

# A clear voice for clinicians and the community

Report of the Clinical and Community Advisory Group

October 2004



**NSW DEPARTMENT OF HEALTH**

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# Introduction

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## Introduction

Ensuring that clinicians and members of the community have a clear voice in health decision-making at local, Area and statewide levels is a key objective of the *Planning Better Health* reforms being introduced within the NSW public health care system.

Every Area Health Service (AHS) will be required to establish an Area Health Advisory Council (AHAC) which will be one of the key ways of achieving greater involvement of clinicians (such as doctors, nurses, allied health professionals, Aboriginal health workers), consumers and community members in the planning and delivery of health services.

In early August 2004, the Minister for Health, the Hon Morris Iemma MP, appointed the Clinical and Community Advisory Group (CCAG) to consult with clinicians and the community on the functions, composition and operation of the Area Health Advisory Councils.

The CCAG was co-chaired by the Rt Hon. Ian Sinclair AC and Ms Wendy McCarthy AO. The other members were:

- Professor Judy Lumby, Executive Director, The College of Nursing
- Mr Noel O'Brien, Former Chair, New England Area Health Board
- Professor John Overton OAM, Anaesthetist (retired) and former Deputy Executive Director, Children's Hospital at Westmead
- Dr Sue Page, National President, Rural Doctors Association
- Mr Tom Slokkee, Former Chair, Southern Area Health Board

## Terms of reference

The terms of reference of the CCAG as outlined in *Planning Better Health* were to conduct consultations with clinicians and the community about:

- The functions of the proposed Area Health Advisory Councils.
- The composition and operation of the proposed Area Health Advisory Councils.
- How the functions and operation of the proposed Area Health Advisory Councils will assist in ensuring that the principles of consumer and community participation as outlined in the *Framework for Managing the Quality of Health Services* and the NSW Health and Equity Statement *In All Fairness – Increasing Equity in Health across NSW* can be addressed.
- Exploring the linkages between existing Area clinician, consumer and community participation structures (including Area Health Service Quality and Clinical Councils) and the proposed Area Health Advisory Councils.
- Exploring the linkages between the Health Care Advisory Council, Clinical Excellence Commission and the Area Health Advisory Councils.
- The ongoing role of the Health Participation Council given the changes to statewide and Area clinical and community structures.

In relation to the last term of reference, CCAG did not have an opportunity to consult formally with the NSW Health Participation Council (HPC) about its future. It is understood that the HPC will be submitting a separate report to the Director-General about this matter.

## Consultation process

During the period 16 August to 29 September, CCAG held 62 consultation sessions in 35 locations across NSW, as follows (see detailed schedule at Appendix A):

Armidale	Nowra	Broken Hill
Tamworth	Penrith	Deniliquin
Gosford	Griffith	Coffs Harbour
Camperdown	Port Macquarie	Grafton
Bathurst	Taree	Westmead
Orange	Dubbo	Parramatta
Queanbeyan	Walgett	Concord
Newcastle	Lismore	Moree
Liverpool	Tweed Heads	Randwick
St Leonards	Albury	Westmead (Children's Hospital)
Wagga Wagga	Batemans Bay	North Sydney
Wollongong	Bega	

Over 2,300 people participated in these sessions, which were publicised in the local media and on the NSW Health website. In addition, CCAG received 190 written submissions.

Numbers attending individual meetings ranged from 15-200, with most meetings attracting between 30-70 people. A rally in Broken Hill which was attended by CCAG members involved considerably larger numbers. Some comments were made about the adequacy of the notice for several meetings (this was most common in the first couple of weeks of the consultation program), and the time of day at which some meetings were held. Notwithstanding its very full schedule, CCAG added several additional consultation sessions to its itinerary in an effort to visit as many local centres as possible within the time available.

## General observations arising from the consultation sessions and submissions

CCAG encountered genuine interest from clinicians and members of the community in the NSW Health reforms as a whole, and in the proposed establishment of Area Health Advisory Councils (AHACs) as part of these reforms.

