

Community representation in hospital decision making: a literature review

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Abstract

Objective. Advancing quality in health services requires structures and processes that are informed by consumer input. Although this agenda is well recognised, few researchers have focussed on the establishment and maintenance of customer input throughout the structures and processes used to produce high-quality, safe care. We present an analysis of literature outlining the barriers and enablers involved in community representation in hospital governance. The review aimed to explore how community representation in hospital governance is achieved.

Methods. Studies spanning 1997–2012 were analysed using Donabedian's model of quality systems as a guide for categories of interest: structure, in relation to administration of quality; process, which is particularly concerned with cooperation and culture; and outcome, considered, in this case, to be the achievement of effective community representation on quality of care.

Results. There are limited published studies on community representation in hospital governance in Australia. What can be gleaned from the literature is: 1) quality subcommittees set up to assist Hospital Boards are a key structure for involving community representation in decision making around quality of care, and 2) there are a number of challenges to effectively developing the process of community representation in hospital governance: ambiguity and the potential for escalated indecision; inadequate value and consideration given to it by decision makers resulting in a lack of time and resources needed to support the community engagement strategy (time, facilitation, budgets); poor support and attitude amongst staff; and consumer issues, such as feeling isolated and intimidated by expert opinion.

Conclusions. The analysis indicates that: quality subcommittees set up to assist boards are a key structure for involving community representation in decision making around quality of care. There are clearly a number of challenges to effectively developing the process of community representation in hospital governance, associated with ambiguity, organisational and consumer issues. For an inclusive agenda to real life, work must be done on understanding the representatives' role and the decision making process, adequately supporting the representational process, and developing organisational cooperation and culture regarding community representation.

What is known about the topic? Partnering community is recognised as a fundamental element of hospital quality improvement strategies and the implementation of the Australian agenda for advancing the quality of health service standards. It is also known that developing collaborative environments and partnerships can be a challenging process, and that it is good practice to consider the factors that will influence their success and develop an approach built on the identification of potential challenges and the incorporation of facilitators.

What does this paper add? This paper draws out key obstacles that can challenge the process of involving community representation into hospital governance structures.

What are the implications for practitioners? There is little published on the challenges to community engagement in the hospital governance setting. By doing this, this paper encourages the recognition that although partnering with the community is an essential aspect of achieving quality of care, it requires significant effort and support to be an effective aspect. The paper highlights challenges and facilitators that practitioners should consider if planning for successful community representation on hospital committees.

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Introduction

This literature review identifies key barriers and enablers to involving community representatives in hospital governance. Community involvement or 'customer centeredness' is a core

principle of the current Australian agenda for advancing the quality of health service standards. To be customer centred requires partnerships that are extensive and built across many stakeholders, particularly community representatives.

This approach can be challenging and requires the consideration of factors that will influence the success of the collaborative processes put in place.¹ Community involvement in planning for safety and quality, particularly through representation, is a core element of achieving care that is responsive to needs. This study is a literature review aimed at identifying key barriers and enablers to involving community representatives in hospital governance. The aims of the policy directions are not disputed by this review but it does highlight that implementation of the policy partnership standards requires a supportive environment at both the structural and operational levels to be meaningful and useful.

The National Safety and Quality Health Service Standards² are framed around three core principles: consumer centred; driven by information; and organised for safety. The associated Australian safety and quality framework for healthcare provides an outline of 10 standards to advise health service organisations in Australian on how to deliver safe and high-quality care. The first two, governance for safety and quality in health service organisations, and partnering with consumers, are identified as the overarching requirements for the effective implementation of all the standards. The other standards focus on specific clinical areas of care: healthcare-associated infections, medication, patient identification, handovers, blood and blood products, pressure injuries, clinical deterioration and falls.

The standards clearly place the onus on hospital senior executives and boards to involve consumers, patients and carers in planning for safety and quality. This is achieved by inviting members onto committees and advisory groups, some for process redesign work, or engaging participants in planning groups for new facilities. A member of a committee, steering or advisory group who is involved to voice the perspective of the consumer and take part in decision making on behalf of consumers is often referred to as a consumer or community representative.³ Although the objective of consumer involvement has met with widespread agreement, little research and few strategies focus on how to maximise the impact of this involvement.

