social Pinpoint is currently being used by Western and Murrumbidgee LHDs and being explored by others (Northern LHD), all of which are considered to be the leaders of community engagement across NSW.

    Social Pinpoint has the potential to allow consumers to be able to register interest in being a consumer at any time, while also providing a platform where consumers can be easily engaged to provide feedback for other documents (e.g., framework, redevelopments, policies, flyers). It is a tool that can be used by all teams across the LHD (e.g., acute, community, mental health, health infrastructure) as it has the potential to engage with a wide demographic of consumers including young people and seldom heard consumers who can be traditionally difficult to engage.

# Conclusion and next steps

## Implementation Process

Existing LHCs will be supported through the implementation of approved recommendations, and this will continue moving into the future. Where communities are not currently represented on a LHC, recommendations will be implemented with the hope of allowing communities across the LHD to have the opportunity to actively engage with HNE.


- Completion of recruitment of Manager Community Engagement and Partnerships position.
- Strengthening Local Health Committees across Hunter New England Local Health District report to be tabled at August HNE ELT and HNE Board meetings for review.
- Formation of LHC working party.
- Support reestablishment of LHCs who have expressed interest.
- Ensure consumers are celebrated and acknowledged.
- Work with SRC to update LHC page on HNE website.
- Feedback to LHCs regarding report and recommendations.
- Development of draft LHC supporting documents
- Support representation of LHCs at Annual Public Meeting.
- Complete consultation with LHCs to timetable LHC meetings for following year.
- Commencement of recruitment of Administration Officer position.

- Develop and implement LHC evaluation tool.
- Transition of LHC meeting documents to SharePoint.
- Develop process to update and maintain education register.
- Implementation of LHC supporting documents.
- Commence drafting of HNELHD Guideline and Procedure
- Support the reestablishment of LHCs in Northwest.
- Support the reestablishment of LHCs in the majority of Lower Mid North Coast
- Continue to support existing LHCs.
- Commence bi-monthly reporting to review mandatory training requirements.

- Continue to support reestablishment of LHCs.
- Continue to support existing LHCs.
- Continue to embed standardisation and processes across all LHCs.
- Commence bi-monthly reporting to review mandatory requirements (e.g., vaccination, NCRC, WWCC).

Refer to Appendix F: Proposed Implementation Process for additional information. It is acknowledged that many actions are dependent on others and work being completed by committees and that although every attempt will be made to adhere to the proposed timeframes, these will continually be reviewed and updated as required.

## Reporting and Monitoring

Manager Community Engagement and Partnerships to draft an evaluation tool and assist with implementation of this across all LHCs. This is to be timed in alignment with the frequency of other meetings being evaluated at the service (e.g., February). The evaluation tool to explore participation considering the International Association of Public Participation (IAP2).

### Local
Formal reporting requirements with local managers, senior HNE Managers, and General Managers are to be refined and reviewed as the organisational restructure continues to evolve.

### District
The LHCs report (a minimum of annually) to the HNE Community and Patient Partnership Committee meeting, a sub-board committee. This is reporting is currently occurring for a XXX This update is to also be shared with HNE ELT. Reporting is to be coordinated and completed by the Manager Community Engagement and Partnerships.

The same reporting template can also be provided to relevant Partnering with Consumer Committees for their information. This reporting line can be displayed on any relevant organisation charts through a dotted line.

Manager Community Engagement and Partnerships to continue to report annually to the District Partnering with Consumers Committee, as detailed in the committees' action plan. This to include progress of the implementation of the recommendations detailed throughout the report.

### State
Six monthly reports are required to the Regional Health Division, Ministry of Health. This is to be completed by the Manager Community Engagement and Partnerships.

# Governance and Supporting Documents

## Australian Commission on Safety and Quality in Healthcare

- National Safety and Quality Primary and Community Healthcare Standards: National Standard 2 Partnering with Consumers recognises the importance of working with consumers in the planning and delivery of their own health care, and providing clear communication to minimise risks of harm.

## NSW Health Policy, Procedures and Guidelines

- Aboriginal Health Impact Statement PD2017_034 aims to ensure NSW Health staff incorporate the health needs and interests of Aboriginal people in the development of new and revised health policies, programs and strategies.
- Communications - Use & Management of Misuse of NSW Health Communications Systems PD2009_076 Provides guidance and direction about the mechanisms required to minimise inappropriate use and the controls required to monitor the use of NSW Health communications systems and devices.
- Consumer and Community Representative Selection - Guidelines - NSW Department of Health provides details on the selection and recruitment of consumer and community representatives to NSW Health committees.
- Consumer, carer and community member remuneration GL2023_016 sets out NSW Health's commitment to remuneration and reimbursement of consumers, carers and community members for their time and contributions to agreed engagement activities. It guides circumstances where payments will be made, the rates of payment and the methods of payment.
- Consumers Representatives - Working with Consumers in NSW Health, Guidelines for Secretariat GL2005_043 provides guidelines for the secretariat of Ministry of Health committees to support consumer representatives appointed to committees.
- NSW Government Social Media Guidelines
- NSW Aboriginal Health Plan 2013 – 2023 PD2012_066 10 year plan, developed in partnership with the Aboriginal Health and Medical Research Council sets the framework using six key strategic directions to Close the Gap in Aboriginal health outcomes by spreading responsibility for achieving health equity for Aboriginal people in NSW, across all NSW Health operations.

- NSW Health Code of Conduct PD2015_049 sets standards of ethical and professional conduct in NSW Health
- Occupational Assessment, Screening and Vaccination Against Specified Infectious Diseases PD2023_022 provides a framework for the assessment, screening and vaccination of all workers and students to reduce the risk associated with vaccine-preventable diseases in accordance with the risk category of their position.

