HEALTH ISSUES CENTRE

Making Space

for the Consumer Voice in Quality and Safety

A RESOURCE GUIDE FOR COMMUNITY ADVISORY COMMITTEES IN PUBLIC HEALTH SERVICES

Making Space

FOR THE CONSUMER VOICE IN QUALITY AND SAFETY

A GUIDE FOR COMMUNITY ADVISORY COMMITTEES IN VICTORIAN PUBLIC HEALTH SERVICES

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A Guide for Community Advisory Committees in Public Health Services
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www.healthissuescentre.org.au

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Section One

Consumer Participation in Quality and Safety: Introduction and Context

Introduction

Community members and consumers apply to join Community Advisory Committees for a variety of reasons, but many are motivated by a drive to change things and a desire to get involved in consumer participation because of their own, their families' or their friends' experiences of care. Sometimes these experiences have been wonderful, and people feel enormously grateful to the health service for saving lives and restoring health to people. Sometimes systems fail; when this happens people want to make sure that the health service recognises its mistakes and addresses problems so that other consumers do not have the same negative experiences.

People's stories can provide a rich source of insight into quality health care, and provide the basis for understanding how the health care system can be improved for everyone.[1] Community Advisory Committees have been established in Victoria as a mechanism for enabling the Boards of Public Health Services to ensure that the health services they provide meet the needs of the community, and that the experiences and views of consumers are taken into account in the decisions made by the Board. Community Advisory Committees have an important role in enabling community views to influence quality and safety in Public Health Services.

Purpose of this Guide

This Resource Guide was developed by Health Issues Centre to assist members of the Community Advisory Committees (CACs) in Victoria's Public Health Services to develop their understanding of quality and safety in health services. It aims to assist CACs to understand how decisions affecting quality and safety are made in Public Health Services,[2] so that the CAC can provide advice on how community participation can contribute effectively to quality and safety activities. To achieve this, the CAC will need to establish the authority and credibility to comment on quality and safety.

The CAC should aim to provide advice that finds a balance between what the community believes is important and what the health service can reasonably achieve. It will need to work through the priorities that the Public Health Service has identified, taking account of the resources that are available as well as the service's capacity to implement and reform quality systems. Through a more detailed understanding of the quality and safety environment in Public Health Services, CACs will be better able to make some space for consumers' views to inform the health service's priorities.

[1] See Appendix 2 for references to examples of consumers' experiences and how this can inform the development of quality in health care

[2] Following amendments to the *Health Services Act 2004* (Vic.), the Metropolitan Health Services and the five regional health services are now called Public Health Services

Consumers, carers and communities

The terms *consumer*, *carer* and *community* are used throughout this guide and will also be heard frequently in the course of your work on the Community Advisory Committee. The Department of Human Services has recently released a policy document on consumer participation in health, *Doing it with us not for us: Participation in your health service system 2006-09: Victorian consumers, carers and the community working together with their health service and the Department of Human Services*.

Through its research and consultation process in developing this document, the following definitions of these terms were developed:

- Consumers are people who are current or potential users of health services. This includes children, women and men, people living with a disability, people from diverse cultural and religious experiences, socioeconomic status and social circumstances, sexual orientations, health and illness conditions.
- Carers are families and friends providing unpaid care to consumers. (Carers, under this definition, include people who are receiving a carer's pension.)
- Communities are groups of people who have interests in the development of an accessible, effective and efficient health and aged care service that best meets their needs.

Areas for Community Participation in Quality and Safety

The CAC needs to identify its key areas of interest across the wide range of quality and safety activities undertaken by the Public Health Service. There are a number of areas where consumer, carer and community participation can generate better outcomes for quality and safety in health care, including:

- Consumer or carer involvement in treatment decisions.
- Consumer or carer involvement in the development of health information that is relevant and helpful to consumers.
- Service delivery that is informed by consumer feedback.
- Decisions that are informed by the experiences of consumers in the areas of planning, developing, delivering and evaluating health services (e.g., by drawing upon information gained from consumer feedback or complaints, or by consumers working with health professionals on committees or working groups).
- Involvement in quality improvement activities at the organisational level such as through the CAC or Quality Committee.

Focusing the Work of the Community Advisory Committee

The CAC will be most effective if it can focus its efforts on where it can make the most impact, according to the opportunities that are available in the service, the interests of members, and the time and resources that are available to the committee.

The CAC's influence on decision-making processes within the health service will develop with its understanding of the quality and safety environment. It is important for the CAC to develop a realistic appreciation of how the health service operates, and to advocate for developments and innovations that are sustainable. This will become possible as the CAC establishes itself within the health service, creating links and establishing partnerships with different units of the service, and identifying where and how quality and safety impacts across the service, in all units and on all levels.

Consumers and Health Service Staff

Consumers who join Community Advisory Committees and get involved in improving quality and safety are often confronted with the differences in power and status between members of the general public and staff in medical institutions. These differences are built on ideas about medical expertise and will be familiar to any consumer who has sat in a meeting with consultants and professors. In this context, consumers involved in hospital activities need to recognise the potential for their contribution to be dominated by feelings of gratitude or intimidation in the face of clinicians' greater knowledge of the technical and structural issues that impact on health care. But be patient! Health consumer knowledge and confidence are growing, there is an ever-increasing network of consumers and consumer organisations, and health worker attitudes to consumer participation are shifting, as government policies identify the integral role of consumers, and legislate to require health services to demonstrate consumer involvement.

Section Two

The Governance of Quality and Safety in Public Health Services

The Policy Environment and Internal and External Structures Supporting and Monitoring Quality and Safety

This section presents a brief introduction to the broad policy environment supporting the role of the Community Advisory Committee in improving the quality of health care in your health service. It outlines, in relation to improving the quality of care in health services, the links between:

- the objectives of the Victorian Government's Department of Human Services
- the governance role of Public Health Service boards
- the role of the Community Advisory Committee.

Government and the Department of Human Services

The Department of Human Services supports the Victorian Government's Ministerial portfolios of Health, Community Services, Aged Care and Housing. Almost 80 per cent of the Department of Human Services' budget is spent on services delivered by 2,800 agencies under funding agreements with the Department. (*Departmental Plan 2005-2006* Victorian Government Department of Human Services Victoria 2005 www.dhs.vic.gov.au/dhsplan) Included in these agencies are metropolitan and rural hospitals (health services).

The objectives of the Department of Human Services are:

- To build sustainable, well-managed and efficient services
- To provide timely and accessible human services
- To improve safety and quality of human services
- To promote least intrusive human service options
- To strengthen the capacity of individuals, families and communities
- To reduce inequalities in health and wellbeing.[3]

These objectives are consistent with the outcomes articulated in the government document *Growing Victoria Together*.[4]

[3] Victorian Government Department of Human Services. Victoria – Public hospitals and mental health services Policy and funding guidelines 2004-05, Melbourne Victoria 2004 (http://www.health.vic.gov.au/pfg2004)

[4] The document can be found at the http://www.dpc.vic.gov.au website.