Methods

An integrative literature review was undertaken in August 2012 with the aim of identifying and critically reviewing scholarly and peer-reviewed articles, inclusive of varied methodologies, related to the topic of community representation in hospital governance. Initial background information gathering included identification of grey literature not formally published in journals among key institutions namely, the Australian Commission on Safety and Quality in Health Care (<http://www.safetyandquality.gov.au/>, accessed 19 November 2014), the Health Issues Centre (<http://www.healthissuescentre.org.au/>, accessed 19 November 2014) the Consumer Health Queensland website (<http://www.hcq.org.au/>, accessed 26 November 2014) and State Health websites. Journal article searches were conducted using a Summons Search Service platform. This platform is connected to a broad range of databases including: Medline (via EBSCOhost) Science Direct, PubMed, Social Service Abstracts (via Proquest) and CINAHL (via EBSCOhost), ABI/Inform Complete (Proquest) and Emerald full text. The search terms were 'community representation' and 'hospital governance'. The search was limited to scholarly and peer-reviewed articles written in English and filtered by the subject terms 'healthcare industry', 'health services' and 'hospitals'. This resulted in 185 citations, which reduced to 175 with the removal of duplications. Abstracts were scanned for appropriateness (i.e. relating to reference to community representation or to governance), resulting in a new sample size of 48 papers. A first read of articles was conducted to review the content for appropriateness to the study, with 15 removed after the first read. Figure 1 outlines a summary of this screening process. Data were extracted from the sample papers and entered into a spreadsheet noting titles, authors, years, study methods and key points highlighted within predetermined categories of interest. Aligned with the Donabedian quality framework structure, process and outcome, the predetermined categories of interest were: (1) structures and mechanisms for community representation, and (2) process challenges to achieving community representation. The analysis included thematic analysis in relation to both

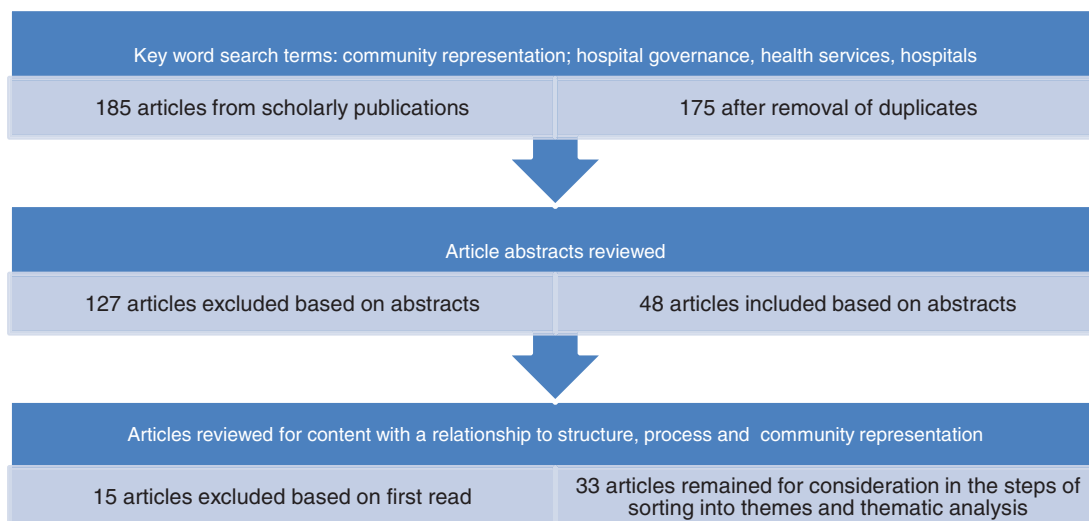


Fig. 1. Screening process.

structures, and barriers and enablers to operationalising the process of effective representation.

