

CONSUMER, CARER AND COMMUNITY ENGAGEMENT FRAMEWORK

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MESSAGE FROM THE CEO

EACH's Consumer, Carer and Community Engagement Framework is based on the foundation belief that the engagement of consumers, carers and the community in the planning, design, delivery and evaluation of services delivers better outcomes. These improved outcomes occur across a range of measures including quality, efficiency, effectiveness and safety of services as well as generating a sense of ownership, empowerment and responsibility for their own health/care.

EACH recognises that consumers and carers want to be able to access the services they need, when they need them, in their local communities. This is achieved through the delivery of an integrated and “joined up service delivery system” that is developed in partnership with consumers/carers, delivering better outcomes for the community as a whole.

EACH CONSUMER, CARER AND COMMUNITY ENGAGEMENT FRAMEWORK

(EXECUTIVE SUMMARY)

EACH's Consumer, Carer and Community Engagement Framework is based on the belief that the engagement of consumers, carers and the community in the planning, design, delivery and evaluation of services delivers better outcomes. These improved outcomes occur across a range of measures including quality, efficiency, effectiveness and safety of services as well as generating a sense of ownership, empowerment and responsibility for their own health/care. EACH is committed to ensuring that there are effective mechanisms and processes through which the consumer voice is heard and acted on across all its services.

Consumer/carer engagement in health and community services typically operates at three levels:

1. Clinicians provide specialist knowledge about the presenting condition and most effective (evidence-based) treatment. Role of the client is to follow treatment instructions.
2. Clinicians engage the client in order to achieve a fuller understanding of the condition, its context in the client's life and life of the family. They then identify the most efficacious intervention given the clinician's specialist knowledge.
3. The consumer/carer perspective is systematically engaged throughout the process of service planning, policy and systems development and service provision. This level of consumer/carer engagement is sometimes referred to as co-creation as it moves the consumer/carer experience from being dependant on an individual clinician's practice to being embedded across the organisation's policies and procedures through to actual service delivery.

The transition to Level 3 Consumer/Carer Engagement requires a transformation in the way organisations and service providers typically work and also a unique set of skills from consumers/carers who are engaged to become informed advisers on the consumer/carer experience. To achieve this transformation, the involvement and feedback of consumers becomes integral to the development of the organisation's strategic planning, program and team planning processes across the organisation.

Evidence of organisations having adopted a Level 3 approach to consumer/carer engagement is now a mandatory requirement of the National Health and Safety Accreditation requirements.

THE FRAMEWORK

The EACH Consumer, Carer and Community Strategy Engagement Framework seeks to deliver against EACH's Vision. It incorporates organisational service processes and includes an engagement strategy and action plan.

The Framework recognises differences in the level of empowerment depend on factors such as the purpose of the engagement, accountability for outcomes, the stake each party holds in the outcome and expertise. These differences in empowerment occur along a continuum ranging from merely informing consumers, to totally empowering consumers with full decision-making responsibility. The Consumer/Carer/Community Engagement Framework guides the way EACH will establish and develop partnerships with consumers, carers and the community to work together towards a shared vision of health and wellbeing.

This includes:

- Informing the organisation of the needs of people who use our services and of people who are potential users of our services but who may experience barriers to access;
- Enabling better planning, design and delivery of services to better meet consumer, carer and community needs;
- Gathering feedback about initiatives and reforms that affect service delivery;
- Monitoring and reporting on the quality and safety of services delivered;
- Empowering consumers to work as active partners unlocking the potential to contribute to more efficient and effective service delivery.

DEFINITIONS

IN ITS CONSUMER, CARER AND COMMUNITY ENGAGEMENT FRAMEWORK, EACH UTILISES THE FOLLOWING DEFINITIONS OF KEY TERMS:

CONSUMERS

Consumers are people who use, or are potential users, of social and community health services including their family and carers. They may participate as individuals, in groups, as consumer representatives or communities.

CARER

A carer is an individual who provides, in a non- contractual and unpaid capacity, ongoing care or assistance to another person who, because of disability, frailty, chronic illness or pain requires assistance with everyday tasks. {The Carers (Recognition) Act 2008}.

COMMUNITY

Community refers to groups of people with a common local or regional interest in health and well-being. Communities may connect through a community of place such as a neighbourhood, suburb, region, a community of interest such as consumers, industry sector, profession or environment group; or a community that forms around a specific issue such as improvements to health and well-being or through groups sharing cultural backgrounds, religions or languages.

CONSUMER ENGAGEMENT

Consumer engagement informs broader community engagement. Consumers actively participate in their own healthcare and in health policy, planning, service delivery and evaluation at service and agency levels.

COMMUNITY ENGAGEMENT

Community engagement refers to the connections between government, communities and citizens in the development and implementation of policies, programs, services and projects. It encompasses a wide variety of government-community interactions ranging from information sharing to community consultation and, in some instances, active participation in government decision making. It incorporates public participation with people being empowered to contribute to decisions affecting their lives through the acquisition of skills, knowledge and experience⁵

SOCIAL AND COMMUNITY HEALTH SERVICES

The scope of social and community health services is broad, encompassing the range of factors described as the social determinants of health which include health, disability, mental health, psychosocial services, housing and homelessness, early childhood and family support. These are community based services which include health promotion, disease prevention, treatment, primary, social and support services.

CONTEXT

EACH'S VISION IS FOR A HEALTHY AND INCLUSIVE COMMUNITY. EACH RECOGNISES THAT INEQUITIES IN HEALTH AND WELLBEING IS CAUSED BY FACTORS SUCH AS UNEMPLOYMENT, INSECURE HOUSING, FINANCIAL INSECURITY, SOCIAL EXCLUSION, ADDICTION AND OTHER SOCIAL DISADVANTAGES. IN RESPONSE, EACH OFFERS A WIDE RANGE OF PROGRAMS THAT ADDRESS THESE SOCIAL DETERMINANTS OF HEALTH AND WELLBEING, AIMING TO SUPPORT EVERYONE TO LEAD HAPPIER, HEALTHIER LIVES AS VALUED AND PARTICIPATING COMMUNITY MEMBERS.

To achieve its Vision, EACH believes consumer participation and consultation is central to the planning, implementation and evaluation of service delivery across all its services. The involvement and feedback of consumers is used in the development of the organisational strategic planning process and program and team planning across the organisation, as well as in the development of our annual Quality and Safety of Care report to the community.

Consumer participation is a key standard within national and state quality accreditation systems. The Victorian Government policy, 'Doing It With Us Not For Us', is a foundation policy statement guiding reforms within mental health, disability and alcohol and drug (AoD) sectors.

This framework promotes collaborative, integrated and effective engagement by EACH with consumers, carers and communities. This engagement occurs within the context of EACH's wider engagement with other community and government stakeholders including Medicare Locals, other NGOs, health practitioners, private hospitals and local, State and Commonwealth governments.

