The Southern Health system’s Community Health Council: establishment and processes to engage with communities, whānau and patients

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ABSTRACT

AIMS: This paper aims to: describe steps to establish the Southern Health system’s Community Health Council (CHC) and its associated advisors; discuss support for the CHC, advisors and staff; and reflect on engagement activities, what has worked well, and opportunities for development.

METHOD: Prompts for establishing the CHC came from the Health Quality & Safety Commission and previous commissioners of the Southern District Health Board (SDHB). Following support from the Iwi Governance Committee and SDHB and WellSouth Primary Health Organisation (PHO) chief executives and their leadership teams, advertisements called for people interested in joining the CHC. After group interviews, the CHC was established in 2017.

RESULTS: It became evident that an 11-member CHC could not support all requests for engagement throughout the Southern Health system. Consequently, the CHC developed a framework for engagement, a large team of CHC advisors, and a Roadmap to support engagement activities.

CONCLUSIONS: The CHC has supported over 120 CHC members and advisors working on over 95 engagement projects throughout the Southern Health system. It is hoped that the processes described will be useful to the establishment of robust community, whānau and patient forums intended to sit at the centre of Aotearoa New Zealand’s restructured health system.

INTERNATIONALLY, the importance of involving patients (often referred to as consumers), families and wider communities in improving healthcare services and planning has been increasing in recognition since the 1970s. Notably, the 1978 Alma Ata Declaration on Primary Health Care specifically declared that: “The people have the right and duty to participate individually and collectively in the planning and implementation of their health care”. More recently, the World Health Organization (WHO) emphasised the importance of achieving “people-centred” health systems which requires engagement with, and learning from, patients, service users and communities. The Minister of Health recently announced plans for restructuring Aotearoa New Zealand’s publicly funded health system. The restructured system is intended to place people at the “centre of our future health system that is listening and acting on the voices of consumers, whānau, and communities in the design and delivery of health services”, including through the use of national, regional and local forums.

In February 2017, the Southern Health system held its inaugural Community Health Council (CHC) meeting. Terms of Reference stated the CHC was to “work collaboratively with the Southern District Health Board (SDHB), WellSouth Primary Health Network (PHO), governance and management teams to develop effective partnerships and communication pathways for its communities, whānau and patients”. In 2021, the CHC continues to meet monthly; chaired by Karen Browne since February 2019.

New Zealand’s Health Quality & Safety Commission (HQSC) has prepared reports and, recently, indicators of effective engagement. Publications focused on consumer/community councils establishment, operation and organisation are currently lacking in New Zealand. Therefore, this paper aims to: describe steps taken to establish both Southern Health system’s CHC and a related group of CHC advisors; discuss processes developed to support the CHC, CHC Advisors and staff; and reflect on the engagement activities, what has worked well, and
opportunities for future development. It is hoped this information will be useful to others as New Zealand moves towards expanded roles for consumers, whānau, and communities within a restructured health system.

Method

Preparatory work

Prompts for the CHC’s formation were HQSC guidance to DHBs that consumer councils be established, and the (then) SDHB Commissioners’ expectations that a council be formed in the Southern Health system. In 2016, a steering group formed (including Karen Browne and members of the former Alliance South), and an establishment chair Sarah Derrett was interviewed and appointed (unpaid) to help establish the CHC.

In other regions, the few councils that had formed by late 2016 were usually called “consumer councils” and affiliated with a single DHB. The Southern Health system’s council differed because it was to advise the broader Southern Health system, comprising services provided by both the SDHB and WellSouth PHO to a population of 326,280 people (10% Māori) residing over the largest geographical area (>62,356km²) of any DHB. The council members were needed from throughout the region. In recognition of geographically dispersed “communities” and considering patients as key stakeholders (even as “owners” of New Zealand’s taxpayer funded system)—the Community Health Council name was decided.