# HNE Health Policy, Procedures and Guidelines

- Development/Review and Approval of Written Consumer Information Resources HNELHD GandP 20_08 Describes how the development/review and approval of written consumer information resources is governed in HNE Health. Please note, that clinical forms that need to be stored as part of the patient health record are excluded.
- Digital Media use for or on behalf of HNE Health HNELHD Pol 23_05 in conjunction with the HNE Health Digital Framework directs the use of digital mediums to communicate HNE Health messages to both internal and external audiences.
- Education Framework HNELHD Pol 22_01 Promotes the education and training infrastructure required to build and maintain workforce capability through a culture of learning to support patient and family centred care.
- Implementing the Partnering with Consumers Framework HNELHD Pol 22_07:PCP 1 provides information, tools and resources to implement the core components of the Partnering with Consumers Framework and to support the effective management of Partnering with Consumer committees at various levels within HNE Health.
- Partnering with Consumers Framework HNELHD Pol 22_07 outlines the core components required to support partnering with Consumers at patient, service and organisational levels.
- Recruitment, Onboarding and Orientation of Consumers HNELHD GandP 20_11 outlines planning, recruitment and orientation requirements for Hunter New England Local Health District (HNELHD) staff partnering with consumers at the service/program level and at the organisational level.
- Staff Responsibility when using Social Media/Networking for Personal and Professional Use PD2015_049:PCP 1 describes the responsibilities of staff when using social networking sites/social media for personal and professional use.

# NSW Health Frameworks, Guides and Reports

- All of us: engaging consumers, carers and communities across NSW Health is a high-level guide to respectful engagement.
- Elevating the Human Experience: Our guide for patient, family, carer, volunteer and caregiver experiences
- NSW Regional Health Strategic Plan 2022 – 2032
- Strengthening local health committees in regional NSW discusses community engagement through LHCs. It presents the findings of a review and guiding principles to strengthen LHCs in regional NSW.
- Strengthening local health committees in regional NSW – Addendum

# HNE Health Frameworks and Guides

- HNE Digital Framework was developed to guide the use of all digital mediums for communicating district messages to both internal and external audiences.
- HNE Framework for Partnering with Consumers, provides a conceptual framework and outlines HNE Health's approach to partnering with patients, their families and our communities more broadly.
- HNE Orientation Guide for Consumer Representatives provides an orientation package for new consumer representatives.

# Resources

- Co-design toolkit – Agency for Clinical Innovation
- Partnership foundations – Agency for Clinical Innovation

- ‘Unique and essential’: a review of the role of consumer representatives in health decision-making. Consumers Health Forum of Australia. (2015)
- Consumer and Community Rep Selection Guidelines.pdf (seertechsolutions.com.au)
- ACI-Aboriginal-Framework.pdf (seertechsolutions.com.au)
- Whole of Health Program (nsw.gov.au)
- Consumers Health Forum of Australia | Consumers Shaping Health (chf.org.au)
- Community engagement: a health promotion guide for universal health coverage in the hands of the people
- Health matters: community-centred approaches for health and wellbeing (2018)
- International Association for Public Participation

# Glossary of terms

| Term | Definition |
|---|---|
| **Aboriginal** | Within this document, the term 'Aboriginal' has been used to refer to people who identify as Aboriginal, Torres Strait Islander, or both Aboriginal and Torres Strait Islander. This has been done because the people indigenous to NSW are Aboriginal and we respect that many Aboriginal people prefer the term 'Aboriginal'. We also acknowledge and respect that many Aboriginal NSW Australians prefer to be known by their specific language group(s) or First Nations people. |
| **Consumer/community representative** | People who use, have used, or are potential users of health services. While some consumers have formal roles (such as being a Consumer Representative or Patient Leader), others do not and may not want to. All perspectives are valuable, and no one can represent all consumer perspectives. Different people and services might use terms such as: patients, clients, users, service users and residents [5]. |
| **Carer** | A person who provides care and support to a family member, friend or as part of a kinship system. Consumers and carers are different people with different perspectives |
| **Community** | A group or groups of people or organisations who share common local or regional interests or characteristics. These may include but are not limited to culture, language, religion, beliefs, geographic location, gender or profession. Individuals may identify with more than one community and may represent various interests [5]. |
| **Consumer Connect** | Consumer Connect is a platform for consumers to engage in health and medical projects, research, and services. Consumer Connect aims to help consumers join health and research teams as easily as possible, to improve health services and patient outcomes.<br>Join our consumer registry – NSW Regional Health Partners |
| **Engagement** | Consumers, carers or communities taking part in the planning, design, delivery, measurement and evaluation of systems and services. There are different levels of engagement |
| **Engagement activity** | Specific ways that consumers, carers and communities take part. Here are a few examples: co-design, service design, research, hospital redevelopments, policy, strategy and reform. |
| **Lived or living experience** | The knowledge you get when you have lived or are living through something. For example, a person with lived experience of mental illness brings their understanding and knowledge from their direct experience |
| **Local health committee** | Local health committees is a universal term used to describe the health service managed community group or local community engagement and health advocacy.<br>Local health committees offer formal opportunities for the community to provide input into local health services. It is the body/group supporting local community engagement and health advocacy in a regional local health district [5]. |
| **Safety** | Safety can be physical, emotional, legal and cultural. No one should be harmed by their experience of engagement. |
| **Volunteering** | Volunteering is defined as 'activities taking place for the benefit of communities, and the volunteer, and is conducted of the volunteer's own free will for no financial payment in designated volunteer positions'. (Volunteers - Engaging, Supporting and Managing Volunteers (nsw.gov.au)) |