PURPOSE AND SCOPE OF THE EACH CONSUMER, CARER, COMMUNITY ENGAGEMENT STRATEGY

The purpose of EACH's Consumer, Carer and Community Engagement Framework is to inform and embed effective consumer, carer and community engagement within the planning, structures, processes and service delivery practices across EACH.

This includes:

- To inform the organisation about the needs of people who use our services and of people who may be potential users of our services but who may experience barriers to access or variable quality of services
- To enable better planning, design and delivery of services to better meet the needs of people who use our services
- To gather feedback about initiatives and reforms that impact upon service delivery
- To monitor and report on the quality and safety of services delivered
- To empower consumers to work as active partners in their health and well-being, unlocking the potential available to contribute to more efficient and effective service delivery
- To achieve better outcomes through collaboration between providers and service users.

EACH's Consumer, Carer and Community Engagement Strategy is based on a set of principles and a framework to guide and support effective engagement action. It reflects national, state, and international approaches to Consumer, Carer and Community engagement whilst recognising that there is no 'one size fits all' approach.

Rather, it supports the development of strategies that are tailored to meet the needs of local communities guided by consistent principles which underpin the EACH Consumer, Carer and Community Engagement Framework.

The Framework places consumers at the centre, surrounded by the community and builds on the work that has been undertaken by government and non-government stakeholders in the area of Consumer, Carer and Community engagement.

EACH's consumer, carer and community engagement strategies inform and support the quality and safety of services delivered by EACH including:

- identifying the consumers who access our services as well as potential consumers and population groups not accessing services
- identifying the barriers to access and /or unmet community needs
- identifying variation in service quality and safety and monitoring strategies taken to improve quality and safety of services
- achieving a better understanding of the diversity of the people who are current or potential users of the services
- identifying key actions required to reach and engage appropriately with the local community and target population groups
- identifying processes that are effective, innovative and responsive to engagement, particularly for 'hard-to-reach' groups, and
- identifying opportunities to work collaboratively with a broad range of consumers, carers and communities necessary and relevant to service planning, design, delivery and service monitoring and evaluation.

UNDERLYING PRINCIPLES

The following nine principles of Consumer, Carer and Community engagement underpin the EACH approach to enhancing the health and well-being of consumers of services delivered by EACH and the community. They reflect the principles of current national and state health reforms.

PRINCIPLES OF CONSUMER, CARER AND COMMUNITY ENGAGEMENT

PRINCIPLES	PRINCIPLE STATEMENT	PRINCIPLE IN PRACTICE
PARTICIPATION	Consumers and communities participate and are involved in decision making about their health and well-being.	Consumers and communities are involved in decision making and EACH demonstrates how it uses this feedback to plan, design, deliver, monitor and evaluate services.
PERSON - CENTRED	Engagement processes are Consumer, Carer and Community centred.	The values and the needs of consumers, their families/carers and the community are embraced by EACH to improve the manner in which it undertakes engagement.
ACCESSIBLE AND INCLUSIVE	The needs of consumers and communities experiencing barriers to service access and engagement are considered and steps are taken to enhance the accessibility of services and inclusion.	Experiences of consumers and communities, drives strategies to increase access to services and to facilitate the inclusion of people who experience poorer health outcomes.
PARTNERSHIP	Consumers, carers, community and health services work in partnership.	Consumers, carers and the community at all levels of engagement, partner with EACH around the planning, designing, delivery, monitoring and evaluation of services.
DIVERSITY	The engagement process values and supports all consumers, carers and communities.	EACH understands and embraces its different consumer demographics and communities and engages with a diverse range of individuals and groups.
MUTUAL RESPECT AND VALUE	Engagement is undertaken with mutual respect and valuing each other's experiences and contributions.	Working with consumers, carers and communities in a respectful way to improve service planning, provision, monitoring, review and funding outcomes.
SUPPORT	Consumers, carers and communities are provided with the support they need to engage meaningfully with the health and community services systems.	EACH undertakes a process to understand the needs of consumers, carers and the community and implements processes to provide them with the support that they need to engage.
INFLUENCE	Consumers, carers and community engagement influences policy, planning and system reform and feedback is provided about how the engagement has influenced outcomes.	Consumers, carers and communities influence improvements in policy, planning, delivery and design of services through the provision of information and feedback.
CONTINUOUS IMPROVEMENT	Consumer, carer and community engagement is regularly reviewed and evaluated to drive continuous improvement.	Information from the review and evaluation of EACH's engagement activities is utilised to improve future engagement and share learning's and knowledge with staff and other stakeholders.

BENEFITS FOR CONSUMERS CARERS AND COMMUNITIES

Research shows that consumer, carer and community engagement in social and community health services is strongly associated with good outcomes for all concerned, as demonstrated through:

- increasing the level of satisfaction with services
- building an environment where individuals are more likely to take responsibility for their own health and well-being
- helping make service planning decisions that reflect the needs and wishes of the community
- increasing the sense of ownership of services
- providing an efficient and effective means of understanding local needs and issues rather than relying on information from indirect or secondary sources
- improving service quality and safety, particularly in regard to access and service responsiveness
- improved marketing of the service
- helping to attract people interested in working with and supporting services
- injecting innovation and creativity into service planning and delivery
- increasing the level of social capital in the community.

In engaging with consumers and communities it is important to recognise that consumers choose how and when they will engage. This often depends on the nature of the service or activity, the consumer's perception, whether the activity will improve health outcomes and the consumer's life, health and social circumstances at the time.⁷ It is therefore important that EACH provides meaningful opportunities for consumer engagement, that:

- facilitate access
- recognise barriers to engagement
- demonstrate how consumer engagement will contribute to better health outcomes for individuals, their families/carers and the broader community.

BENEFITS FOR EACH

The development of structures and processes which facilitate systematic consumer/carer/community engagement across EACH underpins our shared goals of providing more efficient, effective services to the community.

Information gained through such collaboration is used to improve service planning, design, delivery and evaluation in order to:

- better meet the needs of consumers and the community, including people from diverse backgrounds
- empower and support consumers as active partners in managing their own health and wellbeing
- facilitate more efficient and effective use of services
- make services more accessible, responsive and tailored to meet the individual and collective needs of current and potential users of our services, including:
 - Aboriginal and Torres Strait Islander people
 - gay, lesbian, bisexual, transgender, intersex and queer (GLBTI) community
 - older persons
 - people from culturally and linguistically diverse backgrounds
 - people with a disability, and
 - people with mental illness

BENEFITS FOR EACH (CONT.)

- engage and work more effectively with carers and/or family members
- address unmet needs of consumers who may experience increased disadvantage and poor outcomes due to barriers in accessing our services
- improve integration to deliver better health and wellbeing services for consumers, families and carers across our services
- improve the responsiveness and efficiency of services/programs in relation to funding, quality, safety and consumer satisfaction
- identify service priorities that are based on Consumer, Carer and Community driven needs
- improve knowledge and understanding of key areas of success and opportunities for improvement based on feedback from people who use the service.