Importantly, with CEO support the SDHB funded a facilitator Charlotte Adank to help implement and support the CHC. The chair and facilitator met with representatives from the few consumer councils that had already formed, and some kindly shared their Terms of Reference. The CHC’s Terms of Reference—ultimately endorsed in early 2017—had input from the SDHB, WellSouth, the Iwi Governance Committee, and detailed the CHC’s: purpose, function, membership (and ex-officio attendees such as SDHB and WellSouth CEOs); role of the appointed chair; and rotational membership to ensure both continuity of CHC activities and refreshed membership.

The Iwi Governance Committee advised a designated iwi representative should sit on the CHC, and their chair kindly agreed to help interview and select CHC members. Plans for the CHC’s establishment were also presented to the SDHB Commissioners and SDHB/WellSouth executive teams ahead of calling for expressions of interest (EoI) for members.

Establishing the CHC

A press release and advertisements calling for EoIs were prepared in late 2016. Advertisements were placed in newspapers, emailed (eg via iwi contacts, Māori health providers, mayoral networks, and MP offices), and placed on SDHB and WellSouth websites. Respondents received an information pack about the CHC and the Southern Health system. Over four weeks, more than 90 EoIs were received by the CHC facilitator.

CHC members were sought with skills in communication, teamwork, decision-making, strategic abilities, strong networks, and with interest/experience in at least one health area (eg Hauora Māori, disability, long-term conditions, mental health, rural health, older people’s/women’s/youth’s/children’s health, Pacific people’s health, or primary health). Applicants were shortlisted according to their reported health interests, community networks and geographical location. SDHB/WellSouth staff are part of their “communities”; although also likely to be privy to information and potential conflicts of interest arising from their employment. Therefore, CHC members were sought if they were not current SDHB/WellSouth employees, contracted providers or had other conflicts of interest. Eighteen people were shortlisted for interview, for a CHC intended to comprise up to twelve members (including the chair).

The chair and facilitator decided, in discussion with the CEOs and with advice from SDHB Human Resources, that group interviews (4–5 applicants) would be held. Interviewees were informed of this in advance. An interview panel was established, comprising a chair (independent of SDHB/WellSouth), Iwi Governance Committee chair, CHC chair, a member of the SDHB executive, and SDHB patient engagement lead; the CHC facilitator attended. After introductions, and a brief discussion of applicants’ interests, a warm-up exercise asking each applicant to discuss three positive personal characteristics and one “more challenging” characteristic with each other. The panel then asked who, from the group, the applicants would prioritise for CHC membership—and why.

The main exercise was a scenario framed as a popular reality TV cooking show. The panel gave the group demographic information (ingredients) about the Southern Health system and asked them to identify (prepare) the top 3 health issues affecting the region, and then to give a two-minute presentation to the panel (taste test) about those issues, and why they were selected. This allowed the panel to see how people worked together and prioritised their top issues. For instance, did all
people have an opportunity to speak, were people open to agreeing collectively, and how were challenges managed? It also provided an opportunity for interviewees to demonstrate that they could avoid focusing solely on “their” health areas of interest. Interviewees were assured there were no right or wrong answers, and that the panel was interested in how they worked as a group.

Reference checks were undertaken for shortlisted potential CHC members. Initially, eight CHC members received letters of offer (two were Māori, including Kelly Takurua), and comprised the inaugural CHC with the chair. Geographic representation was imperfect; two additional members from other areas were interviewed and appointed within six months of the inaugural meeting.

**Formative activities**

An orientation pack was distributed, staff IDs were issued (emphasising the importance of the CHC), and an induction day was held. Before the first meeting, CHC members’ reimbursement for meeting attendance, travel costs, and accommodation (necessary for those travelling long distances) was established. CHC meetings were to be monthly. Therefore, 8–10 hours per month was estimated as the time necessary for “lay” CHC members to attend the four-hour meeting, have time to read materials, and to provide some time for engagement in specific Southern Health system projects.

The first meeting’s agenda included: Terms of Reference and a Code of Conduct; the establishment of an Interests Register; an introduction to the Southern Health system’s Clinical Council (and how it aligned with, and differed from, the CHC); and an overview of executive leadership teams. CHC members brainstormed, independently of ex officio meeting attendees, important early areas to focus on. It was evident the following questions needed to be addressed: who/how should the CHC advise, how do staff engage with the CHC, and how can the CHC ensure its networks are central to the advice provided to the Southern Health system? The ensuing work undertaken by the CHC and facilitator to address these questions is presented below.