While the specific brief of CCAG was to consult about the proposed AHACs, issues relating to the larger reforms were also raised by participants at a number of the meetings. Some people were cynical about the reforms while others regarded them as an opportunity for greater involvement by both clinicians and community members. Irrespective of differences in attitude and perspective, all participants were keen to ensure that the changes would deliver significant benefits to the community.

### Size of AHSs and location of Area offices

Many people saw risks in the larger size of the AHSs and the location of the new Area offices. It was feared that these would lead to a centralisation of managerial control and delays in decision-making in relation to local health services. The smaller and more remote communities were apprehensive that their voice would not be heard at the Area level.

Area CEOs will need a management structure with appropriate decision-making authority delegated to local managers. Such arrangements will be critical for developing trust and good working relationships between local communities, clinicians, local health service managers, the Area Executive team, and the CEO.

## Workforce issues

There was widespread support for the redirection of administrative savings to frontline patient care, especially in light of the Minister's commitment that the savings will stay in the Area Health Service in which they are made. However, concern was expressed about a potential reduction in particular positions within the new AHSs, including staff working with local Aboriginal communities. Rural residents were also anxious about the implications of the reforms for local employment opportunities and local businesses, including the sourcing of contracts and supplies.

## Role and composition of the Area Health Advisory Council

The difference between the advisory role of the AHACs and the corporate governance role of the former Area Health Boards was canvassed in all consultations. Some people thought that the AHACs would lack authority while others saw the potential for the Councils to have a significant influence on Area decision-making, provided they developed strong relationships with Area-level clinical and other bodies, and local health participation groups. Adequate resourcing of AHACs will be vital to their effective operation.

Different views were put forward regarding the size and composition of AHACs and the benefits and disadvantages of selecting Council members according to a 'representational' versus an individual 'skills based' model. It was generally recognised that it would not be possible for a group relatively small in number to 'represent', in any direct sense, the many and varied stakeholder interests within an AHS, and that Council members' individual and collective skills would therefore be an important consideration.

## Flexibility

Another issue frequently raised was whether a 'one size fits all' approach should be adopted across all nine AHSs (eight AHSs and the Children's Hospital at Westmead). Some people argued that differences amongst the Areas in terms of geography, demography, service arrangements and participation structures should be reflected in the composition and operation of AHACs. Others acknowledged that introducing a standard model for all AHACs would be more straightforward in terms of legislative provisions and statewide policy, planning and implementation processes. Nonetheless, there was a strong feeling that rural issues are very different from metropolitan issues, and that both differ significantly from remote issues.

# 2 Recommendations

1. General comment
2. Role and Functions
3. Membership
4. Operation

## 1. General comment

The consultations confirmed that there is widespread support for proposals to strengthen the involvement of clinicians and community members in health care decision-making in NSW. The Area Health Advisory Councils (AHACs) have the potential to be a strong 'voice' for all stakeholders within an Area, including clinicians, members of the community and consumer groups. One of the most important benefits of the AHACs will be the opportunity they will provide for clinicians and community members working in partnership.

The effectiveness of each AHAC will depend on the calibre of its members, its relationships with the Area CEO, and its links with other clinical and consumer groups operating at the local community, Area and statewide levels.

## 2. Role and functions

### Charter

Key aspects of the 9 AHACs (8 Area Health Services and the Children's Hospital at Westmead) should be standard across all Areas, and set out in a Charter which addresses, inter alia, the:

- role and functions of the AHACs, including their key relationships
- role and responsibilities of individual members (including a Code of Conduct)
- accountability strategies.

The Charter should reflect the special role and responsibilities of the AHAC for the Children's Hospital at Westmead.

### Key roles

The role of the Councils as proposed in *Planning Better Health* was generally supported by participants in the consultation process.

In general terms, the AHAC should:

1. be a voice for all health stakeholders within the Area (eg doctors, nurses, allied health professionals, Aboriginal health workers, community members, consumer groups, patients and carers) in Area decision-making processes
2. advise and assist the Area CEO in fulfilling his/her responsibility for protecting, promoting, maintaining and improving the health status of the Area's population, and reducing the gap in health status across the population
3. communicate the policies of the AHS to local communities and obtain feedback on them.