THE FRAMEWORK

EACH's Consumer, Carer and Community Engagement strategy is delivered through three elements of an integrated framework:

1. ORGANISATIONAL PROCESSES:

- service planning and design
- service delivery
- service monitoring and evaluation

2. LEVELS OF ORGANISATIONAL STRUCTURE:

- individual – one to one involvement
- program/service – team or service level of involvement
- organisation - across the wider system of EACH
- community and networks – external stakeholders and community networks

3. CONTINUUM OF EMPOWERMENT, INFLUENCE & DECISION-MAKING FROM LOW LEVELS OF INFLUENCE AND IMPACT THROUGH TO HIGH LEVELS OF EMPOWERMENT AND DECISION-MAKING

1. ORGANISATIONAL PROCESSES

Consumer, Carer and Community engagement has impact across three key organisational processes:



SERVICE PLANNING AND DESIGN - informing priority setting and resource allocation. Examples of this in practice may include but are not limited to:

- EACH staff actively engage with consumers in individual planning meetings to make decisions about their individual care.
- Staff partners with consumers to make decisions about design and delivery of their service provision.
- EACH uses Consumer, Carer and Community engagement mechanisms to inform and influence program/team plans from a consumer/community perspective.
- EACH has Consumer, Carer and Community engagement mechanisms in place for services, programs and facilities when developing new initiatives and projects to ensure these reflect and incorporate Consumer, Carer and Community needs.
- EACH has mechanisms in place to provide access to orientation and training for consumer representatives at program and organisation levels.
- EACH has Consumer, Carer and Community engagement mechanisms in place to influence and provide input into strategic and operational plans from a Consumer, Carer and Community perspective.

SERVICE DELIVERY - informing recommendations for improving consumer experience and the quality and safety of service provision. Examples in practice may include but are not limited to:

- Staff engage with the consumer during their service provision to ensure they have informed consent processes in place about their care.
- Staff provide consumers with information about their service provision to meet their individual needs.
- EACH has consumer engagement mechanisms in place to involve consumers, their carers and family with regards to service delivery.
- EACH has Consumer, Carer and Community engagement mechanisms in place to review and evaluate service models and programs.

SERVICE MONITORING AND EVALUATION - informing the use of evaluation and performance data to identify and drive improvement. Examples in practice may include but are not limited to:

- Staff ensure consumers are given opportunities to provide feedback about their satisfaction level in relation to the care they received.
- Staff use consumer feedback mechanisms to review the safety and quality of the service provided.
- Staff provide consumers with information about making complaints.
- EACH has mechanisms in place to engage consumers and the community around client satisfaction at the service, program and facility level.
- EACH has Consumer, Carer and Community engagement mechanisms in place to review and evaluate service models, programs or facilities.
- EACH has Consumer, Carer and Community engagement mechanisms in place to influence and have input into the redesign of existing programs or services.
- EACH has processes in place to evaluate their Consumer, Carer and Community engagement mechanisms which includes Consumer, Carer and Community representatives as part of the process.

2. LEVELS OF ORGANISATIONAL STRUCTURE

Consumer, Carer and Community engagement operates at four different areas or levels within the organisation as shown in the following table:

LEVEL OF ENGAGEMENT	WHERE THE ENGAGEMENT OCCURS	EXPLANATION
1. INDIVIDUAL	Individual health and well-being	This level focuses on engaging with the individual consumer and/or their family /carer as partners in their own health and wellbeing, support and treatment.
2. PROGRAM/ SERVICE	Program delivery/Service delivery	This level focuses on engaging with consumers and the community to have input into how programs/services are delivered, structured, evaluated and improved.
3. ORGANISATION	Organisational	This level focuses on how EACH engages with consumers and community at the organisational level to improve the quality and safety of services.
4. COMMUNITY & NETWORKS	Local community and Networks	This level focuses on how EACH engages with its local community agencies and networks to advocate for improved quality and safety of services and to address gaps in service delivery.

3. EMPOWERMENT CONTINUUM

The Framework's approach to effective Consumer, Carer and Community engagement recognises that there are differences in the level of influence or empowerment which will be allocated to different kinds of engagement, depending on factors such as the purpose of the engagement, accountability for outcomes, the stake each party holds in the outcome, expertise, etc. These differences in influence or empowerment occur along a continuum ranging from merely informing consumers, to totally empowering consumers with full decision making responsibility according to the participatory mechanisms and levels of empowerment shown below:



LEVELS OF EMPOWERMENT:

1. INFORMATION

Information is a one-way exchange and occurs for the purpose of conveying facts, and decisions, and enhancing knowledge and understanding to inform decision-making and support engagement.

2. CONSULTATION

Consultation involves two way exchanges and is used by the organisation to find out what consumers and communities think about a particular issue, their perspectives, and 'lived' experiences of health system policies, programs and services. Consultation provides consumers and communities with an opportunity to share views, needs, interests and aspirations from their perspective. Consultation aims to seek views and opinions, use these to inform agency decision-making, enhance policies and services, and increase acceptance of a decision or initiative.

3. INVOLVEMENT

Involvement is about shared decision making involving planning, delivery and evaluation of services, programs and policies. Consumers/carers/communities jointly own the processes and outcomes. This may occur on an ongoing basis, on a single issue, or on a range of issues or policy matters.

4. COLLABORATION

Consumers, carers and communities work together with EACH and other stakeholders to develop solutions and initiatives; decisions are made within specified guidelines (sometimes referred to as 'co-creating' the solution or initiative).

5. EMPOWERMENT

Consumers and communities make decisions within specified guidelines and the decisions are implemented.

