Inquiry on the Roles of Community Advisory Committees of Metropolitan Health Services

Family and Community Development Committee

Parliament of Victoria
May 2004

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry on the Roles of Community Advisory Committees of Metropolitan Health Services

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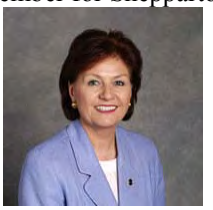

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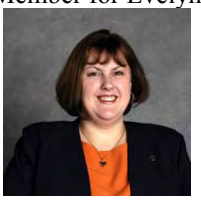

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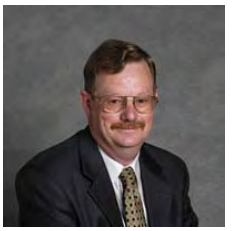

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PARLIAMENTARY COMMITTEES ACT 2003

S.11. The functions of the Family and Community Development Committee are, if so required or permitted under this Act, to inquire into, consider and report to the Parliament on–

(a) any proposal, matter or thing concerned with-

(i) the family or the welfare of the family;

(ii) community development or the welfare of the community;

(b) the role of the Government in community development and welfare including the welfare of the family.

TERMS OF REFERENCE

Examining the Roles of Community Advisory Committees of Metropolitan Health Services

The Governor in Council under Section 4 of the *Parliamentary Committees Act 1968* approves of the following terms of reference to the Family and Community Development Committee of Parliament for inquiry, examination and report.

The Committee is required to examine:

1. Review establishment, composition and objectives of these Committees in all Metropolitan Health Services.
2. Report on work programs and achievement of all Committees.
3. Report on effectiveness of relationships with Metropolitan Health Services Boards of Management and senior management of the Health Services.
4. Recommendations about the future directions of the Committees with regard to the membership, communications and community interactions with Metropolitan Health Services.

The Committee is requested to report to Parliament by 31 March 2004.

Dated 13th August 2003

CHAIRMAN'S FOREWORD

I have great pleasure in presenting the Family and Community Development Committee's *Final Report* on its *Inquiry into Community Advisory Committees of Metropolitan Health Services.*

In 2000, as a response to a Ministerial Review of Health Care Networks, the Department of Human Services published the *Community Advisory Committee Guidelines: Non-Statutory Guidelines for Metropolitan Health Services*. It defined the purpose and the establishment of Community Advisory Committees as the facilitation of "appropriate community and consumer participation at all levels in the Health Services." As a basis for operation the Community Advisory Committee (CAC) is accountable to the Health Service Board and reports to it. Its members have a responsibility to assist in communication between the Health Service and the community.

Since their establishment, the CACs have progressed through an initial developmental stage and are now operating as a valued link between communities, consumers and Metropolitan Health Services. To assist their continued development, the Family and Community Development Committee was requested by the Government in 2003 to prepare a report outlining achievements and identifying possible areas for improvement.

Chapter 1 of the *Report* gives a brief theoretical introduction to community participation in health and the background to the creation of Community Advisory Committees in Victoria. Chapter 2 discusses the establishment, composition and objectives of these Committees in all Metropolitan Health Services. Chapter 3 examines the role of the CACs and how this impacts on membership and relationships within the organisation, and the resourcing required for CACs to function effectively.

On behalf of the Committee I would like to thank those who gave their time to participate in this Inquiry, either through appearance at Public Hearings or preparing written submissions. The Metropolitan Health Service Community Advisory Committees and the Health Issues Centre in particular deserve special mention.

Bob Smith MLC

Chairman

FINDINGS

Finding 1: The Committee supports the Department of Human Service's definition of the role of Community Advisory Committees: "to assist the Health Service to appropriately integrate consumer and community views at all levels of its operations, planning and policy development and to advocate to the Board on behalf of the community."

Finding 2: The Committee finds that Community Advisory Committees make a valuable contribution to the furtherance of community and consumer participation and representation in Metropolitan Health Services. As such they should be actively supported and encouraged.

Finding 3: The Committee supports the current role of Community Advisory Committees as specified by the non-Statutory guidelines.

Finding 4: The Committee finds that resourcing for Community Advisory Committees needs to be maintained by each Metropolitan Health Service Board at responsible levels adequate to maintain the functional ability of their Community Advisory Committee.

RECOMMENDATIONS

Recommendation 1: That the Boards of Metropolitan Health Services discuss a work plan with the Community Advisory Committee on an annual basis and fund the Community Advisory Committee to an agreed amount negotiated between the Metropolitan Health Service and the Community Advisory Committee that reflects the needs of the work plan.

Recommendation 2: That a report of activities and outcomes of the Community Participation Plan be included in the Metropolitan Health Service's Annual Report.

Recommendation 3: The Committee supports the current membership composition of Community Advisory Committees as outlined in the non-statutory guidelines but recommends a clarification of the ability of members of organisations to become Community Advisory Committee members in an individual capacity.

Recommendation 4: That Metropolitan Health Services, including those who provide state-wide services, try to recruit representatives from different age groups, geographic areas, and cultural backgrounds as well as rural areas to serve on Community Advisory Committees to reflect the Health Service's community and its particular characteristics.

Recommendation 5: That Metropolitan Health Services institute induction and ongoing training programs for new members of Community Advisory Committees.

Recommendation 6: That Community Advisory Committee members may be reimbursed for reasonable expenses accepted by the Board to acknowledge their contribution and significance to the Health Service.

Recommendation 7: That seventy-five percent of community representatives of Community Advisory Committees be community members who are not involved in provision of health services and that a maximum of two members of the Board, including the Chair, also be members of the Community Advisory Committee.

Recommendation 8: That Metropolitan Health Service Boards in consultation with Community Advisory Committees adopt a formal reporting process in order to facilitate two-way communication.

Recommendation 9: That Community Advisory Committees be consulted by the Board regarding major strategic changes to hospital policy or services to the community.

Recommendation 10: That senior executive staff whose contract details are determined by the Board have benchmarks

for consumer participation included in their performance assessment.

Recommendation 11: That Metropolitan Health Services undertake a biennial consumer participation audit in consultation with the Consumer Advisory Committee to facilitate consumer and community engagement. The need for these audits could be reviewed after the first four years.

Recommendation 12: That Metropolitan Health Services enable prospective members to observe other Community Advisory Committees in action and learn about their activities.

Recommendation 13: That the role of Community Advisory Committees is promulgated by the Board and senior management to enhance health staff understanding of the value of community and consumer participation.

Recommendation 14: That Community Advisory Committees receive adequate levels of secretariat support to fulfil the activities associated with their workplan.

Recommendation 15: That ongoing research be undertaken by the Health Issues Centre to monitor the performance of Community Advisory Committees.

ACRONYMS

A&RMC	Austin & Repatriation Medical Centre
CAC	Community Advisory Committee
CP	consumer participation
CPP	Community Participation Plan
HIC	Health Issues Centre
MHS	Metropolitan Health Services
RCH	Royal Children's Hospital
RVEEH	Royal Victorian Eye & Ear Hospital
RWH	Royal Women's Hospital

CHAPTER ONE
VICTORIAN STRATEGIES FOR CONSUMER PARTICIPATION IN HEALTH

Introduction

1.1 This chapter first provides an overview of consumer participation in health, its meaning, its participants and its forms. It then reviews Victorian strategies for promoting consumer participation in health with an emphasis on the Community Advisory Committees (CACs) of the Metropolitan Health Services. Finally, it notes the current issues surrounding the working of the CACs which have found resonance in the submissions and evidence gathered by the Committee during the course of its Inquiry.

Consumer Participation in Health

1.2 Consumer and community participation in health refers to the contribution of consumers, carers and communities to health policy planning, evaluation, management and service delivery. Specifically, it is about "people who use health services and who have a say about how their own health is maintained and how health services are provided to them and others". [1] Consumer participation in health covers a range of individuals and groups – from individuals who have, or may, utilise health services; carers of those with an illness, disability or the frail; and communities or groups.[2]

1.3 Such participation takes different forms. Where it is 'consumer' participation, it refers to an individual's role in planning and managing their own health care. 'Community' participation refers to the involvement of individual representatives of a community or representatives of community groups in planning, implementing and evaluating the provision of health services to their community.[3] Community involvement may take place at the health service level (eg. Melbourne's Metropolitan Health Service areas) or health system level (eg. State or federal planning).

1.4 The National Resource Centre for Consumer Participation in Health notes that consumer participation may mean different things to different people. For consumer groups it may mean:

- Representing the views of consumers by seeking as much information as possible;
- Advocating for the position of the disempowered;
- Improving health services;
- Providing education and training for consumers;
- Providing education opportunities for health care staff; and
- Supporting consumers who are actively involved in the health arena.

1.5 For health service providers it may mean:

- Incorporating consumer participation in the health service organisation and its services by working with consumers;
- Consulting with consumers' representatives on the health service organisations' committee;
- Setting up complaints mechanisms which seek to improve services;

- Setting up opportunities for interpersonal and/or personal discussions between consumers and service providers;
- Organising for in-service education opportunities presented by consumer organisations and consumers; and
- Consumer participation in health means the purposeful contribution of individuals and communities in planning for and managing their own health needs. [4]

Levels of Participation

1.6 There are different levels of consumer participation in the health care system: the individual, health service planning and review, and health system policy development.

1.7 Individual participation refers to an individual's involvement in decision-making about the management of their health condition. Successful individual participation involves the provision of accessible written and verbal information about their health condition, including treatment options, likely outcomes and the opportunity to ask questions and receive answers.

1.8 Health service planning and review is focused on the planning and implementation of specific programmes. Individuals are involved as representatives of the community, a community or a group. Ideally, such a representative may have extensive knowledge on a particular issue and is in a position to communicate decisions between the represented community or group and the health service. It is at this level that CACs operate.

1.9 Health system policy development, as the phrase infers, is system-wide planning and has a similar structure to health service planning and

review. However, the focus is on broad healthcare policy and will incorporate many community or group views.[5]

1.10 A "Ladder of Participation" illustrates the varying degrees of community participation at the health service provider level:[6]

Degree of control	**Participants' action**	**Illustrative mode**
High ↑	Has control	Organisation* asks community to identify the problem and to make all the key decisions on goals and means. Willing to help community at each step to accomplish goals.
	Has delegated control	Organisation identifies and presents a problem to the community, defines the limits and asks community to make a series of decisions, which can be embodied in a plan it can accept.
	Plans jointly	Organisation presents tentative plan subject to change and open to change, from those affected. Expect to change plan at least slightly and perhaps more subsequently.
	Advises organisation	Organisation presents a plan and invites questions. Prepared to modify plan only if absolutely necessary.
↓	Is consulted	Organisation tries to promote a plan. Seeks to develop support to facilitate acceptance or give sufficient sanction to plan so that administrative compliance can be expected.
	Receives information	Organisation makes a plan and announces it. Community is convened for information purposes. Compliance is expected.
Low	None	Community not involved.

* In this context, 'organisation' refers to a health service, hospital or department.

Methods of Participation

1.11 Health care providers may employ a number of methods of consumer participation which correspond to the levels of participation. At the individual level, consumer satisfaction surveys, complaints mechanisms, phone-ins, toll-free information and referral, and direct consumer feedback at the time of service are invaluable means of gathering information. At the community level, public meetings, focus groups and community representatives on boards, management committees etc. are the most common methods adopted.[7]

The benefits of consumer participation in health

1.12 The Consumer Focus Collaboration is a national body with representatives from consumer, professional, private sector organisations, as well as all health departments. It supports the following statements regarding consumer and community participation:

- Active consumer participation in decision-making in individual care leads to improvements in health outcomes;
- Access to quality information facilitates decision-making and supports an active role for consumers in managing their own health;
- Active consumer participation leads to more accessible and effective health services;
- Effective consumer participation in quality improvement and service development activities in health services is achieved through the adoption of a range of methods; and
- Effective consumer participation uses methods that facilitate participation by those traditionally marginalised by mainstream health services.

1.13 Active involvement of consumers at all levels of the development, implementation and evaluation of health strategies and programs is integral to their success.[8]

Victorian Strategies for Consumer Participation in Health

1.14 Current Victorian public health policy includes a strategy to improve community and consumer participation in Victoria's public health services. This strategy has been adopted for a number of reasons:

1. Quality and accessibility of the public health care system is of considerable concern to the community that utilises that system. The involvement of the community in policy planning is valuable in terms of democratic participation and in improved social cohesion and health outcomes;
2. Recent reports suggest that increased community and consumer participation supports effective system-wide planning and improvements in health care quality and safety; and
3. Individuals have a recognised right to participate in decision-making about their own health care.[9]

Metropolitan Health Services and Community Advisory Committees

1.15 The Boards of the Metropolitan Health Service Networks commenced in August 1995, replacing previous hospital boards and meaning the loss of community representatives on those boards. To address this issue, the Metropolitan Health Planning Board recommended that each Health Service Network establish a CAC to advise its Board. It became a statutory requirement that each Metropolitan Health Services establish a CAC as part of a strategy of consumer information and

participation. The CACs are advisory only and have no executive function.

1.16 By 1999, the Ministerial Review of Health Care Networks found that there was little to guide the establishment, composition and functioning of the CACs and their relationship with the Board. The Review Panel provided an overview of the nature, composition, Terms of Reference and achievements of each CAC. It was concerned at delays in establishing CACs, the overrepresentation of community-based healthcare professionals and the effectiveness of reporting requirements where the CAC reported to the Health Care Network CEO rather than to the Board.

1.17 As a result of its investigations, the Ministerial Review of Health Care Networks outlined the following objectives for improving consumer/community involvement in Metropolitan Health Services:

1. To ensure that community interests are appropriately represented at the Metropolitan Health Services Board-level.
2. To ensure that each Metropolitan Health Services establishes and maintains a CAC.
3. To ensure that the membership of CACs are able to reflect the perspectives of the community served by the Metropolitan Health Services.
4. To clarify the role of CACs.
5. To ensure that reporting and accountability arrangements between Boards and their CACs are appropriate and effective.
6. To ensure that an evaluation of the effectiveness of CACs is conducted.

7. To ensure that adequate mechanisms are established and maintained to support Metropolitan Health Services and their CACs. [10]

1.18 In response, the Department of Human Services published the *Community Advisory Committee Guidelines: Non-Statutory Guidelines for Metropolitan Health Services*. It defined the purpose of CACs as the facilitation of "appropriate community and consumer participation at all levels in the Health Services."[11] The CAC is accountable to the Health Service Board and reports to it. Its members have a responsibility to assist in communication between the Health Service and the community. The Health Service Board is accountable to the Minister for Health and the Department of Human Services has overall responsibility for the implementation of health policy, including community participation strategies.

1.19 Membership is between nine and twelve people appointed by the Health Service Board, with at least one member of the Board also appointed to the CAC. Applicants can be sought through nominations from peak bodies, identification of appropriately qualified individuals and through open advertisement.