In carrying out the above, AHACs should:

- serve as a conduit for two-way communication between local clinicians and communities and the Area Health Service, including the provision of feedback on Area activities to improve the accessibility, quality and equity of services. One way to achieve this might be through approaches to local media using the Chair as the designated spokesperson
- adopt an holistic view of health which encompasses the notions of 'wellbeing' and quality of life and ensures a balanced focus across the full spectrum of health interventions including population health, health promotion, illness prevention, early intervention, acute care, post-acute care, rehabilitation, extended care, palliative care
- function at a strategic rather than an operational level
- establish links with other key clinical and community bodies at the Area and statewide levels, such as the Area Clinical and Quality Councils, the Health Care Advisory Council, the Health Priority Taskforces, the Clinical Excellence Commission.

In line with *Planning Better Health*, the AHAC should provide advice/input to the Area and feedback to local clinicians and communities on the following Area-level processes:

- strategic planning (clinical services, facility, organisational) including identification of major service gaps, appropriate service levels, significant changes in service delivery models, workforce recruitment and development strategies
- priority setting including monitoring the equity of resource allocation within the Area
- policy development in relation to the Area's health services
- monitoring the health status of the Area's population against agreed indicators
- monitoring the Area's performance in promoting and establishing clinical networks
- monitoring the delivery of health services and service access
- developing/consolidating/monitoring the effectiveness of structures and processes for local clinical and community consultation.

AHAC Chairs should be involved in the selection process for Area CEO positions. It is understood that this is not possible for the current recruitment process, but it should be the case for all future appointments.

### Workplan

A rolling two-year workplan for the activities of the AHAC should be developed with the Area CEO and in consultation with clinical and community stakeholders, taking into account the Area Clinical Services Plan. The workplan should identify an agreed budget and should include key performance indicators for monitoring, reviewing and communicating the performance of the AHAC and the Area.

## 3. Membership

### Size and mix

The AHACs in the four largest AHSs – Greater Western, Greater Southern, Hunter New England and North Coast – should have a **maximum of 12 members, in addition to the Chair**, in recognition of their unique characteristics.

The other five AHACs (four AHSs and the Children's Hospital at Westmead) should have a **maximum of eight members, in addition to the Chair**. Where particular issues or special needs are identified in any of these AHSs, the Area CEO and AHAC Chair should be able to make a submission to the Director-General seeking approval to expand the AHAC by up to four more members. Any such submission should consider the financial implications of appointing additional AHAC members within the identified budget.

Each of the AHACs should have a balance of clinicians and community members, with at least one community member being an Aboriginal person.

The Area CEO must attend AHAC meetings but should not be a member of Council.

Factors that must be taken into account in achieving an appropriate mix of members on each AHAC include:

- geography (including communities of different sizes)
- facilities / services (of different sizes and types [eg hospitals, community health services, MPSs])
- clinicians (eg doctors, nurses, allied health professionals, Aboriginal health workers)
- cultural diversity across the Area
- gender
- age
- other significant issues that may affect health service delivery in the Area (eg special needs groups).

### Skills

Separate from the above factors relating to the mix of members on an AHAC, individual Council members must possess certain attributes, and must also have (or demonstrate the capacity to develop) certain skills. These are listed in the following table.

## Recommendations

<b>Knowledge (Desirable)</b>	<b>Skills (Essential)</b>	<b>Attributes (Essential)</b>
<ul style="list-style-type: none"> <li>Awareness of local Area health needs and activities</li> </ul>	<ul style="list-style-type: none"> <li>Teamwork</li> <li>Communication</li> <li>Consultation and negotiation</li> <li>Advocacy</li> <li>Strategic thinking</li> <li>Critical analysis</li> </ul> <p><b>Skills (Desirable)</b></p>	<ul style="list-style-type: none"> <li>Passionate about improving people's health</li> <li>Good standing in the community</li> <li>Existing relevant connections/ networks (community or clinical)</li> <li>Willingness to commit time Integrity/Ethics</li> <li>Objectivity and sense of fairness</li> <li>Flexibility; comfortable with change</li> <li>Cultural sensitivity</li> <li>At least 3 references</li> </ul>
	<ul style="list-style-type: none"> <li>Leadership track record</li> <li>Ability to motivate others</li> </ul>	