Boards and Governance

In order to meet their strategic, statutory and financial obligations, health service boards need to implement systems of strong corporate governance. Importantly, in accordance with recommendations contained in the Victorian Public Hospital Governance Reform Panel Report released in November 2003, new governance arrangements now apply to Public Health Services.[5] The package of reforms includes new accountability instruments and tools; enhanced performance reporting mechanisms; improvement in communication and relationships; and structural changes to progress system-wide changes. One of the reforms identified was that all health services deemed to be Public Health Services are required to have a Community Advisory Committee.

Within corporate governance of Public Health Services, special attention must be shown to clinical governance as it relates specifically to quality. Clinical governance is the process and framework through which a health service achieves accountability for continuously improving the quality of its service and safeguards high standards of care by creating an environment in which excellence in clinical care can flourish in a patient-centred environment.

A focus on integrated quality initiatives needs to be established in an environment with a just culture that promotes learning and knowledge, values staff and supports promotion of partnerships with consumers/patients, carers and the community.

Community Advisory Committee

The Community Advisory Committee has a responsibility to support the health service in developing links with the community, consumers/patients, and carers. Similarly, CACs have a key responsibility in the development and ongoing monitoring of key performance indicators for health service quality.[6]

The Community Advisory Committee is to assist the Public Health Service to appropriately integrate consumer and community views at all levels of its operations, planning and policy development. Also, it is to advocate to the Board on behalf of the community. Therefore, the CAC has a responsibility to advise on governance, policy and strategy in relation to community participation and its impact on health service outcomes. However, the CAC does not have executive authority. It is an advisory committee only, accountable to the Board of the health service which, in turn, is accountable to the government through the Department of Human Services.

Public Health Service structures and external checks on quality and safety

The following section provides an overview of the major structures in quality and safety within Victorian Public Health Services and the external checks on quality in health care.

The Board of Directors

The Boards of Directors of Public Health Services are responsible for providing strategic leadership in accordance with the agreed directions of the organisation, and for ensuring appropriate controls are in place to foster efficient and effective practice. The Directors are collectively and individually responsible for leading, monitoring and controlling the health service's strategic and financial performance. This is what is meant by the term "governance". These responsibilities are set out in the *Health Services Act 1988*, Section 65s.

"Clinical governance" refers to the responsibility of the Directors to ensure that appropriate structures, processes and monitoring systems are in place to assure and promote, according to best practice standards, the safety and quality of health care services. An effective Board delegates managerial responsibility to the chief executive officer, who, in turn, engages hospital staff in meeting these responsibilities.

[5] Public health services include all formerly designated metropolitan health services and Barwon Health, Bendigo Health Care Group, Ballarat Health Services, La Trobe Regional Hospital and Goulburn Valley Health.

[6] Victorian Government Department of Human Services. Community Advisory Committee Guidelines: Non-statutory guidelines for metropolitan health services, Melbourne, Victoria 2000

The Quality Committee

The Quality Committee is a high level decision-making structure that is directly accountable to the Board of Directors for all matters of safety and quality in the service. It oversees and is responsible for implementing the health service's Quality Plan and will have a system in place for regularly reporting to the Board on matters relating to the Plan.

The Board is required by legislation to establish a Quality Committee. Under the *Health Services Act 2004* (Vic.) s 65S, the Quality Committee is responsible for ensuring that:

- Effective and accountable systems are in place to monitor and improve the quality and effectiveness of health services provided by the service.
- Any problems identified with the quality or effectiveness of the health services provided are addressed in a timely manner.
- The public health service continuously strives to improve the quality of the health services it provides and to foster innovation.

The Board is responsible for appointing members of the Quality Committee and specifying its functions. The legislation requires that these functions include:

- Ensuring that a comprehensive quality plan or strategy for the service and its component parts is implemented and regularly reviewed.
- Receiving reports containing aggregated data relevant to the functions of the committee from senior managers within the service, quality assurance committees and such other persons or bodies as the Board thinks fit.
- Investigating and making recommendations to the Board in relation to actions that should be taken to improve quality and achieve best practice in quality systems for health services.

The Community Advisory Committee

The Board of each Public Health Service is required by legislation to establish a CAC. The CAC's role is to advise the Board on how the Public Health Service can meet its statutory responsibilities to establish and maintain effective systems:

- to ensure that the health services provided meet the needs of the communities served by the public health service and that the views of users … are taken into account.[7]

The CAC's overall responsibility is to oversee the implementation of strategies to develop consumer and community participation and to monitor the change this participation generates in the health service. The CAC does this by providing advice and recommendations to the Board on opportunities and techniques for involving the community in the development and evaluation of health services, by monitoring consumer participation in the organisation, and by advocating to the Board on behalf of the community. It may be useful to think of the role of CAC members as:

- Developing a community perspective on how the health service could be improved, by identifying what the priorities for the community are and suggesting practical strategies for addressing these needs.
- Providing critical advice to the Board and staff, based on this community perspective.
- Making suggestions about new initiatives and techniques that the health service could develop and implement to meet community expectations.

The roles and responsibilities of CACs are detailed in the Department of Human Services' *Community Advisory Committee Non-Statutory Guidelines for Metropolitan Health Services*.[8]

[7] Health Services Act 2004 (Vic.) s 65 S Board of Directors 2C
[8] The Guidelines are available electronically - www.health.vic.gov.au/consumer under "Publications"

External Checks on Quality and Safety

The Department of Human Services lays the foundation for clinical governance in Public Health Services through a range of legislative, policy, and funding frameworks. The Department's policy and funding guidelines establish a system of reporting against defined quality of care measures and key performance indicators to promote improvements in systems and professional practices, and to provide a framework for continuous improvement. This mandates individual health services to report to the community through annual Quality of Care reports. The Quality of Care reports are an important strategy for raising health service accountability and transparency to the community for quality and safety.

The Victorian Quality Council has developed a safety and quality improvement framework to provide direction to Public Health Services. The *Better Quality Better Health Care Framework* recognises consumer and community involvement as an essential component of effective safety and quality improvement. The Framework is organised according to six dimensions of quality:

- Safety
- Effectiveness
- Appropriateness
- Acceptability
- Access
- Efficiency

as they apply across the different decision-making structures in the health system:

- Government
- Board
- Quality Committee
- Chief Executive Officer
- Organisational leaders, clinicians and teams
- Consumers and the community.

An organisation-wide approach to safety and quality improvement identifies four key elements:

- Governance and leadership
- Consumer involvement
- Competence
- Education and information management.