1.20 Members of CACs should be able to reflect the diversity of the community served by the Health Service. This diversity may be defined by ethnicity, language, age, gender, chronicity of illness, specific illness or disability, role as consumer or carer, socio-economic status and geography.

1.21 The majority of members should be linked to established community or consumer groups though they are appointed as individuals and not as organisational representatives. Health Services that provide a

significant level of service to rural communities must appoint at least one rural consumer or community member.[12]

Work of Community Advisory Committees

1.22 The Department of Human Services defines two critical roles for the CACs:

> "to assist the Health Service to appropriately integrate consumer and community views at all levels of its operations, planning and policy development [and] to advocate to the Board on behalf of the community."[13]

Finding 1: The Committee supports the the Department of Human Service's definition of the role of Community Advisory Committees as stated above

1.23 The CACs' role has been defined by statute as encompassing the following:

- advising the Health Service Board on the appropriate structures and processes necessary within the Health Service to ensure effective consumer and community participation at all levels of service planning and delivery;
- identifying and advising the Health Service Board on priority areas and issues requiring consumer and community participation;
- developing a strategic Community Participation Plan for approval by the Health Service Board and monitoring the implementation and effectiveness of the approved Plan;
- advocating on behalf of the community, including promotion of greater attention and sensitivity to the needs of disadvantaged and marginalised consumers and communities;

- facilitating two-way communication between consumer and community groups and the health service;
- participating in the health service strategic planning process; and
- participating in the development and ongoing monitoring of key performance indicators for health service quality.[14]

1.24 Since their establishment, CACs of Victorian Metropolitan Health Services have developed work programmes and Community Participation Plans in order to fulfil this role. These are discussed in greater detail in Chapter Three ("Work Programs and Achievements").

Finding 2: The Committee finds that Community Advisory Committees make a valuable contribution to the furtherance of community and consumer participation and representation in Metropolitan Health Services. As such they should be actively supported and encouraged.

Finding 3: The Committee supports the current role of Community Advisory Committees as specified by the Non-Statutory Guidelines.

Current issues in Community Advisory Committees

1.25 The National Resource Centre for Consumer Participation in Health has identified the following issues as areas of further work in the broad area of consumer participation in health:

- collaborative links between consumer groups and individuals;

- more and improved consumer participation in the policies and processes of health organisations and in government;
- more consumer participation in large-scale government policies;
- evaluation of consumer participation based on evidence;
- communications and dissemination of consumer participation research and practice; and
- more work with health professionals and service managers to raise awareness about/further promote the benefits of consumer participation.[15]

1.26 A case study of methods of community participation noted the benefits and disadvantages of community representation on boards, management committees etc of health service providers. The benefits were: a cross section of views; the provision of an outside perspective; a 'reality check' for organisations; encouraged accountability; and kept the community in touch. The disadvantages centred on the problems of voluntary membership: lack of time, a personal desire to be involved for the 'wrong' reasons; the difficulty of keeping members informed on complex issues; a long learning curve; and a high drop off rate.[16]

1.27 To varying degrees, each CAC has experienced some of these problems and formulated their own solutions. Induction programs have been developed to counter the lack of prior knowledge that CAC members may have; each CAC has paid attention to the mix of consumer and community representation; and genuine efforts are made to encourage the flow of information between Board and CAC. There remain concerns about what can be demanded of volunteers: membership of a CAC requires a considerable commitment in terms of meetings, inductions and professional development and keeping abreast of issues within the Health

Service and their own community. This has prompted debate about the need for, or level of, financial reimbursement. Funding for the ongoing and sufficient resourcing of CACs was also raised since this support facilitates the work of the volunteer members as well as cementing the place of consumer participation within each Health Service.[17]

1.28 Chapters Two ("Establishment, Composition and Objectives") and Three ("Organisational Relationships, Work Programs and Achievements") will canvass these issues in greater detail. Chapter Four ("Future Directions") will address possible solutions for dealing with these issues.

ENDNOTES

[1] National Resource Centre for Consumer Participation in Health. (2003). *Information Sheet: An Introduction to Participation in Health*. Melbourne. p 1

[2] Ibid. p. 1.

[3] Consumer Focus Collaboration. (2001). *The Evidence Supporting Consumer Participation in Health*. Melbourne, National Resource Centre for Consumer Participation in Health. (2003). *Information Sheet: An Introduction to Participation in Health*. Melbourne.

[4] National Resource Centre for Consumer Participation in Health. (2003). *Information Sheet: An Introduction to Participation in Health*. Melbourne. pp 4-5. The "ladder of participation" was developed by the Community Participation Group of the United Kingdom Health For All Network (1991).

[5] National Resource Centre for Consumer Participation in Health. (2001). *Fact Sheet No. 2: Methods of Consumer Participation*. Melbourne.: 1-2.

[6] Ibid. p 2.

[7] Ibid.: 3-4.

[8] Consumer Focus Collaboration. (2001). *The Evidence Supporting Consumer Participation in Health*. Melbourne. p 2.; Consumer Focus Collaboration. (2000). *Improving Health Services Through Consumer Participation: a resource guide for organisations*. Adelaide: Commonwealth Department of Health & Aged Care. pp 1-2; Victorian Quality Council. (2003). *Better Quality, Better Health Care*. Melbourne: Metropolitan Health and Aged Care Service Division, Department of Human Services, Victorian Government. p. 20.

[9] *Department of Human Services. (2000). Community Advisory Committee Guidelines: Non-Statutory Guidelines for Metropolitan Health Services. Melbourne: Acute Health Division.*: 1.

[10] Duckett, S.J. (2000). Ministerial Review of Health Care Networks: Final Report. Melbourne: Department of Human Services.: 112.

[11] Department of Human Services. (2000). *Community Advisory Committee Guidelines: Non-Statutory Guidelines for Metropolitan Health Services*. Melbourne: Acute Health Division.: 1.

[12] Ibid.: 9-10.

[13] Ibid.: 9-10.

[14] Ibid.: 5-6.

[15] National Resource Centre for Consumer Participation in Health. (2003). *Information Sheet: An Introduction to Participation in Health*. Melbourne. 5.

[16] Sega, L. (1997). *A Guide to Community Participation: written for health and community organisations in the Riverland of the South Australia.* Berri.

[17] Austin Health. (2003). Public Hearing. Melbourne: Family & Community Development Committee, Bayside Health. (2003). Submission. Melbourne, Dental Health Services Victoria. (2003). Submission. Melbourne, Eastern Health. (2003). Submission. Melbourne, Melbourne Health. (2003). Submission. Melbourne, Northern Health. (2003). *Submission*. Melbourne, Peter MacCallum Cancer Centre. (2003). Submission. Melbourne, Royal Children's Hospital. (2003). Public Hearing. Melbourne: Family & Community Development Committee, Royal Victorian Eye & Ear Hospital. (2003). *Submission*. Melbourne, Royal Women's Hospital. (2003). Public Hearing. Melbourne: Family & Community Development Committee, Royal Women's Hospital. (2003). Submission. Melbourne, Southern Health. (2003). Submission. Melbourne, Western Health. (2003). *Submission*. Melbourne.

CHAPTER TWO
ESTABLISHMENT, COMPOSITION AND OBJECTIVES

- **Introduction**
- **Austin and Repatriation Medical Centre**
- **Bayside Health**
- **Children's Hospital**
- **Dental Health Services Victoria**
- **Eastern Health**
- **Melbourne Health**
- **Northern Health**
- **Peninsula Health**
- **Peter MacCallum**
- **Royal Victorian Eye and Ear Hospital**
- **Southern Health**
- **St Vincent's**
- **Western Health**
- **Women's Hospital**

Introduction

2.1 As previously mentioned, in 2000 the Victorian Department of Human Services (DHS) advised that all Metropolitan Health Services should establish a Community Advisory Committee (CAC). The basis for this decision was threefold:

1. The acknowledgement that the quality and accessibility of the public health care system is of considerable importance to the community.
2. Recent published literature suggested that increased community and consumer participation supports effective system wide planning and improves quality and safety of health care.
3. Individual health care consumers have a well-recognised right to

participate in decision making about their health care and there is evidence to show that this involvement improves health outcomes.[1]

2.2 The establishment of the CACs were guided by five key principles:

- the Community Advisory Committee is appointed in an advisory capacity to the Health Service Board and will have no executive authority;
- the CAC is a high level committee which provides a central focus for all strategies and mechanisms for community participation and consumer involvement in the Health Service;
- The CAC's two critical roles are to appropriately integrate consumer and community views at all levels of operation, planning and policy development and to advocate directly to the board on behalf of the community;
- The CAC has a predominant responsibility to advise on governance, policy and strategy in relation to community participation and its impact on health service outcomes; and
- The role of the CAC will need to be compatible with its size, composition and available resources.

2.3 Although these basic principles are common for all Metropolitan Health Service CACs the differences in communities and consumers served has created variations in application. This is more apparent between the health services with a designated patient base and thus a more state-wide purview and those that serve a particular community. However differences also exist between the community-based health services as suburban characteristics come into play. This chapter

examines the determining factors behind the roles, objectives and membership of each CAC.

Austin and Repatriation Medical Centre

2.4 After initial consultation between the Board and health consumer representatives positions on the CAC were advertised in the press and applicants interviewed and approved by the Board. The first meeting of the Austin and Repatriation Medical Centre (A&RMC) CAC was held on 24 April 2001.[2]

2.5 As agreed at the early development meetings the CAC has a responsibility to advise on governance, policy and strategy in relation to community participation and its impact on health service outcomes.

2.6 The Board has a complementary responsibility to seek informed advice in a timely manner from the CAC on major strategic issues and developments.

2.7 The CAC's role is to:

- advise the Health Service Board on the relevant structures and processes as well as key priority areas and issues to ensure effective consumer and community participation at all levels of service planning and delivery;
- advocate on behalf of the community to the Health Service Board and ensure the needs of disadvantaged and marginalised consumers and communities are represented.[3]

2.8 The membership of the CAC is determined by the following factors:

- membership of the CAC should reflect consumers and communities, not health care providers; and

- Health Services will reflect the constituency of its communities as defined in terms of ethnicity, language, age, gender, chronicity of illness, specific illness or disability, role as consumer or carer, socio-economic status and geography.[4]

2.9 The objective of the CAC is to:

- advise the Health Service Board on measurable strategies to enhance and promote consumer and community participation at all levels within the Health Service, including the development of a strategic Community Participation Plan;
- identify and advise the Health Service Board on priority areas and issues requiring consumer and community participation;
- develop, monitor and evaluate the implementation and effectiveness of a Community Participation Plan;
- assist the Health Service Board and the Executive with their communication to the community and consumers;
- advise the Board on major strategic issues and initiatives which impact on the community;
- advocate on behalf of the community ensuring the needs of the diverse groups are represented and enacted eg.

  Non English Speaking Background
  Veterans
  Aged
  Disabled
  Indigenous
  Rural
- participate in the Health Service's broad strategic planning and service development processes; and

- undertake other activities and projects as agreed with the Health Service Board from time to time.[5]

2.10 Orientation for new members continues throughout the year with meetings held at A&RMC's three campuses with a tour of the various services provided on each campus. This practice continued during 2002 and has been arranged for 2003. The Community Development Officer and A&RMC staff attend sessions conducted by Health Issues Centre for CACs.

Bayside Health

2.11 In August 2000, in response to the review of the health care networks the Bayside Health CAC was formed. The original purpose of the Committee was:

- to bring the voices of the community into the decision-making processes of Bayside Health and hence to develop services that are more responsive to the needs of the catchment population; and
- to improve the accessibility, appropriateness and the quality of services to consumers.[6]

2.12 From August 2000 to May 2001 the CAC comprised only three members from the Board of Directors and met under preliminary terms of reference. The Committee advised the Board on the process and selection criteria for the appointment of community representatives. Bayside Health sought to attract community members from a wide range of interest areas that reflected the diversity within the Bayside Health catchment area. The community positions on the CAC were advertised and a selection panel recommended to the Board the appointment of 8 community members for a period of up to two years.[7]

2.13 The CAC's current composition is:

- the Chair of the Board;
- at least one additional Director, one or more of whom shall also be a member of the Primary Care and Population Health Advisory Committee; and
- up to ten individuals from the community who are not members of the staff of Bayside Health or current or recent healthcare providers, for a renewable terms of up to two years.[8]

2.14 As a group members, have come from a wide range of community networks and broad range of health-related interest areas. These include aged care, HIV/AIDS, alcohol and drug issues, chronic pain and mental health. There has been representation from across many municipalities in the metropolitan catchments of Bayside Health. Until 2002, there was also representation from rural Victoria, but the distances involved and other pressures made continued participation difficult.[9]

2.15 One Community member made the following comment about the Committee's composition:

> Our interaction with the Board, the Chief Executive and senior staff has proved to be an effective way of maintaining good communication channels and has given community members a sound understanding of the operations and strategic direction of Bayside Health. This has enabled the CAC to be effective and to add value to programs initiated by the Board and management.[10]

2.16 The objectives of the CAC as found in the terms of reference are stated as follows:

- assist the Board with its communication with the community and consumers;
- advise the Board on major strategic issues and initiatives;

- advise the Board and the Chief executive Officer on priority areas and issues requiring consumer participation, and on matters of community interest or concern;
- provide advice on strategies to enhance and promote consumer and community participation, including the development, implementation, monitoring and evaluation of a Community Participation Plan;
- in consultation with the Quality Committee review, endorse and monitor the Bayside Health Quality Plan, Quality Indicator Suite and Quality of Care Report;
- participate in Bayside Health's strategic planning and service development processes;
- advocate to the Board on behalf of the community; and
- consider any matter referred to it by the Board of Directors.[11]

Children's Hospital

2.17 Consumer participation at the Royal Children's Hospital (RCH) has been undertaken at a variety of levels for a significant number of years and a formal RCH-wide consultative committee, the Family Care Committee (which was a sub-committee of the Board), was in place for at least 15 years prior to the formation of the Women's and Children's Health Care Network. The current CAC, which was set up in 2000, comprises consumer representatives from three organisations - the Association for Children with a Disability, the Chronic Illness Alliance and the Islamic Council of Victoria, as well as individual members. In addition, the CAC regularly consults with a group of leaders from 12 ethnic communities.[12]

2.18 The Women's and Children's Health Service (W&CH) adopts the following guiding principles in providing services to the community:

- Consumer participation in health care is a democratic right;
- Adopting consumer-focused approaches improves health outcomes and status, service quality, safety and efficiency and ensures equitable service provision;
- Service planning and design will locate the consumer at the centre of care;
- The consumer perspective will be integrated into the service planning and development process; and
- WCH is committed to continuing and increasing consumer participation in everyday practices across all levels of the organisation.[13]

2.19 The role of Royal Children's Hospital CAC (RCH CAC) is to support and advise the Royal Children's Hospital and Women's and Children's Health (W&CH) on enhancing and promoting a consumer-focused and consumer-responsive approach in all aspects of health service planning and delivery for children and young people and to ensure the best interests of children and young people, (actual and potential service users), their carers and families are upheld.