Results and discussion

Structures that allow for a community voice in decision making

The notable structures for involving representation in hospital governance were local boards, and advisory groups or committees. Local hospital boards have oversight for governance in healthcare. They are responsible for formulating organisational ends (vision, mission and objectives), ensuring suitable performance from senior management, quality of care provided in the organisation, finances and financial performance of the organisation, and effective and efficient governance.⁴ As stakeholders of the public hospital system and its performance, there is pressure on boards to ensure a balanced approach to both financial oversight and the quality of care, including diverse representation to meet the range of responsibilities. An Australian study identifies 13 skill areas that board members are required to cover to meet their governance roles: corporate management, finance auditing, law, human resources, capital management, strategic information technology, clinical governance, risk management, health service issues and planning, community representation, government liaison, media relations, and commitments to values and clients of the service.⁵ The study also found that the board pursues involvement in many areas through board committees. Boards with a quality committee are more likely to adopt a comprehensive range of quality practices.⁶ However, the lack of a tool to evaluate committee performance can present a barrier to ensuring the desired quality of structures and processes are in place.⁵

The Australian Safety and Quality Framework for Health Care⁷ suggests a range of activities for health service executives and boards to 'involve consumers, patients and carers in planning for safety and quality'. Recommendations include involving patients, carers and consumers as members on committees and advisory groups, as advisors for redesign work on care processes, or as participants in planning groups for new programs or facilities. Quality committees are obvious platforms for including consumers in decision making. Evaluation of this input is important to ensure that this community engagement strategy is working effectively.

Consumer representation, typically from an organisation of consumers, on steering groups and committees is recognised as the major technique for consumer engagement in Australia.⁸ Consumer representation from organisations ideally comes with a structure to consult peers, can tap into a breadth of experiences and is accountable to a set of consumer interests, not just that of the committee. However, the concerns relate to an onus to represent lay voices or groups, particularly disadvantaged groups that a representative may not have contact with. Consequently, part of the concern is that organisations will limit their engagement approach to consumer representation strategies only.

Barriers and facilitators to the process of community representation

A key barrier to effective community representation is ambiguity around clarity of roles, and how and what decisions are to be

made. Ambiguities can be a problem at an individual level and they can also cause confusion at a strategic level, which leads to postponement of decisions, amplifies tensions and presents difficulties moving forward. According to Dimpierre *et al.*,⁹ when strategic ambiguity is coupled with a culture among stakeholders of sticking to one line of thought in decision making, it can lead to 'escalated indecision' rather than effective collaborations.

A study in New South Wales, Australia, surveyed staff views on the legitimacy of community representatives sitting on health service committees as part of the Area Health Service's formal community participation program.¹⁰ Staff had a positive attitude towards the community participation and believed that community representatives have a legitimate role in representing the community. However, staff expectations of the community's role on committees did not match the reality that they observed. Less than 50% of the staff surveyed felt the community and the health service agreed on the community representatives' role. The researchers recommended reviewing and enhancing training and support for representatives and staff. It is important to question the expectations of the representative and the health service staff. Researchers have found that ambiguity and lack of clear 'specification of the means and aims of user involvement' (p. 1056)¹¹ can result in staff pursuit of involvement declining in favour of pursuing other areas of work which they are clear about.

The 2008 report on the evaluation of community advisory committees (CACs) to boards of the Victorian Public Health Services acknowledges that CACs had contributed to placing community participation on the agenda of Health Service Boards; however, they also found that there was uncertainty about the purpose and role among the CACs.¹² It is becoming more recognised that a holistic consumer engagement strategy must go beyond a CAC. Consequently, it is important for community representatives on hospital governance boards or committees and for others in those structures to have clarity about their role in the scheme. The report warns that without this broader context, CACs risk attempting an unmanageable and perhaps inconsistent agenda, resulting in frustration from council members and other consumer involvement stakeholders.