**Results**

**A framework for engagement**

The CHC established a working sub-group to develop a Community, Whānau and Patient Engagement Framework to guide engagement activities (Figure 1). Te Tiriti o Waitangi was a starting point in considering the strategic goal, informing the guiding principles and continuum of engagement approaches (eg meaningful engagement was desirable at all levels, but especially at collaboration and empowerment, and with specific engagement of Māori). The CHC’s engagement approaches followed those outlined by the HQSC, aligned with earlier research. Four domains of engagement were identified, beyond only “personal care and hospital services” to wider “community and public health services”.

**Operationalising engagement**

Many requests came forward for engagement on a range of activities or projects. CHC members were rapidly involved in a range of these (eg working with the Executive Director of Strategic Communications to develop a new Southern Health system website; sitting on senior staff recruitment panels). It was soon clear that CHC members could not support all incoming engagement activities. A plan was prepared to invite other community members to form a larger network of CHC advisors. People who had expressed interest in joining the CHC were initially approached. A form was developed to send to these people, as well as future potential CHC advisors, to identify their areas of health interest to help match CHC advisors to incoming engagement activities. The SDHB and WellSouth also supported the reimbursement of CHC advisors for engagement work.

Meetings with staff were held to discuss the Framework and the growing network of CHC advisors. Guidance was required regarding expressing interest in working with CHC advisors; linking staff with interested advisors; supporting both staff and advisors in the process; and assessing the process and outcomes of engagement. One of the CHC’s clinical champions advised that it was critical the CHC advisors remain closely linked to the CHC, to avoid risking engagement activities becoming uncoordinated.

The CHC developed a Roadmap outlining the process of engagement (Figure 2). To help match new projects with advisors, staff completed a form describing their proposed project including the purpose of engagement, anticipated duration, other members of the project (eg clinicians, managers, executive leads), and their desired CHC advisor qualities. Following a meeting between staff and potential advisors, if agreement was reached, the advisor(s) would be sent a welcome pack, and engagement would begin. CHC members would then communicate as mentors with advisors, and every second month engagement project reports would be circulated to the CHC.
Figure 1: Community Health Council's Community, Whānau and Patient Engagement Framework

**Community Health Council - Community, Whānau and Patient Engagement Framework**

**Our Strategic Goal**
Our communities, whānau and patients are active partners in the Southern health system design, planning and decision-making to achieve improved health processes and outcomes.

**Our Guiding Principles**
- Respectful & Equal process
- Genuine & Trusting
- Meaningful & Purposeful
- Empowering & Sustainable
- Inclusive & Accessible

**Across These Domains**
- Personal care & health decisions
- Community & public health services
- Policy, strategy & governance
- Programme, service & facility design

**Our Engagement Approaches**

- **Inform**
  Provide health information in ways that assist understanding

- **Consult**
  Help to get feedback on particular health issues (e.g., policy or decisions)

- **Involve**
  Work directly with people to ensure that their concerns & aspirations are understood & considered

- **Collaborate**
  Partner with communities, whānau & patients to address particular issues and help to apply solutions

- **Empower**
  Communities, whānau & patients are a key part of the decision-making in the Southern health system

**TIRITI O WAITANGI**
PARTNERSHIP, PARTICIPATION, PROTECTION
Figure 2: Roadmap to guide the Community Health Council’s advisor engagement process.

- **Advisors:** Community members (usually found within the CHC network).
- **Lead staff member:** Southern DHB staff member leading the project.
- **CHC member:** Appointed CHC member who supports the Advisor.

The path to **Community, Whānau and Patient Engagement**

- Advisor/s meets with lead staff member to discuss details of project. Either party can opt out.
- CHC member appointed to support Advisor/s.
- Welcome Pack sent to Advisor/s and relevant forms returned. CHC member makes contact with Advisor/s.
- Engagement follows CHC principles and CHC member supports as required.
- Project complete.
- CHC sends feedback forms to Advisor/s and lead staff member.
- Project Team confirms Advisor/s and lead staff member chosen.
- Community Health Council (CHC) and/or staff identify potential Advisor/s.
- Lead staff member sees the need for community engagement.
Figure 3: Overview of Southern Health system engagement activities undertaken by CHC advisors.

