

CHARTER OF THE NORTHERN SYDNEY AND CENTRAL COAST AREA HEALTH ADVISORY COUNCIL

1. The Role and Function of the Area Health Advisory Council

The **role** of the Northern Sydney and Central Coast Area Health Advisory Council is to facilitate the involvement of providers and consumers of health services, and of other members of the local community, in the development of the Area Health Service's policies, plans and initiatives for the provision of health services.

Functions:

The NSCC Area Health Advisory Council has the following functions:

- a. To advise through existing structures providers and consumers of health services, and other members of the local community, as to the Area Health Service's policies, plans and initiatives for the provision of health services,
- b. To seek through existing structures the views of providers and consumers of health services, and of other members of the local community, as to the Area Health Service's policies, plans and initiatives for the provision of health services, and to advise the Chief Executive of the Area Health Service of those views,
- c. To confer with the Chief Executive of the Area Health Service in connection with the operational performance targets set by any performance agreement to which the Area Health Service is a party.
- d. To advise the Chief Executive on how best to support, encourage and facilitate community, consumer and health service provider involvement in the planning of health services by the Area Health Service,
- e. To liaise with other Area Advisory Councils in relation to both local and State-wide initiatives for the provision of health services,
- f. To publish reports (annually or more frequently) as to its work and activities,
- g. Such other functions as are conferred or imposed on it by regulation.

2. Responsibility and Scope of Activities

The role of the AHAC is **advisory** in matters of:

- (i) Strategic planning;
- (ii) Priority setting;
- (iii) Policy development;
- (iv) Monitoring
 - a. health status;
 - b. health service delivery;
 - c. performance;
 - d. the development of clinical networks;
 - e. the appropriateness and effectiveness of engagement processes with clinicians and the community.

The Area Health Advisory Council does not have an operational or management role.

A key function of the AHAC is to ensure that views of clinicians, patients and the community about the accessibility, quality and safety of the health services provided by the Area Health Service (AHS) are being obtained by the AHS and given due consideration in decision making. The AHAC also has a role in facilitating local consultation mechanisms.

The AHAC will undertake this function by working with the Area Health Service to ensure that clinicians, patients and the community are effectively engaged and consulted and that local consultation mechanisms are effectively operating. This may include holding AHAC meetings in different locations in the Area.

3. Communication, Roles, Relationships and Stakeholder Engagement

3.1 Area Chief Executive

The CE is responsible for both the governance, and strategic framework of the AHS. The CE's critical role in balancing and achieving effective governance and strategic outcomes for the Health Service is recognised by the NSCC AHAC.

The CE is also responsible for the management of the AHS including the effective engagement of and consultation with clinicians, patients and the community. Developing an effective working relationship between the CE, senior staff of the AHS and the AHAC Chair and members is recognised as critical to the effective functioning of the AHAC.

3.2 Chair

The Chair will be responsible for meeting preparation, attending associated briefings and meetings and providing advice and leadership on clinician and consumer input to the establishment and operation of the AHAC.

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

3.3 Stakeholders

It is the responsibility of the Area Chief Executive to incorporate the views of clinicians, consumers and the community in the planning, delivering, monitoring and evaluation of health services provided by the Area Health Service, including the Area Healthcare Services Plan.

To assist in this process the NSCC AHAC will work with the Chief Executive to develop a communication protocol for interaction with key clinical and community stakeholder groups operating at Area and local levels. The protocol will detail the mechanisms that the AHAC will use to ensure that clinicians, patients and the community are effectively engaged and consulted and that local consultation mechanisms are effectively operating.

It is recognised that Area Health Services use a range of strategies to inform and involve consumers in decision-making in the health system. The NSCCAHS has existing structures for community engagement at a local level that function with differing levels of effectiveness. These structures are variously called Health Councils, Health Consumer Networks, Consumer & Community Health Forums and consultative committees. The role and activities undertaken vary and include needs assessment, input into planning and health promotion activities. The effectiveness of these communication systems will be assessed and developed when needed. AHAC will gain the views of these groups where appropriate and is not intended to replace them.

The NSCC AHAC will meet periodically with the chairs of local health advisory groups within the Area. This will be either on a whole-of-Area basis, or on a sector basis where appropriate.