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# Appendices

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# Appendix A: Consultation with LHCs

| Consultation with LHCs | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Sector | Local Health Committee | Consultation LHC Delegate (Virtual or face-to-face) | | Consultation with LHCs (Face-to-face) | | | | |
| | | Date | Position | Date | Number of consumers | | Number of staff* | |
| | | | | | Attended | On LHC | Attended | On LHC |
| Hunter Valley | Denman | 08/11/2023 | Denman MPS HSM Administration Officer | | | | | |
| Hunter Valley | Merriwa | 08/11/2023 | Merriwa MPS HSM | 31/01/2024 | 2 | 6 | 3 | 4 |
| Hunter Valley | Murrurundi | 06/03/2024 | Scone HSM/ Murrurundi Acting HSM | Not completed | 0 | 4 | 0 | 4 |
| Hunter Valley | Muswellbrook | 15/11/2023 | Muswellbrook Hospital HSM | | | | | |
| Hunter Valley | Scone | 06/03/2024 | Scone HSM/ Murrurundi Acting HSM | 06/03/2024 | 4 | 5 | 3 | 4 |
| Hunter Valley | Singleton | 07/11/2023 | Singleton Hospital HSM | 11/04/2024 | 3 | 7 | 4 | 4 |
| Lower Mid-North Coast | Forster | 07/12/2023 | Forster Community Health HSM | 04/04/2024 | 3 | 7 | 4 | 4 |
| Lower Mid-North Coast | Taree-Manning | 31/10/2023 | LMNC Quality Coordinator | 13/03/2034 | 5 | 9 | 4 | 6 |
| Mehi | Moree | 04/12/2023 | Acting Moree Hospital HSM | 07/02/2024 | 0 | 4 | 3 | 3 |
| Mehi | Narrabri | 27/11/2023 | Narrabri Community Health HSM | 05/03/2024 | 2 | 5 | 2 | 3 |
| Mehi | Warialda | 01/11/2023 | Warialda MPS HSM | 04/04/2024 | 6 | 7 | 2 | 2 |
| Peel | Barraba | 21/11/2023 | Barraba MPS HSM | 02/04/2024 | 5 | 5 | 1 | 2 |
| Peel | Gunnedah | 13/11/2023 | Gunnedah Hospital HSM | 05/03/2024 | 1 | 3 | 2 | 2 |
| Peel | Manilla | 13/11/2023 | Manilla MPS HSM | 05/03/2024 | 6 | 7 | 2 | 2 |
| Peel | Nundle | 29/11/2023 | Tamworth/Nundle Community Health HSM | 06/02/2024 | 4 | 6 | 3 | 3 |
| Peel | Walcha | 27/11/2023 | Acting Walcha MPS HSM | 21/02/2024 | 4 | 4 | 3 | 2 |
| Peel | Werris Creek | 20/12/2023 | Werris Creek MPS HSM | | | | | |
| Tablelands | Armidale | 10/01/2024 | Armidale Hospital DON and Deputy DON | | | | | |
| Tablelands | Vegetable Creek - Emmaville | 01/11/2023 | Vegetable Creek – Emmaville MPS HSM | 01/02/2023 | 4 | 6 | 2 | 3 |
| Tablelands | Glen Innes | 04/12/2023 | Glen Innes Hospital HSM | | | | | |
| Tablelands | Guyra | 11/01/2024 | Guyra MPS HSM | | | | | |
| Tablelands | Inverell | 07/11/2023 | Inverell Hospital HSM and Inverell LHC Chair | 21/02/2024 | 3 | 4 | 4 | 4 |
| Tablelands | Tenterfield | 27/10/2023 | Tenterfield HSM | Not completed | 0 | 6 | 0 | 2 |
| Greater Newcastle | Port Stephens | 19/03/2024 | Facility & Clinical Integration Manager | 27/03/2024 | 5 | 9 | 5 | 7 |

| Consultation with LHCs | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Sector | Local Health Committee | Consultation LHC Delegate (Virtual or face-to-face) | | Consultation with LHCs (Face-to-face) | | | | |
| | | Date | Position | Date | Number of consumers | | Number of staff* | |
| | | | | | Attended | On LHC | Attended | On LHC |
| | | | Raymond Terrace and Karuah HealthOne | | | | | |
| | | | | **Total** | **57** | **104** | **47** | **61** |

| Virtual consultation offered to LHCs | | | |
|---|---|---|---|
| Date | Number of people registered | Number of consumers | Number of staff* |
| 15/04/2024 | 4 | 0 | 1 |
| 16/04/2024 | 3 | 0 | 0 |
| 17/04/2024 | 0 | 0 | 0 |

*includes local HNE staff (e.g., Sector General Manager, Hospital HSM, Community Health HSM, clinician, administration officer, Aboriginal Health Worker/Practitioner, Aboriginal Health Liaison Officer, Aboriginal Health Coordinator) but excludes Community Partnership and Engagement Manager)