Community & Public Health
- After hours primary care Southland
- Local Diabetes Team
- Laboratories advisory group
- Frailty steering group
- [Staff administrator’s symposium focused on patient experience]
- [Home as first choice programme resource development]
- [Sexual health steering group]

Policy, strategy & governance
- Clinical Leadership Group (new Hospital build)
- SDHB Clinical Council membership
- Digital strategy governance group
- Falls governance group
- Maternity Quality Improvement Programme
- Locality Network - Central Otago/Lakes
- Board Advisory Committee memberships
- Strategic plan refresh steering group
- Disability Working Group
- Recognition and Response Committee
- COVID-19 Clinical Governance Group
- Staff Excellence Awards
- Interviewing for senior management roles
- [Former Alliance South Leadership Team]
- [Southern health website]

Personal care & health decisions
- Improving communication via patient letters
- Long term conditions – primary care
- Shared goals of care
- [Pressure injury steering group]
- [Allied Health Uniforms recognition]
- [Video campaign – hello my name is]
- [Southland radiology video about patient preparation]
- [Educational video about rehabilitation]

Programme, service & facility design
- Rheumatology service redesign
- Endoscopy oversight group
- ED mental health user space
- Mental Health Review
- Hospital patient flow taskforce
- Evaluation of merged hospital ward
- Safer care for older people
- Bariatric working group
- CHC Advisors on Facilities in Transformation groups for new hospital build
- [ED/Acute service flow video]
- [Perioperative workforce]
- [Pre-operative leadership group]
- [Cleaning & orderly services contract negotiation]
members with meeting papers to ensure coordination. Upon completion of the engagement project, the CHC facilitator would communicate with both the lead staff member and the CHC advisor to collect information about what worked well and what could be improved.

**Outcomes of engagement**

Since the Roadmap’s launch in 2018, more than 120 CHC advisors have been involved in over 95 engagement projects (Figure 3). Engagement activities have occurred across all four Framework domains, and across the full range of engagement approaches from Informing (eg communication with the CHC about surgical prioritisation approaches) to Empowering (eg CHC members and Advisors sitting on governance groups). Projects had a range of durations (ie from a few hours to years). A number of CHC Advisors have been involved in more than one project, although not simultaneously.

At a symposium organised by the CHC in October 2019 (attended by 70 people, including many advisors, executive teams, and guest speakers from an Australian consumer council), staff and CHC advisors identified key engagement lessons from the Roadmap. Staff and clinical leaders noted the importance of truly integrating advisors into their project teams. Staff commented on the power of CHC advisors talking from their lived experiences, and how such storytelling can be a powerful window into patient experiences, helping to motivate improvement activities. Staff also acknowledged that having CHC advisors involved can sometimes be daunting for staff. CHC advisors noted: the importance of clarifying their role (with them and with others on the project team) when they join new projects; the importance of relationship building; the benefits of having more than one advisor on major projects for mutual support; and the importance of informing advisors of the ultimate outcome of the project. Written feedback from staff and advisors collected at the conclusion of each project is another valuable source of feedback from engagement activities. However, this needs to be formalised, and ethical approval must be sought, for this to be a source of information for future public reporting. Additional insights into how the voice of the community, whānau and patients can make a difference are presented in the publicly available Community Health Council Annual Reports (Table 1).

**Discussion**

From the outset, the group interview process used in forming the CHC embedded the importance of collaboration, and enabled the CHC to quickly establish group activities for developing the engagement processes (ie Framework and Roadmap). The fact that over 95 engagement activities have been completed, or are ongoing, involving more than 120 CHC advisors, points to the success of the CHC since its formation. CHC’s Framework envisaged engagement across the spectrum of domains and approaches. The CHC did not mandate engagement activities. Instead, we developed tools to support and encourage staff and CHC advisors. We believe these strengthened engagement projects, alongside executive team and Iwi Governance support. Prior to the CHC’s formation, apart from paid SDHB mental health consumer advisors, engagement in health system improvement activities tended to be intermittent and opportunistic.