2.20 The Objectives as stated in the terms of reference are:

1. To ensure that appropriate mechanisms exist to maximise consumer participation.
2. To assist in developing and monitoring an integrated consumer feedback model to enable regular and systematic consumer feedback, organisational response and communicating such responses to consumers and staff.

3. To participate in the development and ongoing monitoring of key performance indicators for health service quality.
4. To provide advice and recommendations to the W&CH CAC, the W&CH Board and RCH management with regard to relevant community perspectives, consumer participation, priorities, service developments and resource allocation.
5. To act as a conduit and advocate on behalf of consumers and their families and carers, and communities regarding access and equity in service provision.
6. To undertake related activities and projects as agreed by RCH management and/or the W&CH Board.[14]

2.21 The RCH CAC comprises the following members:-

1. Seven community representatives, including:-
   - Representatives from nominated peak bodies whose members are frequent users of the services offered by the RCH; and
   - Individual representatives or parent advocates who are able to provide a different perspective to that of the peak body representatives.[15]
2. Up to five members of the health service, representing:-
   - The W&CH Board;
   - Hospital Executive Committee;
   - Medical staff;
   - Nursing staff; and
   - Allied Health staff.
3. In addition, the Consumer Liaison Officer, CAC Resource Officer and Board Secretary will be in attendance.

Membership appointments are renewed every 12 months with a maximum of a three-year term.

2.22 As the RCH CAC represents a limited range of children, young people and their carers or families' experience, the development and monitoring of alternative strategies to engage a broad range of consumers and their families and carers was considered a critical role for the committee. These strategies are embedded in the RCH CAC annual work plan.

2.23 In addition criteria for membership have been adopted. Peak body representatives undertake to:

- Consult with member organisations and members who use RCH services, and agree to advocate on behalf of other users in order to represent consumer issues from the broadest possible community perspective;
- Nominate and support suitable consumer representatives to RCH committees, projects and working parties as required;
- Act as a central information referral point for users to be informed about the role of the RCH CAC and the process for referring issues to the committee; and
- Provide representatives to the RCH CAC.[16]

2.24 The following process for recruitment to RCH CAC has also been adopted:

1. Organisations, peak bodies and individuals are invited to submit expressions of interest to nominate an individual to the RCH CAC;
2. W&CH will nominate at least one Board member who satisfies selection criteria to the RCH CAC;

3. The RCH CAC considers nominations and, after consultation with hospital management, recommendations for appointment to RCH CAC are then made to the W&CH Board; and
4. Committee membership will attempt to reflect the diversity of the communities served by RCH.[17]

2.25 The RCH CAC works to provide timely input and advice to the W&CH Board on major strategic issues and developments. It is expected that the W&CH will also ensure that the committee is adequately resourced in order to fulfil its responsibilities. The RCH CAC is accountable to the W&CH Board. The RCH CAC has a responsibility to represent consumers and communities, ensure RCH responsiveness to consumers and assist with two-way communication between the RCH and the community.

2.26 The RCH CAC will endeavour to fulfil its responsibility through development and implementation of an annual Community Participation Plan (CPP). The CPP will be developed by the Committee and, after consultation with hospital management, referred to the W&CH Board for approval.

2.27 An annual report monitoring the effectiveness of the Committee's CPP and activities will be presented to the RCH Hospital Executive Committee and the Board. RCH CAC membership, activities and outcomes of recommendations made to the WCH Board shall be included in the W&CH annual quality report.

2.28 The committee has the following procedural rules:

- The RCH CAC will meet at least bimonthly;
- A quorum will consist of 50 percent of the current membership;

- Where a decision from the Committee is required or a recommendation is to be forwarded to the W&CH Board, a quorum must be present and the decision/recommendation will be based on a majority vote of the members of the committee present;
- In all methods of reporting, the RCH CAC ensures the confidentiality of consumers is maintained and all information that may identify a consumer is kept confidential. Committee members and community representatives have a duty to clarify issues of confidentiality before speaking publicly about matters discussed at Committee meetings. In the event that this criterion is not met continuation of membership may be reviewed;
- The sitting member of the W&CH Board will chair the RCH CAC;
- The W&CH Board Secretary will routinely draft and forward minutes from each committee meeting to the Board;
- The Executive Director of the RCH or designated senior executive and the Divisional Director of the Community Division will be in attendance for at least a part of each meeting to ensure effective information provision and practicality of issues arising. The W&CH Chief Executive Officer shall be invited to attend on a quarterly basis or more often as required;
- Health care providers may be invited as a resource to the Committee;
- Two consumer representatives of the RCH CAC who meet the attendance criteria will be nominated by the committee to be represented on the W&CH CAC which coordinates consumer

participation across W&CH. These positions will be rotated annually;

- Committee members may be invited and are encouraged to join additional RCH and W&CH committees, subcommittee meetings or working groups. Members sitting on such committees are expected to report regularly to the RCH CAC on the progress and in particular any issues that may require broader consumer debate; and
- Attendance at RCH CAC meetings is necessary. Committee members are expected to attend at least 2/3 of the total annual committee meetings. In the event that this criterion is not met continuation of membership may be reviewed.[18]

Dental Health Services Victoria

2.29 The Community Advisory Committee of Dental Health services Victoria (DHSV) was formally established as a Committee of the Board in early 2001 in line with requirements under the *Health Services (Governance) Act 2000*.[19]

2.30 Following the approval of the terms of reference for the CAC and the appointment of two members of the Board as Chair and Deputy Chair, two forums were held to develop community interest, one in Wangaratta and a second in Melbourne. Public advertisements were placed state-wide to recruit membership. A number of applicants were interviewed by the Chair and Deputy Chair. Recommendations were made to the Board and appointments were made for staggered periods of time. From the beginning the Board determined to pay a sitting fee to each community member of the CAC.[20]

2.31 The role of CAC is to:

- Advise the Board of Directors on strategies which improve and promote consumer and community participation at all levels;
- Identify and advise the Board of Directors on priority areas and issues requiring consumer and community participation;
- Develop a strategic Community Participation Plan for consideration by the Board;
- Monitor the implementation and effectiveness of the approved Community Participation Plan;
- Assist the Board of Directors and senior management in their communication with DHSV's community and consumers;
- Act as representatives of the community to the Board of Directors;
- Ensure that individual confidentiality and privacy is protected and access to information is in the interest of the public;
- Assist the Quality Assurance Committee and the Board of Directors in the development and ongoing monitoring of key performance indicators for service quality and accessibility; and
- Undertake other activities and projects as agreed with the Board of Directors from time to time.[21]

2.32 All appointments to the CAC are made by the Board of Directors for periods up to 3 years. Appointments will vary in term to ensure continuity within the Committee. Members of the Board of Directors shall be appointed Chair and Deputy Chair of the CAC. At least one of these members should have skills and experience in community consultation.

2.33 Up to 7 additional members of the CAC shall be appointed from individuals with links to the following communities:

- Young people and parents of children eligible for school dental care;
- Aged concession card holders; and
- Young and middle aged concession card holders.[22]

2.34 DHSV believes that members of the CAC should be able to reflect the special needs and interests of specific communities to assist DHSV with consultation processes. These groups include people from diverse backgrounds such as:

- non-English speaking backgrounds;
- disabilities and other special needs;
- rural areas; and
- Aborigines and Torres Straight Islanders.[23]

Committee members must be 16 years of age or over.

2.35 The Chief Executive of DHSV and the General Manager – Human Resources and Corporate Communications are invitees to the Committee. Committee members are eligible for reappointment. The Board of Directors may on the advice of the Chair of the CAC terminate the appointment of any member of the committee at any time.

Eastern Health

2.36 The lead time to the first committee meeting in April 2001 was about five months. Eastern Health received expressions of interest from people who considered they had capacity to reflect views of the community; links to the community and consumer groups; and the ability to bring knowledge of the opinions and policies of community groups to the committee. Individuals employed by or who represented organisations that provided health care were considered ineligible for membership.[24]

2.37 A four-person panel of Board members and Eastern Health staff interviewed candidates and those selected were from different local government areas in the Eastern Health catchment.

2.38 The committee was convened for some time before it could be said to have been established.

2.39 In 2002, there having been attrition of some of the foundation members, a second recruitment drive was done. Advertising action was taken and the vacancies were notified on the Eastern Health website and in the local press. As well, the vacancies were notified to a mail-out to 300 volunteers of Eastern Health, a meeting of 50 Eastern Volunteers, current committee members and some clinicians. Eastern Health received 19 requests for information and ten of those applied for membership. There was no provision for prospective members to observe a CAC meeting before applying for a vacant place.[25]

2.40 All applicants were considered suitable for membership of the committee. The suitability of applicants was assessed against the selection criteria. The selection panel considered information given in the application forms and responses to prepared conversational guides in the meetings. The following guide was used to assess each candidate against the criteria.

SCORE	**SCORE DESCRIPTION**
1	Insufficient or inadequate evidence supplied
2	Does not meet criteria
3	Meets criteria at an acceptable level
4	Meets criteria at a high level
5	Meets criteria at an excellent level

2.41 The panel ranked applicants on demonstrated ability to meet the essential selection criteria. Each applicant met the criteria and those with the highest ranking were invited to join the committee. The remaining candidates were asked to form a 'consumer bank' that Eastern Health might call on for advice on specific topics. Each agreed.[26]

2.42 Typical of candidates' stated reasons for seeking membership of the committee was this statement from an applicant, "I would like opportunity to give constructive feed-back so that services are improved…. and strengthened where they are already good".

2.43 Members of the Committee are invited to a tour of Eastern Health's campuses within a few months of their commencement. Many members have been able to attend education sessions that have dealt with topics being discussed in Committee and with processes that groups can use.

Melbourne Health

2.44 The CAC was established in mid 2001. In its first months of operation, its meetings were focussed on orientation of members to Melbourne Health and discussion of its role in promoting and enabling consumer participation within the organisation. The CAC's initial findings were that the extent of consumer participation in Melbourne Health services varied across the organisation. This reflected:

- variation in the nature of services provided;
- varying extent to which patients are "repeat customers";
- differences in lengths of stay and length of contact with the service; and
- diversity of the catchment population (from local residents, to state-wide, depending on the level of specialty of the service.[27]

The composition and objectives of the CAC were accordingly designed to take these variations into consideration.

2.45 The CAC is constituted to provide leadership and direction to community participation for Melbourne Health and has a responsibility to advise the Board of Melbourne Health on governance, policy and strategy in relation to community participation and its impact on health service outcomes. It is intended that the CAC should reflect consumers and communities, not health care providers, thus membership reflects the constituency of Melbourne Health's communities.

2.46 The membership of the CAC:

- will be appointed by the Board and shall comprise at least one Board member in addition to the Chair;
- will have a Chair appointed by the Board;
- will have an Executive sponsor appointed by the CEO to ensure executive support; and
- shall comprise up to nine individuals from Melbourne Health's communities who may serve for up to two years at a time with the opportunity for reappointment for a further term.[28]

2.47 The objectives of the CAC are as follows:

- to advise the Health Service Board on strategies to enhance and promote consumer and community participation at all levels within the Health Service, including the development of a strategic Community Participation Plan;
- to identify and advise the Board of Melbourne Health on priority areas and issues requiring consumer and community participation;

- to develop, monitor and evaluate the implementation and effectiveness of a Community Participation Plan;
- to advise the Board and the health service in their communication with the community and consumers;
- to advise the Board on major strategic issues and initiatives which impact on community and consumers; and
- to assist the Board in the development and ongoing monitoring of key performance indicators for service quality and accessibility.[29]

Northern Health

2.48 Work towards the establishment of the Northern Health CAC began in November 2000. Terms of reference were approved by the Northern Health Board of Management in December 2000. The inaugural meeting with community members was held in June 2001.[30]

2.49 Bundoora Extended Care Centre has had a CAC for approximately 15 years. Broadmeadows Health Service established a CAC two years previously. Both these committees provide regular reports to the Northern Health CAC and to their respective site executive management.

2.50 The committee is chaired by a Northern Health Board of Management member. Two other Board members are also members of the CAC. The health service Chief Executive Officer is also a member of the committee. The committee is supported by the Community and Primary Care Projects Manager.

2.51 There are nine community/consumer members and they reflect the cultural diversity of the population serviced by Northern Health-Bundoora Extended Care Centre, Broadmeadows Health Service and the Northern Hospital.

2.52 Vacancies are filled by calling for expressions of interest in relevant publications. Applications are screened by the Committee Chair and the Community and Primary Care Projects Manager. Where expressions of interest have not been received to fill vacant positions, specific communities, organisations and individuals may be targeted. Interviews are conducted and the successful applicant is selected. Appointments to the committee are confirmed by the Northern Health Board of Management.

2.53 The CAC has two critical objectives;

- to assist the Health Service to appropriately integrate consumer and community views at all levels of its operations, planning and policy development and
- to advocate to the Board on behalf of the Community.[31]

2.54 Specifically it advises the Board on

- mechanisms to coordinate community participation;
- strategic planning;
- quality improvement and accessibility of services provided by Northern Health; and
- community needs.[32]

2.55 In addition the Community Participation Action Plan 2001-2004 sets the framework for the work undertaken by the CAC and for the site based community participation groups. The five objectives of the action plan are:

1. to strengthen organisational capacity to enable community participation across Northern Health;
2. to provide leadership in addressing health care needs;

3. to actively engage key stakeholders;

4. to support the Northern Health CAC; and

5. to strengthen quality improvement of Northern Health's Services.[33]

Peninsula Health

2.56 Peninsula Health established a CAC, which reports to the Board of Directors, in April 2001, as legislated by the State Government.

2.57 Peninsula Health has one CAC and two Community Advisory Groups - one for the Northern catchment area and one for the Southern catchment area.

2.58 Peninsula Health's CAC and Groups meet regularly and provide feedback, perspective, ideas and advice to the Board and Staff. The committee and groups are made up of community members whose interests and activities give them access to public opinion. In selecting members of the committees, attempts are made to ensure that members represent groups in the community.[34]

2.59 The community members volunteer their time and have a dual interest in improving the quality and safety of healthcare and advising the Health Service about community viewpoints.

2.60 The primary role of this CAC is to provide advice on needs, demands, and service development from a community perspective whilst also harnessing community support for the Health Service and its programs.

2.61 Appointments of community members are made on the basis of their capacity to represent a broad range of community views and interests. The CAC provides direct input and acts as a conduit to key

community groups where more detailed consideration of particular services and programs is required.

2.62 The CAC comprises up to six community members, three Peninsula Health Board members and representatives of the Health Service. Chief Executive Dr Sherene Devanesen is also an ex-officio member. The Director of Quality and Customer Services provides administrative support for the CAC.

Peter MacCallum

2.63 In response to the Department's initiative the Peter MacCallum Cancer Centre (Peter Mac) established a process for advertising, recruiting and selecting suitable members of the community to join its inaugural committee in early 2001.[35]

2.64 After an introductory session was held in April 2001, bi-monthly meetings were planned and the first meeting of the group was held on June 20th, 2001. Peter Mac sees the primary function of the CAC as a vital link with the larger community to both receive and disseminate information about its services, support networks and the unique needs of those with cancer and their families.