# Appendix B: Consultation with key stakeholders

| Consultation with key stakeholders | | | |
|---|---|---|---|
| | **Service/Organisation** | **Position** | **Date consultation completed** |
| Internal to HNE Health | Belmont Partnering with Consumers Committee | Belmont Quality & Safety Manager | 31/10/2023 |
| | District Allied Health | Allied Health Manager: NDIS, Disability and Clinical Quality and Improvement | 21/12/2023 |
| | HNE Aboriginal Health | Aboriginal Health Coordinator, Tablelands and Peel Sector | 11/12/2023 |
| | | Aboriginal Health Coordinator - Greater Newcastle Sector | 12/12/2023 |
| | | Aboriginal Health Coordinator, Hunter Valley and Lower Mid North Coast | 24/01/2023 |
| | | Acting Program Manager: Aboriginal Health Performance Improvement Program | 24/01/2023 |
| | HNE Aged Care and Rehabilitation Services | ACARS Clinical Network Manager | 13/11/2023 |
| | HNE Children Young People and Families Advisory Committee | Children, Young People and Families Services Network Manager | 30/11/2023 |
| | HNE Drug and Alcohol Clinical Services | District Manager Drug and Alcohol Clinical Services | 29/11/2023 |
| | HNE Financial Services | Acting Manager, Management Accounting | 29/05/2024 |
| | HNE Internal Audit and Corporate Services | Privacy and Right to Information Officer | 16/04/2024 |
| | HNE ICT Records, Privacy & Information Security | HNE Cyber Security Manager | 29/04/2024 |
| | HNE Information Communications & Technology Infrastructure & Operations, Service Delivery | ICT Support Analyst | 03/04/2024 |
| | HNE Mental Health | Participation Manager - Lived Experience | 29/11/2023 |
| | HNE Multicultural and Refugee Health | Service Manager, Multicultural and Refugee Health | 07/11/2023 |
| | HNE Oral Health | District Manager Oral Health | 28/11/2023 |
| | HNE Violence Abuse and Neglect | District Manager Violence Abuse and Neglect | 08/11/2023 |
| | HNE Workforce Operations People and Culture | Consultant | 09/04/2024 |
| | John Hunter Hospital Partnering with Consumers Committee | Quality Manager/Executive Support \| John Hunter Hospital | 02/11/2023 |
| | NSW Regional Health Partners Consumer Connect | Consumer Engagement Officer, NSW Regional Health Partners | 21/11/2023 |

| Consultation with key stakeholders | | | |
|---|---|---|---|
| | **Service/Organisation** | **Position** | **Date consultation completed** |
| | Peel Sector Partnering with Consumers Committee | | 17/04/2024 |
| | | Peel Sector Quality Manager | 20/11/2023 |
| External to HNE Health | Aboriginal community members – Armidale | 4 community members including 3 Aboriginal Elders | 27/02/2024 |
| | Central Coast LHD | Manager Consumer and Carer Engagement | 22/09/2023 |
| | Glen Innes Community Members | 4 community members who were engaged as LHC members, but a meeting has not been held. | 18/04/2024 |
| | Inverell Health Forum | Committee comprised of 12 consumers and administration officer from Inverell Council as secretary | 10/04/2024 |
| | Murrumbidgee LHD | Manager Executive Services – Communications | 08/11/2023 |
| | Northern NSW LHD | Community Engagement Manager | 28/09/2023 |
| | Tamworth Aboriginal Medical Service | Chief Executive Officer or delegate | 20/03/2024 |
| | Ungooroo Aboriginal Corporation | Chief Executive Officer or delegate | 11/04/2024 |
| | Western NSW LHD | Community Engagement Lead | 28/09/2023 |

| Consultation offered with other key stakeholders who declined/did not respond to offer to participate | | |
|---|---|---|
| | **Service/Organisation** | **Position** |
| Internal to HNE Health | HNE Aboriginal Health | Aboriginal Health Coordinator, Mehi |
| External to HNE Health | Armajun Aboriginal Health Service | Chief Executive Officer or delegate |
| | Awabakal Ltd | Chief Executive Officer or delegate |
| | Biripi Aboriginal Corporation Medical Centre | Chief Executive Officer or delegate |
| | Hunter New England and Central Coast Primary Health Network | Executive Manager, People, Operations and Engagement or delegate |
| | Pius X Aboriginal Corporation | Chief Executive Officer or delegate |
| | Tobwabba Aboriginal Medical Service Incorporated | Chief Executive Officer or delegate |
| | Walhallow Aboriginal Health Corporation | Chief Executive Officer or delegate |

# Appendix C: Location of LHCs across HNELHD

# Appendix D: Proposed LHCs considering Modified Monash

| Location within HNE | Modified Monash Category | Existing LHC | Proposed LHC considering Modified Monash Category | Comment |
|---|---|---|---|---|
| Armidale | 3 | ✗ | ✓ | Community and local management interested in re-establishing LHC |
| Ashford | 5 | ✗ | ✗ | Outreach from Inverell |
| Barraba | 5 | ✓ | ✓ | |
| Belmont | 1 | ✗ | ✗ | |
| Bingara | 5 | ✗ | ✓ | |
| Boggabilla | 4 | ✗ | ✓ | Community access to Goondiwindi Hospital for acute services. |
| Boggabri | 5 | ✗ | ✓ | |
| Bulahdelah | 5 | ✗ | ✓ | |
| Bundarra | 5 | ✗ | ✓ | |
| Cessnock | 3 | ✗ | ✓ | Community interested in re-establishing LHC combined with Kurri Kurri, but not HNE management. |
| Denman | 5 | ✗ | ✓ | Local management interested in re-establishing LHC. |
| Dungog | 5 | ✗ | ✓ | |
| Forster | 3 | ✓ | ✓ | |
| Glen Innes | 4 | ✗ | ✓ | Community and local management interested in re-establishing LHC. |
| Gloucester | 5 | ✗ | ✓ | |
| Gunnedah | 4 | ✓ | ✓ | |
| Guyra | 5 | ✗ | ✓ | Community and local management interest in re-establishing LHC |
| Hawks Nest - Tea Gardens | 5 | ✗ | ✓ | Consideration to be included in Port Stephens LHC |
| Inverell | 4 | ✓ | ✓ | |
| Kurri Kurri | 1 | ✗ | ✓ | Community interested in re-establishing LHC combined with Cessnock, but not HNE management |
| Maitland | 1 | ✗ | ✗ | |
| Manilla | 5 | ✓ | ✓ | |
| Merriwa | 5 | ✓ | ✓ | |
| Moree | 4 | ✓ | ✓ | |
| Mungindi | 6 | ✗ | ✓ | |
| Murrurundi | 5 | ✓ | ✓ | |
| Muswellbrook | 4 | ✗ | ✓ | Local management interested in re-establishing LHC |
| Narrabri | 4 | ✓ | ✓ | |
| Nelson Bay | 4 | ✓ | ✓ | Included in Port Stephens LHC |
| Newcastle | 1 | ✗ | ✗ | |
| Nundle | 5 | ✓ | ✓ | |
| Premer | 5 | ✗ | ✗ | Outreach services are provided by Quirindi Community Health. |