Reflecting on the CHC’s activities since early 2017, there are aspects to strengthen. Engagement with Māori via the Iwi Governance Committee happened early and was crucial. However, at any one time there have been no more than two Māori CHC members. We recognise many Māori are closely involved in other activities immediately relevant to their iwi, hapū and whānau. However, although equity issues are to the fore of the CHC’s agenda (in part because of Māori CHC members), further work is required to ensure the CHC’s activities are relevant (and seen to be relevant) to Māori health and wellbeing to increase Māori membership. The CHC continues to focus on how best to increase Māori CHC members and advisors. Ultimately, engagement will be evidenced through an improved health system that is accessible and achieves optimal outcomes for Māori—and all.

The CHC quickly recognised processes were also needed to support staff wanting to engage with communities, whānau and patients. The Framework and Roadmap addressed this need alongside Welcome Packs and Codes of Conduct (emphasising confidentiality) for CHC advisors. However, communication must be ongoing so that newly recruited staff can also learn about engagement processes; genuine engagement can be unfamiliar and daunting for both staff and community advisors. With a restructured system, online learning packages may help orientate staff to the role, practice
Table 1: Examples of feedback about the CHC, CHC advisors & engagement activities.

<table>
<thead>
<tr>
<th>Person</th>
<th>Role</th>
<th>Feedback*</th>
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<tbody>
<tr>
<td>Ms Odele Stehlin</td>
<td>Previous Chair, Iwi Governance Committee</td>
<td>As we move to reduce the inequities in our health system, the CHC is a critical component of this and ensuring whānau voice, is a voice of change. Thank you for all the work that has taken place so far, it is a journey and a necessary and fundamental one.</td>
</tr>
<tr>
<td>Anonymous</td>
<td>CHC Advisor</td>
<td>As an outsider I am freed from following historical and current organisational thinking about particular issues and possible solutions, I can 'think outside the box', challenge the status quo, support novel ideas put forward by individual staff who may initially lack team support.</td>
</tr>
<tr>
<td>Mr Mike Hunter</td>
<td>Consultant Surgeon &amp; Intensivist</td>
<td>We’ve got consumers in the room listening and bringing the different perspective to what we’re doing. It’s hard to see the full picture when you’re inside the frame.</td>
</tr>
<tr>
<td>Mr Chris Fleming</td>
<td>CEO, SDHB</td>
<td>Already, they have made a difference to the culture at the DHB, with the comment, ‘We need to hear from the Community Health Council” becoming increasingly second nature as issues are proposed and discussed across many forums.</td>
</tr>
<tr>
<td>Mr Andrew Swanson-Dobbs</td>
<td>CEO, WellSouth</td>
<td>Council members helped us to interview community representatives for our board of trustees and provided guidance to general practices in our network when they were setting up their own patient engagement groups.</td>
</tr>
<tr>
<td>Dr John Adams</td>
<td>Chair, Clinical Leadership Group (CLG) for the new build of Dunedin Hospital</td>
<td>The advisors’ input has made significant difference. CHC Advisors are often able to raise basic questions that complement the approach from hospital staff. Several areas have had changes in design and direction as a result of CHC advisor input. In CLG, the CHC Advisors input has been “grounding”. There have been clear reminders that this hospital is for the people of the region. The support of our lay advisors to decisions that are having to be made, has also been very important to clinicians. Sometimes clinicians worry when they are having to make compromises, that the public will not understand why something has been done, and the participation of the advisors in those conversations is reassuring. Advisors’ opinions also give clinicians strength to stand up for what is needed, when hard conversations are necessary. We would hope that CHC advisor input is not only maintained but increased into the future, and we congratulate the CHC on the quality and capacity for involvement of the people selected for these roles.</td>
</tr>
<tr>
<td>Mrs Jo Millar</td>
<td>CHC Advisor, CLG for the new build of Dunedin Hospital (&amp; President, Grey Power Otago)</td>
<td>Due to my interest I was very pleased to be appointed as a Community Health Council Advisor on the CLG of the new build of the hospital. It has been very gratifying to be able to participate as a consumer as the Ministry of Health has a policy of the patient being the focus and priority in all facets of health treatment.</td>
</tr>
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*Quotes are all from the Community Health Council Annual Reports*
and potential of community forums and advisors. Similarly, online learning packages could help ensure that community forum members understand their roles, and the purpose and value of engagement activities. The CHC found it important for projects to have a specified “end”, and that advisors be adequately informed of the outcomes of projects, in terms of whether the goals were achieved. Sometimes these loops were not closed, and this will be important in the restructured health system. When establishing new forums, we recommend notifying forum members and staff that feedback will be collected to learn how to improve engagement activities—and that de-identified findings may be published to support improvement. Ethical approval should be sought to support such data collection and reporting from the outset.