2.65 The Terms of Reference for Peter Mac CAC state that the group will:

- Advise the Health Service Board on strategies to enhance and promote consumer and community participation at all levels within the Health Service;
- Develop and monitor the implementation and effectiveness of the community participation as per the Community Participation plan;

- Assist the Health Service Board and the Executive in their communication with the Health Service's community and consumers;
- Advise the Board on major strategic issues and initiatives;
- Participate in the Health Service's broad strategic planning and service developmental processes;
- Assist the Health Service Board in the development and ongoing monitoring of key performance indicators for service quality and accessibility; and
- Undertake other activities and projects as agreed with the Health Service Board from time to time.[36]

2.66 Progress of the CAC is reported under the objectives of the Community Participation Plan and falls under the following criteria:

1. Increase staff awareness of Consumer Participation (CP) in clinical practice;
2. Ensure CP from diverse groups such as:
   - Culturally and linguistically diverse
   - Disabled
   - Elderly
   - Teenagers;
3. Reduce the use of medical terminology within the hospital;
4. Increase CP input into Peter Mac service planning and delivery; and
5. Increase community awareness of consumer role at Peter Mac.[37]

Royal Victorian Eye and Ear Hospital

2.67 The RVEEH has a long history of involvement in the community fostered by the RVEEH Auxiliaries now known as 'The Friends' of the

hospital. The Auxiliary has hosted community sessions throughout Victoria since 1922. Beyond this involvement, the hospital has previously focussed on working with communities in an advisory role.[38]

2.68 Some examples of this are health promotion activities such as:

- Education on eye safety in the work environment;
- Diabetes education (including outreach programs);
- Presentations to schools; and
- Community health education.[39]

2.69 A partnership in low vision rehabilitation services between RVEEH and Vision Australia Foundation was established in 1998. The CAC of RVEEH was officially established in 2001.

2.70 The ambulatory nature of RVEEH services coupled with a state-wide catchment means that engaging with patients creates difficulties. In response to these challenges, the hospital has recently focussed its community engagement strategies around treatment groups and relevant community organisations; all inform and consult with the CAC.

2.71 RVEEH's CAC currently consists of nine members including two representatives from the RVEEH Board. The members of the CAC have been chosen in accordance with their relationship to and knowledge of specific treatment groups and community agencies. Some have been patients at the hospital and other work in community organisations that are directly concerned with vision or ear, nose and throat health and associated lifestyle issues.[40]

2.72 As many members are currently employed by community organisations it has been important for RVEEH to clarify how CAC members are to 'represent' consumers. The need to clarify the issue of

representation was identified in mid 2002 when REEV undertook an internal review of the CAC. The consultant engaged to facilitate the feedback process reported that the following questions were raised by members:

- are CAC members representatives of their organisations/interest groups?
- if CAC members are providing advice on behalf of the community, should the CAC have formal structures to ensure linkages with the community?[41]

2.73 It was confirmed during the review that members do not represent organisations in their advisory role. As individuals they bring knowledge, experience and information that assists them to give informed, carefully considered advice. Their role is to use their wisdom and expertise to jointly develop advice and recommendations to the Board. These characteristics of the CAC have been reiterated in the recruitment and orientation process where a number of representative groups have been identified whose representation is seen as important:

- vision impaired
- ear nose and throat
- lower socio-economic
- aged
- cultural
- rural
- community development.[42]

2.74 At present the CAC consists of up to ten members appointed for up to two years of which up to eight persons are selected by the Board

from nominees and up to two are hospital Board members, one of whom should chair.

2.75 The objectives of the RVEEH CAC are derived from the Community Participation Plan and included in the RVEEH Policy and Procedure manual. They can be briefly stated as follows:

Purpose and Scope

- to ensure that the specialist services provided by the RVEEH are accessible and responsive to the needs and perceptions of consumers and the wider Victorian community; and
- to ensure RVEEH is committed to engaging consumers and the community in the ongoing development of services and systems.

Policy

- to engage the community and consumers in the planning and the improvement of RVEEH specialist services:
- to integrate consumer and community participation in service provision, evaluation and improvement;
- to provide the community and consumers with accessible information that informs, educates and promotes the specialist services of RVEEH; and
- to evaluate the effectiveness of consumer and community engagement initiatives.[43]

Southern Health

2.76 In February 2001 a Southern Health CAC Information Forum was conducted to inform interested community members about the CAC and seek their assistance to recruit suitable members. An advertisement was then placed in local newspapers seeking applicants for the Committee,

and letters were sent to 30 relevant community agencies seeking nominations.[44]

2.77 The applications received for membership of the Southern Health CAC were assessed against the following criteria:

- involvement in broad community networks;
- links to advocacy groups;
- geographical spread across the catchment area;
- representative of the catchment area's diverse cultural groups;
- gender balance;
- age balance;
- understanding of health issues affecting the community; and
- ability to assist in the establishment of Southern Health's community participation strategy.[45]

2.78 Following this process, nine community members with strong links to the broader community were appointed to the CAC by the Southern Health Board. Three Southern Health Board members, who met the key selection criteria, also sat on the CAC and provided a conduit between the Board and the broader membership of the CAC. The Southern Health Chief Executive Officer and Director of Primary Care and Mental Health attended the CAC to provide support and information. The new CAC met for the first time in April 2001.

2.79 The current CAC comprises three Board members and nine community members who have strong links with the broader community.[46] The CAC also has an Executive Officer who provides administrative support to the Committee.

2.80 The role of the CAC is to give advice to the Board on how Southern Health could more effectively engage its community and to

represent community views to the Board. As expressed in the terms of reference the role of the Committee will be to:

- Advise the Board on strategies to enhance and promote consumer and community participation at all levels, including the development, implementation and monitoring of the strategic Community Participation Plan;
- Identify and advise the Board on priority areas and issues requiring consumer and community participation;
- Participate in the health Service's broad strategic planning and service development processes;
- Assist the Board and the Executive in their communication with the Health Service community and consumers;
- Assist with the development and monitoring of key performance indicators for service quality and accessibility, in particular, the indicators of the Annual Quality of Care Report; and
- Undertake projects and activities as agreed with the Board.[47]

St Vincent's Health

2.81 The St Vincent's Health CAC was established in 2001 with the overall aim of ensuring effective consumer and community participation across the health service and to assist in monitoring the quality of services provided.

2.82 The St Vincent's Health CAC membership currently includes 10 community or consumer members, 1 Board member, and 3 staff members who support and co–ordinate the committees activities. Representatives are hoping to appoint two additional consumer members with strong community links to rejuvenate the membership in early 2004. The CAC met 5 times in 2003 and the CAC's work group met 6 times to

formulate the 2003 Quality of Care Report as well as implementing strategies to further the marketing of the CAC.[48]

2.83 The St Vincent's Health CAC Chair meets regularly with the Chairpersons of the other Metropolitan Health Service CACs to learn from each other's experiences and to discuss the impact of the CACs' work on the wider health system in regard to enhancing consumer and community participation.

2.84 One of the central goals outlined in the St Vincent's Health Strategic Plan is to strengthen and develop partnerships with patients and within the community as a whole. As a result a number of mechanisms have been established for enhancing consumer and community participation in health care and service delivery.

2.85 The establishment of the St Vincent's Health CAC has strengthened this stated commitment to effective consumer and community participation. The CAC advises the St Vincent's Health Board of Directors on strategies and issues to promote consumer and community participation across the health service. It assists in monitoring the quality of care and services provided and advocates to the Board on behalf of the community.

2.86 The CAC is made up of:

- twelve members of the community who do not have a healthcare background, but have the capacity to reflect community views, have links to community groups and are interested in increasing consumer participation in healthcare;
- four health service members; and
- one member of St Vincent's Health Board who is the chairperson.[49]

2.87 The CAC meets every two months, and reports regularly to the Board of St Vincent's Health and other relevant committees.

It focuses on the following areas:

- Advising the Board on strategies to enhance and promote consumer and community participation across St Vincent's Health;
- Identifying and advising the Board on priority areas/issues requiring consumer and community participation from across the health service;
- Participating in health service strategic planning and service development;
- Assisting the Board and the different areas of the health service in any communications with the community and consumers;
- Development, implementation, monitoring and evaluation of the Community Participation Plan for St Vincent's Health; and
- Acting as an advocate to the Board on behalf of the community.[50]

Western Health

2.88 The members of the Western Health CAC have been selected on their capacity to reflect the different communities in the western region of Melbourne. Not only do they come from different parts of the west, they also have many interests and community connections. Some are involved in local councils and community health services, others with particular community groups such as cultural and linguistically diverse communities.[51]

2.89 The CAC is responsible for ensuring that Western Health undertakes effective strategies involving consumer consultation and community engagement. It does this by identifying and advising on

priority areas and issues for consultation and engagement and generally advocating on behalf of the communities of the west to the Board. It has an annual plan, a budget, and a resource officer to assist it administratively. Senior staff from the Health Service and members of the board are also involved to ensure the opinions and advice of the CAC is heard at the highest levels in the organisation.[52]

2.90 A key responsibility of the CAC is to provide a report to the Board on its activities and the actions taken by the Board in relation to recommendations made to it by the committee. The Health Service's Annual Report incorporates details of work undertaken by the CAC.

2.91 The CAC is responsible for ensuring that Western Health undertakes effective strategies involving consumer consultation and community engagement.

As stated in the Terms of Reference the role of the CAC is to:

1. Identify and advise the Western Health Board on priority areas and issues requiring community engagement and consumer participation.
2. Advise the Western Health Board on strategies to enhance and community engagement and consumer participation at all levels within the health service, including the development of a Western Health Community Participation Plan (CPP).
3. Monitor the implementation and effectiveness of the CPP.
4. Develop an annual plan and budget in relation to the CAC.
5. Advise and assist the Western Health Board and the executive in their communication with the Health Service's communities.
6. Generally advocate on behalf of the communities of the west to the Board.

7. Participate in the Health Service's broad strategic planning and service development processes.
8. Undertake other activities and projects as agreed with the Board from time to time.
9. Liaise with other Board Committees as appropriate, in particular with the Primary Care and Population Health Advisory Committee.
10. Promote the role of the CAC to the community.
11. Evaluate the effectiveness of the CAC itself.[53]

2.92 The Membership of the CAC is to be formulated accordingly.

- two Board Members, one of whom is the Chair
- Chief Executive Officer
- Chief of Operations, Community
- Manager, Community Integration
- Community Members

Health Care providers, staff and observer may attend as a resource to the CAC by invitation and in an advisory capacity.

Women's Health

2.93 The CAC on Women's Health (CACWH) was established in 1999 to provide a forum for community representatives to voice community concerns and to participate in service planning, development and delivery at The Royal Women's Hospital (RWH). The legislatively-based CACWH is a subcommittee of the Board and is supported by the Consumer Participation Coordinator.[54]

2.94 The composition of the CACWH has been diversified and expanded to include wider representation of the concerns within women's health. There are currently ten members of the CACWH who

meet monthly. CACWH members are appointed as individuals, rather than representatives of an organisation, and aim to reflect the diversity of the community served by the RWH. The CACWH represents a diverse range of women's experience with demonstrated skills in the following areas:

- expertise in consumer representation;
- knowledge of women's health issues;
- understanding of broad health policy and hospital organisational structures;
- understanding of women's health networks and good liaison with a range of health organisations and agencies;
- understanding of diverse groups of women and their needs in accessing and utilising health services;
- experience in strategic planning and service development; and
- commitment to the W&CH philosophy and to the guiding principles of a social or holistic model of women's health.[55]

2.95 The key tasks of the CAC are to act as a link from the community to the Health Service, oversee the implementation of an integrated consumer feedback program within the RWH, advise the Board of community concerns in such areas as the hospital site redevelopment and to provide representation in the service and strategic planning processes.

2.96 The CACWH supports and advises both Board and management on enhancing and promoting a consumer focused and consumer responsive approach in all aspects of women's health service planning and delivery. The focus of the CACWH is to uphold the best interests of all consumers, including actual and potential service users, their partners, carers and families.

ENDNOTES

[1] *Department of Human Services. (2000). Community Advisory Committee Guidelines: Non-*

Statutory Guidelines for Metropolitan Health Services. Melbourne: Acute Health Division.: 1.

[2] *Submission 15, Family and Community Development* Committee Austin & Repatriation Medeical Centre.

[3] *Submission 15, Family and Community Development* Committee Austin & Repatriation Medeical Centre.

[4] *Submission 15, Family and Community Development* Committee Austin & Repatriation Medeical Centre.

[5] *Submission 15, Family and Community Development* Committee Austin & Repatriation Medeical Centre.

[6] *Submission 5,* Family and Community Development Committee, Bayside Health

[7] *Submission 5,* Family and Community Development Committee, Bayside Health

[8] *Submission 5,* Family and Community Development Committee, Bayside Health

[9] *Submission 5,* Family and Community Development Committee, Bayside Health

[10] *Submission 5,* Family and Community Development Committee, Bayside Health

[11] *Submission 5,* Family and Community Development Committee, Bayside Health

[12] www. rch.com.au, Children's Hospital Community Advisory Committee

[13] www. rch.com.au, Children's Hospital Community Advisory Committee

[14] www. rch.com.au, Children's Hospital Community Advisory Committee

[15] www. rch.com.au, Children's Hospital Community Advisory Committee

[16] www. rch.com.au, Children's Hospital Community Advisory Committee

[17] www. rch.com.au, Children's Hospital Community Advisory Committee

[18] www. rch.com.au, Children's Hospital Community Advisory Committee

[19] *Submission 11*, Family and Community Development Committee, Dental Health Services Victoria

[20] *Submission 11*, Family and Community Development Committee, Dental Health Services Victoria

[21] *Submission 11*, Family and Community Development Committee, Dental Health Services Victoria

[22] *Submission 11*, Family and Community Development Committee, Dental Health Services Victoria

[23] *Submission 11*, Family and Community Development Committee, Dental Health Services Victoria

[24] *Submission 12*, Family and Community Development Committee, Eastern Health

[25] *Submission 12*, Family and Community Development Committee, Eastern Health

[26] *Submission 12*, Family and Community Development Committee, Eastern Health

[27] *Submission 3*, Family and Community Development Committee, Melbourne Health

[28] *Submission 3*, Family and Community Development Committee, Melbourne Health

[29] *Submission 3*, Family and Community Development Committee, Melbourne Health

[30] *Submission 9*, Family and Community Development Committee, Northern Health

[31] *Submission 9*, Family and Community Development Committee, Northern Health

[32] *Submission 9*, Family and Community Development Committee, Northern Health

[33] *Submission 9*, Family and Community Development Committee, Northern Health

[34] *Submission 7*, Family and Community Development Committee, Peninsula Health

[35] *Submission 1*, Family and Community Development Committee, Peter MacCallum Cancer Centre

[36] *Submission 1*, Family and Community Development Committee, Peter MacCallum Cancer Centre

[37] *Submission 1*, Family and Community Development Committee, Peter MacCallum Cancer Centre

[38] *Submission 2*, Family and Community Development Committee, The Royal Victorian Eye & Ear

Hospital

[39] *Submission 2*, Family and Community Development Committee, The Royal Victorian Eye & Ear

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[40] *Submission 2*, Family and Community Development Committee, The Royal Victorian Eye & Ear

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[41] *Submission 2*, Family and Community Development Committee, The Royal Victorian Eye & Ear

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[42] *Submission 2*, Family and Community Development Committee, The Royal Victorian Eye & Ear

Hospital

[43] *Submission 2*, Family and Community Development Committee, The Royal Victorian Eye & Ear

Hospital

[44] *Submission* 13, Family and Community Development Committee, Southern Health

[45] *Submission* 13, Family and Community Development Committee, Southern Health

[46] Amongst the associations the community members have are connections with St Joseph's Catholic Church Social Justice Group, Child Support Agency, Silver Circle home care, the Victorian Road Accident Support Association Inc, the Southern Ethnic Advisory and Advocacy Inc, RoadSafe Outer South East Inc, St Anthony Coptic Orthodox College of Frankston, Kingston Council Access and Equity and Advisory Committee, Cranbourne Community Health Service, Cranbourne Ambulance Auxiliary, St Johns Anglican Church, Shire of Cardinia, City of Greater Dandenong customer Research Panel, Shalimar Park Pre-School, Marionite Catholic Church, St Gerald's Primary School, Community Service Representative at Killester College, Red Cross, @55 Bus Project, Health Issues Centre, Australian Privacy Foundation, Office of the Federal Privacy Commissioner's Privacy Roundtable, Victorian Electronic Services Delivery Network Group, Breastcare Consumer Reference Group at Southern Health, National Council of Women Victoria.