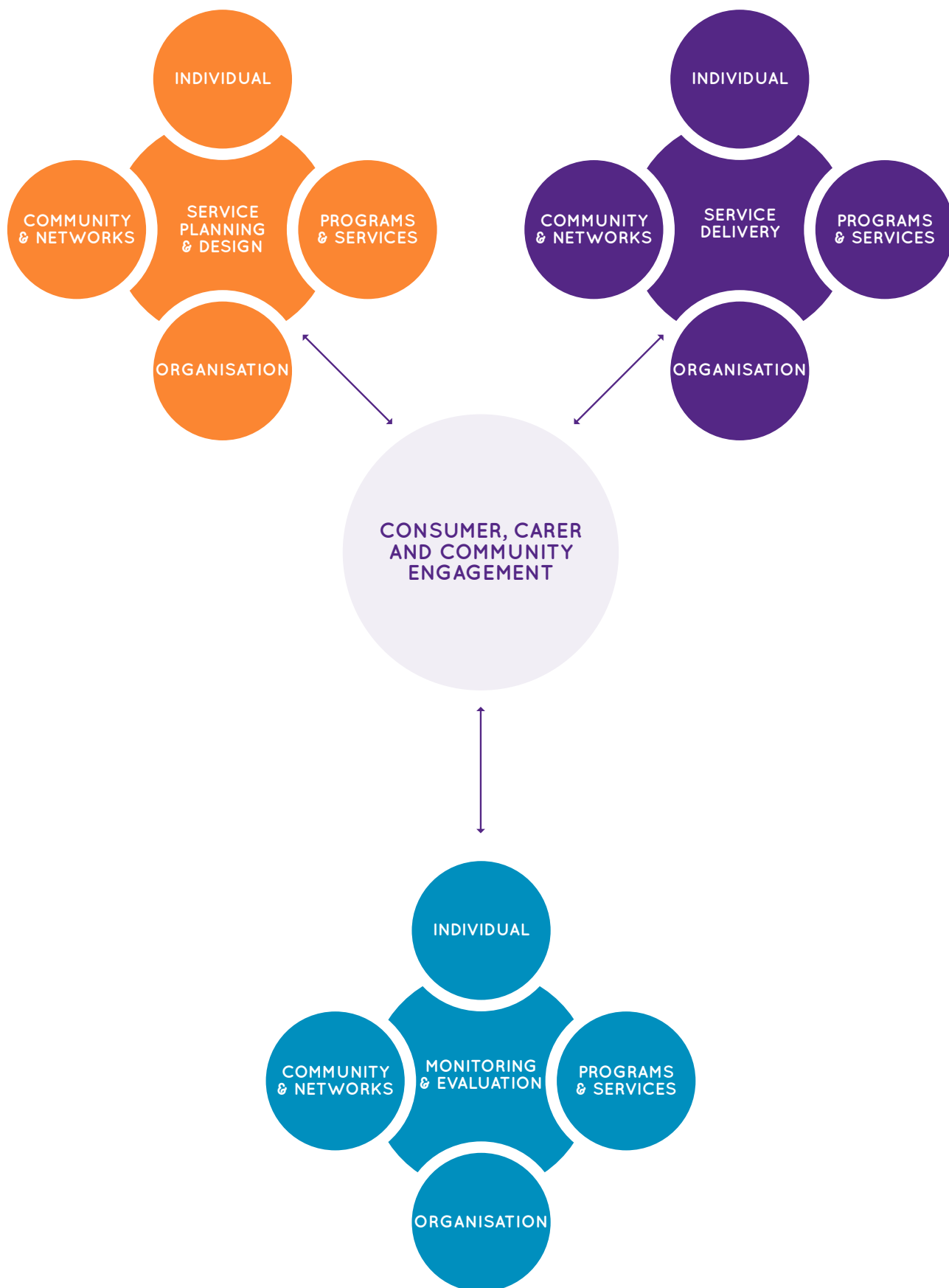
STAGES AND LEVELS OF INFLUENCE/ EMPOWERMENT

	INFORMATION	CONSULTATION	INVOLVEMENT	COLLABORATION	LEVEL
WHAT IS THE NATURE OF THE ENGAGEMENT?	Information is given to consumers and communities.	Information is gathered from consumers and communities.	Consumers and communities are involved in the process.	Organisations and consumers /communities work together in partnership.	Consumers and communities make decisions about solutions, ideas and initiatives and feed this back to services.
WHEN TO USE THIS ELEMENT?	This element is utilised to enhance knowledge and understanding and support transparency. It can provide information that assists consumers to access health and well-being services or manage their health. It can provide information on something that has been decided and is to be implemented.	This element is used to gather information and have discussions with consumers and communities.	Program delivery/ Service delivery This element is used when organisations seek to work with consumers and ensure their views are reflected in decisions and solutions.	This element is used when organisations seek to work partnership with consumers and communities to identify joint solutions and develop initiatives.	The element is used when organisations seek to enable consumers and communities to decide solutions, ideas and outcomes, and implement them.
WHAT IS THE LEVEL OF CONSUMER/ COMMUNITY INFLUENCE?	Level of consumer /community influence is nil.	Consumer / community involvement and influence is low.	Consumer / community have some influence.	High consumer /community involvement and influence.	Consumer / community control.

ENGAGEMENT MECHANISMS

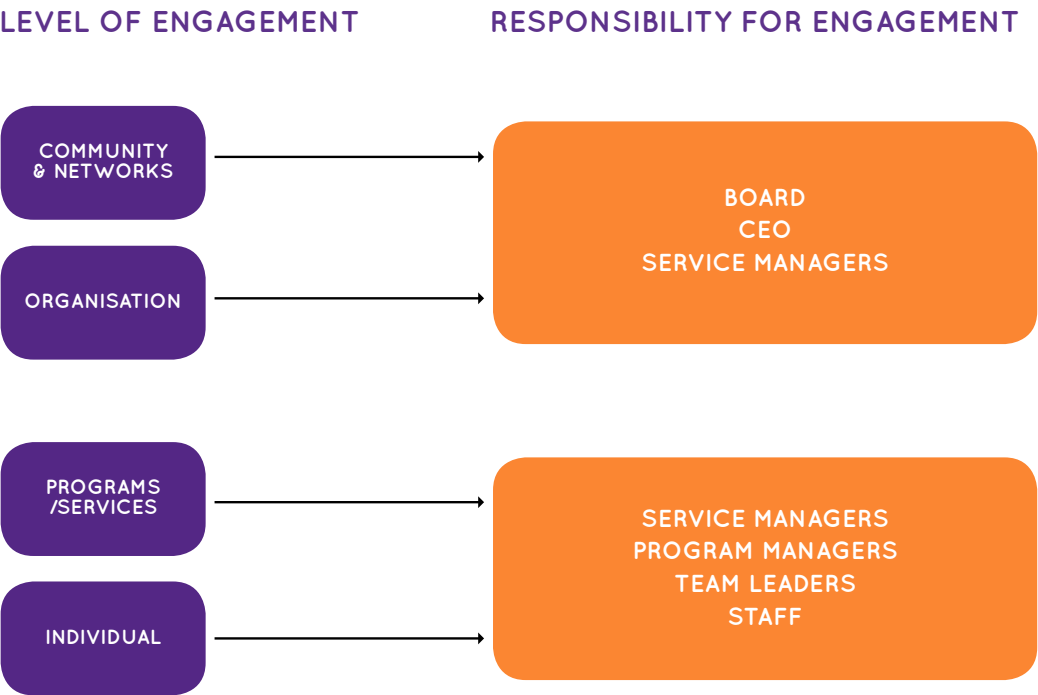
The following table provides some examples of different types of engagement mechanisms across the five stages:

INFORM	CONSULT	INVOLVE	COLLABORATE (CO-CREATE)	EMPOWER
<ul style="list-style-type: none"> • WEBSITES • DISPLAYS • MEDIA RELEASES • EDUCATION PROGRAMS • FACT SHEETS • INFORMATION DELIVERY FORUMS 	<ul style="list-style-type: none"> • CARE PLANNING • FOCUS GROUPS • SURVEYS • PUBLIC MEETINGS • E-CONSULT • CONFERENCES • DISCUSSION PAPERS 	<ul style="list-style-type: none"> • CARE PLANNING • WORKSHOPS • DELIBERATIVE POLLING • ROUNDTABLES • BALLOTS • CONFERENCES • PANELS • TASK FORCES • WORKING PARTIES 	<ul style="list-style-type: none"> • ADVISORY COMMITTEES • SCENARIO BUILDING • CLINICAL NETWORKS • PLANNING COMMITTEES 	<ul style="list-style-type: none"> • MULTI-PURPOSE SOCIAL AND COMMUNITY HEALTH SERVICES • STEERING COMMITTEES • STRATEGY GROUPS • QUALITY COMMITTEES • BOARDS • POLICY COUNCILS • STANDING STRATEGIC COMMITTEES.