The Framework is designed to be adapted to fit the local environment of each health service, and should be used by CACs in conjunction with this guide.[9]

[9] Copies of the Better Quality Better Health Care Framework are available from the Victorian Quality Council, Tel: 1300 135 427 or Email: vqc@dhs.vic.gov.au

Accreditation is the evaluation process that health services must undergo to continue receiving government funding. It also provides the public with a check on the safety or otherwise of the service.

Accreditation is a formal process that requires health services to undertake an internal check on the quality of care, based on agreed standards. A health service is then required to undergo an external check by professionally qualified independent surveyors. Accreditation standards have been developed by health care professionals and consumers; they are continually reviewed, and are subjected to rigorous pilot testing so that they reflect contemporary best practice principles, and are achievable and measurable. At a minimum, accreditation means a service can demonstrate a commitment to constantly implementing improvements, including practical solutions that take into consideration the needs of consumers. At the next level, health services should be able to demonstrate to the surveyors that quality improvement activities are evaluated. At the most advanced level, the results from the evaluation are integrated into quality systems and promoted throughout the health service.

Different agencies are responsible for overseeing the accreditation of Public Health Services. The main accrediting bodies are:

- **The Australian Council on Healthcare Standards (ACHS)**, an independent organisation dedicated to improving the quality and safety of health care through continual review, assessment and accreditation. ACHS has developed the Evaluation and Quality Improvement Program (EQuIP) Guide, and oversees the process of evaluation and assessment by professionally qualified surveyors of all health care organisations including, but not limited to, hospitals, nursing homes, day surgeries, some community health services, aero-medical and ambulance services. Most, but not all, of the acute sector health services employ this system for accreditation.
- All Victorian public area mental health services and statewide specialist services under the auspice of health services are required to undergo an external and in-depth review against the **National Standards for Mental Health Services (NSMHS)**, as part of the organisation-wide EQuIP accreditation process. The EQuIP standards and NSMHS are complementary; however, the latter are specific to mental health services.
- **The Quality Improvement Council (QIC)** is a national, non-profit organisation that aims to promote and assist health and community services, including counselling services, drug and alcohol services, home-based services, community-based mental health services and multi-service welfare services, through a continuous quality improvement framework. In Victoria, many community-based health and welfare organisations measure and improve their standards and gain accreditation with QIC via state-based organisations such as Quality Improvement and Community Services Accreditation (QICSA).
- Residential care units, including aged care homes, are accredited by the **Aged Care Standards and Accreditation Agency**. The assessment process includes interviews with residents and relatives about their experiences with the homes.

Activity for the CAC

The CAC should request a report from the health service on all of the accreditation processes that it is involved in.

The CAC's Contribution to Quality and Safety

Once the CAC has an understanding of the major structures for quality improvement, it needs to understand how these are operationalised in the Public Health Service. The Public Health Service's *Quality Plan* should have identified a number of strategies or activities for involving consumers and the community in quality and safety. The Quality Plan should also detail proposed activities to meet the requirements of external accrediting bodies and the Department of Human Services.

The Department of Human Services' *Community Advisory Committee Guidelines Non-Statutory Guidelines for Metropolitan Health Services* identifies a specific role for CACs in quality and safety. The CAC's role is to:

- Participate in the development and ongoing monitoring of key performance indicators for health service quality.
- Monitor the quality and accessibility of the health service as a whole or its component services and departments.

Activity for the CAC

The CAC can start by identifying the overall aims of the health service in relation to quality and safety, how decisions are made and where responsibilities lie. This exercise could begin by answering the following questions:

- What are the key components of the Public Health Service's *Quality Plan?*
- Which of these key components are most relevant to the CAC? Which would benefit most from consumer involvement?
- Are there opportunities for the CAC and consumers/carers/community to contribute to these key components?
- What is the role of the Quality Committee?
- How does the Quality Committee communicate with the CAC?
- How does the Public Health Service report to the community on quality and safety?

The challenge for the CAC will be to advocate for improvements within the structures that are already established, to identify where consumer voices will be most beneficial and to provide advice that is credible and achievable within the health service's resources.

Responding to Diversity in the Community

Cultural Diversity

Many terms have been used to describe Australia's wonderfully diverse population. All-encompassing terminology used in the 1950s and 1960s to describe various groups in the Australian community, such as "new Australians", "non-Australians", "migrants" and "foreigners", are seen now as inappropriate on the grounds that they are discriminatory, disrespectful, and dismissive. In recent times, deliberate efforts to be sensitive and inclusive have resulted in successive governments using terms like "multicultural", "non-English speaking background" and "ethnic background". Currently, the politically-favoured terms are "culturally and linguistically diverse communities", (often abbreviated to CALD) or people from culturally and linguistically diverse backgrounds (CALDB). Unfortunately, this reduction to CALD or CALDB is often used as an opportunity to box people who are "different to us". In relation to our community, and to our work in health, language can be a powerful tool for alienating or including groups not represented within our own particular circle.

The Community Advisory Committee needs to develop an awareness and understanding about these issues around cultural difference and to use language and terminology with care. Victorian communities are certainly diverse and each community has its own unique characteristics and profile, whether that be:

- A much larger than average group of older people
- A large group of people under 25
- People from one particular ethnic background, such as a community of Indigenous Australians
- People from one particular ethnic background, perhaps from different linguistic areas, such as Chinese people from southern China (Cantonese) and from northern China (Putonghua/Mandarin)
- People who have recently arrived here as refugees
- A high gay and/or lesbian population
- A large group of single parents
- A significant group of homeless young people.

Each of these groups will have health care needs directly related to their particular situation and background. The health service needs to have systems in place for identifying and responding appropriately to these particular needs. One of the CAC's roles is to advise the health service on ways to identify and consult with the diverse groups within the community, especially those who, for one reason or another, are often unseen or marginalised.

CACs need to be mindful of the many and varied individual needs of community members and to be in a position to advise the health service of possible particular needs in their community. A CAC that is aware of cultural diversity will be inclusive and will advocate for minority groups when giving advice or preparing reports for the health service on consulting with "the community".

Quality and safety systems aim to ensure that health care is responsive to a person's individual situation and takes account of the ways different consumers perceive, access, and use a health care service. In order to develop systems that meet community expectations, each Public Health Service needs to recognise and understand the diversity within the communities it services. Community expectations vary between different groups; it is important that health services develop quality systems, models of care and professional practice that are sensitive to diversity and that respond to consumers' individual health care needs. There are three major areas that are critical to the needs of the diverse groups in the community.