[47] *Submission* 13, Family and Community Development Committee, Southern Health

[48] *Submission 10*, Family and Community Development Committee, St Vincents Health

[49] *Submission 10*, Family and Community Development Committee, St Vincents Health

[50] *Submission 10*, Family and Community Development Committee, St Vincents Health

[51] *Submission 8*, Family and Community Development Committee, Western Health

[52] *Submission 8*, Family and Community Development Committee, Western Health

[53] *Submission 8*, Family and Community Development Committee, Western Health

[54] *Submission 4,* Family and Community Development Committee, The Royal Women's Hospital

[55] *Submission 4*, Family and Community Development Committee, The Royal Women's Hospital

CHAPTER THREE
WORK PROGRAMS, ACHIEVEMENTS AND ORGANISATIONAL RELATIONSHIPS

Introduction

3.1 The role of the Community Advisory Committee is the major determinant of the work which it chooses to do and the nature of the relationships it chooses to build within the community and the health service itself. It is also a major component in determining the character of the membership CAC itself. This chapter discusses the roles of the CACs in general and specific: examining the non-statutory guidelines, variations between CACs and the effect on their work programmes and organisation.

The Role of Community Advisory Committees

The Non-Statutory Guidelines

3.2 The type of work a Community Advisory Committee undertakes flows directly from its role, both self-determined and as prescribed by the *Community Advisory Committee Guidelines: Non-Statutory Guidelines for Metropolitan Health Services* (hereafter "the Guidelines").

3.3 These Guidelines mandate the following activities:

1. "Advising the Health Service Board on the appropriate structures and processes necessary within the Health Service to ensure effective consumer and community participation at all levels of service planning and delivery;
2. Identifying and advising the Health Service Board on priority areas and issues requiring consumer and community participation;
3. Developing a strategic CPP for approval by Health Service Board, and monitoring the implementation and effectiveness of the approved Plan;
4. Advocating on behalf of the community, including promotion of greater attention and sensitivity to the needs of disadvantaged and marginalised consumers and communities;
5. Facilitating two-way communication between consumer and community groups and the Health Service;
6. Participating in the Health Service strategic planning process; and
7. Participating in the development and ongoing monitoring of key performance indicators for Health Service quality."[1]

3.4 The Guidelines further state that the role of a CAC may encompass:

1. "Directly advising the Health Service Board on consumer and community issues relevant to specific health service initiatives and services;
2. Monitoring the quality and accessibility of the Health Service as a whole or its component services and departments;

3. educating Health Service staff on the benefits to be gained from effective consumer and community participation."[2]

The specific content and direction of these activities is for each CAC to determine, based on the needs of their own Health Service and community.

3.5 As required by the Guidelines, each CAC has developed its own Terms of Reference. Without exception, these closely reflect the mandated activities outlined in the Guidelines.

3.6 In the course of the public hearings conducted by the Committee, it became evident that there was debate about whether the role of a CAC was predominantly strategic (planning and monitoring) or operational (developing and implementing).

3.7 A strategic role is strongly implied by the Guidelines with the requirement that CACs be involved in the Health Service's strategic planning process and the specific reference to a strategic CPP. As the Guidelines make clear, the CAC will be

> "a high level committee which will provide a central focus for all strategies and mechanisms for community participation and consumer involvement in the Health Service. The Community Advisory Committee will be an enabler of community participation, rather than representing the sole response of the Health Service to its responsibility to engage the community."[3]

Further, the CAC will have a "predominant responsibility to advise on governance, policy and strategy in relation to community participation and its impact on Health Service outcomes."[4] This specifies the advisory functions of CACs rather than any governance function, i.e. they do no act as a Board.

3.9 The Guidelines emphasise the need for CACs to audit, develop and direct community participation throughout the Health Service in a strategic manner. This does not preclude CACs from becoming involved in operational matters (ward redesign, the improvement of facilities for carers etc). Indeed, their mandated role of "identifying and advising the Health Service Board on priority areas and issues" suggests that CAC members should be proactive in acquiring and acting upon consumer feedback. Involvement in some operational matters is almost unavoidable.

3.10 Many of the CACs commented on the balancing act between a strategic and operational function. There was a strong view presented by members of various CACs that the more strategically oriented the CAC, the more successful it was likely to be. In the case of Austin Health, Ms Jo Manton, a Board member and Chair of the CAC articulated this view:

> "I think we have interpreted what we believe the guidelines are about. The guidelines to us are pretty much about big-picture strategic planning. They didn't include the small picture, the coffee you've just talked about. But I think in reality we have recognised that in an organisation of this size it would be a waste of our resources to be concentrating on the small picture issues to a large degree. The things we can influence more, I believe, are the big picture issues we have talked about – the strategic planning, the consumer information – which has been crucial…While we sometimes get down to actually, "Yes, let's" – like the poster that is going to be put up in the emergency department – it is more about a strategic direction.
>
> The guidelines talk about that. I think we were quite clear in the early days that that is really what the role was to be; it was supposed to be the bigger picture strategic planning role. I think we have taken that on board fairly quickly and fairly well. I don't know

> whether we have had any real confusion about that…I think there is a difference between strategic directional tasks and day-to-day hands-on tasks."[5]

3.11 Ms Sharon Butler, Board member and Chair of the Royal Children's Hospital CAC commented on the challenge of defining a role for the CAC and the balance between strategic and operational roles:

> "We did actually spend a bit of time talking about what have been the barriers to being able to operate effectively. And I think one of the challenges is around clarity of role. What is the actual role of the Community Advisory Committee? Is it in fact to do these things…or is it to put forward, to advise that this is what should happen and these are the sort of processes as to how they should go about it.
>
> I think that role clarity is really critical…I think more…strategic rather than an operational focus is really important. Because operationally…it is relatively easy to keep people busy, but what we need to do is to make sure the work is meaningful, not just busy."[6]

3.12 The balance between a strategic and operational role for CAC is a difficult and necessary feat. As Ms Fiona Smith, chair of the CAC at the Royal Victorian Eye and Ear Hospital commented,

> "On the question of strategic involvement versus practical issues, I do not think you will ever get rid of that tension. The reality is that you do not want to try and make the CAC a replacement board. You have got to allow the board to do its governance and strategic decision-making and planning. It is how the CAC fits with that which is the really tricky thing we are all learning about."[7]

It is vital to the success of CACs that they be clear on their role within the Health Service. Once this has been clarified, the CAC is able to work effectively for the benefit of consumers and the Health Service.

The work of Community Advisory Committees

3.13 The following are examples of the work of various CACs, grouped according to the activities mandated by the Guidelines.

Provision of advice to ensure effective consumer and community participation at all levels of planning and delivery; Identifying and advising the Health Service Board on priority areas and issues requiring consumer and community participation

3.14 The CAC of the Children's Hospital has been able to combine these roles. It has achieved significant results in resolving ongoing car parking issues for parents and has been active in the development of a Family Resource Centre which caters for the diverse needs of families whose relative is receiving treatment. The CAC was operationally linked to the needs of consumers through an issues database and was able to propose, develop and monitor the implementation of the Family Resource Centre.[8]

3.15 Similarly, the CAC of the Royal Women's Hospital was able to have input into the Hospital's redevelopment: in recommending and monitoring the form of community consultation and in the design phase. As was noted by a committee member, it required a process of discussing options with a meaningful timeframe for a response, having the CAC's views listened to and acted upon.[9]

3.16 These instances serve to exemplify the positive impact that a CAC can have on the quality of services offered by a Health Service. It also reinforces the necessity of good relationships and understanding between the CAC and the Health Service Board.

Advocating to the Health Service Board on behalf of the community; Facilitating communication between consumer and community groups and the Health Service

3.17 There was general agreement among members of CACs that as much as they represented their community to the Health Service Board they also represented the Health Service to the community. They were aware that part of their role was to go back into the community to share information and encourage individuals, community and consumer groups to communicate their needs and ideas.

3.18 Ms Fiona Smith, Chair of the RVEEH CAC, noted the advocacy role of CACs and how they can facilitate communication between community and Health Service:

> "I think the role of the committee clearly needs to be driving the community strategy that the health service has. It clearly needs to oversight that and its progress. I think it does have a natural advocacy role to the board, and I think that now that we are two years on, a service like the Eye and Ear is becoming braver about the community advisory committee and people are thinking, 'Yes, well, maybe we could resource community forums, with the CAC facilitating that'. So I think the service is getting used to this resource and seeing it as valuable and will become braver and bolder in how it uses it."[10]

Participating in the Health Service strategic planning process

3.19 All CACs have been involved in the annual strategic planning process for each of the Health Service Networks. The form of this involvement differs across CACs. Some observations were made to the Committee in the course of its Inquiry about the ability of CACs to participate effectively and fully in this process. It was noted in one

instance that in the initial stages at least, CAC members doubted that they were able to be heavily involved in the strategic planning process. Another observation was that the limited capacity of a voluntary CAC to deal with the strategic planning issues had led to a change in recruitment focus, with more attention being given to those who are connected to that Health Service's 'communities of interest'.[11]

3.20 The involvement of CACs in Health Services strategic planning was welcomed generally but it has raised issues of the limited capacity of a volunteer group in terms of time, knowledge and resources.

Developing a strategic Community Participation Plan

3.21 A Community Participation Plan (CPP) is an expression of the Health Service's commitment to consumer participation in health. It articulates to the Health Service's community what it understands consumer participation to mean and lays out objectives and activities to implement that view. The CPP is a whole of Health Service strategy for the implementation of effective and wide-ranging community and consumer participation in health. Ideally, a CPP should identify:

- The consumers and community of the Health Service;
- The principles and purpose of consumer participation in health; and
- Clear goals and objectives.

The CPP will contain discrete tasks which become the responsibility of the appropriate senior staff.

3.22 A well-designed CPP places itself in the broader context of service quality and improvement and overviews the current state of consumer participation in health in its Health Service. It explicitly acknowledges and supports the principles and benefits of community

participation (refer to Chapter 1, para. 1.12). For example, Melbourne Health states the following at the beginning of its CPP (2002/03):

> "Some services within Melbourne Health have well developed and formalised consumer participation strategies. Others have well developed processes that are ad-hoc rather than formalised, while other areas have minimal consumer participation. While there is little formal recognition of consumer participation in planning and service development processes, this does not mean there is no informal recognition of its value.
>
> The Committee's short-term objective is to develop an accurate picture of the extent of consumer participation across Melbourne Health, promote the inclusion of consumer participation in planning processes and to enhance organisational capacity to do this. The medium to longer-term outcome is for consumer participation to be acknowledged as an essential part of Melbourne Health's way of operating and, as such, formally integrated into strategic and operational plans and performance indicators."[12]

3.23 These statements express an awareness of current programmes, place importance on the value of community participation, commits Melbourne Health to improving its performance in this area and demonstrates an awareness that successful implementation of community participation initiatives occurs at the strategic and operational levels.

3.24 A very few CPPs were sparse documents that revealed little. Where tasks were defined they were general with little detail about evidence of outcome. Others offered well developed strategies communicated in a clear and precise manner. They had clear strategies, discrete tasks with responsible staff and measurable outcomes. The most developed CPPs demonstrated more elaborate tasks within sophisticated

organisational relationships in addition to discrete tasks, clear lines of responsibility and evidence of outcomes.

Monitoring the quality and accessibility of the Health Service

3.25 Involvement in the Health Service's annual Quality of Care Report was generally agreed to be an important component of the CAC's activities. Both the Austin and Royal Women's CACs made particular mention of their involvement with the Quality of Care Report. They felt that they had been able to contribute significantly to its format and the type of information contained within it so that it was accessible and interesting to their communities.[13]

Recommendation 1: That the boards of Metropolitan Health Services discuss a work plan with the Community Advisory Committee on a 12 monthly basis and fund the CAC to an agreed amount negotiated between the Metropolitan Health Service and the CAC that reflects the needs of the work plan.

Recommendation 2: That a report of activities and outcomes of the Community Participation Plan be included in the Metropolitan Health Service's Annual Report.

Educating Health Service staff on the benefits of consumer participation in health

3.26 It is vital that not only the Health Service Board and members of the CAC have a clear view of their roles, but also staff within the Health

Service. Ns Noala Flynn raised this issue in commenting on the start-up process for the CAC of the Peter MacCallum Cancer Centre:

> "As the chairperson I set up this committee and we wanted people representing the community. We needed them to understand where the role of the advisory committee fitted. It has taken a little while to do that. I think we have got to a good standing now, but it took some time to understand the role and to see what the role was. As the chair the biggest challenge for me was the staff in the hospital understanding the role of the community advisory committee. It was certainly something new. We have done a survey and the community advisory committee members have had the opportunity at each meeting to visit different parts of the hospital and get to be recognised by the staff. That has probably been one of the main challenges."[14]

Resources and Support for Community Advisory Committees

3.27 The following table outlines the self-defined role of each CAC, the resources and support available to it and the payments made (if any) to their members.

