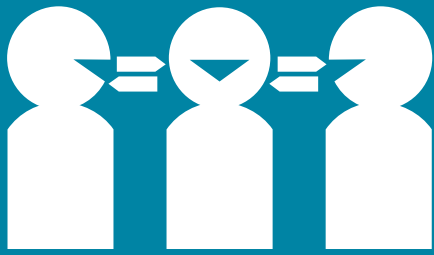


Doing it with us not for us Strategic direction 2010–13

Participation in your health service system: Victorian consumers, carers, and community working together with their health services and the Department of Health



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Foreword

Doing it with us not for us is the Victorian government's policy on consumer, carer and community participation in the health care system. As Minister for Health and Minister for Mental Health we value the partnerships and working relationships that the policy has forged across health care since its launch in January 2006. The success of the policy has been well documented in health services' Quality of Care Reports to their communities and participation remains highly valued as an aid to improve health outcomes and the quality of health care, an important democratic right and as an accountability mechanism.

The new *Strategic direction 2010-13* for *Doing it with us not for us* builds upon the first term of the policy. The policy's aim, objectives and priority actions remain but new standards, indicators and targets have been set. Importantly, the scope of the standards, indicators and targets encompass all the public health care sectors in Victoria. We know participation enables designing, developing, planning and delivering health care in Victoria. Participation will only remain successful if we continue to listen and respect each other as equal contributors to the participation process. We need to build trust and openly evaluate and learn from our actions. These are the underlying principles of participation and *Doing it with us not for us*.

We commend the new *Strategic direction 2010-13* to you and look forward to working with you all in continually improving and ensuring high quality health care is accessible to our diverse community.



Hon Daniel Andrews MP
Minister for Health



Hon Lisa Neville MP
Minister for Mental Health



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Mary Draper (Chair), Rita Bloomfield (Deputy Chair), Tony McBride, Sophie Hill, Raelene Lesniowska, Catherine McKean, Linda Sorrell, Jan Child, Jim Higgins, Graeme Roberts, Debbie Zauder, Linda Mack, Evelyn Webster, Robin Ould, Alison McMillan, Vera Boston, Beth Wilson, Janet Laverick, Gill Pierce, Cath Harmer, Patricia Reeve and Michael Janssen.

The new *Strategic direction 2010-13* is centred upon a comprehensive suite of participation standards, indicators and targets for health services. The development of these was led by the Health Issues Centre and Reference Committee members: Margaret Summers, Mary Draper, Cath Harmer, Evelyn Webster, Gillian Lang, Joyce Goh, Linda Mack, Tony Triado, Jan Child, Tere Dawson and Tony McBride. Thank you is also extended to all the participants of the iterative workshop held to consolidate the standards.

Introduction

The *Doing it with us not for us* policy grew from the Victorian Government's commitment to involving people in decision making about health care services and the need for a strategic policy to guide the process (Department of Human Services 2006a). Participation in health is an essential principle of health development, clinical governance, community capacity building and the development of social capital. Participation is valued because it is:

- an aid to improve health outcomes and the quality of health care
- an important democratic right
- a mechanism to ensure accountability.

The policy's Strategic direction for 2010-13 targets the Victorian public health service system including acute, subacute, mental health, community health, and residential aged care facilities. Importantly, it introduces a new comprehensive suite of participation standards and indicators to facilitate the monitoring of the on-going implementation of *Doing it with us not for us*.

Policy statement

Participation

Participation occurs when consumers, carers and community members are meaningfully involved in decision making about health policy and planning, care and treatment, and the wellbeing of themselves and the community. It is about having your say, thinking about why you believe in your view, and listening to the views and ideas of others. In working together, decisions may include a range of perspectives.

There are many different types of participation and these have been commonly grouped as:

- Information (precursor)
- Consultation
- Partnership
- Delegation
- Control

No one type of participation is better than another. It is important to use the type of participation that suits your particular need.¹

Guiding the way in which consumers, carers, the community, community organisations, health services and the Department of Health work together to make participation successful are the nine principles of participation:

¹ Please see the last page for a table providing examples of the different types of participation.

- | | |
|------------------------|---------------------------------------|
| • Trust | • Responsiveness |
| • Respect | • Dissemination |
| • Openness | • Evaluation |
| • Equal opportunity | • Shared ownership and accountability |
| • Advocacy and support | |

Aim

For consumers, carers and community members to participate with their health services and the Department of Health in improving health policy and planning, care and treatment, and the wellbeing of all Victorians.

To achieve the aim, seven objectives outlining what needs to be done in order to make participation happen give further direction to all stakeholders:

Objectives

1. To take participation seriously – *‘Doing it with us not for us’*.
2. To share information to create consumer and carer friendly access to services.
3. To improve communication between all stakeholders.
4. To build the capacity of all stakeholders to undertake participation.
5. To integrate participation into the quality and safety program.
6. To learn from our experiences and the evidence on participation.
7. To ensure participation resources are available to all stakeholders.