These are:

1. **Access into the Public Health Service,** which entails a range of strategies, including:
    - Ensuring that all the different groups in the community are informed about what services are available and how they are provided, utilising a range of strategies for the provision of information such as via the internet, in brochures, through advertisements in community newspapers, by speaking to community groups, through partnerships and communication strategies with local networks and community workers, and ensuring that signage to guide consumers through buildings is clear and in relevant community languages.
    - Provision of culturally appropriate services. This will vary depending upon the communities to be serviced; communities will need be consulted directly as services should be responsive to identified need. If services are not culturally appropriate, consumers may be reluctant to seek assistance when they need it.
    - Timely use of interpreters and translated materials.
    - Effective referral processes between the acute and community health sectors. Ensuring that health services staff, community health workers and consumers understand these referral processes.
2. **Processes for the assessment of specific cultural and language needs** in providing health interventions:
    - Health service staff will need training in access and equity issues in general and for their particular region.
    - In relation to individual consumers seeking care, processes need to be in place for:
    - facilitating communication between staff and consumer/carer to ensure that health needs are clearly understood by staff
    - ensuring that health information and advice is understood by consumers; and
    - ensuring that consumers are able to provide informed consent.

    These processes should be clearly documented and the service will need to ensure that all staff have access to information or training so they are able to make appropriate assessments and access interpreters, community workers and other specialist ancillary health teams as needed.
3. **Community participation strategies** that facilitate input and feedback from all sections of the community to provide accurate and comprehensive needs assessments and evaluations of the quality of care.

Activity for the CAC

The CAC could facilitate a focus on cultural diversity and quality by requesting that an audit be undertaken on quality activities which identify and respond to diversity in the community. This would provide a useful benchmark for the CAC to monitor the health service's performance and identify further opportunities for the service to improve its response to these issues.

Section Three

What Community Advisory Committee Members Need to Know about Quality and Safety

Information and resources about Quality and Safety

In order for the CAC to assist the health service to meet community standards for quality and safety, the CAC needs to ensure that, in the service's work on quality and safety—such as developing its Quality Plan or its annual Quality of Care Report—consideration is given to the consumer perspective. The Public Health Service already has systems for identifying how well it is doing in this area; it needs the CAC's help to learn more about what the community thinks about quality and safety in the service. In order to undertake this work, CAC members need training, education and access to information and resources.

"Quality and Safety" in health has developed to become a highly specialised area supported by its own language and concepts. Quality outcomes are standardised, measured, compared against benchmarks; data is aggregated following rigorous systems of internal and external checks. To help CAC members understand the language and concepts used in quality and safety, this guide includes an appendix on terms and definitions (Appendix 1), and references to resources that discuss quality and safety in more detail (Appendix 2).

An orientation program for CAC members

The CAC should request an orientation program from the Public Health Service for its members. Information needs to be presented with the opportunity for questions on quality and safety issues, and reinforced by written information so that CAC members can continually refer to it over the coming months and years. The orientation program should include:

- An overview of the range of services provided by the service.
- A report on the service's Quality Plan, including who is responsible for specific areas and tasks, how priorities are identified and how the service engages the community in improving quality and safety.
- An explanation of the accreditation requirements and other public reporting processes, with a focus on those standards relevant to consumer and community participation. This should include information about what these standards mean, how these standards have been developed, how the organisation rates and what these results mean about the quality of its services.
- An explanation of the registration requirements for clinical staff and the role of the professional colleges in the continuing professional development of clinicians.
- An outline of the Department of Human Services' reporting requirements in relation to the Quality of Care report.
- An explanation of the six dimensions of quality according to the Victorian Quality Council's *Better Quality Better Health Care* Framework.
- An explanation of the Department of Human Services' indicators for consumer, carer and community participation.

Agreeing on Priorities

The CAC needs to discuss how it is going to decide on priorities for consumer and community involvement in quality and safety. This discussion should include consideration of:

- Where are the opportunities for greater community participation in quality and safety?
- What are CAC members most concerned about in quality and safety and why?
- How much support is there in the community for addressing these quality and safety issues?
- What will these priorities require in terms of timing, resources and support?

Monitoring Quality and Safety

In monitoring quality and safety, the CAC should focus on asking:

- Is there a process for evaluation?
- Can the health service demonstrate improvements in specific areas?
- Is the health service focused on improving the important things?
- How does the health service know this?
- In what ways are consumers and carers to be involved?

Techniques for Community Participation

Finally, the CAC should familiarise itself with a range of strategies for community participation and identify which of these are practised within the health service. It will also be useful for the CAC to be able to provide advice on the strengths and limitations of these techniques, in order to recommend which are most appropriate to the service's aims and objectives. Complaints and feedback forms are a standard technique used in every health service. Surveys, interviews and focus groups are also commonly used. Over 40 methods are described in documents available on Health Issues Centre's website, www.participateinhealth.org.au

The following section discusses lesser-known techniques such as patient shadowing, patient diaries, and consumer presentations to staff.

Patient shadowing involves a patient being accompanied on their journey through the health system; their experiences of accessing services and moving through the system are observed and documented. This can provide information about service integration, service performance, and what is important to consumers in quality and safety.

A patient diary can provide a rich source of information about patient experiences of care, especially for people requiring long-term health interventions. This approach has been useful for helping staff to understand consumers' experiences across the whole system of health care interventions. It is a useful technique for working with children and young people, who are less likely to participate in a committee, fill out a survey or make a complaint.

Personal stories about individuals' experiences can be a powerful way to understand quality and safety, how systems can go wrong, what kind of impact this can have on people, and what needs to be done differently. This can be done through inviting people to come and speak to the CAC, or through advocating for consumers to speak at staff development forums.

The *Complaints Management Handbook for Health Care Services* provides 10 case studies of complaints and consumer feedback programs in a range of health care services. The outcomes of these cases demonstrate the ways in which health services have worked in partnership with consumers, in situations where complaints have occurred, in order that service quality can be improved. (Australian Council for Safety and Quality in Health Care, *Complaints Management Handbook for Health Care Services*, 2005, pp. 59 - 79)

Networking with Other Consumers

Quality and safety is an area of interest to consumers around Australia, and there are a number of organisations, formal networks and conferences that can assist in building the knowledge and expertise of CAC members.