Table 1: Resources for Metropolitan Consumer Advisory Committees

CAC	Role	Resources & Support	Payment
Austin	Strategic planning for community participation (CP); quality of care; consumer information; communication between Board, Health Service & community.	Community Development Officer Executive support provided by Executive Director, Ambulatory & Nursing Services	Reimbursement of costs

CAC	Role	Resources & Support	Payment
Bayside Health	To bring the voices of the community into the decision-making processes of Bayside Health in order to: -Develop services that are more responsive to the needs of the catchment population/community -Improve the accessibility, appropriateness and quality of services to consumers.	Community Development Officer	Reimbursement of costs
Royal Children's Hospital **(has its own CAC reporting to the Board of Women's & Children's Health)**	To establish plans and programs through the CAC to ensure effective consumer participation in strategic planing, and service planning, delivery & evaluation.	Community Engagement Consultant Secretariat support provided by WCH executive	Reimbursement of costs
Royal Women's Hospital **(has its own CAC reporting to the Board of Women's & Children's Health)**	To establish plans and programs through the CAC to ensure effective consumer participation in strategic planing, and service planning, delivery & evaluation.	Community Participation Officer Secretariat support provided by WCH executive	Sitting fee
Dental Health Services Victoria	Integrating CP at all levels of operations, planning and policy development; community advocacy; advise on means of increasing quality, accessibility and non-discriminatory practices in provision of services.	CAC Resource Officer	Sitting fee

CAC	Role	Resources & Support	Payment
Eastern Health	To assist Eastern Health to integrate consumer and community views at all levels of its operations, planning and policy development.	CAC Resource Officer	Reimbursement of costs
Melbourne Health	To advise the Board on governance, policy and strategy in relation to community participation and its impact on health service outcomes.	CAC Resource Officer	Reimbursement of costs
Northern Health	To assist the Health Service to appropriately integrate consumer and community views at all levels of its operations, planning and policy development; consumer advocacy.	Community & Primary Care Projects Manager	None for regular CAC activities; reimbursement of some costs for extraordinary activity
Peninsula Health	Fostering greater consumer and community participation in service planning and improvement.	Director of Quality & Customer Services Also has two Community Advisory Groups from northern and southern catchment areas.	Sitting fee available to claim; travel costs
Peter McCallum Cancer Centre	Identify and advise on issues requiring consumer and community participation; consumer advocacy; liaison btw community & Board.	Patient Advocate Secretary A senior executive holds the consumer participation portfolio	Reimbursement of costs

CAC	Role	Resources & Support	Payment
Royal Victorian Eye & Ear Hospital	To assist the Board in integrating consumer and community views at all levels of its operations, planning and policy development; community advocacy.	Community Development Officer Quality and Community Relations team	Reimbursement of costs
Southern Health	To develop, monitor and implement the CPP as part of the Health Service's commitment to community and consumer participation in service planning and improvement.	Executive Officer to the CAC	Reimbursement of costs
St Vincent's Health	To ensure effective consumer and community participation across the Health Service and to assist in monitoring the quality of services provided.	CAC Resource Coordinator Director of Quality & Strategy Manager, Quality and Risk	Reimbursement of costs
Western Health	To assist the Board in strategic planning; consumer advocacy.	Manager, Community Integration	Flat rate for reimbursement of costs, each CAC related activity

Finding 4: The Committee finds that resourcing for Community Advisory Committees needs to be maintained by the Metropolitan Health Service Board at responsible levels adequate to maintain the functional ability of each CAC.

Summary

3.32 The place of the CAC within the Health Service structure is reflected in its work plans and CPPs. A CAC which has strong Board support, a clearly understood and strategic role and whose recommendations are valued will have a clear work plan, discrete and accountable tasks and a manageable timeframe for the implementation of that Plan. CACs that are less secure in their Board support, or are unsure of their place and valued within a Health Service are more likely to have a work plan that is vague in outlook, purpose and timeline and have poorly defined accountability for the completion of tasks. Similarly, CPPs will reflect the status and ability of the CAC and the Health Service's commitment to that CAC.

Membership

3.33 The diverse nature of the CACs across the MHS is often reflected in their membership and recruitment strategies (see Chapter 2). The ambulatory nature of some services coupled with a state-wide catchment means that engaging with consumers (past, present, future) is challenging, while other services seek to find representation over a wide cultural and socio-economic demography. In response to these challenges, most MHS CACs have focused community engagement strategies and membership around treatment groups and relevant community organisations.

3.34 Some CACs, however, felt that the non statutory guidelines placed restrictions on the participation of individuals from chronic illness and community organisations limiting the scope of recruitment:

> We, as has been expressed, also have some difficulties with the membership side of the CAC, which again flows on to what you can expect practically of a committee at this stage. I think there are

> some limitations at the moment within the statutory guidelines for these committees in terms of drawing members from community organisations. Some of that perhaps needs to be looked at.[15]

3.35 With many members currently employed by community organisations it has been important to clarify how CAC members are to 'represent' consumers. The need to clarify the issue of representation was identified when Royal Victorian Eye and Ear Hospital undertook an internal review of their CAC. The consultant engaged to facilitate the feedback process reported that the following questions were raised by members: "Are CAC members representatives of their organisations / interest groups? If CAC members are providing advice on behalf of the community, should the CAC have formal structures to ensure linkages with the community?"

3.36 It was confirmed during the review meeting that members do not represent organisations in their advisory role. As individuals they bring knowledge, experience and information that assists them to give informed, carefully considered advice. Their role is to use their experience and expertise to jointly develop advice and recommendations to the Board.[16]

Recommendation 3: The Committee supports the current membership composition of Community Advisory Committees as outlined in the non-statutory guidelines but recommends a clarification of the ability of members of organisations to become Community Advisory Committee members in an individual capacity.

3.37 In addition to relevant community and chronic illness organisations it was argued that Boards have rarely used their own clients as a resource:

> They come to places like the Chronic Illness Alliance, the Health Issues Centre and so on and say, 'Have you got a person to sit on our advisory committee?', instead of looking at who is in the waiting rooms and their outpatients departments.[17]

3.38 Yet while all CACs stressed the importance of the participation of former clients, difficulties were noted:

> Whilst we have tried to get a good representation from our prospective and existing patient community, that does not necessarily lead to the best participation in terms of the skills of people as well, and indeed their actual representation role.[18]

Such problems could possibly be alleviated by training and development (see below).

3.39 One of the largest obstacles to recruitment experienced by CACs was confusion over role:

> There are difficulties in recruiting people because often the role is not clear. We have just appointed our second round. We have a really good core group now of experienced members so we are now building on that. It is difficult to recruit people because, one, they are not quite sure what their role is; and two, they do not get paid, so they are voluntary.[19]

3.40 Taking the importance of the role of the CAC as contributing to strategic planning issues and giving advice on all areas of programs,

some MHS found it a very hard to ask for a volunteer CAC that met bimonthly given the work load and the amount of information to process. However, formal induction or orientation processes, ongoing training, resource officer support and encouragement at executive and board level were seen as measures to ameliorate these concerns.

> We have a formal orientation procedure for members. They are invited to lots of things within the hospital. We try to involve them in things that are happening within the hospital as well. I cannot emphasise enough that you need support from the top so that it is not just a cosmetic exercise. You also need resourcing. We have a resource officer who looks at on-ground small issues that arise. She actually does the job of a committee on a day-to-day basis for little issues. Then we invite members from different parts of the hospital to address the committee, usually on a monthly basis. They might run different handbooks past us, that sort of thing.[20]

Recommendation 4: That Metropolitan Health Services, including those who provide state-wide services, try to recruit representatives from different age groups, geographic areas, and cultural backgrounds as well as rural areas to serve on Community Advisory Committees to reflect the Health Service's community and its particular characteristics.

Recommendation 5: That Metropolitan Health Services institute induction and ongoing training programs for new members of Community Advisory Committees.

Recommendation 6: That Community Advisory Committees members may be reimbursed for reasonable expenses accepted by the board to acknowledge their contribution and significance to the Health Service.

Relationship with the Board

3.41 The work of the CACs is both proactive and responsive. There is a heavy reliance on access to information to facilitate effective decision making. The guidelines describe CACs as having a responsibility to "assist with two way communication between the healthy service and the community".[21] The effectiveness of the CAC will depend on its credibility with the community, but more importantly, its engagement with the Board and the Executive of the MHS, and its ability to facilitate good communication between hospitals, consumers and community.

Board Representation on CACs

3.42 The most obvious link between CAC and Board is membership. From the chart below it can be seen that most CACs have a similar number of board members on the Committee-normally two or three. In most cases a board member is also the Chairman of the CAC.

3.43 In meetings with CACs two views as to the general relationship of the CAC to the Board were expressed- whether they act as a sub committee of the Board or an advisory Committee to the Board.

Table 2 - Board Representation Metropolitan Consumer Advisory Committees

CAC	Representation	CAC	Representation
Austin	2 Board members	**Northern**	3 Board members; CEO
Bayside	Chair of the Board and at least one additional Director	**Peninsula**	3 Board Members; CEO ex-Officio
Royal Children's	1 Board member; CEO in attendance	**Peter McCallum**	1 Board member
Royal Women's	1 Board member; CEO in attendance	**Royal Vic. Eye & Ear**	2 Board members;
Dental Health Services	2 Board members;	**Southern**	3 Board Members; CEO
Eastern	2 Board members;	**St Vincent's & Mercy**	1 Board member
Melbourne	2 Board members;	**Western**	2 Board Members; CEO

3.44 If the CAC acts as a Board sub-committee the relationship would be more direct and collaborative and representation by the board in CAC membership would be expected:

> Just in terms of the composition of the committee — management, board and so on — what you are trying to create is a collaborative process, not an adversarial one. I think you need to bring board and management along in any of these initiatives. I do not have any problems in the committee asking hard questions, and I would like

> to think that, as chair, even though I am a board member, I play that role fairly strongly, I hope, to support what the committee is trying to do. But ultimately the focus has to be to produce a collaborative outcome so that you can bring about the culture change you want.[22]

3.45 As an advisory committee the membership would be more autonomous and less Board membership would be a necessity:

> On the role of the chair, it has always been my view that to have a robust community advisory committee the chair should be independent of the board but the community advisory committee members at the Eye and Ear do not share that view and I think lots of my colleagues do not share that view, but that is my personal view.[23]

3.46 The difference in this view of CACs can be gauged by the attitude of community members to the participation of Board members. From evidence presented to the Committee it would appear that these attitudes evolve.

3.47 Initially some members of CACs expressed reluctance to express opinions in the presence of Board members and Executive staff but all expressed enthusiasm for the process as committee functions became more familiar and confidence grew:

> We have been lucky in that the chief executive officer of Bayside and the chair of the board have both agreed to attend meetings. There was the dilemma about how the CAC members would feel, and they felt very strongly that while at first they were unable, because of the lack of experience within a complex system, to articulate their views, they wanted them to stay because they wanted them there as an audience, to hear what they had to say. That worked extremely well. They are now very confident in challenging the decisions and asking for things to be tabled. I know there were CACs that did not have that level of support, and I think

> having them there has made a difference to how our community advisory committee works. We have other staff members there as well.[24]

3.48 As a corollary it was argued that Boards themselves should in fact take on a higher level of community representation:

> I guess there are a lot of things you could do, but one of the things that would create synergy between board governance and responsibilities and community input is to have more local people on boards.[25]

3.49 However most Board members who were members of CACs felt strongly that they were on the Board as community representatives and thus the most appropriate member to fill both roles:

> I consider myself to be a community rep on the board, because I have no idea why I was voted on otherwise when I applied. I consider myself to be a local community member on the board.[26]

> I was appointed to the board I believe as someone who could articulate the views of the community, given that I was working at the Brotherhood of St Laurence and I had worked in local government.[27]

> I have been chair of the CAC at the Peter MacCallum Cancer Centre for three years. I have come onto the board with a strong community interest and background.[28]

3.50 In preparing their submission to the Committee the Royal Victorian Eye and Ear Hospital CAC members considered their impressions of the relationship of the committee with the Board. The committee noted that the size and specialisation of the Hospital allowed for a good relationship with the Board. It was also noted that senior members of Executive and the Board were in regular attendance at the meetings and that the CAC minutes and projects were regular items for

both Executive and Board consideration. The Committee stated that they felt valued by both Executive and the Board. At present the RVEEH has two Board members as representatives on the CAC one who acts as the Chair. As previously stated, this level of Board representation is fairly common amongst all the CACs.

3.51 As part of an initiative to enhance committee functioning, RVEEH conducted a review of all sub – committees in 2002 and recommendations from the CAC review were as follows:

- Continuance of the Chairing of the CAC by a Board member;
- Feedback by the Board on the performance of the CAC on either six monthly or annual basis ;
- Structured input by the Board into the determination of the priority areas for CAC deliberation at least annually; and
- Board requests to the CAC for advice and recommendations on an 'as needed' basis. [29]

3.52 The review also identified the potential for the CAC to become a resource for hospital management and it has since been utilised for such issues as master planning, infrastructure upgrades and advise on internal committees.

3.53 These views are a reasonable characterisation of the views of all CACs to the inclusion of Board members on the CAC. There was also widespread support for the Board member to act as the chair of the CAC:

> I think that having a board member as chair helps very much with the collaborative process. I guess my feeling is that the board has some operational imperatives that it needs to be concerned about. That cannot help but taint the way in which you chair and guide the CAC. I know I am alone here, but that has never stopped me, but I think that to have a robust CAC having a robust chair that is not

> caught up in the operational imperatives that the board might be, could be a healthy thing. Again, not being prescriptive about it, some of us could try that in the next three or five years to see how that works.[30]

3.54 Yet although the participation of Board members on the CAC was seen to be a significant advantage in increasing effectiveness, most CACs wanted the Board to clearly define their role and in some cases define areas of activity:

> In some cases boards need to be bolder, as obviously is happening in some cases, about giving the CACs a clearer and broader role.[31]

> The reality is that you do not want to try and make the CAC a replacement board. You have got to allow the board to do its governance and strategic decision-making and planning. It is how the CAC fits with that which is the really tricky thing we are all learning about. [32]

3.55 In summary, while the practice of Board members acting on CACs was seen as a benefit creating a necessary conduit, as well as a CAC voice on the Board itself, there was seen to be a need for the development of more formal mechanisms of communication between both groups as a whole.

Recommendation 7: That seventy-five percent of community representatives of Community Advisory Committees be community members who are not involved in provision of health services and that a maximum of two members of the Board, including the Chair, also be members of the Community Advisory Committee.

Recommendation 8: That Metropolitan Health Service Boards in consultation with Community Advisory Committees adopt a formal reporting process in order to facilitate two-way communication.