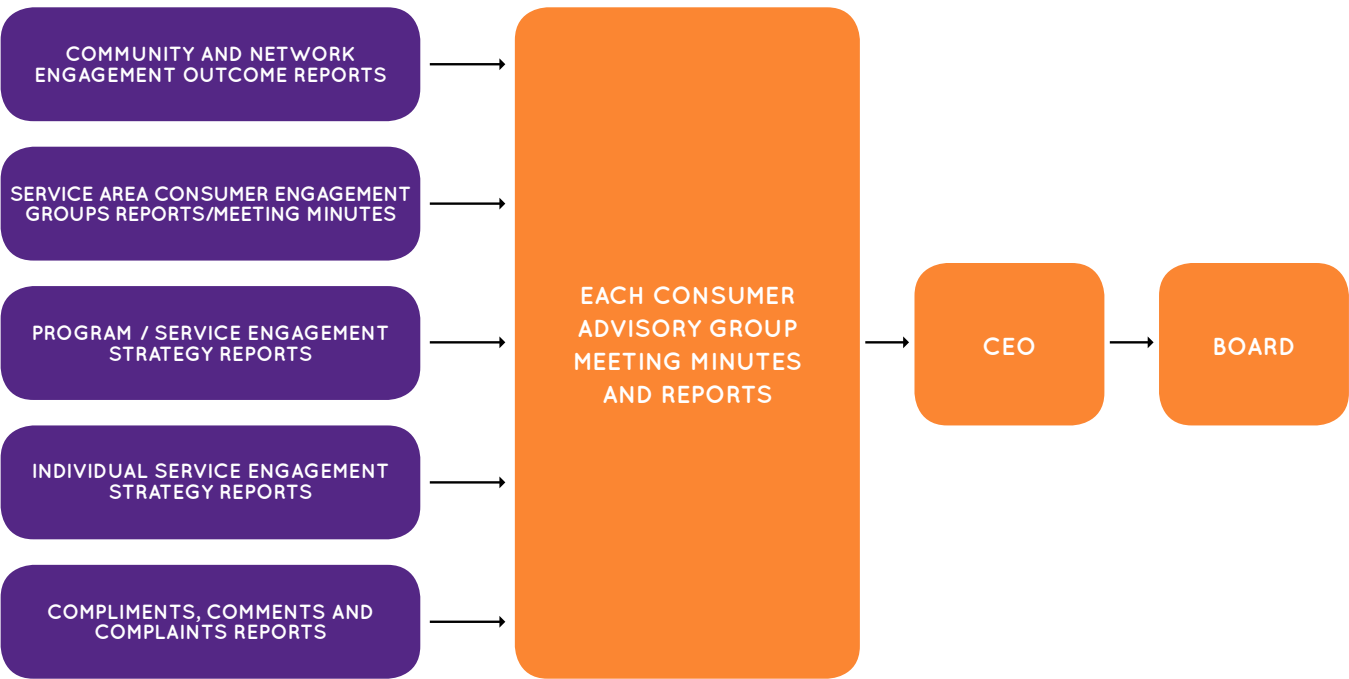


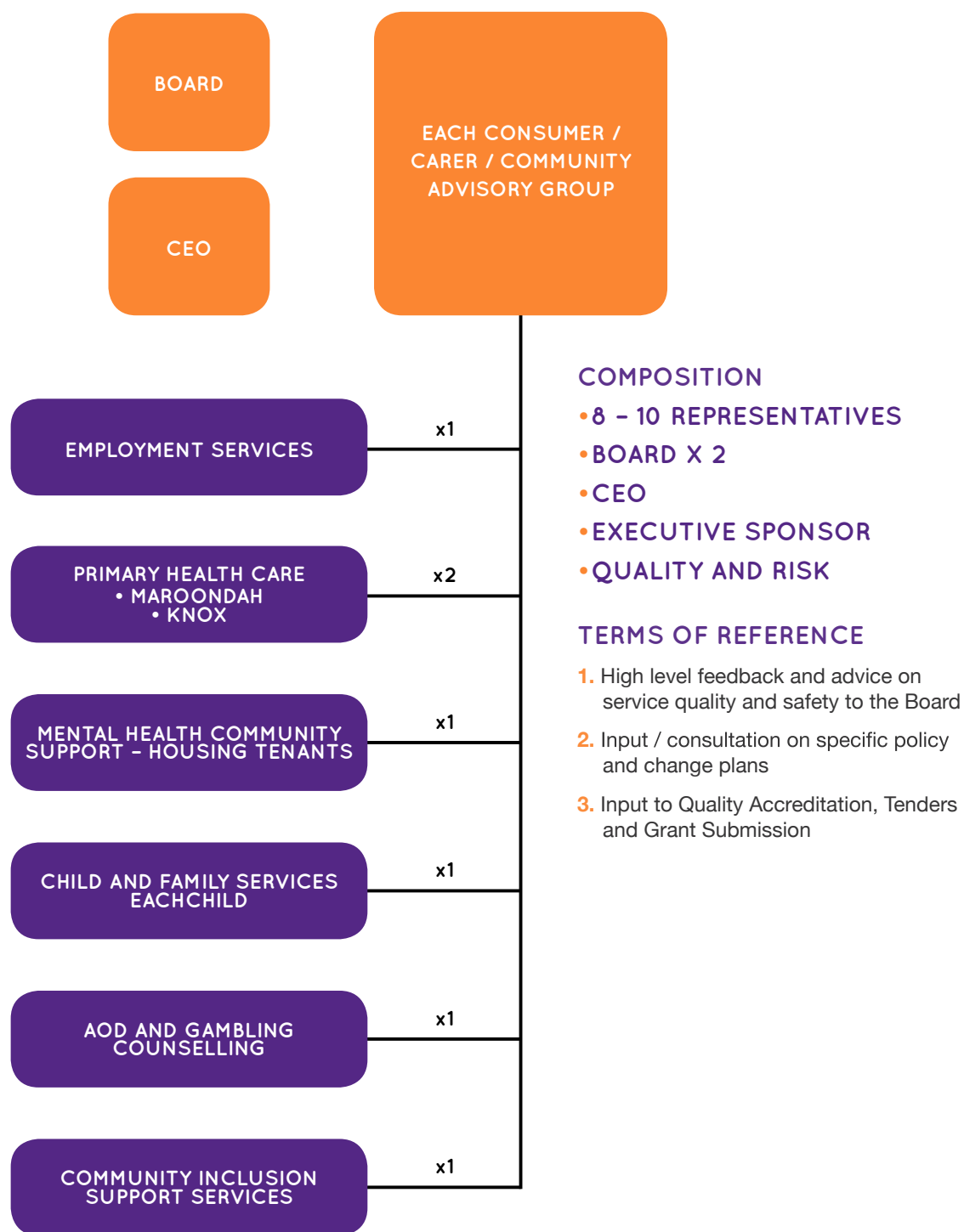
LEVELS OF RESPONSIBILITY

The diagram below demonstrates the levels of responsibility within EACH for implementation of Consumer, Carer and Community engagement:



LINES OF COMMUNICATION





CONSUMER, CARER AND COMMUNITY ENGAGEMENT STRATEGIES.