The AHAC Chair will require some unique skills and attributes beyond those identified for AHAC members, including:

<b>Knowledge (Desirable)</b>	<b>Skills (Essential)</b>	<b>Attributes (Essential)</b>
<ul style="list-style-type: none"> <li>Management and leadership</li> <li>Effective networks</li> </ul>	<ul style="list-style-type: none"> <li>Effective communication (written, verbal and presentation skills)</li> <li>Conflict resolution</li> <li>Experience as a Chair</li> </ul>	<ul style="list-style-type: none"> <li>Ability to see and convey the 'big picture'</li> <li>Innovative/lateral thinker</li> <li>Fast learner; picks up new concepts quickly</li> <li>Good listener</li> </ul>

The Chair and the majority of AHAC members should live in the Area.

All positions on AHACs should be part-time appointments.

AHACs should have the capacity to co-opt people with specialist knowledge and skills for specific issues for a time limited period.

## Selection process

The selection of Chairs and members of AHACs should be separate processes, and AHAC Chairs should be appointed prior to the selection of other Council members.

The selection process for both should involve a call for nominations via an EOI process followed by interviews of short-listed candidates by a selection panel. The panel will forward its recommendations for appointment to the Minister for decision after mandatory pre-qualifying checks such as a criminal record check.

It is recommended that the CCAG Co-chairs and members be formally involved in the selection process for the inaugural AHAC appointments because of the understanding they have developed of the AHAC's role and the responsibilities of the Chair and members. Subsequent appointments will not require this participation.

The CEO should not be involved in the formal selection processes but should be informally consulted prior to appointments being made.

An information package containing details of the AHAC role and functions and terms and conditions of appointment should be made available to all applicants.

## Periods of appointment

CCAG recommendations regarding periods of appointment for AHAC Chairs and members allow for changes in the composition of the Council while ensuring continuity in its work.

Inaugural Chairs should be appointed for a three year term, with provision for a further four year term.

In relation to the inaugural members of Councils, 50 per cent should be appointed for an initial two year term, and the other 50 per cent for an initial four year term. Both groups of inaugural members should be eligible for a further four year term.

Subsequent appointments of both Chairs and members should be for a four year term with provision for a further four year term.

The maximum period of membership for all AHAC members, including Chairs, should be two terms, after which the individuals concerned will be ineligible

for Council membership. This will ensure an appropriate balance between continuity/experience and the need for fresh ideas and perspectives.

## Reappointment process

Ministerial decisions relating to the reappointment of individual AHAC Chairs should be informed by the Director-General's review of each Chair's work against the role description.

Ministerial decisions relating to the reappointment of individual AHAC members should be informed by a review, involving the AHAC Chair, of each member's work against the role description.

## Vacancy in office

The Chair may retire or resign at any time by letter to the Director-General, and an AHAC member by letter to the Chair, in each instance giving not less than one month's notice.

If the office of Chair, or the position of any member, becomes vacant during the term of appointment, the Director-General or nominee should recommend another person to the Minister for appointment for the balance of that term. The usual selection processes should then apply.

## Leave of absence

In circumstances of demonstrated need, individuals holding AHAC positions should be able to apply for a leave of absence. In the case of members, approval should be sought from the AHAC Chair. In the case of AHAC Chairs, approval should be sought from the Director-General or nominee. Depending on the period of the leave of absence, consideration may be given to replacing the individual through a temporary appointment. In each instance, absences should be reported to the AHAC members.

## Dismissal provision

The Minister, on the advice of the Director-General, should be able to remove the Chair or any member of the AHAC from office. Grounds for removal may include, for example, breaches of criminal law, bankruptcy, breaches of the Code of Conduct, persistent failure to attend meetings, actions which undermine the standing and effectiveness of the AHAC.

## Recommendations

An Induction Manual should be made available to all AHAC members upon commencement outlining the terms and conditions of their appointment including attendance, remuneration, disclosure of any pecuniary or other interests, leave of absence, reappointment and dismissal procedures.