| Location within HNE | Modified Monash Category | Existing LHC | Proposed LHC considering Modified Monash Category | Comment |
|---|---|---|---|---|
| Quirindi | 5 | ✗ | ✓ | |
| Raymond Terrace | 1 | ✓ | ✓ | Included in Port Stephens LHC and anticipated to continue. |
| Scone | 5 | ✓ | ✓ | |
| Singleton | 4 | ✓ | ✓ | |
| Tamworth | 3 | ✗ | ✓ | |
| Taree | 3 | ✓ | ✓ | |
| Tenterfield | 5 | ✓ | ✓ | |
| Tingha | 5 | ✗ | ✓ | Suggestions of combining with Inverell LHC. |
| Toomelah | 4 | ✗ | ✓ | Community access Goondiwindi Hospital for acute services. |
| Toronto | 1 | ✗ | ✗ | |
| Uralla | 5 | ✗ | ✓ | |
| Vegetable Creek - Emmaville | 5 | ✓ | ✓ | |
| Walcha | 5 | ✓ | ✓ | |
| Warialda | 5 | ✓ | ✓ | |
| Wee Waa | 5 | ✗ | ✓ | Have a different forum/committee. Require advice regarding this. |
| Werris Creek | 5 | ✗ | ✓ | |
| Wingham | 3 | ✗ | ✓ | |

# Appendix E: Approximate costings for facilitating LHCs

| Annual LHC Meeting Costs | |
|---|---|
| **Salaries** | |
| Administration Officer (Level 4) | $78 614 |
| Health Service Manager (Level 3) | $160 491 |
| | |
| **Goods and Services** | |
| Travel | $5 000 |
| Cost with social media targeting | $1 000 |
| Social Pinpoint | $30 000 |
| Annual cost associated with end of year celebrations and acknowledgement for each LHC | $200* |
| | |
| **Mandatory training** | |
| Remuneration for consumers completing mandatory training for 2.5 hours at $40. This is estimated to be 3 consumers annually considering recruitment and retention of consumers to LHC. | $300** |
| **Total** | **$275 105** |

| Per LHC Meeting Cost | |
|---|---|
| **Item** | **Cost for 1 hour meeting** |
| Refreshments | $20 |
| Printing | $10 |
| Remuneration for 1 consumer chair | $60 |
| Remuneration for 5 consumers*** at $40 hour | $200 |
| **Total** | **$290** |

| Overall costs of facilitating LHCs | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Number of LHCs** | **1** | **18** | **20** | **25** | **30** | **35** | **40** |
| Annual costs | $275 305 | $287 705 | $279 105 | $280 105 | $281 105 | $282 105 | $283 105 |
| Mandatory training | $300 | $5 400 | $6 000 | $7 500 | $9 000 | $10 500 | $12 000 |
| Meeting costs *** | $1 740 | $31 320 | $34 800 | $43 500 | $52 200 | $60 900 | $69 600 |
| **Total** | **$277 345** | **$324 425** | **$31 9905** | **$331 105** | **$342 305** | **$353 505** | **$364 705** |

*not included in total of annual meeting costs but included in overall costs of facilitating LHCs.

**LHC currently have an average of 6 consumers.

***meeting bi-monthly (6 meetings annually).

# Appendix F: Current Manager Community Engagement and Partnerships Position Description

## Role Description

*The role description should be no more than 3-4 pages*

NSW GOVERNMENT Health

## Community Engagement and Partnerships Manager

| | |
|---|---|
| **Cluster** | **NSW Health** |
| **Local Health District / Agency** | **Hunter New England Local Health District** |
| **State Award** | *Health Managers (State) Award* |
| **Position Classification** | *Health Manager Level 3* |
| **Category** | **Must match StaffLink & will be updated by Recruitment** |
| **Vaccination Category** | **Pulls from Stafflink** |
| **ANZSCO Code** | **Pulls from Stafflink** |
| **Agency Website** | **www.health.nsw.gov.au** |
| **StaffLink Position Number** | *Enter number here* |
| **Does this role have management responsibilities?** | *No* |

### Primary Purpose

*A concise summary of the primary purpose of the role, answering the question: 'Why does this role exist?' The role purpose should be no more than 3-4 lines*

The Community Engagement and Partnerships Manager provides leadership to support the implementation and maintenance of Consumer and Community Participation strategies and processes across the Hunter New England Local Health District, with a particular focus on strengthening the role of Local Health Committees across the organisation. Community involvement in local health decision making plays a vital role in keeping people healthy, particularly in our rural and regional communities. The position will be an advocate for these communities and design and implement a Local Health Committee model that engages local communities to play a key role in the design and delivery of local health services.

NSW GOVERNMENT

1

## Key Accountabilities

*Key Accountabilities' should be:*

1. *Outcome focused, rather than process focused,*
2. *Ordered according to what is most important/ critical for the success of the role*
3. *As specific to the role as possible while not detailing tasks.*

*There should be a maximum of 8 **'Key Accountabilities' in total.***

- Provide leadership and facilitate the processes and strategies for Consumer and Community Participation across the District.
- Develop the District's response to the Strengthen Local Health Committee report. This will include:
  - Community and staff consultation across the District to gather feedback and insights into Local Health Committee operations
  - Recommending and developing an appropriate structure/s and activities for Local Health Committees within Hunter New England Health
  - Developing resources and guidelines to support the effective running of Local Health Committees.
- Work closely with relevant staff and the community to increase knowledge and skills in Consumer and Community Participation.
- Build capacity and provide ongoing support for a culture of consumer and community involvement in health services.
- Participate on relevant committees, working parties and other forums, both at the LHD and state level as required.
- Assist in training and knowledge transfer about consumer engagement and partnerships as required.