The Consumer, Carer and Community engagement strategies are linked to the EACH strategic plan to provide an integrated approach across the organisation for Consumer, Carer and Community engagement. The EACH Consumer, Carer and Community engagement strategies are derived from the Victorian Department of Human Services, 'Doing it with us not for us' Strategic Direction 2006 – 2009. The criterion from this strategic direction have been linked to the EACH strategic priority objectives.

EACH STRATEGIC PRIORITIES ARE

- Priority 1** EACH will actively address the social determinants of inequity and disadvantage.
- Priority 2** EACH will be an effective and reliable provider of high quality services which are person-centred, responsive, outcome focused and innovative.
- Priority 3** EACH will develop innovative and entrepreneurial partnerships with Community, Government, NGO and Corporate sectors that strengthen its capacity to achieve its vision.
- Priority 4** EACH will build robust organisational systems, business solutions and management practices; and develop resilient and capable staff to ensure sustainability and success in the face of change.

CRITERION TO ACHIEVE THE STRATEGIC PRIORITY ('DOING IT WITH US NOT FOR US')	EACH PRIORITY STRATEGIC OBJECTIVES
The organisation demonstrates a commitment to Consumer, Carer and Community participation appropriate to its diverse communities.	3.1 - Seek and develop opportunities to work closely with communities where we have skills and capacity to add value
Consumers, and, where appropriate, carers are involved in informed decision-making about their treatment, care and wellbeing at all stages and with appropriate support.	2.3 - Empower service users, consumer groups and communities
Consumers, and, where appropriate, carers are provided with evidence-based, accessible information to support key decision-making along the continuum of care.	2.3 - Empower service users, consumer groups and communities
Consumers, carers and community members are active participants in the planning, improvement, and evaluation of services and programs on an ongoing basis.	2.4 - Measure outcomes and effectiveness and improve our methods accordingly
The organisation actively contributes to building the capacity of consumers, carers and community members to participate fully and effectively.	1.2 - Develop partnerships with other sectors to promote collaborative action for health and wellbeing 1.3 - Strengthen community capacity and resilience 3.1 - Seek and develop opportunities to work closely with communities where we have skills and capacity to add value

REFERENCES

- 1 Health Participants Queensland, (2010). Participant Engagement Framework: August 2010. Brisbane:
- 2 'Doing it with us not for us' Strategy 2006-2009, Rural and Regional health and Aged care Division, Victorian Government, Department of Human Services 2006.
- 3 Adapted from Department of Communities (2005) Engaging Queenslanders: an introduction to community engagement and Health Participants Queensland, (2009). Participant Representatives Program: Participant Handbook.
- 4 Health Participants Queensland, (2009). Participant Representatives Program: Participant Handbook.
- 5 Queensland Health, (2010). Community Engagement Manual.
- 6 World Health, (1998). Health Promotion Glossary. Adapted from definition of health sector. Geneva. www.who.int/hpr/NPH/docs/hp_glossary_en.pdf Accessed on 19/1/12.
- 7 EACH Strategic Plan 2011 – 2015
- 8 EACH Policy and Procedure Manual – Consumer/Carer/Community Engagement
- 9 Harrower, L, 2013 Architects of our own Health & Community Services Health Issues.

DEFINITIONS

CEWG: This relates to the Consumer Engagement Working Group that was set up to develop the Consumer Engagement Strategy and to develop the Consumer Advisory Committee (CAC).

CAC: This relates to the Consumer Advisory Committee which will be the ongoing committee advising the Board of a range of actions and activates that related to Consumer engagement with EACH.

CCC: This relates to Consumers, Carers, and Community. This is about engaging the Consumers, Carers and the General Community of EACH for consultation and feedback.

CONSUMER PARTICIPATION ACTION PLAN					
AREAS OF ACTION	STRATEGIES	MEASURABLE TARGETS	RESPONSIBILITIES	TIMELINES	PROGRESS/ OUTCOMES
The development of the EACH Consumer Engagement Framework	Establishment of Consumer engagement working group (CEWG) with representation from the Board of Management, staff, consumers and carers	The existence of CEWG Regular meetings scheduled agenda and minutes recorded and actioned	Jackie/Liz	December 2013	Established and fully functional.
	Development of Consumer, Carer and Community Engagement framework	Completed framework	CEWG	June 2014	Completed September 2014
	Facilitate consultation and presentation of Framework to CMG	Consultation Completed with CMG	CEWP/ other Consumer Groups across EACH	March 2015	
	Facilitate launch of final Consumer Engagement Policy with staff, Consumers, Carers and Community	Consumer Engagement Strategy launched at the 40 Year EACH Celebration	CEWG and other Consumer groups across EACH	April 2015	

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CONSUMER PARTICIPATION ACTION PLAN (CONT.)

AREAS OF ACTION	STRATEGIES	MEASURABLE TARGETS	RESPONSIBILITIES	TIMELINES	PROGRESS/ OUTCOMES
Establishment of EACH Consumer Advisory Committee (CAC)	Develop and implement a Marketing Strategy which will communicate to all Consumers, Carers and Community members re recruitment to CAC	Newsletters, Brochures, Intranet, networks internally and externally	Health Promotion/ CEWG. and other consumer groups across EACH	April 2015	
	Invite Consumers, Carers and Community Members and Expressions of interest for CAC membership circulated through Marketing Strategy	Expressions of interest applications received from potential CAC members	CEWG/ other consumers groups across EACH	January 2014	Completed April 2014
	Development of CAC terms of reference	Completed ToR	CEWG	January 2015	
	Development of CAC membership position description	Completed position descriptions	CEWG	January 2015	
	Recruitment of CAC members	Selection of CAC members	CEWG and other Consumer Groups across EACH	January 2015	
Development of CAC annual plan	Develop an annual for CAC activities across EACH	Completion and delivery of annual plan	CAC/CEWG and other Consumer Groups across EACH	May 2015	
Development of a Consumer, Carer and Community (CCC) feedback strategy	Review of EACH feedback strategies and those of other organisations Create appropriate strategies incorporating new technology with an emphasis on access and inclusion	Development of a number of diverse strategies to capture CCC feedback using multiple methods and modes	CAC/CEWG and other Consumer Groups across EACH	July 2015	

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CONSUMER PARTICIPATION ACTION PLAN (CONT.)