As Victoria was the first Australian state to legislate mandated community involvement committees to advise area health boards, the evaluation of the Victorian experience was significant. The external evaluation highlighted facilitators of CAC success as adopting diverse approaches to consumer involvement, allocating adequate time, having clear lines of accountability, ensuring appropriate and reliable resourcing and support for advisory committees towards achievements of the committee's agreed role, providing appropriate information and training to all participants and ensuring that members had a clear understanding of the health sector and health service bureaucracy, ensuring meetings were open and inclusive, appreciating the circumstances of those participating and ensuring that meeting environments were not intimidating, and reporting to participants so that they knew what resulted from their involvement.¹³

An Australian literature review on conceptualising consumer engagement recognised four barriers, with the most significant noted as the potential to 'paralyse the decision making process' (p. 40)⁸ particularly related to the efforts to reach consensus. This paralysis resonates with the notion of escalated indecision. The

three other areas of concern were the time and resources needed to support community engagement endeavours adequately, consumer issues and organisational issues that present barriers. The consumer issues relate to an imbalance felt between the consumer participant and other players such as funders, bureaucrats and health professionals. On committees, this is recognised as their being set apart not only by their 'lay knowledge' and an unfamiliarity with the policy process, but also by the experience of generally being the only stakeholder not there as part of their employment. A tension between expert and lay knowledge on committees is also identified, whereby the consumer voice can feel isolated and intimidated. Consequently, for participants to be effective players at the policy table, they need to be able to develop an understanding of the health system and its issues, and feel comfortable contributing to discussions on them. This level of involvement calls for preparation time, support and training for participation. At an organisational level, barriers relate to poor support for community engagement within the organisation through a poor understanding of working with consumers and negative attitudes to doing so, which can also occur at the level of the policy makers and committees responsible for including representatives. In addition to time and money to support the community engagement strategy, an organisational champion is considered important. It is also important to commit to dealing with the outcomes and not shifting important discussions to outside the committee room to avoid community representation involvement.

The contemporary push for collaborative governance in which state and non-state stakeholders join to work on complex problems through processes of collective decision making

(p.107)¹⁴ presents many challenges, including that of increasing user group participation in decision making.¹⁵ Facilitators of engagement are key to the success of the future of collaborative governance and will include facilitative leadership, collaborative process variables including trust building, commitment to process and shared understandings; routes for user groups to influence decision making; capacity within the community through empowered individuals and collective actions of 'user' groups; and professional and organisational respect for the adversarial role of user groups instead of fearing that they will be antagonistic.^{14,16}

The historical development of public sector management techniques may have contributed to organisational cooperation and cultural issues hindering the acceptance of community involvement in decision making. Storey and Holti highlighted that public healthcare organisations are typically 'subject to a challenging tripartite regime of market, hierarchy and networks' (p. 150)¹⁷ and warn that this is so complex that disengagement from governance reform would be highly penalising. The hierarchical principal from before the 1990s is characterised as authoritarian and has socialised health professionals to value professional autonomy and to feel undermined by the involvement of other professionals and non-professionals into the structure of decision making. Consequently, for successful modern collaborative forms of governance, which include the involvement of service users, health professionals will need training and socialisation to perceive other stakeholders as supports in the decision making process and not as interference.¹⁸ Governance reform also needs to consider the potential barriers arising from the market regime.

Table 1. Summarising barriers and facilitators of community representation on hospital committees