Communication with Area-level clinical bodies will be via an Area Medical Staff Executive Council and the Clinical Council.

Communication with the Area Quality and Improvement Committee and the Clinical Excellence Commission will occur, with the aim of delivering safe and quality clinical services based on best available evidence and the most clinically and financially effective models.

3.4 NSW Health –state level and peak groups

The Chairs of AHACs will attend a meeting of the Health Care Advisory Council (HCAC) twice a year. AHACs will report through the Chief Executive by exception to the HCAC of any issues that have potential state-wide implications.

Issues can be brought through the Chief Executive to the attention of specific Health Priority Taskforces where the need arises.

Issues can be brought to the attention of the Clinical Excellence Council (CEC) through the Chief Executive or delegate.

3.5 Website Access

Section 29 (2) of the *Health Services Act 1997* requires the text of the AHAC Charter to be available on the internet website of the NSCCAHS as well as the NSW Department of Health.

3.6 Public Comment

Any public comment made by the AHAC Chair and members must be done so as a private citizen and not on behalf of the Chief Executive or Area Health Service.

AHAC members must not access, use, disclose or release any internal Area Health Service documents or privileged information unless there is a need to do so in the course of AHAC business and the member has been authorised to do so. Members must protect the privacy of client information as required by the AHS Privacy Code of Conduct. Circ 2001/46

4. Conflict Resolution

Should a significant and unresolvable difference of opinion between the CE and the AHAC occur, conflict resolution processes will be put into place

Where it can be demonstrated that all other avenues of conflict resolution have been exhausted and in exceptional circumstances only, it may be necessary for the CE and the AHAC Chair to seek a joint meeting with the Director-General or delegate, and that delegate should be no less in seniority than a Deputy Director-General.

“If such a meeting is considered necessary by AHAC, the AHAC Chair shall advise the CE, by notice (in writing or electronically) of its intention to seek such a meeting. The CE will have seven (7) days or such longer period as agreed by AHAC to respond to the notice (in writing or electronically) At the expiration of the notice period the Chair may seek such a meeting.”

5. Appointment of Chair and Members

Section 26 of the *Health Services Act 1997* refers to the constitution of AHACs.

5.1 Membership

The Area Health Advisory Council is to consist of between 9 and 13 members appointed by the Minister, with roughly equal numbers of health professionals and community members. At least one member must be a person who has expertise, knowledge, or experience in relation to Aboriginal health.

5.2 Term of Appointment

Inaugural Chairs are appointed for a four year term. 50% of inaugural members are to be appointed for a two year term and 50% for four years.

Subsequent appointment of Chairs and members should be for a period not exceeding four years.

5.3 Reappointment Process

A member whose term of office expires may apply for reappointment. The maximum period of membership for AHAC Chairs and members is 8 years.

The Minister following a review process involving the Chief Executive will make decisions regarding the reappointment of the AHAC Chairs and members.

5.4 Co-opting of Members

The Chair of AHAC may invite people with specialist expertise to attend AHAC meetings for a time limited period as required.

5.5 Vacancy in Office

The Chair may retire or resign at any time by letter to the Chief Executive, 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 Minister will appoint another person for the balance of the term.

5.6 Leave of Absence

In circumstances of demonstrated need, individuals holding AHAC positions can 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 Chief Executive. 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.

5.7 Dismissal Provision

The Minister can remove the Chair or any member of the AHAC from office. Grounds for removal may include breaches of criminal law, bankruptcy, breaches of the code of conduct, persistent failure to attend meetings or actions that undermine the standing and effectiveness of the AHAC or the AHS.

6. Meetings

6.1 Frequency

Regular meetings of the AHAC will occur at least on a monthly basis. Additional meetings will occur as agreed to by the CE and Chair of AHAC

6.2 Quorum

The meeting quorum will be 7 members of the AHAC. A minimum of two health care professionals and two community members should be represented at each meeting.

6.3 Disclosure of Interests by Members

At the commencement of each meeting the Chair will invite members to declare whether there are any matters in the agenda which that have a “direct or indirect pecuniary interest”. This will provide members with an opportunity to discharge their obligations as Council members.