AREAS OF ACTION	STRATEGIES	MEASURABLE TARGETS	RESPONSIBILITIES	TIMELINES	PROGRESS/ OUTCOMES
Identification of all existing Consumer, Carer and Community (CCC) engagement activities	Map all existing CCC engagement activities currently occurring across EACH	Development of map of all current CCC engagement activities	CEWG CEWG and other Consumer Groups across EACH	Aug - Sept 2014	Completed
Professional development training and support to EACH staff in consumer engagement.	Review of existing PD modules Adaption of Professional development packages appropriate for EACH needs	Roll out of PD to staff	CAC/HP	Mar - Aug 2015	
Development of Consumer Data Base	Develop a strategy to capture details of consumers, carers and community members interested in being involved in various activities across all EACH services	Existence of CCC data base	CAC/ IT/ administration	Mar - Aug 2015	

APPENDIX 1

CONSUMER/CARER PARTICIPATION IN HEALTH & COMMUNITY SERVICES – FROM INDIVIDUAL PRACTICE TO SYSTEMIC ENGAGEMENT

SUMMARY

Consumer/carer engagement in health and community services can be described as being at three levels:

1. Clinician provides specialist knowledge about the presenting condition and most effective (evidence-based) treatment. Role of the client is to follow treatment instructions.
2. Clinicians engage the client in order to achieve a fuller understanding of the condition, its context in the client's life and life of the family, to identify the most efficacious intervention given the clinicians specialist knowledge. Client-centred practice at this level depends on individual professional practises.
3. Organisations seek to embed consumer/carer experience in a broad range of domains across the organisation so that the consumer/carer perspective is systematically engaged in all aspects of the organisation's decision-making which has an impact on client care. This might involve organisational professional development policies to include client-centred care as a mandatory unit for all staff through to consumer/carer input to service redesign, evaluations and quality committees. This moves the engagement of the consumer/carer experience from being dependant on an individual clinician's practice to being systemically embedded in the organisation's policies and procedures.

The transition to a Level 3 Consumer/carer Engagement Strategy requires a paradigm shift for the health and community service organisation but also a unique set of skills from consumers/carers who are engaged across the organisation to become expert advisers (consultants) on the consumer/carer experience. In addition to specific targeted training, such consumer/carer consultants need to have specific role-descriptions which require focussed attention, commitment and accountability.

Increasingly, the transition to engagement of consumer/carers in Level 3 activities requires targetted allocation of roles for specific purposes and outcomes, coordination and support and adequate remuneration in recognition of the role and its responsibilities.

Furthermore, evidence of the organisation having adopted a Level 3 approach to consumer/carer Engagement is now a mandatory requirement of the National Health and Safety Accreditation requirements.

PRACTITIONER- DRIVEN CLIENT-CENTRED PRACTICE

Consumer/carer involvement in health and community services is reflected in concepts such as ‘client –centred care, child and family centred-practice’, etc. These terms have often been adopted by practitioners and service organisations alike to describe their practices as consistent with best-practice – because they put the consumer/carer at the centre of the health and community services intervention.

But what does this really mean?

Broadly speaking, terms such as ‘client /consumer/carer centred care’ refer to the practitioner taking account of consumer/carers preferences in treatments and interventions. This might mean that clinicians adjust their interventions (which are normally based on ‘evidence based best practice’) to take account of unique circumstances of the consumer/carer or the family. This brings into consideration the balance between effectiveness and efficacy.

At this level consumer/carer-centred care relies on individual practitioners being sufficiently trained in consumer/carer-centred care to recognise that their clinical judgement needs to be supplemented by the client and or family’s ‘expert knowledge’ of their own condition and or circumstances which have a bearing on the effectiveness of the outcomes. For example, a physician assessing and recommending a course of action with an autistic child needs to be guided by the child’s parents in terms of planning and post intervention recovery in order to optimise outcomes of any medical procedure. Similarly, personal knowledge of the unique characteristics of your own chronic disease, or managing the ageing of a parent requires client/family centred practices to be demonstrated by practitioners in order to get best outcomes.

At this level, practitioners benefit from professional development which specifically highlight examples of how services are improved by consumer/carer involvement; consumer/carers stories are invaluable in illustrating the positive impacts of consumer/carer-centred care and the negative impacts when ignored. Consumer/carer stories are increasingly being used as valuable training texts for practitioners and reminders to Boards of the ever-present consumer/carer experience which sit behind the various dashboards which increasingly dominate governance reporting.

ORGANISATIONAL CONSUMER/CARER ENGAGEMENT

Once we move to an organisational (system) level of consumer/carer engagement the focus shifts from the individual practitioner’s practice to achieving a consistent level of consumer/carer-directed care at an organisational level:

“Doing the right thing at an organisational level means continually checking to make sure the inputs are being gathered from the right people to make sure the right thing is being done.” - Harrower. L, Architects of our own health and community services, 2013, Health Issues

Harrower goes on to identify the following items that consumer/carers want in a health system (based on a workshop conducted as part of the Children's Health and community services Australasia Conference, 2013).

1. A robust system for capturing patient and family opinion, including mechanisms for acting on feedback
2. Strong and adequately resourced patient, youth and family advisory councils – strongly connected to clinical governance structures and strategic planning
3. CEO and other senior staff to be visible and available for quality and safety walk-arounds with staff and consumer/carers
4. All staff trained in client and family-centred care; focussing on communication as an essential aspect
5. Consumer/carer participation at every level of the organisation.

These five principles of consumer/carer engagement clearly represent a vast paradigm shift from the Level 1 of consumer/carer engagement and represent a move to systematisation of the consumer/carer input to care which is different to the Practitioner dependent consumer/carer participation evident in Level 2.

This type of Consumer/Carer Engagement (level 3) is well summed up in the following quotation:

"As consumer/carers working with service providers as equal partners in the design and delivery of 21st century health and community services, we're looking to build organisations that not only heal the sick, but that understand, educate and nurture the communities they serve." - Harrower. L. , Architects of our own health and community services, 2013, Health Issues

TRAINING, SUPPORT AND REMUNERATION OF CONSUMER/CARER CONSULTANTS

Active strategies to obtain consumer/carer involvement for the purposes of feedback, consultation, or to gain support for planned activities has been an established part of community participation strategies of most organisations for many years. Mostly, this has been on a non-remuneration basis.