- Health Issues Centre has a network of consumers and regularly conducts training sessions, forums and conferences in partnership with other consumer agencies. To register your interest and to receive regular information about consumer activities and issues via Health Issues Centre's monthly *eNews,* contact Health Issues Centre on (03) 9479 5827 or see details at www.healthissuescentre.org.au
- The Cochrane Collaboration Consumer Network encourages consumer involvement in its research. For information about how to get involved in the network, go to www.cochrane.org/consumers/
- Consumers can participate in research being undertaken by the Consumers and Communication Review Group, which is based at La Trobe University. For more information, go to www.latrobe.edu.au/cochrane
- The Consumers' Health Forum of Australia Inc. (CHF) is the national voice for health consumers. It helps shape Australia's health system by representing and involving consumers in health policy and program development. It provides government and policy-makers with a consumer perspective on health issues and balances the view of health care professionals, service providers and industry. Health consumers have a unique and important perspective on health. They include patients and potential patients, carers and organisations representing consumers' interests (Information from CHF website www.chf.org.au)

Australian Commission on Safety and Quality

Australian Health Ministers recently agreed that the new Australian Commission on Safety and Quality in Health Care would commence operation from 1 January 2006. The Commission succeeds the Australian Council for Safety and Quality in Health Care, which was established in January 2000 for a five-year term, and ceased on 31 December 2005. Ministers agreed that the new Commission will build on the achievements of the Council and the transition to new arrangements will ensure this valuable work is not lost. While attention on improving the safety of hospitals will be maintained, quality improvement in primary health care and the private sector will also become priority areas. Achieving safe, effective and responsive care for consumers will be a key objective of the Commission. (Information from the Commission's website www.safetyandquality.org)

Conferences

Conferences that focus on quality and safety issues in health care provide an opportunity for consumers to meet like-minded people, to learn about new developments, and to spend a couple of days being immersed in ideas about quality and safety. The health system is increasingly interested in examples of effective partnerships between services and the community across a range of issues. CACs could consider opportunities for making presentations to conferences and workshops about initiatives in Public Health Services to improve community participation in quality and safety.

Scholarships for Consumers

Every year, to 2005, the Australian Council for Safety and Quality in Health Care sponsored consumers to attend its annual conference. The scholarships were awarded to consumers who had an interest in safety and quality in health care, had the skills and networks and were prepared to take the lessons from attending the conference back to their local communities in order to improve the development and delivery of health services at the local level. Generally, the scholarship paid for conference registration, travel and accommodation. The new Commission for Safety and Quality took over the Council in January 2006. It retains the same website (www.safetyandquality.org) where you should be able to access information if such scholarships are to continue. In 2005, the Department of Human Services also offered similar sponsorships to each of the CACs. This may continue and CACs will be advised of such opportunities directly.

Section Four

Stages of Development for the Community Advisory Committee and Examples of Activities

Stages of CAC development

The CAC's capacity to influence decisions about community participation in quality and safety needs to be recognised as part of a developmental process of building knowledge, capacity, credibility and relationships with the organisation and with the community. This section outlines three likely stages in the development of a CAC's capacity to provide advice on effective community participation in quality and safety, and suggests different activities that a CAC could undertake to build its monitoring and advocacy role in the Public Health Service.

STAGE 1

The CAC is focused on becoming informed about quality and safety in the context of the Public Health Service. The overall aim is to build reciprocal relations of trust between the Public Health Service and the CAC and to develop an understanding of how the health service operates. Following from this, the CAC needs to establish communication strategies, including guidelines on managing sensitive information, with the relevant parts of the health service.

Key areas of activity for the CAC in Stage 1

Develop regular reporting relationships with quality staff, including the opportunity to discuss issues and ask questions.

Receive reports about quality improvement activities involving consumers.

Participate in the development of the Quality of Care Report.

Establish baseline data for monitoring consumer participation in quality and safety across the organisation.

Develop key performance indicators (KPIs) for community participation in quality and safety.

Agree on a communication protocol with the Quality Committee.

STAGE 2

The members develop an understanding of the place of quality and safety in the health system and the CAC has developed effective relationships for exchanging information and ideas with key quality staff. It is now in a position to comment on the service's strengths and weaknesses in relation to quality and safety. Activities at this stage should include reflecting on the work of the CAC to date and building on its successes.

Key areas of activity for the CAC in Stage 2

Discuss findings from patient satisfaction surveys, complaints, accreditation reports etc., and make recommendations for developing a structured and integrated approach to community participation in quality improvement.

Participate in specific activities, such as developing patient information, undertaking surveys, participating in focus groups, preparing reports.

Discuss and make recommendations about appointments to relevant quality committees.

Continue to monitor performance indicators for community participation in priority areas.

STAGE 3

By this stage, the CAC is confident in its capacity to provide advice and recommendations to the health service about involving the community in quality improvement activities. The CAC provides vision and leadership about a strategic and systematic approach to identifying and addressing the major challenges in consumers contributing to improving quality and safety.

Key areas of activity for CAC in Stage 3

Provide input to the organisation's Strategic Plan and Quality Plan on community expectations regarding the priority issues in quality and safety.

Oversee the development of policies for integrating consumer and community participation across the health service as a whole.

Educate staff about the benefits of consumer and community participation in quality and safety.

Inform staff about different techniques for working effectively with the community to improve quality and safety.

Report to the community on how quality and safety is monitored and evaluated in the service.

Identify opportunities to promote the CAC's work to the health sector.

Consumer participation activities

A range of examples of the work of Victorian CACs was presented at the *Victorian Consumers Participate in Health* conference held in Melbourne in October 2005. The presentations can be viewed and downloaded from Health Issues Centre's website http://www.healthissuescentre.org.au by following the "Resources" link to Victorian Consumers Participate in Health Conference Proceedings**.**

In 2003, the Victorian Quality Council commissioned Health Issues Centre and the National Resource Centre for Consumer Participation in Health to undertake a needs assessment to inform increased consumer and community participation in quality and safety in the acute health sector (McBride et al. 2004)

The study identified the following consumer and community participation activities taking place in Victorian health services:

- Consumer participation at policy level (e.g. developing a consumer participation policy for a health service or on Victorian Quality Council).
- Consumers at governance level including committees, working groups, advisory groups, reference groups (e.g. Community Advisory Committees, Quality Committees, Clinical Advisory Committees or Ethics Committees).
- Consumers in specific services, programs or projects (e.g. consumer advocates in mental health system, consumers on review of obstetric services or Clinical Support Systems).
- Consumer input via consultations, surveys, questionnaires, focus groups, workshops and forums.
- Audits or self-assessment being conducted to establish level of consumer and community participation occurring (e.g. use of self-assessment tool of the National Resource Centre for Consumer Participation in Health)
- Communication strategies (e.g. using community newsletters)
- Providing advice to services and feedback to the community (e.g. Community Advisory Committees reporting back to the community).

Reference: McBride, T., Dawson, M.T., Robinson, S., Maher, H. (2004). How *much consumer participation is there in quality activities in Victoria?,* Health Issues, No.81, pp. 7-9.

Section Five

APPENDICES

Appendix 1

Terms and Definitions

The following definitions have been developed by the Australian Council for Safety and Quality in Health Care. The original version, including references for definitions, is available from the Council's website: www.safetyandquality.org (The Australian Council for Safety and Quality in Health Care has now been succeeded by the Australian Commission on Safety and Quality but maintains the same website address www.safetyandquality.org with a link to the former site.)