Priority actions

Priority actions, for all of the stakeholders to implement to ensure the aim and objectives are met, are set out below. The priority actions integrate the strategic direction across the four key levels of the health service system.

1. Individual care level	3. Health service organisational level
2. Program or department level	4. Department of Health level

At each level there is a need for all stakeholders to work together to create an environment that encourages participation. The environment should be based on the principles of participation. It should also respect the diversity of people within our community including:

- children and young people
- women and men
- people living with a disability
- different sexual orientations
- culturally and linguistically diverse communities.
- different socioeconomic status
- different social circumstances
- diverse health and illness conditions
- Aboriginal and Torres Strait Islanders

For the *Strategic direction 2010-13* the priority actions remain unchanged, but key implementation tasks for health services have been added. These have been added at each level to guide health services in achieving the priority actions for 2010-13 and to meet the new comprehensive participation standards and indicators.

Priority actions - individual care level

This level is about the consumer and, if appropriate, their carer(s), being actively involved in their own care and treatment. Health services and the Department of Health need to support this participation through the following priority actions.

1. Promote the rights and responsibilities of patients to the community, consumers and carers.
2. Communicate clearly and respectfully with consumers and carers.
3. Provide accessible information to consumers, carers and community members about health care and treatment.
4. Communicate and provide information about treatments and care to consumers and carers that is developed with consumers and, where appropriate, carers.
5. Listen and act on the decisions the consumer and, where appropriate, their carer(s) make about their care and treatment.

Key implementation tasks:

- Provide and promote the new Australian health care charter for Victorian public health services to all consumers
- Use the *Well-written health information: a guide* (Currie et al 2000) in the development of health information and the *Checklist* to review your documents.

Priority actions - program or department level

This level is about staff working in the wards, programs and departments in hospitals, rehabilitation settings, community health centres, primary care services, mental health and

aged care services. It is about these staff developing and providing information, care, treatment and research with consumers, carers and the community.

6. Involve consumers, carers and community members from the planning stage through to evaluation and monitoring.
7. Create welcoming and accessible services for the diverse members of your community.
8. Provide training to staff in communication skills and how to involve consumers and carers in decision making.
9. Promote the importance of consumers and carers providing feedback to improve services.
10. Establish links with community organisations to provide emotional support and ongoing information to consumers and carers.
11. Involve consumers, carers and community members in the development of clinical guidelines and research.

Key implementation tasks:

- Use consumer experience and satisfaction surveys to improve service delivery, and make welcoming and accessible services for all members of our diverse community.

Priority actions - health service organisational level

This level targets the organisational decision makers in health services, hospitals, community health centres, aged care, mental health and primary health services. It focuses on how participation can be promoted and increased at the organisational level at each health care service.

12. Integrate participation of consumers, carers and community members, representatives or nominees into the quality and safety program.
13. Community representatives or nominees to be involved in the review of system level issues regarding consumer and carer feedback and complaints.
14. Include the involvement of consumers, carers, community members, representatives or nominees in all aspects of the organisation's planning and development.
15. Provide staff training and education on how to use the different types of participation.
16. Ensure position descriptions include participation components.
17. Evaluate, monitor and report on participation to the community and the Department of Health.

Key implementation tasks:

- Resource consumers, carers and community members to participate on your quality, ethics, and governance committees.
- Consult with consumers, carers and your community in developing and reviewing your strategic plan, designs and Community Participation Plan.
- Produce with your community an annual Quality of Care Report.
- Ensure you work with your diverse community members to build your Cultural Responsiveness and Disability Action plans.

Priority actions - Department of Health level

This level relates to the staff working in the Department of Health. It describes how the staff within these health areas should work with consumers, carers and community members and encourage participation in the Department of Health and its work with health services.

18. Use the same processes of working with and accessing consumers, carers and community members, representatives or nominees across the Department of Health.
19. Provide support, guidance and resources to health services and consumers, carers and community members on participation.
20. Provide training and education to Department of Health staff on how to use the different types of participation, and evidence-based participation and communication.
21. Encourage health services to evaluate and monitor participation within a quality improvement framework.
22. Encourage the inclusion of participation skills and knowledge in the tertiary education of health professionals.
23. Advocate for a whole of Department of Health policy on participation.



Key implementation tasks:

- Promote the use of the Department of Premier and Cabinet *Guidelines for the appointment and remuneration of part-time non-executive directors of state government boards and members of statutory bodies and advisory committees*
- Offer to all Department of Health staff training on working with consumers, carers and community members on departmental committees
- Appropriately identify *Doing it with us not for us* as part of the policy context in the development of new health policies, guidelines and resources.