In fact, active participation is often converted to being recruited to membership of Boards of Management or some other community committee. I'm sure that most of us have been co-opted to be a member of a kindergarten committee, school council, neighbourhood house or some other honorary citizenship role. These have been almost exclusively voluntary contributions of time, skills and resources, given freely in the community interest

Over recent years however, the practice of remunerating consumer/carer involvement in the health system as part of a systematic change, policy or quality improvement process has been increasing. Even for consumer feedback focus groups, organisations expect to moderately reward consumer/carers who are willing to give up an hour of their time to give their opinions and views. Where a consumer/carer is expected to provide regular attendance and thoughtful input to committees, it is now standard practice to offer remuneration as well as payment for out-of-pocket expenses across many health and community service settings. This is particularly the case for Level 3 Consumer/carer Engagement activities.

The rationales for remuneration are many: sitting at the table with paid employees devalues the input of consumer/carers, the time spent in preparation and follow-up is the same as for paid staff, the value of the input needs to be seen as just as specialised and valuable as that of the professional staff, etc.

Against this is the view that active citizenship and altruistic community contribution is fundamental to a civil society; something which society values but does not demand nor remunerate. In this sense, it is like volunteerism – which would be changed forever if volunteers received a salary. However, even in this comparison there is a grey area, as carers can receive a pension or modest financial support.

Notwithstanding the above, it is clear that there is a growing movement which legitimises the remuneration of consumer/carers in health and community services organisations for certain participation and contributions. These are usually for activities described as part of Level 3 organisational strategies (at least) although some organisations remunerate almost any solicited consumer/carer participation activity.

IMPLICATIONS:

Training - The assumption in Level 3 activities is that the consumer/carer participant is acting as a skilled consultant to the process. Their 'lived experience' may be the only skill required, however, in order to make a constructive contribution their experience is more valuable if they have assessed and considered it and been able to deliver it in a way which suits the context. Furthermore, their own personal experience is more valuable if it can be seen as representing a population or group experience. Therefore, rather than being a forum for expressing a personal opinion or complaint, a consumer/carer's negative experience adds more value if it presented as illustrative of others potential experiences. Similarly, assessment of system change proposals requires the ability to adopt an objective consumer/carer perspective on behalf of the many, rather than the self.

Clearly this has an implication for training and selection. Fortunately, there are several avenues through which consumer/carers can now receive accredited training which can make their contribution more penetrating.

Coordination and Support - It is a lonely experience to be the only minority representative on a committee. – particularly when the power balance is weighted in favour of the professionals. For this reason it is preferable to have at least two consumer/carers on any activity, and to ensure that their participation is well coordinated and that they are appropriately supported. This might mean ensuring their documentation reaches them, that they have transport, that they know and are paired with at least one of the professional staff on the committee and any other barriers to full participation are removed in advance.

[It is useful to apply the elements of the SCARF model in supporting consumer/carer participants (Status, Certainty, Autonomy, Relatedness and Fairness)].

Remuneration - For the reasons identified above, I think we need to recognise that the use of Consumer/Carer Consultants, along with Carer Consultants and Peer Consultants represents a new paradigm in consumer/carer participation and engagement in the health and community services sector. Evidence of an active Consumer/Carer Engagement Strategy (at every level of the organisation) is a mandatory requirement to achieve and maintain quality accreditation.

Not only that, but at philosophical and practical levels we have overwhelming evidence of services being made more effective, efficient, acceptable and safe where there is systematic engagement of consumer/carer consultants in a structured and systematic manner across the organisation.

Along with this approach goes the requirement to train, support and remunerate consumer/carer consultants appropriately. Not only does this fairly recognise their contribution, but also entitles the organisation to develop a specific project brief and role, select appropriately, review performance and terminate their roles as part of the engagement and project brief.

RECOMMENDATIONS:

It is recommended that this paper is considered and, if agreed, a remuneration schedule be developed for Consumer/Carer Engagement processes across EACH.

Remuneration be in accordance with the current Knox Consumer/Carer Participation Plan and budgeted annually.

This paper and recommendations to be added as an Appendix to the EACH Consumer/Carer, Community Engagement Plan.



Peter Ruzyla
CEO

APPENDIX 2

TERMS OF REFERENCE – EACH CONSUMER ADVISORY COMMITTEE

1. BACKGROUND / INTRODUCTION

EACH believes consume, carer and community participation and consultation is central to the planning, implementation and evaluation of services delivery across all its services. The development of EACH's Consumer, Carer and Community Engagement Framework aims to inform and embed effective consumer, carer and community engagement within the planning, structures, processes and service delivery practices across EACH.

This includes:

- To inform the organisation about the needs of people who use our services and of people who may be potential users of our services but who may experience barriers to access or variable quality of services.
- To enable better planning, design and delivery of services to better meet the needs of people who use our services.
- To gather feedback about initiatives and reforms that impact upon service delivery.
- To monitor and report on the quality and safety of services delivered.
- To empower consumers to work as active partners in their health and well-being, unlocking the potential available to contribute to more efficient and effective service delivery.
- To achieve better outcomes through collaboration between providers and service users.

In recognising consumer, carer and community participation, EACH will engage the assistance of the Community Advisory Committee to address these needs.

2. ROLE/PURPOSE

The Consumer Advisory Committee (CAC) will:

- Provide high level feedback and strategic advice to the board and ensure that consumer, carer and community views are integrated into EACH's operations, planning and policy development.
- Strengthen and report on organisations systems, structures and processes to enable consumers to participate in service planning, delivery, review and evaluation.
- Listen to the community and networks and identify their need.
- Work with community to enable participation.
- Oversee the development and implementation of an organisation wide consumer participation strategy that meets consumer, community and funder expectations and accreditation standards.
- Analyse and feedback on comments, compliments and complaints.
- Assist with the development and monitoring of key performance indicators for service quality and accessibility in particular, the indicators of the Annual Quality of Care Report.
- Undertake projects and activities as agreed with the Board.
- Advise the Board on governance, policy and strategy in relation to community participation and its impact on health service outcomes.
- Review and monitor EACH's communications with consumers and community for appropriate health literacy standards.
- Input into Professional Development and Human Resource processes.

3. TERM

This group will come together for a period of 24-36 months from 2015.

4. MEMBERSHIP

The selection criteria for membership to the CAC will be agreed by the Board and will be made up of ten and fifteen people appointed by the Board and will include:

- Two Board members
- EACH's Chief Executive Officer
- One General Manager - Executive Sponsor
- One Quality Manager
- One consumer representative from each of the following service areas:
 - Alcohol and other Drugs/ Gambling Counselling
 - Employment services
 - Child and Family
 - Community Inclusion Support Services
 - Primary Health Care - Knox
 - Primary Health Care - Maroondah
 - Mental Health - Community support
 - Mental Health - Housing tenants
- Two consumer representatives from Youth and Family services

5. REPORTING

The minutes, work plans and community participation plan of the Community Advisory Committee will be provided to the Board on an ongoing basis for ratification.

6. MEETINGS

The meetings will run monthly on the second Thursday of each mo

7. QUORUM

A quorum is 50% of the CAC membership.

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