Term	Preferred Definition
A	
Accreditation	A formal process to ensure delivery of safe, high quality health care based on standards and processes devised and developed by health care professionals for health care services. Public recognition of achievement by a health care organisation, of requirements of national health care standards.
Adverse drug event	A particular type of adverse drug event where a drug or medication is implicated as a causal factor in the adverse event. This encompasses both harm that results from the intrinsic nature of the medicine (an adverse drug reaction) as well as harm that results from medication errors or system failures associated with the manufacture, distribution or use of medicines.
Adverse drug reaction	A response to a drug which is noxious and unintended, and which occurs at doses normally used or tested in man for the prophylaxis, diagnosis, or therapy of disease, or for the modification of physiological function.
Adverse Event	An incident in which unintended harm resulted to a person receiving health care.
Agent	Someone or something that can produce a change.
Appropriate	Care, intervention or action provided is relevant to the client's needs and based on established standards.
Accessible	Ability of people to obtain health care at the right place and right time irrespective of income, physical location and cultural background.
B	
Benchmarking	The continuous process of measuring and comparing products, services and practices with similar systems or organisations both inside or outside the health care industry for continual improvement.
Blame	Being held at fault (implies culpability)
Breakthrough collaborative	A cooperative effort which brings together health care organisations with a common commitment to redesign an aspect of their care (such as medication) and make rapid and sustainable changes to produce positive results in their organisations. It relies on the spread and adaptation of existing knowledge to multiple sites in order to accomplish a common aim, engaging multidisciplinary teams and creating partnerships between managers and clinicians.

Term	Preferred Definition

C

Clinical Audit	The process of reviewing the delivery of care against known or best practice standards to identify and remedy deficiencies through a process of continuous quality improvement.
Clinical governance	The framework through which health organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.
Complaint	An expression of dissatisfaction or concern with an aspect of a health care service. Complaints may be expressed orally or in writing and may be made through a complaints process or as part of other consumer feedback mechanisms such as consumer surveys or focus groups.
Competence	A range of abilities including clinical skills, knowledge and judgement together with communication skills, personal behaviour and professional ethics.
Clinical privileges	The scope of clinical practice which a health professional is authorised to undertake within an organisation.
Credentialing	The process of assessing and conferring approval on a person's suitability to provide specific consumer/ patient care and treatment services, within defined limits, based on an individual's licence, education, training, experience and competence.

D

Dimensions of quality	Measures of health system performance, including measures of effectiveness, appropriateness, efficiency, responsiveness, accessibility, safety, continuity, capability and sustainability.
Disability	Any type of impairment of body structure or function, activity limitation and/or restriction of participation in society, associated with a past or present harm.
Disease	A physiological or psychological dysfunction.

E-F

Effective	Care, intervention or action achieves desired outcome.
Efficient	Achieving desired results with most cost effective use of resources.
Error	Error will be taken as a generic term to encompass all those occasions in which a planned sequence of mental or physical activities fails to achieve its intended outcome, and when these failures cannot be attributed to the intervention of some chance agency.
Error (active)	An error in which the effects are felt almost immediately.
Error (latent)	An error whose adverse consequences may lie dormant within the system for a long time, only becoming evident when they combine with other factors to breach the system's defences.
Evidence based health care	The conscientious and judicious use of current best evidence from clinical care research in making health care decisions.

Term	Preferred Definition

G-H

Harm	Death, disease, injury, suffering, and/or disability experienced by a person (see loss).
Hazard	A source of potential harm or a situation with a potential to cause loss.
Health	A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.
Health Care	Services provided to individuals or communities to promote, maintain, monitor, or restore health. Health care is not limited to medical care and includes self care.

I-J-K

Iatrogenic	Arising from or associated with health care rather than an underlying disease or injury. Consequences of omission (failing to do the right thing) as well as commission (doing the wrong thing) are included.
Incident	An event or circumstance which could have, or did lead to unintended and/or unnecessary harm to a person, and/or a complaint, loss or damage.
Injury	Damage to tissues caused by an agent or circumstance.

L-M-N

Liability	Being answerable, chargeable, or responsible; under legal obligation.
Loss	Any negative consequence, financial or otherwise.
Monitor	To check, supervise, observe critically, or record the progress of an activity, action or system on a regular basis in order to identify change.
Mortality	Death from disease or injury.
Morbidity	The negative consequences (symptoms, disabilities or impaired physiological state) resulting from disease, injury or its treatment.
Near Miss	An incident that did not cause harm.
Negligence	An action in tort law, the elements of which are: the existence of a duty of care breach of that duty material damage as a consequence of the breach of duty. The existence of a duty of care is a legal obligation to avoid causing harm, and arises where harm is foreseeable if due care is not taken.
Nosocomial	Pertaining to or originating in a health care facility (synonymous with "health care acquired").

Term	Preferred Definition

O-P-Q

Outcome	Results that may or may not have been intended that occur as a result of a service or intervention.
Open disclosure	The process of open discussion of adverse events that result in unintended harm to a patient while receiving health care and the associated investigation and recommendations for improvement.
Performance indicator	A statistic or unit of information which reflects, directly or indirectly, the extent to which an anticipated outcome is achieved or the quality of the processes leading to that outcome.
Preventable	Potentially avoidable in the relevant circumstances.
Preventive (Preventative)	That which hinders, obstructs or prevents disease.
Quality	The extent to which the properties of a service or product produces a desired outcome.
Qualified privilege legislation	Qualified privilege legislation varies between jurisdictions but generally protects the confidentiality of individually identified information that became known solely as a result of a declared safety and quality activity. Certain conditions apply to the dissemination of information under qualified privilege.

R-S-T-U

Risk	The chance of something happening that will have an impact upon objectives. It is measured in terms of consequences and likelihood.
Risk Management	The culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects.
Root cause analysis	A systematic process whereby the factors which contributed to an incident are identified.
Safety	The degree to which the potential risk and unintended results are avoided or minimised.
Sentinel Events	Events in which death or serious harm to a patient has occurred. An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. An incident with actual or potential serious harm, or death. A condition that can be used to assess the stability or chance in health levels of a population, usually by monitoring mortality statistics. Thus, death due to acute head injury is a sentinel event for a class of severe traffic injury that may be reduced by such preventive measures as use of seat belts and crash helmets.
Standard	Agreed attributes and processes designed to ensure that a product, service or method will perform consistently at a designated level.
Surveillance	Supervision, close watch Oversight; watch; inspection; supervision.
System	An interdependent group of items forming a unified whole. An organised body of material or immaterial things.
System failure	A fault, breakdown or dysfunction within an organisation's operational methods, processes or infrastructure.