Communication between the CAC and the Board

3.56 A major issue for the successful functioning of CACs is communication between the CAC and the Board:

> You need to work hard at creating as much interaction as you can between the board and the community advisory committee — and that is a challenge. Everyone's time is precious and that is a challenge. But that is the key to it, I think. [33]

3.57 In earlier attempts at community and consumer participation this had been a stumbling block:

> With the previous committee, before the one set up under the terms of reference we all have, in that case it was virtually 50 per cent community and 50 per cent divisional directors from the hospital. The community representatives met for an hour first and then the divisional representatives came in for the second part. The difficulty was that the minutes never went anywhere near the board, and there was no real activity as a result of it all.[34]

3.58 Some Committees commented on members feeling confused as to their function as feedback on CAC activity from the Board was limited:

> One of the committee members who has been on for a while said that she does not feel embedded in the system. She does not feel that role is authentic. We have to develop mechanisms to make people feel they are as much part of the system as the board members who are appointed, to have a role that is clear and that they are actively involved in — that they are identified very clearly as people within the system.[35]

> The community advisory committee members see their role as an advisory body to the board of directors. They would like to get involved in a lot of things happening in Southern Health, but they do not know whether their role or the issues they put up have been taken into account. We have decided that anything that they participate in terms of providing advice to the board we would like to get feedback on — how the advice has been taken, whether it has been accepted by the board. Because at the end of the day it is the board of directors who make the decisions. [36]

> We did an evaluation a year ago, and the CAC members said, 'We want the board to give us more feedback about what it does with our advice and recommendations' and, 'We want the board to help us settle a list of priorities and projects that we will work on, because we want to know that we are really relevant to what you are doing as a board'. [37]

3.59 Most CACs felt that mechanisms for communication needed to exist to create a fluid two way flow of information:

> …there need to be more formal processes, such as how do we get information up to the board and back from the board — how do we get advice up and back? I think those strategic matters need to be addressed. [38]

3.60 As an example, the RVEEH has adopted a series of communication mechanisms which operate between the CAC and the Board:

- CAC Minutes are provided on a regular basis to the Board along with additional Briefing notes and reports as requested by the Board from time to time;
- Two Board members, along with the CEO, attend the bi-monthly CAC meetings;

- Chairman and CEO attend significant events including celebrations and orientation sessions; and
- Feedback and CAC instigated programs are convened via formal papers to the Board, generated and researched by the allocated CAC Resource Officer (Community Development Officer).[39]

3.61 Other CACs have similar mechanisms to facilitate the flow of information between the board and the CAC:

> The members have been very involved in being part of the hospital, so they have been involved as representatives on the quality committee and on the ethics committee. An executive sponsor comes to the CAC meetings, and members put recommendations that go back to the executive and then to the board. [40]

> Our CAC members are invited to participate in the strategic planning and service development processes. At the same time, with any documentation we circulate to them we ask them to respond by email, by fax or in person, so our CAC members are very well involved in that way including the whole broad strategy of Eastern Health.[41]

3.62 Other CACs wanted to make the flow of communication more formal:

> The other issue that the community advisory committee is keen on developing — although we have not called it 'core business' — is the embedding in legislation that you have to do a community and consumer assessment prior to changing anything that is in the strategic plan, so that if you are going to close a service the CAC is advised of that and has a view on it although its members may not agree, and that the community is advised on any new initiatives.[42]

Recommendation 9: That Community Advisory Committees be consulted by the Board regarding major strategic changes to hospital policy or services to the community.

Relationship with Senior Management and Medical Staff

Relationship with CEO and Senior Management

3.63 All of the CACs the Committee met with expressed a good working relationship with hospital management by either having the executive officer on the committee, regularly in attendance, or attending as an *ex officio* member (see Table 2). Similarly to the participation of board members CACs viewed this positively as a link between the CAC and senior management. [43] In addition, many CACs had other representatives of senior staff, such as the director of planning or the director of nursing in an attendance in an advisory capacity.[44] Many CACs felt that this executive level involvement in the CAC sent "a clear message to the organisation about the importance of the CAC." [45]

3.64 The question did arise, however, as to the ability of the CAC to have the confidence to speak freely and frankly and act independently in the presence of senior management. Some CACs felt that this was a necessary sacrifice:

> They do not have to be there. I see it as a trade-off, in a way. If you want to get action, then you need to have representation in management and the board, otherwise you can meet in camera all the time and it goes nowhere; no-one takes any notice. [46]

3.65 Others saw the Chair of the CAC having a positive role in maintaining autonomy:

> I am a board member and I am also a chair of a CAC, and I see my role as being responsible to the board and also responsible to the community. I definitely would not let the CEO dominate a meeting or run the meeting that he wants to. He is only there to respond to questions or give information.[47]

3.66 It was also suggested that such problems could be alleviated procedurally:

> …quite often matters are discussed in camera, if you like, and we say, 'We would like to have 20 minutes or half an hour before we invite the chief executive and the executive director to come in'. They attend the meeting, but I do not think they are officially members of the committee as such. [48]

Relationship with Staff

3.67 As a committee whose main aim is to embed a community and consumer perspective within the health service, the most important relationship the CACs engage in is that with staff in general. This can also prove to be the most problematic and pose the biggest challenge:

> The issue that I have tried to work on throughout that three years is the development of community participation as something that was core business for the organisational part of Dental Health Services Victoria (DHSV) to deliver. That has been a slow journey because I think the culture of clinical people is not one where the community is a strong force in the way they make decisions. [49]

> Our clinicians have an entrenched culture, so we would like our CAC to slowly change the culture...[50]

3.68 The Committee heard three different responses to this challenge. The first was the reliance on the relationship forged between the CAC, the Board and the senior management:

> The nature of our CAC is such that we have the executive director of the RWH, who is a member, come to every meeting. The chief executive comes quarterly. We have an annual strategic planning meeting, which the chief executive and the executive director both attend, so it all becomes part of the general strategic plan of the hospital. We have noticed that there has been more of an acceptance with the hospital. Staff feel more comfortable. Initially everyone is very suspicious of this whole notion of community participation, which I am sure everyone here has recognised, but people then realise it is not something to be afraid of and that it gives staff and patients some avenue to have matters addressed...[51]

3.69 The second was education and communication:

> In relation to the cultural change, the biggest challenge that I found particularly was actually educating professionals in the hospital about the community advisory committees. I felt they were threatened by the community advisory committees. That was the biggest challenge, I think, in bringing them on board. We have just recently done a survey of the staff to find out and got back some really good reports. Every month community advisory committees do a tour of a particular part of the hospital. In doing this survey and asking people how they knew about it there has certainly been a bit of a change, but that was one of the biggest challenges — getting it through the health professionals in the hospital.[52]

3.70 The third was including community participation as a key performance indicator for chief executive officers which would necessitate a response throughout the whole organisation:

> One of the things I would like to see, if there were ever any model key performance indicators suggested for chief executive officers, is that community participation be one of the elements in the model KPIs that might be provided to health services for establishing KPIs in any particular year.[53]

In this context the CAC would be viewed as the intermediary between the community and the organisation and a necessary consultant on all structural change and development.

Recommendation 10: That senior executive staff whose contract details are determined by the Board have benchmarks for consumer participation included in their performance assessment.

Recommendation 11: That Metropolitan Health Services undertake a biennial consumer participation audit in consultation with the Consumer Advisory Committee to facilitate consumer and community engagement. The need for these audits could be reviewed after the first four years.

Training and Research

3.71 All of the CACs stressed the importance of ongoing training for members:

> I think it is a learning and a development process. You need to upskill your members along the way.[54]

3.72 The Committee received evidence supporting the participation of CAC members in conferences and seminars on community and health consumer issues, as well as possible up-skilling in electronic media. It was also suggested that prospective CAC members have the opportunity to attend meetings before formal induction to familiarise themselves with procedures and functions.[55]

3.73 It was argued that not only would this prepare members for constructive committee service but ongoing training as well as sponsorship to attend conferences and other capacity building exercises would be seen as recognition of the member's role in the Metropolitan Health Service.[56]

Recommendation 12: That Metropolitan Health Services enable prospective members to observe other Community Advisory Committees in action and learn about their activities.

Recommendation 13: That the role of Community Advisory Committees is promulgated by the Board and senior management to enhance health staff understanding of the value of community and consumer participation.

Recommendation 14: That Community Advisory Committees receive adequate levels of secretariat support to fulfil the activities associated with their workplan.

3.74 The Committee also received evidence that the ongoing development of CACs in Metropolitan Health Services could be hampered by a lack of research that specifically addresses consumer and community participation in the hospital setting using the committee

model. Health Issues Centre believes that there needs to be a more sophisticated understanding of consumer and community participation as a quality assurance mechanism. In this view a better understanding of effective strategies in different service contexts and in different population groups is essential for developing an evidence base. Practitioners, managers, CEOs and Board members need credible and compelling evidence about benefits and successful techniques for working in collaboration with consumers.[57]

3.75 At the same time, the people who have been members of, and working with, CACs have a wealth of knowledge about effective processes and tangible outcomes that should be documented, critically analysed, collated and disseminated. Qualitative research and evaluation could deliver insightful analysis about the impact of CACs, and consumer and community participation, on standards of care in the acute setting, and make practical recommendations about constructive change at all levels.[58]

3.76 This research could be used to inform the development of resources to support consumers, staff and management to work in partnerships that build knowledge and understanding of the benefits of consumer and community participation.

Recommendation 15: That ongoing research be undertaken by the Health Issues Centre to monitor the performance of Community Advisory Committees.

Endnotes

[1] Department of Human Services. (2000). *Community Advisory Committee Guidelines: Non-Statutory Guidelines for Metropolitan Health Services*. Melbourne: Acute Health Division. pp. 5-6.

[2] Ibid. p. 6.

[3] Ibid. p. 5, emphasis added.

[4] Ibid. p. 5.

[5] Austin Health. (2003). Public Hearing. Melbourne: Family & Community Development Committee. pp. 8-9.

[6] Royal Children's Hospital. (2003). Public Hearing. Melbourne: Family & Community Development Committee. p. 16.

[7] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee. p. 11.

[8] Royal Children's Hospital. (2003). Public Hearing. Melbourne: Family & Community Development Committee. pp.10-11.

[9] Royal Women's Hospital. (2003). Public Hearing. Melbourne: Family & Community Development Committee. See p. 14; also pp 16-17.

[10] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee. p. 6.

[11] Ibid. pp. 5-6.

[12] Melbourne Health. (2002). *Community Participation Plan*. Melbourne. p. 2.

[13] Austin Health. (2003). Public Hearing. Melbourne: Family & Community Development Committee, Royal Women's Hospital. (2003), p. 2; Public Hearing. Melbourne: Family & Community Development Committee. p. 11.

[14] Peter MacCallum Cancer Centre. (2003). Public Hearing. Melbourne: Family & Community Development Committee. p.18.

[15] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee. Mr Charles Griss, St Vincent's & Mercy.

[16] *Submission 2*, *Family and Community Development Committee,* The Royal Victorian Eye & Ear Hospital

[17] Dr C. Walker, Chief Executive Officer, Chronic Illness Alliance. Public Hearing. Melbourne: Family & Community Development Committee.

[18] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee. Mr Charles Griss, St Vincent's & Mercy.

[19] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee. Ms Jenni Lee, Bayside.

[20] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee. Ms Elaine Canty, Women's.

[21] Department of Human Services. (2000). *Community Advisory Committee Guidelines: Non-Statutory Guidelines for Metropolitan Health Services*. Melbourne: Acute Health Division.

[22] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee. Mr Charles Griss, St Vincent's & Mercy.

[23] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee. Ms Fiona Smith, Royal Victorian Eye and Ear

[24] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee. Ms Jenni Lee, Bayside.

[25] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee.Ms R. Witham, Board Chair, Western Health

[26] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee. Ms D. Macmillan, Peninsula Health.

[27] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee. Ms Natalie Savin, Dental Health Services Victoria.

[28] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee. Ms Noala Flynn, Peter MacCallum.

[29] *Submission 2*, *Family and Community Development Committee,* The Royal Victorian Eye & Ear Hospital

[30] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee. Ms Fiona Smith, Royal Victorian Eye and Ear.

[31] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee. Mr Tony McBride, Health Issues Centre.

[32] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee. Ms Fiona Smith, Royal Victorian Eye and Ear.

[33] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee. Ms Fiona Smith, Royal Victorian Eye and Ear.

[34] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee. Ms Elaine Canty, Women's.

[35] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee. Ms Jenni Lee, Bayside.

[36] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee. Mr N. Melham, Southern.

[37] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee. Ms Fiona Smith, Royal Victorian Eye and Ear.

[38] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee. Ms Jenni Lee, Bayside.

[39] *Submission 2*, *Family and Community Development Committee,* The Royal Victorian Eye & Ear Hospital

[40] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee. Ms Noala Flynn, Peter MacCallum.

[41] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee. Mr Robert Chong, Eastern.

[42] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee. Ms Jenni Lee, Bayside.

[43] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee.Melham

[44] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee. Mr Robert Chong, Eastern.

Submission 13, *Family and Community Development Committee,* Southern Health.

[45] *Submission* 13, *Family and Community Development Committee,* Southern Health

[46] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee. Ms Elaine Canty, Women's.

[47] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee. Mr Robert Chong, Eastern.

[48] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee. Ms Elaine Canty, Women's.

[49] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee. Ms Natalie Savin, Dental Health Services Victoria.

[50] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee. Mr Robert Chong, Eastern.

[51] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee. Ms Elaine Canty, Women's.

[52] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee. Ms Noala Flynn, Peter MacCallum.

[53] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee. Ms Natalie Savin, Dental Health Services Victoria.

[54] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee. Mr Charles Griss, St Vincent's & Mercy.

[55] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee. Mr Robert Chong, Eastern.

[56] Chairs of Community Advisory Committees. (2003). Public Hearing. Melbourne: Family & Community Development Committee. Mr Charles Griss, St Vincent's & Mercy.

[57] *Submission 14*, *Family and Community Development Committee,* Health Issues Centre.

[58] *Submission 14*, *Family and Community Development Committee,* Health Issues Centre.