## 4. Operation

### Relationships, communication and accountability

An early and ongoing priority for the AHAC should be to build relationships of mutual accountability characterised by trust, integrity and respect with:

- the Area CEO
- clinical, community and other relevant groups within the AHS boundaries
- local health participation groups
- bodies external to the AHS.

These relationships should be underpinned by open and effective two-way communication.

### Relationship with the Area CEO

Developing an effective working relationship between the CEO, senior staff within the AHS and the AHAC, in particular the Chair, will be critical to the effective functioning of the AHAC.

The CEO's Performance Agreement with the Director-General should contain key performance indicators pertaining to the effectiveness of his/her relationship with the AHAC. When undertaking the CEO's annual performance review, the Director-General should seek input from the AHAC on how well the CEO has performed against these indicators.

### Relationships with clinical, community and other relevant groups within the AHS boundaries

Each AHAC must establish constructive strategic relationships with key clinical and community stakeholder groups operating at Area and sub-Area levels. Links with Area-level clinical bodies such as the Area Medical Staff Executive Council and Nursing Council will be important.

AHAC representation and cross-membership should be considered for relevant internal Area Committees after consultation between the AHAC Chair and the Area CEO.

Each AHAC should meet at least annually with the Area-level group being established to progress the Area Workforce Development Strategy.

Links should be formed between the AHAC and relevant groups and organisations outside the public health system but with an interest in health services within the AHS boundaries. Such groups could include:

- special interest groups such as Aboriginal community controlled organisations
- health, aged care and community care organisations in the private-for-profit and non-government (not-for-profit) sectors
- other NSW and Australian government agencies
- cross-agency Area/Regional level structures such as the Premier's Department Regional Coordination Management Groups.
- Universities and other higher education bodies with an interest and expertise in health education and research.

### Relationship with local health participation groups

The success of AHACs will depend in part upon local health participation groups undertaking vital linking work (co-ordination, negotiations, problem-solving) at the local level and then feeding up to the AHAC those issues which need to be considered and addressed at an Area level. Identifying, maintaining and enhancing existing participation structures at the local level is seen as critical to ensuring an effective two-way communication channel between the AHAC and local communities.

In the first year of the new arrangements involving AHACs, there should be no major consequential changes in pre-existing consultative, advisory and participation structures within each AHS.

During this first year, each AHAC should co-ordinate a review of consultative, advisory and participation structures within the Area in consultation with the groups and individuals involved in those arrangements.

The objectives of this review would be to establish strong working relationships between the AHAC and other relevant Area-level and local groups, and as part of this, to identify opportunities for strengthening local (ie sub-Area) participation and developing an implementation plan to achieve this.

In AHSs where local health participation structures do not exist or are under-developed, the AHAC should work with local communities to establish a minimum of three to four local health participation groups in the Area.

The implementation plan arising from each AHAC review should ensure that, within an agreed period, all local health participation groups within each Area:

- are based in communities and focus on all health needs (not just those met by the local hospital or other facility)
- have a membership which reflects the local community, and represents a balance of community members (including Aboriginal people) and clinicians (including general practitioners)
- invite representation from key stakeholders such as the Ambulance Service of NSW, Local Government, volunteer groups and other key interest groups/organisations
- include local health service managers as members
- receive adequate support from the Area to consult locally, provide advice on key issues to the AHAC, and communicate feedback from the AHAC
- have a designated 'spokesperson' who can liaise with local media and others in relation to issues involving the health participation group following consultation with the local health services manager.

### Relationships with bodies external to the AHS

AHACs should have a relationship with key state-level bodies within NSW Health for matters of statewide relevance. These bodies should include but are not necessarily limited to the:

- Health Care Advisory Council
- Health Priority Taskforces
- Clinical Excellence Commission
- NSW Institute of Rural Clinical Services and Teaching.