Appendix 2

Resources

Consumer experiences and stories

- Fiona Tito Wheatland, *What do Australian health care consumers want from their health care system?* Address to the National Health Summit 17 August 2003
- Anne Cahill, *A tale of a few hospitals* (article reprinted from "Australian Health Review" Vol 27 No 2 2004)

If you are interested in these articles, you may access them through your CAC's Resource Officer or by calling Health Issues Centre on (03) 9479 5827.

Frameworks

- Australian Council on Health Care Standards 2003 *The EQuIP Guide: A Framework to Improve Quality and Safety of Health Care*, 3rd edn. available electronically from http://www.easternhealth.org.au/boxhill/standards-june2002.pdf
- Victorian Quality Council 2003*, Better Quality Better Health Care: A Safety and Improvement Framework for Victorian Health Services*, Department of Human Services, Melbourne.

Consumer Participation in Hospitals

- Draper, Mary 1997, *Involving Consumers in Improving Hospital Care: Lessons from Australian Hospitals,* Commonwealth Department of Health and Family Services, Canberra (available for loan from the Health Issues Centre library collection)
- Department of Human Services 2005, *Participation indicators – Participation in your health service system: Victorian consumers, carers and the community working together with their health service and the Department of Human Services*, Rural and Regional Health and Aged Care Services Division, Victorian Government Department of Human Services, Melbourne, Victoria, Australia
- Department of Human Services 2006, *Doing it with us not for us -Participation in your health service system 2006-09:Victorian consumers, carers and the community working together with their health service and the Department of Human Services* Rural and Regional Health and Aged Care Services Division, Victorian Government Department of Human Services, Melbourne, Victoria, Australia

Responding to Diversity

- Centre for Culture, Ethnicity and Health, 8 September 2005, *Consumer Participation and Culturally and Linguistically Diverse Communities: Working Together Towards Good Practice* Conference Papers, Presentations etc.
- Centre for Culture, Ethnicity and Health, 2003 *Diversity in Hospitals Responding to the Needs of Patients and Client Groups from non-English speaking Backgrounds Policy and Resource Guide*, (available electronically from www.ceh.org.au under "Acute")
- The Australian Human Rights & Equal Opportunity Commission's website: www.humanrights.gov.au
- The Cultural Diversity in Health website of the Postgraduate Medical Council of NSW: www.diversityinhealth.com
- Victorian Office of Multicultural Affairs website: www.voma.vic.gov.au (see document Valuing Cultural Diversity)
- Victorian Government Department of Human Services website: www.health.vic.gov.au/patientcharter/cald

Reporting to the Community

- Consumer Focus Collaboration 2001, *Review Of Existing Models of Reporting to Consumers on Health Service Quality Summary Report and Guidelines*, Commonwealth Department of Health and Aged Care, Canberra (available on Health Issues Centre's website www.participateinhealth.org.au
- under "R" in publications).

Methods of Community Participation

- Consumer Focus Collaboration 2000, *Improving Health Services Through Consumer Participation: A Resource Guide for Organisations*, Commonwealth Department of Health and Aged Care, Canberra (available on Health Issues Centre's website www.participateinhealth.org.au in publications, under "I")
- For examples of Victorian consumer participation activities, see conference presentations from the *Victorian Consumers Participate in Health* conference held in Melbourne in October 2005. These can be downloaded from the Victorian Consumers Participate in Health Conference Proceedings link at: http://www.healthissuescentre.org.au/new_resources/index.asp

Research into Consumer Participation

- The Cochrane Collaboration provides high quality information on the most effective ways that health services can interact with consumers. The Cochrane's library of research findings is available free to everyone in Australia. Follow the link from www.latrobe.edu.au/cochrane, and choose "log on anonymously".

Department of Human Services

- *Community Advisory Committee Non-Statutory Guidelines for Metropolitan Health Services,* Acute Health Division, Victorian Government Department of Human Services, Melbourne Victoria, 2000
- *Doing it with us not for us − Participation in your health service system 2006-09:Victorian consumers, carers and the community working together with their health service and the Department of Human Services* Rural and Regional Health and Aged Care Services Division, Victorian Government Department of Human Services, Melbourne, Victoria, Australia, 2006
- *Guidelines and Minimum Reporting Requirements for Quality Care Reports 2003/04,* Department of Human Services
- *Participation indicators – Participation in your health service system: Victorian consumers, carers and the community working together with their health service and the Department of Human Services* Rural and Regional Health and Aged Care Services Division, Victorian Government Department of Human Services, Melbourne, Victoria, Australia, 2005
- Quality care report guidelines and key messages 2003–04, Department of Human Services

For any of these DHS documents go to www.health.vic.gov.au/consumer or, for further information on the Consumer Participation and Information Program, contact Cath Harmer on (03) 9616 9055 or via email on catherine.harmer@dhs.vic.gov.au

Websites

- Australian Commission on Safety and Quality: www.safetyandquality.org
- Cochrane Consumers and Communication Review Group: www.latrobe.edu.au/cochrane/
- Health Issues Centre: www.healthissuescentre.org.au
- National Health Service Modernisation Agency: www.modern.nhs.uk
- Resources on Consumer Participation in Health: www.particepateinhealth.org.au
- Victorian Quality Council: www.health.vic.gov.au/qualitycouncil/
- The Picker Institute: www.pickereurope.org

Appendix 3

The Australian Health Care System: Some Introductory Facts

Australia has a very complex health care system with many types of services, providers and funding arrangements. You may already be familiar with this, but, not surprisingly, few consumers are aware of all of the services, organisations and funding responsibilities in the Australian health system. As this might be useful to you in your new role, we have printed some very basic facts here. We also run a training session for consumer members on the Australian Health Care System, and have a range of useful books and reports in our library.

Overview

In Australia, both the public and private sectors fund and provide health care, and all levels of government are involved. Very roughly, the Commonwealth Government has responsibility for national health care funding and broad policy decisions, while the states are responsible for the delivery of services, except general practitioners (GPs). Australia spends less on health care than the US, Canada, Germany and France but more per capita than the UK, New Zealand and Japan.

There is free access to most but not all health care in Australia. Public hospital care is free but there are at least some consumer charges for most other services. Australia's health care system is significantly funded from general taxation revenue collected by the Commonwealth Government. A modest proportion of this comes from the Medicare levy of 1.5% that is charged on individuals who are earning more than $50,000 p.a. However, the fees which individuals pay directly to health providers (known as 'out-of-pocket expenses') make up about one-third of all money spent on the health system.