SUBMISSIONS

	Name	Position	Organisation
1.	Dr David J. Hillis	Chief Executive Officer	Peter MacCallum Cancer Centre
2.	Prof. Graeme Ryan	Chair	Royal Victorian Eye & Ear Hospital
3.	Mr Chris Gibbs	Executive Sponsor, CAC	Melbourne Health
4.	Prof. J. McMeeken	Board Member & Acting Chair, CAC	The Royal Women's Hospital
5.	Dr Michael Walsh	Chief Executive Officer	Bayside Health
6.	Ms Kaye Cole		Private Citizen
7.	Ms Elaine Bennett	Director of Quality Customer Services	Peninsula Health
8.	Ms Rennis Witham	Chair, Western Health Board of Directors	Western Health
9.	Mr Sam Spadafora	Chair, CAC	Northern Health
10.	Ms Mary-Jane White	Quality Manager/CAC Resource Officer	St Vincent's Health
11.	Ms Natalie Savin	Chair, CAC	Dental Health Services Victoria
12.	Mr Robert Chong OAM	Chair, CAC	Eastern Health
13.	Ms Cherie Slater	Executive Officer	Southern Health
14.	Mr Tony McBride Helena Maher	Research & Policy Officer	Health Issues Centre Inc.
15.	Ms Marie Ellis	Secretary to Austin Health Board	Austin & Repatriation Medical Centre
16.	Prof. Paddy Dewan	Pediatric and Fetal Urologist	Sunshine Hospital

WITNESSES

Chairs of the Metropolitan Health Services Community Advisory Committees

Ms R. Witham, Board Chair, Western Health

Ms D. Macmillan, Chair, Community Advisory Committee, Peninsula Health

Ms N. Savin, Chair, Community Advisory Committee, Dental Health Services Victoria

Ms N. Flynn, Chair, Community Advisory Committee, Peter MacCallum Cancer Centre

Ms J. Lee, Chair, Community Advisory Committee, Bayside Health

Ms F. Smith, Chair, Community Advisory Committee, Royal Victorian Eye and Ear Hospital

Mr C. Griss, Board Member and Chair, Community Advisory Committee, St Vincent's Health

Mr R. Chong, Board Member and Chair, Community Advisory Committee, Eastern Health

Mr T. McBride, Health Issues Centre

Ms E. Canty, Community Advisory Committee, Women's and Children's Health

Mr N. Melhem, Board member and Chair, Community Advisory Committee, Southern Health

Austin Health Community Advisory Committee

J. Williams, CEO,

T. Daly, Board Chair,

J. Manton, CAC Chair/board member

H. Ainsworth, CAC member

R. Elworthy, CAC member

M. Fenech, CAC member

R. Finn, CAC member

K. Kingsbury, CAC member

R. Parker, CAC member

M. Petty, Executive Director, Ambulatory and Nursing Services

L. DuBourg, CSU Manager Surgery

Peninsula Health Community Advisory Committee

Mr J. Young, Director, Peninsula Health

Ms D. Macmillan, Director, Peninsula Health and Chairman, Peninsula Health Community Advisory Committee

Ms E. Bennett, Director Quality and Customer Services, Peninsula Health, and Resource Officer, Peninsula Health Community Advisory Committee

Ms B. Hasler, Chairman, Northern Group, Peninsula Health Community Advisory Committee

Ms Jacques, Chairman, Southern Group, Peninsula Health Community Advisory Committee

Ms M. Rowe, Member, Peninsula Health Community Advisory Committee

Ms D. Houghton, Member, Peninsula Health Community Advisory Committee

Mr F. Thompson, Member, Peninsula Health Community Advisory Committee

Dr S. Devanesen, Chief Executive Officer, Peninsula Health

Ms E. Wilson, Executive Director, Rosebud Hospital, and Convenor, Southern Group, Peninsula Health Community Advisory Committee

Dr P. Bradford, Executive Director Medical Services, Peninsula Health, and Co-convenor, Peninsula Health Community Advisory Committee

Peter MacCallum Cancer Institute Community Advisory Committee

Dr H. Wellington (Chair)

Ms N. Flynn, Director

Dr D. Hillis, Chief Executive Officer

Ms J. Tate, General Manager, Radiation and Oncology Division

Ms H. Lampshire, Quality Manager

Ms M. Rydberg, Member, Community Advisory Committee

Mr I. Allen, Member, Community Advisory Committee

Ms J. Moss, Hospital Complaints Manager

Royal Childrens' Hospital Community Advisory Committee

Sharon Butler, WCH Board (Chair)

Christine Minogue, RCH, Divisional Director (Nursing), Community Division

Dr Donna Lawlor, Association for Children with a Disability

Christine Walker, Chronic Illness Alliance

Joanne Tamlyn, Chronic Illness Alliance

Angela McNicol-Smith (Parent Advocate)

Peter Phillips (Parent Advocate)

Angela Clarke, VicHealth Koori Health Research and Community Development Unit

May Helou, Islamic Council of Victoria

Judith Smith, RCH Customer Liaison Officer

Kay Gibbons, RCH, Nutrition and Food Services, Allied Health

Jane Miller, RCH, Social Work

Peter Bunworth, WCH Board Secretary

Cas O'Neill, RCH, CAC Resource Officer

Royal Women's Hospital Community Advisory Committee

Prof. J. McMeeken, Board Member and Acting Chair

Ms D. Fisher, CEO

Ms M. Draper, CAC Member

Ms T. Greenway, CAC Member

Ms V. Garner, CAC Member

Ms C. Ferlazzo, CAC Member

Ms K. Ahmed, CAC Member

Council on the Ageing

Ms Vivian McCutcheon, President

Ms J. Thompson, Policy Manager

Health Issues Centre

Mr T. McBride, Chief Executive Officer

Ms H. Maher, Research and Policy Officer

Department of Human Services

Dr J. Bartlett, Chief Clinical Adviser

Ms C. Harmer, Senior Project Officer, Consumer Participation and Information Program

Professor Paddy Dewan, Pediatric and Fetal Urologist, Sunshine Hospital.(in camera)

Dr C. Walker, Chief Executive Officer, Chronic Illness Alliance.

Ms J. Donovan, Consumers Health Forum of Australia.

EXTRACTS FROM THE PROCEEDINGS

The following extracts from the Minutes of Proceedings of the Committee show Divisions that occurred during the consideration of the draft report on Monday 31 May 2004.

Hon. David M. Davis, MLC moved that:
"Before publishing the report, the Committee obtain from the Metropolitan Health Services, precise resourcing costs of the Community Advisory Committees and that this information be included in the report."

This was seconded by Mrs Helen J. Shardey, MLA.

The Committee then divided:

Ayes 2	**Noes 3**
Hon. David M. Davis, MLC	Ms Heather McTaggart, MLA
Mrs Helen J. Shardey, MLA	Ms Lisa Neville, MLA
	Mr Dale Wilson, MLA

The motion was defeated.

The Hon. David M. Davis, MLC moved a further motion that:
"The Committee insert a section that discusses the impact of the Metropolitan Health Service Governance Review and the implications of its recommendations for Community Advisory Committees and their relationship with Metropolitan Health Services boards."

This was seconded by Mrs Helen J. Shardey, MLA.

The Committee then divided:

Ayes 2	**Noes 3**
Hon. David M. Davis, MLC	Ms Heather McTaggart, MLA
Mrs Helen J. Shardey, MLA	Ms Lisa Neville, MLA
	Mr Dale Wilson, MLA

The motion was defeated.

Minority Report of Members of the Family and Community Development Committee on Community Advisory Committees of Metropolitan Health Services

We regret that it has been necessary to write a minority report on this important Inquiry into Community Advisory Committees.

The undersigned members strongly support consumer and community participation in the decision making of health services. We were impressed throughout the Inquiry by the obvious commitment and enthusiasm of members of the CAC's that we met. We formed the view that CAC's perform a valuable role and make a significant contribution to providing community input into the decisions of metropolitan health services.

The reasons it is necessary to write this report are:

1. Failure to obtain critical background financial information on Community Advisory Committees

The decision by the Committee to not obtain critical information about the financial and administrative support currently provided by Metropolitan Health Services to the Community Advisory Committees has seriously weakened the report.

Labor members voted against a straightforward resolution to obtain critical background information about the costs of running CACs and repeated requests for this information were ignored. Without this basic information the whole report is seriously weakened.

We draw the readers attention to Table 1 – Resources for Metropolitan Consumer Advisory Committees which while a useful table is not sufficient to provide a strong base on which to make broad recommendations about the resources that Community Advisory Committees require.

It is also impossible to adequately compare the effectiveness of the different models of CAC adopted by the various Metropolitan Health Services. The range of models of community participation we were exposed to was considerable but without any ability to balance the costs of those models the reliability of the Inquiry recommendations is lessened.

The Victorian community have a right to know if they are receiving value for money especially where precious health resources are diverted to tasks other than the direct delivery of health care. Of course it is important to note that consumer participation is a legitimate and integral part of the delivery of health services but the costs incurred should be transparent.

2. Issues associated with, and raised by, Labor's review of the governance of metropolitan health services.

The Recent Victorian Public Hospital Governance Reform Panel Report contains a series of significant recommendations that have been accepted by the Victorian Government. In fact

the Government currently has legislation before the Parliament that will fundamentally change governance arrangements in Victorian health care forever. This legislation is based on the Governance Panel's recommendations.

The refusal of Labor members of the Committee to insert a section in this report discussing the impact on Community Advisory Committees of the issues raised by the Governance Panel, and to explore openly the serious impact the Bracks Government's planned changes to the governance of metropolitan and major regional health services, means that this report has not grappled with what will be a major impact on CAC's in the near future.

Liberal members believe that the members of the Governance Panel should have been invited to meet with the Committee and discuss their recommendations and research.

The radical changes proposed by the Governance Panel and put into legislation by the Victorian Government will override many of the issues contained within this Family and Community Development Committee report.

The Governance Panel has recommended a massive shift in power centralising authority with the Minister and the Secretary of the Department of Human Services.

The Minister for Health will be given the power to override Board decisions.

The Minister for Health will have also the power to override local decisions either directly or by enforcing a 'statement of priorities' upon the health service that will proscribe – potentially against the will of a local community – the priorities and programs of the health services.

The Minister for Health will be able to appoint up to 2 'delegates' to the Board of a health service. These delegates will attend meetings and speak at meetings. The power of these ministerial 'spies' – as they are being referred to widely - to influence Boards, report back and to override the community's views will be great.

The Governance Panel's report mentions Community Advisory Committees in just three short sections. The only recommendation that appears to reflect CAC's role is the suggestion that CAC's 'might' be incorporated into a Governance Charter.

This weak recommendation of the Governance Panel does not place CAC's in the central position they should occupy. In our view the Family and Community Development Committee should have investigated these aspects in detail.

Under the governance changes the Minister will have the power to appoint an administrator. The relationship of CAC's to such an individual is a matter the Committee should have canvassed.

Health Services will be required under Labor's new plan to formally take into account the interests of the wider public hospital sector. How the advice of local consumers through their CAC will be incorporated into this new structure is not discussed at all.

The Committee should have grappled with the issue of how massively centralised power in the health system, where the Minister can simply override local decisions, is to be reconciled with proper community participation.

The attitude of the Governance Panel to community participation and full consumer involvement with decisions of relevance to them is shown by their list of witnesses. This list does not appear to contain one health consumer or member of the public. Community Advisory Committees were not consulted in any way. The process was conducted largely in secret with no proper public advertisement. In this context it is sad that the Family and Community Development Committee did not take the opportunity to meet with the Governance Panel and ensure that our report filled some of the obvious gaps.

3. Concerns with Committee processes and the behaviour of the Chairman.

It is certainly not the practice of any of those submitting this report to reflect on other members of the Committee. However a series of observation must be made about the conduct of the Inquiry and the process by which evidence was gathered.

Concern 1.
During the adoption of this report the Chairman, Mr Bob Smith, refused to accept a motion from one of those submitting this minority report that called on the Committee to make public all evidence. The fact is that during the adoption of a report members should be entitled to move whatever motions they believe are appropriate.

Importantly Parliamentary Committees work on the principle that while members may have different views on issues that they are able to vote to express those views and that this will at the time a report is adopted be recorded. Such transparency ensures that the Victorian community can judge for themselves the positions adopted by members of Parliament.

It is certainly not good practice nor, we believe within the sprit of the Parliamentary Committees Act for members to be restricted in this way. The Victorian community would be surprised at this conduct.

At another point in the Inquiry the Chairman of the Committee, Mr Bob Smith insisted a journalist leave a public hearing. The relevant Hansard transcript of the public hearing at the Royal Children's Hospital on 6th October 2003 follows.

ROYAL CHILDREN'S HOSPITAL MELBOURNE (6 OCTOBER 2003, Page 5)

The Chair: Is Peter there?

Mr Courtney WALSH (Journalist, Herald Sun): No, he is just waiting for Julie Webber.

THE CHAIR: What is happening?

MR WALSH: He said to me to come in here and make myself comfortable while he speaks to her.

THE CHAIR: Yes, well could you make yourself comfortable out there because I am not sure you are going to stay here, right. I heard what one of the committee members said about being constrained and I am concerned about that. So I would rather have you out there than him out there. So please.

MR WALSH: I request a ruling from the speaker as to this decision.

THE CHAIR: Feel free.

MR WALSH: So I will just sit there?

THE CHAIR: Yes, make yourself comfortable. Well, actually I would prefer if you were outside. If you want to play games you can play outside.

MR DAVIS: Can I just register my protest to that decision and indicate that I think it is an attempt to gag the public process that this hearing is founded on and it is quite wrong.

THE CHAIR: Okay, so noted.

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THE CHAIR: Excuse me, there is clearly a test of wills going on here with young Courtney. Courtney, I think I have made it abundantly clear to you.

MR WALSH: I have just been advised again of my right to be here.

THE CHAIR: Well, I am saying to you that if people who are about to give evidence tell me that they will be constrained by the presence of the press, I am saying the press won't be here. So please - - -

MR WALSH: This is a public sitting.

THE CHAIR: Well, I will say it again, if people are going to be constrained with your presence and you weren't invited by myself - - -

MR WALSH: So the hospital has no objection, is that - - -

MR BUNWORTH (WCH Board Secretary): Well, no we have been advised by the Chair that it is a public hearing so obviously that would take precedence over any hospital decision I would imagine.

THE CHAIR: Well, as I said Peter you are the one who indicated that you would be constrained in your evidence before this committee if the press are here.

MR BUNWORTH : I won't be giving evidence.

THE CHAIR: As a result of the press being here?

MR BUNWORTH : No, no, no I wasn't planning to anyway.

THE CHAIR: Okay. Okay, then.

No Victorian with a commitment to open government and transparency can defend the arbitrary decisions of the Chair to attempt the exclusion of a professional journalist form a public hearing. We deplore this decision and advise the Chairman against employing such tactics again.

The Chairman's heavy handed approach does not bring credit to the Committee or to it processes and may be outside the provisions of the Parliamentary Committees Act.

Concern 2.
The Authors of the minority report are also concerned about the veracity of some evidence provided to the Committee. Whilst most witnesses provided information and evidence of great candour it is not known whether some evidence presented to the Committee may have been subject to the Guidelines for submissions and Responses to Inquiries promulgated by the Department of Premier and Cabinet in October 2002.

These guidelines require the vetting of evidence to be presented to Parliamentary inquiries by the relevant Department and by Premier and Cabinet. The authors of this report believe that some attempt should have been made to establish whether there had been compliance with these guidelines and some evidence had been changed by the Department of Human Services or by the Department of Premier and Cabinet.

Concern 3.
The authors are of the view that further evidence should have been taken from further key Community Advisory Committees including, Western Health, Northern Health and particularly from the CAC at the Eye and Ear Hospital which provides unique state-wide services. The growth in eye services as the population ages in the next few years will be significant. Only by hearing directly from those involved in these key CAC's could our Committee fully understand their unique perspectives. This information on top of written material would have strengthened our report.

David Davis MLC

Helen Shardey MLA