The nature of these relationships will require further elaboration, but should include the following:

- a routine two-way flow of information to/from the AHACs
- a formal meeting held at least annually involving all Area CEOs, AHAC Chairs and the HCAC Chair, and chaired by the Director-General. This meeting could be scheduled in conjunction with a meeting of the Senior Executive Advisory Board.
- Periodic formal meetings involving all AHAC Chairs and the Chair and CEO of the Clinical Excellence Commission to ensure consumer/ community involvement in the CEC's work
- Invited attendance at an AHAC meeting of the Co-chairs and/or other members of a particular HPT (relating to issues under discussion at the AHAC meeting).

### Meetings

Details relating to the operation of AHAC meetings should be set out in business rules included in the Induction Manual provided to each AHAC member on appointment.

AHACs should meet for at least 10 days (or day equivalents) per year.

The Chair and AHAC members should set the meeting agenda in consultation with the Area CEO.

AHAC meetings should be held in different locations across the Area.

Regular AHAC meetings should be open to the public (including the media) as observers. Standard provisions in relation to confidentiality should apply and any information or matter which is confidential should be discussed 'in camera'.

The AHAC Chair should be recognised as the official spokesperson for the AHAC on matters within the Council's responsibilities and as agreed with the Area CEO.

Minutes of each meeting should be posted on the AHS website and forwarded to the NSW Department of Health for information. Matters dealt with 'in camera' should be separately minuted and also forwarded to the Department for information.

## Recommendations

AHACs should have the capacity to establish special purpose sub-committees where required, chaired by AHAC members.

Each AHAC should meet periodically with the Chairs of local health participation groups within their Area. This could either be on a whole-of-Area basis, or on a sector basis. In addition to these meetings, the AHAC Chair has an ongoing role in establishing and maintaining relationships with local health participation groups and local communities in general.

### Attendance/participation

All members must attend/participate in at least 80 per cent of meetings each year. This provision can only be varied for an individual member with the approval of the AHAC Chair in consultation with other AHAC members.

Members who cannot attend/participate in a particular meeting are not able to nominate an alternate to attend in their place. This provision can only be varied for an individual member in exceptional circumstances, and with the approval of the AHAC Chair in consultation with other AHAC members.

### Telecommunications

Given the likelihood of AHAC members being geographically dispersed over relatively large distances, it will be important to utilise the potential of telecommunications to facilitate regular communication and avoid unnecessary travel. However, technology should not be used as a routine replacement for face-to-face meetings, which are critical for relationship building.

### Resourcing

Adequate resourcing of the AHAC will be pivotal to its effectiveness, where 'resourcing' includes not only funding but also time and support from the Executive and senior management of the AHS. Each AHAC must be supported by a budget allocation which covers the following:

#### *Support for the AHAC*

- Orientation and development of AHAC members (see section following)
- Secretariat support
- Provision of data, information and analyses in a timely and open manner

- Project support – to undertake special projects, co-opt specialist skills or arrange services such as interpreters if required.
- An annual fee for the Chair and for members (payable quarterly) which represents fair compensation for the time and effort they are expected to give to Council work, as well as reimbursement for travel, accommodation and other incidental expenses. The cost of 'backfilling' a position where this is necessary for an AHAC member to fulfil their Council responsibilities should be taken into account.
- Communications – to support publications, websites, telecommunications such as video and teleconferencing, advertising in local media regarding upcoming meetings.

#### *Support for Chairperson*

- Travel – It will be vital for the AHAC Chair to be able to move around the Area in a time-efficient manner, and in particular, to visit the smaller and outlying communities as well as the larger towns and regional centres. The budget for AHAC operations should be sufficient to meet these travel obligations.
- Telecommunications – The Chair must be provided with a mobile phone, fax machine, computer and internet connection.

In light of the larger size of all AHSs and the travel demands this will place on Area Executive staff and AHAC members particularly in rural and remote NSW, it is recommended that NSW Health considers developing a 'preferred providers' list of charter flight operators who are prepared to offer competitively-priced air transport along frequently travelled routes.

### Orientation and development

All members, including Chairs, should be required to participate in an orientation and development program as a condition of appointment. This program should commence with a one-day orientation workshop at the beginning of the members' term of appointment.

Subsequent development sessions should be spaced throughout the year and may be of shorter duration. Familiarisation with AHS facilities and services should be one component of the orientation and development program. AHAC Chairs should have access to media training.