Where a member declares an interest the matter will be noted in the minutes, and the Council will be asked to consider the declaration and to make a decision after appropriate discussion about if the member will be permitted to:

- a) Be present during any deliberation of the Council with respect to that matter; or
- b) Take part in any decision of the Council with respect to that matter.

6.4 Code of Conduct for AHAC members

Members of AHAC will be bound by the NSW Health Code of Conduct (see NSW Health Website for Policy).

6.5 Agenda and Minutes

The Chair will set the meeting agenda in consultation with the Area CE.

All meetings shall be minuted. Once ratified, a summary of the minutes of each meeting are to be posted on the NSCCAHS website and forwarded to the Department of Health (Community & Government Relations Unit) for posting on the NSW Health Advisory Network website.

6.6 Attendance

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.

The Chief Executive is to meet with the Council on a regular basis at such frequencies, times and places as may be mutually agreed with them. Area Senior Executive staff, as appropriate, may also attend AHAC meetings, although they will not be AHAC members.

6.7 Other Considerations

- AHAC representation and cross-membership should be considered for relevant internal Area Committees after consultation between the AHAC Chair and the Area CE.
- The site of AHAC meetings will be jointly determined by AHAC. Meetings may be held outside the Area if deemed more practicable.
- Each AHAC should meet at least annually with the Area-level group being established to progress the Area Workforce Development Strategy.
- 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 advisory 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 on-going role in establishing and maintaining relationships with local health advisory groups and local communities in general.
- Meetings are not generally open to the public. Communication processes will be put in place to ensure that clinicians and members of the community are aware of AHAC priorities, meeting frequency and mechanisms for raising issues.

7. Remuneration

7.1 Chairpersons and Members of the Area Health Advisory Councils

The Premier based on advice from the Statutory and Other Officers Remuneration Tribunal (SOORT) has determined remuneration for AHAC Chairs and members. Payment rates are set and promulgated from time to time.

7.2 Area Health Service and other Government employees

In line with policy decisions against “double dipping” Area Health Service and other NSW Public Sector employees appointed to NSW government boards and committees are not entitled to receive remuneration.

7.3 Travel and Motor Vehicle Allowances

Members of the AHACs are to receive travel and motor vehicle allowances in accordance with the guidelines contained in Premier’s Memorandum 2004-10.

7.4 Administration of payments

All payments are to be made at the end of each quarter. In order to provide sufficient accountability, Chairpersons and members are required to submit sufficient documentation to substantiate days claimed on Council business.

8. Performance monitoring

8.1 Two year plan

A rolling 2 year work plan for the activities of the AHAC will be developed with the Area CE and in consultation with clinical and community stakeholders, taking into account the Area Healthcare Services Plan. The work plan will identify an agreed budget and should include key performance indicators for monitoring, reviewing and communicating the performance of the AHAC and the Area.

The work plan will incorporate a review of local community advisory structures in the first 12 months. Where such a review has already been undertaken or is in the process of being undertaken, the AHAC should be satisfied with the recommendations of the review and monitor its implementation.

The work plan will also include strategies to monitor the Area Health Service’s performance in relation to major health initiatives and annual clinical and consumer performance targets based on key performance indicators (the ‘dashboard’ indicators) and to report to the community and clinicians about Council and Area Health Service activities to improve health service accessibility, quality and patient safety.

Commencing at the end of the second year of its term, there should be annual reviews of each AHAC against key performance indicators contained in the AHAC work plan.

8.2 Annual Report

Section 29 A of the *Health Services Act 1997*, requires each AHAC to prepare an annual report on its activities.

- (1) As soon as practicable after 30 June (but on or before 31 December) of each year, the chairperson of The NSCCAHAAC will provide the Minister with a report on the performance by the AHAC of its role and functions under this Act during the period of 12 months ending on 30 June in that year.
- (2) The report will include performance indicators to measure the AHACs success in the performance of its role and functions under this Act.
- (3) The Minister is to cause the report to be laid before both Houses of Parliament as soon as practicable after receiving the report.

AHAC Annual Reports will be included in the Annual Report of the NSCCAHS.

8.3 Reporting to Department of Health

The AHS is to provide the Department of Health with quarterly reports on all payments made to each AHAC member.