**Mandatory Key Accountabilities:**

Act in accordance with the HNE Health Values Charter and NSW Health Code of Conduct; model behaviours that reflect the Excellence Framework (Every Patient, Every Time) and ensure work is conducted in a manner that demonstrates values of cultural respect in accordance with HNE Health's Closing the Gap strategy.

All staff are expected to take reasonable care that their acts and omissions do not adversely affect the health and safety of others, that they comply with any reasonable instruction that is given to them and with any policies/procedures relating to health or safety in the workplace that are known to them, as well as notifying any hazards/risks or incidents to their managers.

## Key Challenges

*No more than three (3) Key Challenges. This should describe the complexities the role is expected to manage, rather than business as usual activities.*

*'Key Challenges' inform job evaluation and are an important consideration when selecting the capability levels required for the role.*

*Key Challenges should not re-state the role's Key Accountabilities i.e. role outcomes. Instead, they should describe specific complexities and explain why these are challenging.*

Capacity building – engaging community members and staff in order to implement programs that are person centred and sustainable across the diversity of our organisation and communities.

Establish collaborative and influential relationships with stakeholders, consumers and colleagues, to ensure effective achievement of a revised Local Health Committee and Consumer Engagement structure.

Stakeholder management - managing multiple stakeholders with varying priorities and viewpoints.

## Key Relationships

*The key stakeholders and customers the role is expected to interact with routinely, rather than periodically and why.*

| Who | Why |
|---|---|
| **Internal** | |
| Manager | • To set strategy and deliverables, provide updates, escalate issues and measure performance |
| Relevant Executive Team Members | • To work collaboratively to gain insight and guidance for appropriate models and strategies that deliver benefits to their portfolios |
| General Managers and HSMs | • To develop strategies and solutions for Local Health Committees that meet the needs of services and communities locally, as well as more broadly across the District |
| **External** | |
| Community / Consumer representatives | • Understand needs, viewpoints and gain feedback to assist with the development of appropriate and consumer friendly strategies |
| Rural and Regional Health Division of the Ministry | • To develop strategies and solutions that deliver on the Strengthening Local Health Committee Report recommendations. |

## Essential Requirements

1. *Qualifications or certifications (where necessary to practice)*
2. *licensing/registration requirements and Security and other clearances*

Expert understanding of the field of consumer engagement, partnerships and co-design for improvement, and experience in creating and maintaining effective relationships with consumers.

A strong understanding of rural and regional communities and the challenges they face.

Experience or relevant qualification in either consumer engagement, health service delivery or project management would be favourable but not mandatory.

## Selection Criteria

*Selection Criteria be limited to 8 and Knowledge and experience that:*

- *are critical for successful performance in the role,*
- *cannot be met by transferable capabilities demonstrated in other roles,*
- *cannot be developed 'on the job' within a reasonable period of time.*

*Other industry specific knowledge and experience can be screened for through targeted questions during recruitment.*

1. Demonstrated experience in providing high level administrative and project coordination and support to projects in a large and complex organisation.
2. Highly developed analytical skills including the ability to analyse and interpret information, prepare written reports, deal with challenges creatively and achieve business focused solutions.
3. Excellent oral and written communication skills with proven engagement, collaboration and negotiation skills and the demonstrated ability to build, maintain and use relationships with stakeholders.
4. Highly developed organisational, planning and time management skills and experience working in a high volume and demanding professional environment with a capacity to prioritise competing demands and achieve results with a customer focused approach.
5. Proven effectiveness as a team player including a flexible, highly driven, self-motivated approach to work and a capacity to participate in a team to drive organisational development initiatives.

*PLEASE NOTE: Candidates do not need to respond to all selection criteria as part of the application process. Criteria can be utilised to assess the candidate during any part of the selection process such as resume review, interview, and reference checks*