Process challenges/barriers	Process facilitators
Ambiguity around the role and decision making process. ⁸⁻¹¹	Clarity and commitment developed around roles and how and what decision are to be made. ^{11,13}
Poor allocation of resources to support community engagement (time, facilitation, budgets). ⁸	Boards (and those responsible for budgets) held accountable for community engagement, for evaluating community engagement strategies, and for reflection on results and improving practices where needed; a clear policy on being a client-orientated service with user involvement recognised as a measure; and a well thought out and supported strategic plan for community engagement and an appropriate budget (planning, facilitators incorporated, approved budgets attached). ^{5,6,8,11,16,20-22}
Organisational issue: Poor support for and negative attitudes towards community engagement within the organisation; internal stakeholders feeling intimidated by the involvement of consumers in decision making and attempting to shift important discussions to outside committee meetings involving community; accountability gaps; disengagement from governance reform; and staff working within structures that reward different concerns (e.g. conditions for promotions, research publications etc.) ^{8,14-17,19,20,23,24}	Training and socialisation of professionals to participate in collaborations; a high level organisational champion; clear lines of accountability; and adequate time and resources for community engagement reflected in funding, job descriptions, rewards systems and workloads. ^{8,11-14,16,18,22,25,26}
Consumer issues: consumers feeling a tension between expert/funded opinion and their lay knowledge; the consumer voice feeling isolated and intimidated; community apathy and poor participation levels; and community representatives with little opportunity to receive comments from or to feedback to others in the community. ^{8,24,27,28}	Induction and preparation time, including information on the health service and how it is administered; appropriate training; good communication, including communication of clear and agreed roles to all involved and allowing participants to appreciate the process through reporting on inputs and outcomes; meeting environments which are non-intimidating and are open and inclusive; involvement of community workers that are independent of planners and policy makers; links to active user groups in the community; encouraging reflective behaviours through soliciting and encouraging feedback from clients; and incorporating strategies for community engagement, other than community representation, and developing linkages between these strategies. ^{8,10,13,16,29}

Since the 1990s, the market principle, based on industrial market techniques and on price competition, caused power to move from health professionals to hospital management.¹⁹ The challenge the market principle presents is the emphasis on cost-efficiency, as this can be inconsistent with what the professionals or the community perceive as quality or efficiency. The health system seems to be working with increasingly restrictive resources and it is unlikely that the market principle will become a thing of the past. At least two facilitators are required to develop effective collaborative governance that is compatible with market pressures: (1) user involvement needs to be structured in as a measure of efficiency, and (2) there needs to be the development of structures that allow for partnerships in which community advocates, health professionals and other professionals, such as financial managers, can work together and respect each other and negotiate power for the achievement of respective goals.^{16,20}

The key facilitators identified in Gregory's⁸ Australian review to conceptualise community engagement were: a high-level organisational champion, adequate resources (including time) and appropriate infrastructures and framework to support the engagement (e.g. facilitators and planning), good communication, good training and support for consumer representatives and staff, previous successes, accountability and trust, and community workers who are independent of planners and policy makers supporting the engagement. Community engagement practices should be evaluated not only to report on numbers but also as a chance for the organisation to reflect and improve practices. A lack of consensus and certainty on how to evaluate public involvement has been recognised and boards are encouraged to develop and tailor self-assessment processes.²¹ This is not only because of the diverse nature of practices but also because it encourages board ownership of the assessment process and the linking of it to their endeavours to improve involvement. An intended offset is reduction of the potential for organisation cultural barriers, as the assessment will be driven by and part of the local culture.²¹

Table 1 provides a summary of the facilitators and barriers to community representation on hospital committees. The sub-themes that have emerged among the process challenges and barriers to effective community representation in hospital governance decision making on quality of care are: ambiguity around the role and decision making processes, poor allocation of resources to support community engagement, organisational issues and consumer issues. The corresponding subthemes among process facilitators are: clarity and commitment around roles, what and how decisions are made; holding boards accountable for community engagement, including planning, evaluation and review, policies and budgets; developing a supportive internal culture, including training and socialisation strategies, organisational champions, accountability and recognition in resourcing, job descriptions, workloads and rewards systems; and induction, preparation and supports for the community representatives involved in hospital governance decision making on quality of care.

Conclusions

Although community representation on hospital committees is a recognisable part of the reform agenda for healthcare services in

Australia, there is little published research on it. This gap in knowledge may indicate that more focus and consideration are needed to ensure that community representation is an effective aspect of the Australian health service system. This literature review highlights that there are several factors that can contribute to the quality of community representation within hospital decision making. Community representative membership on hospital committees, especially quality committees, is a major technique for structuring consumer involvement in hospital planning for safety and quality. However, this will not lead to effective involvement if the process does not engender clear understanding of the representatives' role and the decision making process, adequately resource support for the representational process, or address any organisational barriers to cooperation and the development of partnering community representatives as a cultural practice.

Competing interests

None declared.

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