Commonwealth Level

The Commonwealth Government funds and administers the Medical Benefits Scheme (which partially pays for GP services), the Pharmaceutical Benefits Scheme (which partially pays for medications) and the Australian Health Care Agreement (which gives funds to the states to run public hospitals). The Department of Health and Ageing is the national health agency (www.health.gov.au), and is responsible for national policy, funding public health programs, research and information management.

Medicare

The Medical Benefits Scheme (Medicare) was introduced in 1975 (when it was known as Medibank) with the aim of providing universal health cover to all Australians on the basis of medical need, rather than ability to pay. However, the reality is somewhat different. Medicare Australia is responsible for administering Medicare (www.medicareaustralia.org.au).

Medicare is available to all Australians and it covers a significant proportion of the costs of seeing all doctors, including GPs and specialists, plus diagnostic tests like pathology or eye tests. How much you pay depends on the policy of individual doctors, which in turn depend on location (rural costs are higher) and specialty (pathology tends to be free at the point of use).

Medicare does not cover dental examinations, ambulance services, allied health services, glasses and hearing aids.

State and territory governments supplement Medicare funding so the above services can be provided in community health services for those who cannot afford them.

Pharmaceutical Benefits Scheme (PBS)

The Pharmaceutical Benefits Scheme (PBS) subsidises approved medications to Australians: PBS listed medicines cost the consumer no more than $29.70. About three-quarters of medications dispensed by Australian pharmacies are included on the PBS. The Scheme is regarded as one of the most effective in the world and has successfully balanced access to reliable effective medicines with controlling the continual pressures of rising costs. Medicare Australia is responsible for administering the PBS (www.medicareaustralia.org.au).

State Level

State governments are primarily responsible for delivering health care services, and funding the gaps left by Medicare. For example:

- States provide funding to public hospitals (which are independently run in regional groups) and regulate them. Some of the money comes from the Commonwealth, which comes with strings attached.
- States directly fund psychiatric hospital and community services, plus a range of community and public health services such as community health services, dental care and child health programs.
- In Victoria, the Department of Human Services is the central health agency (www.dhs.vic.gov.au). It has responsibility for mental health services, child protection, public housing, disability services, hospitals and problem gambling services.

Local Level

Local governments are responsible for some public health services and for public health surveillance but not for clinical medical services. Local governments are also involved in immunisation programs, they run maternal and child health centres and they also undertake some health promotion activities.

Health service delivery

A mix of public and private sector providers deliver health care services:

- The majority of doctors are self-employed and engaged in private practice, although they receive the bulk of their income from Medicare. There are also a growing number of private companies employing doctors and other professionals.
- Public hospitals are run as independent organisations with their own Boards, but directly funded by State governments and closely controlled by them.
- Private hospitals are owned by for-profit or not-for-profit organisations such as health insurance or religious agencies.

Private Health Insurance

Private health insurance is a significant component of the Australian health care system:

- Private health insurance can meet some of the costs of private services that are not covered by Medicare, such as attending a private hospital or seeing allied health workers, such as podiatrists or psychologists. This insurance is now heavily (and controversially) subsidised by the Commonwealth Government.
- Privately insured people also have the potential choice of doctor, hospital and timing of procedure.
- Whether private health insurance is a valuable component of the system or not is highly contested in policy debates.

Research

The National Health and Medical Research Council (NHMRC) is the main funding body for health and medical research (www.health.gov.au/nhmrc)

The Commonwealth Government provides funding for public health research to continually improve the evidence for public health interventions and to contribute to a reduction of future health care costs.

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Smith, K., Marshall, B., Williams, P., Keleher, K., Murphy, B., Dodson, L., Ward, M. 2003. *Achieving Health and Human Development*. MacMillan Education Australia. Melbourne.

Appendix 4

Safety and Quality Fact Sheets

The Australian Council for Safety and Quality in Health Care has developed a range of Fact Sheets related to Quality and Safety in Health. The Council ceased its operations in December 2005 and has been succeeded by the Australian Commission on Safety and Quality in Health Care. The Fact Sheets are still readily available via the website www.safetyandquality.org and include the following topics:

- Minimum data set for safety and quality
- Adverse event rates
- Human factors in health care
- Incident management systems
- Ten tips for safer health care
- Sentinel events
- Pharmaceutical review: improving medication safety in hospitals
- National patient safety education framework
- Charting the safety and quality of health care.

Appendix 5

The Role of the Health Service Board

The public health sector operates within a legislative and regulatory framework set by government with ultimate responsibility for hospital and health services vested in the Federal Minister for Health and Ageing. Each of the Public Health Services is governed by a Board of Directors with governance responsibilities, which focus on providing overall stewardship and oversight of management and operation of services. The role of the Board is governance rather than direct management.

Each of the Directors is expected to be familiar with the legislative and regulatory framework within which the Health Service operates and to attend and participate in meetings of the Board and Committees on which the Directors serve. The Board's first responsibility is to ensure that the organisation has clearly established goals, objectives and strategies for achieving them.

In establishing a Quality Committee, the Board ensures that the issue of the quality of care and services provided by the Health Service is addressed with the same commitment and rigour as it applies to its financial responsibilities. Through its chief executive officer and executive management team, and through the establishment of sub-committees, the Board delegates authority and accountability to execute its statutory responsibilities. A successful quality management process requires commitment by the Board to the quality mission of the organisation. In supporting the quality management process, the Board has to define the organisation's commitment to continually improving the quality of patient care in the mission statement of the organisation. The Board also has a role in ensuring that the voice of the community and consumer is heard and incorporated into the Health Service's quality aims and objectives.

A statutory requirement of each Public Health Service is the establishment of a Community Advisory Committee. The CAC is seen as an important component of an overall strategy to improve community participation in Victoria's public health service. One of the primary considerations supporting the establishment of bodies to facilitate community participation was evidence that increased community and consumer participation supported the effectiveness of system-wide planning and promoted improvement in health care quality and safety.

The Board has a responsibility to ensure that the CAC is a participant in the quality management activities of the health services. The CACs are chaired by a Board member who also sits on the Quality Committee. The *Community Advisory Committee Guidelines*, published by the Department of Human Services in November 2000, state that Health Service Boards should consider the benefits of overlap of membership or systemic information exchange between the CAC, the Quality Committee and the Primary Care and Population Health Advisory Committee (p.10). *The Guidelines* also reflect a statutory requirement as "Participating in the development and ongoing monitoring of key performance indicators for Health Service quality" (p.6). It is clear that the CAC has an integral role in the Board's execution of its quality management responsibilities.

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The Australian Council of Safety and Quality in Health Care, *Complaints Management Handbook for Health Care Services* Commonwealth of Australia 2005

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The Australian Council of Safety and Quality in Health Care, *Partnerships for Health in Action: Promoting Consumer Involvement in Health Care Improvement* Commonwealth of Australia 2005

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