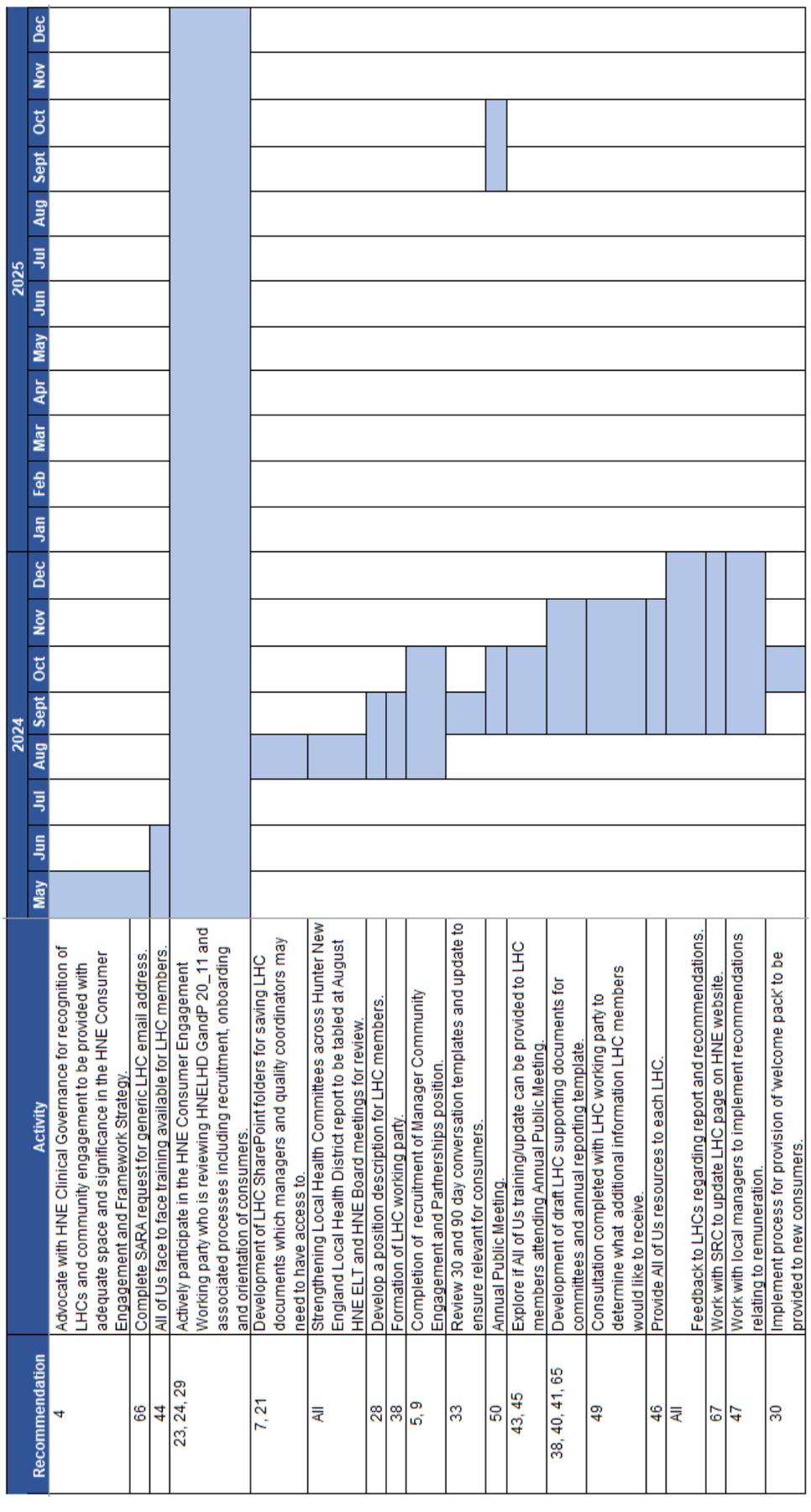
# Appendix G: Facebook accounts aligned with HNE Health

| HNE Service Specific Facebook Pages | | | | |
|---|---|---|---|---|
| **Name of Facebook Account** | **Use shown through the number of posts on the page** | | **Followers** | **Comment** |
| | **Use in 2022** | **Use in 2023** | | |
| Hunter New England Local Health District | 829 | 471 | 105 000 | In 2022 there were a significant number of COVID-19 updates. |
| Hunter New England Health Job | 631 | 1 561 | 24 000 | |
| HNEkidshealth | 288 | 308 | 16 000 | |
| Good for Kids HNE Health | 12 | 56 | 307 | |
| HNE Aboriginal Health Unit | 249 | 59 | 1100 | |
| Warialda MPS Local Health Committee (Community organisation) | 92 | 103 | 903 | The account is primarily focused on MPS residents and facilities and not LHC. |
| Wee Waa Community Hospital (Health and Medical) | 31 | 20 | 878 | |
| Boggabri MPS (government organisation) | 9 | 9 | 366 | |
| Bingara MPS Local Health Committee (community) | 19 | 11 | 668 | |
| Narrabri District Health Service (community) | 51 | 8 | 1700 | 2022 posts primarily focused on updates relating to COVID. |
| Denman Hospital – MPS | 73 | 55 | 799 | Has 'community guidelines' on 22 June 2020 which detail the expectations of using the page. |

*Unofficial Facebook Pages which were created because people on Facebook have shown interest in the health service/department and are not affiliated with or endorsed by anyone associated with the service. They were therefore not included in the review.

| Hospital Auxiliaries aligned with HNE Health Services | | | | |
|---|---|---|---|---|
| **Name of Facebook Account** | **Use shown through the number of posts on the page** | | **Followers** | **Comment** |
| | **Use in 2022** | **Use in 2023** | | |
| Mungindi Hospital Auxiliary (Community service) | 0 | 0 | 217 | The most recent post appears to be October 12, 2020. |
| Tamworth Hospital Auxiliary (Nonprofit organisation) | 0 | 314 | 59 | The first post is April 20, 2023. |
| Vegetable Creek MPS Emmaville Hospital Auxiliary (Charity Organisation) | 9 | 16 | 482 | |
| Emmaville MPS Auxiliary Views and News (Community) | 0 | 4 | 75 | |
| Tomaree Community Hospital Auxiliary (Nonprofit organisation) | 23 | 32 | 99 | First post 25 June 2022. |
| Walcha Hospital Auxiliary (Nonprofit organisation) | 0 | 8 | 14 | First post 27 October 2023. |
| Singleton Hospital Auxiliary - United Hospital Auxiliaries (Hospital) | 5 | 28 | 209 | |