## Annual forums

The AHAC should hold annual forums in different locations within the AHS. At least one of these meetings should be a strategic alliances forum involving invited senior local representatives from shires/municipalities, Divisions of General Practice, state government human service agencies, non-government not-for-profit organisations, and the private health sector.

Other annual forums should be held which are open to members of the public to provide an opportunity for the AHAC to report back to the local community, answer questions, and hear about matters of particular interest or concern to local groups. The forums should facilitate and build upon existing communication links with the AHAC, and also amongst local groups.

## Accountability

In terms of the AHAC's accountability to the community, each Council should consult with local communities in the Area about the most efficient and effective ways of reporting back to them about its work. As a minimum, AHACs should:

- hold meetings which are open to the public (including the media) as observers
- publish the AHAC workplan and minutes of meetings on the Area's website
- use local media as a vehicle for communicating AHAC business and meeting times to local communities
- prepare and publish an annual Report Card to the community, rated against its workplan and key performance indicators.

## Conflict resolution

A protocol should be developed to address situations where there is a significant and unresolvable difference of opinion between the CEO and the AHAC. The protocol should allow the CEO and AHAC Chair to seek a joint meeting with the Deputy Director-General to discuss the issue and reach agreement on the way forward.

The protocol should clearly identify the situations warranting such escalation and should require demonstrated and genuine attempts by both parties to resolve the issue at the local level before it can be activated. There must also be a requirement for the AHAC to be informed of the outcome of this process.

## Review and evaluation

After the first two years, the AHAC arrangements should be assessed to determine whether they are working efficiently and effectively. This evaluation could involve a combination of self-assessment and independent review, and should include consideration of the capacity of the AHACs to perform their role successfully within the resources allocated (budget, time, support and other).

Commencing at the end of the second year, there should be annual reviews of:

- each AHAC against key performance indicators contained in the AHAC workplan
- individual AHAC members against their role description.

To address community concern regarding the possible 'transience' of the new arrangements, CCAG strongly recommends that the AHAC structure should remain for a period of at least 5 years from its commencement in January 2005 before any alternative structures are proposed or implemented.

# Appendix A: Schedule of consultation sessions

<b>Date</b>	<b>Location</b>	<b>No. of sessions</b>
Monday 16 August	Armidale	2
Tuesday 17 August	Tamworth	2
Thursday 19 August	Gosford	2
	Camperdown (Sydney)	1
Friday 20 August	Bathurst	2
	Orange	2
Saturday 21 August	NSW Medical Staff Executive Council	1
Monday 23 August	Queanbeyan	2
Tuesday 24 August	Newcastle	2
Friday 27 August	Liverpool	2
	St Leonards (Sydney)	2
Saturday 28 August	Wagga Wagga	1
Monday 30 August	Wollongong	2
	Nowra	1
Wednesday 1 September	Penrith	2
	Health Services Association	1
Friday 3 September	Griffith	2
	Port Macquarie	2
	Taree	1
Monday 6 September	Dubbo	2
Tuesday 7 September	Walgett	2
Wednesday 8 September	Lismore	2
	Tweed Heads	1
Thursday 9 September	Albury	2
Friday 10 September		
Monday 13 September	Batemans Bay	1
	Bega	1
Wednesday 15 September	Broken Hill	2
Thursday 16 September		
Friday 17 September	Deniliquin	2
Monday 20 September	Coffs Harbour	2
	Grafton	1
Tuesday 21 September	Westmead (Sydney)	1
	Parramatta	1
	Concord (Sydney)	1
Wednesday 22 September	Moree	2
Thursday 23 September	Randwick (Sydney)	2
Friday 24 September	Senior Executive Advisory Board	1
Tuesday 28 September	Children's Hospital at Westmead	1
Wednesday 29 September	Allied Health Alliance	1
	Australian Salaried Medical Officers Federation	1
	Health Services Union	1
	[AMA and NSWNA unavailable]	
Monday 18 October	Medical Services Committee	1





*“involving clinicians and members of the community in decisions about health services in their Area”*