A strength of the CHC was in the steering group’s and CEOs’ conceptualisation of the CHC as a council advising both the SDHB and WellSouth PHO. The Southern Health CHC appears to have been unique in this regard. Silos, and poorly integrated care, could be lessened if new community forums are not exclusively linked to hospital providers. The CHC was fortunate that the DHB and PHO CEOs, executive teams, commissioners, boards and clinical champions all recognised and supported the opportunities for CHC engagement to improve the Southern Health system. Occasionally, some managers have found the concept of the CHC and advisors difficult to grasp; trusting, respectful and genuine relationships are critical to the sustainability of engagement activities as summarised in the Framework’s values. The organisational equivalence of the CHC to the Clinical Council within the Southern Health system helped address such issues. Thinking about how to successfully embed clinical-consumer equivalence within the context of national health system restructuring will be important to avoid new community forums slipping into “tokenistic” tick-box engagement.

Establishing and operating community forums requires adequate resourcing. The CHC would not have succeeded without a paid facilitator role. This role supports the CHC and CHC advisors, manages the Roadmap for engagement, and connections between staff and advisors. Secretarial support is also necessary for minute-taking at monthly meetings and sending out between-meeting resources; the CHC had such support removed after two years which adversely affected the CHC’s responsiveness. A significant communications investment is necessary both to ensure calls for new forum members reach Māori communities, disabled people and other marginalised groups, and to support the visibility of engagement activities and outcomes to our wider communities. The CHC has had occasional valuable communications support; strengthening this would undoubtedly have extended the reach and visibility of CHC activities. Lastly, as mentioned, paid reimbursement of members and advisors is necessary in recognition of the expertise “lay” advisors bring—and to ensure new community forums are not biased towards the wealthy and retired.

Conclusion

It is hoped that the CHC’s planning, processes, and activities described in this paper may be useful to the establishment of robust community, whānau and patient engagement forums within the restructured health system. The CHC has undoubtedly increased engagement within the Southern Health system. Despite some challenges, the CHC member and advisor activities span all four domains and types of engagement. With adequate recruitment, resourcing, training, and processes in place, the proposed community forums should also succeed. Our experiences point to the clear importance of ensuring strong support from executive and governance leadership within the respective organisations, for the purpose, functioning and scope of future forums. Early attention to appropriate engagement with Māori on such forums, according Te Tiriti, is likely to result in improved health for Māori and all New Zealanders. If Māori are attracted to the new community forums (eg with benefits of engagement being clear and relevant), these have potential to provide a genuine “ground up” compliment to the more “top down” activities of Health NZ and the Māori Health Authority in the restructured national health system.
COMPETING INTERESTS
Nil.

ACKNOWLEDGEMENTS
We are most grateful to all the Community Health Council members, advisors and Southern Health staff, who have so generously participated in engagement activities, for their careful and considered work. We thank the Southern Health iwi Governance Committee, and the Southern District Health Board and WellSouth Primary Health Network executive leadership teams, senior clinicians and managers for supporting the establishment and ongoing functioning of the Community Health Council. Lastly, we thank Chris Fleming (SDHB CEO) and Andrew Swanson-Dobbs (WellSouth CEO) for their comments on an earlier draft of this paper.

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REFERENCES