# Appendix H: Proposed Implementation Process



| Recommendation | Activity |
|---|---|
| 4 | Advocate with HNE Clinical Governance for recognition of LHCs and community engagement to be provided with adequate space and significance in the HNE Consumer Engagement and Framework Strategy. |
| 66 | Complete SARA request for generic LHC email address. |
| 44 | All of Us face to face training available for LHC members. |
| 23, 24, 29 | Actively participate in the HNE Consumer Engagement Working party who is reviewing HNELHD GandP 20_11 and associated processes including recruitment, onboarding and orientation of consumers. |
| 7, 21 | Development of LHC SharePoint folders for saving LHC documents which managers and quality coordinators may need to have access to. |
| All | Strengthening Local Health Committees across Hunter New England Local Health District report to be tabled at August HNE ELT and HNE Board meetings for review. |
| 28 | Develop a position description for LHC members. |
| 38 | Formation of LHC working party. |
| 5, 9 | Completion of recruitment of Manager Community Engagement and Partnerships position. |
| 33 | Review 30 and 90 day conversation templates and update to ensure relevant for consumers. |
| 50 | Annual Public Meeting. |
| 43, 45 | Explore if All of Us training/update can be provided to LHC members attending Annual Public Meeting. |
| 38, 40, 41, 65 | Development of draft LHC supporting documents for committees and annual reporting template. |
| 49 | Consultation completed with LHC working party to determine what additional information LHC members would like to receive. |
| 46 | Provide All of Us resources to each LHC. |
| All | Feedback to LHCs regarding report and recommendations. |
| 67 | Work with SRC to update LHC page on HNE website. |
| 47 | Work with local managers to implement recommendations relating to remuneration. |
| 30 | Implement process for provision of 'welcome pack' to be provided to new consumers. |

| Recommendation | Activity | 2024 | | | | | | | | 2025 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec |
| 33 | Implement process to implement 30 and 90 day conversations with new consumers. | | | | | | | | | | | | | | | | | | | | |
| 16 | Report to HNE Community and Patient Partnership Committee. | | | | | | | | | | | | | | | | | | | | |
| 7 | Development of LHC SharePoint for meeting documents which all LHC members have access to. | | | | | | | | | | | | | | | | | | | | |
| 2 | Support reestablishment of LHCs who have expressed interest (e.g. Armidale, Muswellbrook, Denman, Glen Innes, Cessnock, Guyra, Kurri Kurri, Tingha). | | | | | | | | | | | | | | | | | | | | |
| 53, 54 | Ensure consumers are celebrated and acknowledged through arranging end of year thank you for all LHC consumers (e.g. Christmas cards and lunches). | | | | | | | | | | | | | | | | | | | | |
| 48 | Develop email distribution lists of LHC members. | | | | | | | | | | | | | | | | | | | | |
| 55 | Work with local services to ensure that light refreshments are available for LHC meetings. | | | | | | | | | | | | | | | | | | | | |
| 56 | Develop training register and save it in an easily accessible location for all LHCs to access. | | | | | | | | | | | | | | | | | | | | |
| 15 | Meet with Aboriginal Health to determine if Aboriginal Health Impact statement is required. | | | | | | | | | | | | | | | | | | | | |
| 50 | Support representation of LHCs at Annual Public Meeting. | | | | | | | | | | | | | | | | | | | | |
| 11 | Complete consultation with LHCs to timetable LHC meetings for following year. | | | | | | | | | | | | | | | | | | | | |
| 70 | Development of calendar/roster for promotion of LHCs using existing HNE social media accounts. | | | | | | | | | | | | | | | | | | | | |
| 5 | Completion of recruitment of Administration Officer position. | | | | | | | | | | | | | | | | | | | | |
| 25 | Work with local managers review consumers in Stafflink and how they are set up. Implement recommendations from review to ensure that this has been completed correctly. | | | | | | | | | | | | | | | | | | | | |
| 18 | Develop LHC evaluation tool. | | | | | | | | | | | | | | | | | | | | |
| 57, 58 | Develop audit tool to be used to review cultural safety and promote diversity. | | | | | | | | | | | | | | | | | | | | |
| 11 | Ensure LHC meeting appointments for year have been distributed to committee members. | | | | | | | | | | | | | | | | | | | | |
| 34 | determine if mandatory training can be pinned for specific position numbers. | | | | | | | | | | | | | | | | | | | | |
| 15 | Complete Aboriginal Health Impact Statement if required. | | | | | | | | | | | | | | | | | | | | |
| 7 | Transition of LHC meeting documents to SharePoint. | | | | | | | | | | | | | | | | | | | | |
| 56 | Develop process to update and maintain education register. | | | | | | | | | | | | | | | | | | | | |

| Recommendation | Activity |
|---|---|
| 10 | Work with finance to plan merging cost centres. |
| 38, 39 | Implementation of LHC supporting documents. This includes saving documents in SharePoint to ensure they are easily accessible for all committee members and potential |
| 73 | Work collaboratively with Information Communication and Technology and other key stakeholders to explore engagement opportunities such as community engagement |
| 14 | Draft HNELHD Guideline and Procedure, that clearly defines the minimum requirements to support and govern LHCs. |
| 71 | Work collaboratively with SRC and recruitment to ensure HNE website is updated to include available services at each service. This includes referral pathways and contact |
| 3 | Support the reestablishment of LHCs in Northwest. |
| 26 | Commence bi-monthly reporting to review mandatory requirements (e.g. mandatory training). |
| 17 | Report to District Partnering with Consumers Committee Meeting. |
| 19 | Report to HNE Managers and General Managers. |
| 18 | Complete evaluation of all LHCs. |
| 52 | Work collaboratively with local HSMs to ensure that consumers are nominated for awards. |
| 57, 58 | Complete audit of meeting rooms to determine requirements to increase cultural safety and promote |
| 13 | Complete audit of meeting rooms to determine equipment required to facilitate hybrid meetings. |
| 36, 37 | Meet with Organisational Development and Learning and other key stakeholders to review training needs. |
| 10 | Commence using 1 cost centre for all LHCs. |
| 13 | Work with managers to explore purchasing equipment required to support hybrid meetings. |
| 3 | Support the reestablishment of LHCs in the majority of Lower Mid North Coast. |
| 35, 36, 37 | Work collaboratively with Organisational Development and Learning and other key stakeholders to develop and roll out any addition and/or specific training modules. |
| 26 | Commence bi-monthly reporting to review mandatory requirements (e.g. vaccination, NCRC, WWCC). |

NSW GOVERNMENT