Evaluation and monitoring

To identify if the priority actions are being implemented, an evaluation and monitoring process is required. This includes implementing the continuous quality improvement cycle outlined in Figure 1. The cycle shows how stakeholders can improve their participation activities, based on the evidence obtained from evaluating and monitoring participation activities.

Figure 1 Participation evaluation and monitoring cycle



Through project funding guidelines and service agreements, health services and community organisations will be encouraged to conduct evaluation of participation. Evaluations should reflect the priority actions and the participation evaluation and monitoring cycle described in Figure 1.

Participation standards and indicators

There are five new standards for consumer, carer and community participation in Victorian public health services as outlined in Table 1 below. As part of monitoring the implementation of the *Doing it with us not for us Strategic direction 2010-13* it is recommended that health services commence collecting and reporting on this comprehensive suite of participation standards and their associated indicators as detailed in the following section.

In addition, there are a range of sub-measures developed to assist health services in achieving the standards and these can be found in the report documenting the development of the standards and indicators *Recommended suite of consumer, carer and community participation standards for Victorian public health services* (Health Issues Centre 2009), which is located at <http://www.health.vic.gov.au/consumer/>. This report also contains the references supporting the development of the standards.

Any future changes in targets will be outlined in the annual document *Victorian health services policy and funding guidelines* on the web site <http://www.health.vic.gov.au/>.

Table 1. Standards for consumer, carer and community participation in Victorian public health services

1. The organisation demonstrates a commitment to consumer, carer and community participation appropriate to its diverse communities.
2. Consumers, and, where appropriate, carers are involved in informed decision-making about their treatment, care and wellbeing at all stages and with appropriate support.
3. Consumers, and, where appropriate, carers are provided with evidence-based, accessible information to support key decision-making along the continuum of care.
4. Consumers, carers and community members are active participants in the planning, improvement, and evaluation of services and programs on an ongoing basis.
5. The organisation actively contributes to building the capacity of consumers, carers and community members to participate fully and effectively.

Standard 1

The organisation demonstrates a commitment to consumer, carer and community participation appropriate to its diverse communities.

Rationale

Experience shows that consumer, carer and community participation will only be encouraged and facilitated by staff throughout a health service when there is sufficient organisational commitment to support them. This includes visible leadership, policies, processes, and concrete capacity building to enable participation to occur effectively and meaningfully. There is strong evidence from existing standards/indicators and the literature that such commitment by the organisation is a precondition for participation and that it engenders effective participation (Health Issues Centre 2009).

Indicator 1

Numerator: The number of specified strategies implemented or in use

Denominator: The eight specified strategies required

The eight specified strategies are:

- 1.1 The organisation has a consumer, carer and community participation policy or adopts '*Doing it with us not for us*'.
 - 1.2.1 The organisation has developed and is implementing a community participation plan, strategy or equivalent that addresses the five key areas of the Department of Human Services' *How to develop a community participation plan* guideline.
- OR**
- 1.2.2 The organisation contributes to development, implementation and monitoring of the Primary Care Partnership Strategic Plan so that:
 - a) the work of the partnership reflects community needs, and
 - b) consumers experience a better human service system.
 - 1.3 The organisation uses a variety of approaches to record and report on consumer, carer and community participation to the wider community, including an annual Quality of Care Report.
 - 1.4 The organisation has a Cultural Responsiveness Plan that meets the six minimum reporting requirements or its equivalent.²
 - 1.5 The organisation has an Improving Care for Aboriginal and Torres Strait Islander Patients program, or its equivalent, and meets the four key result areas.³

² If no consumers self-identify as being from a culturally and linguistically diverse background or request an interpreter using a health service, the bundle of requirements may be modified for your service.

³ If no consumers self-identify as being Aboriginal and Torres Strait Islander the bundle of requirements may be modified for your service.

- 1.6 The organisation has a Disability Action Plan as specified under the *Disability Act 2006*.
- 1.7 The organisation has systems, processes and structures in place to *consult* and *involve* consumers, carers and community members.
- 1.8 The organisation builds the capacity of staff to support consumer, carer and community participation.

Target for all Victorian public health services is 75%

If all eight specified policies, systems and guidelines are applicable, implement a minimum of six.

OR if only seven specified policies, systems and guidelines are applicable (see footnotes 2 and 3), implement a minimum of five.

OR if only six specified policies, systems and guidelines are applicable, implement a minimum of four.

Data sources

Acute/subacute: Community Advisory Committees, Victorian Patient Satisfaction Monitor, experience and satisfaction surveys.

Mental health: The elements of the measures such as priority actions from the *Caring together – An action plan for carer involvement in Victorian public mental health services* (Department of Human Services 2006b) AND *Strengthening consumer participation in Victoria’s public mental health services – Action Plan* (Department of Human Services 2009) are incorporated in an overall consumer and carer participation plan. Consumer participation plans describe the nature and extent of consumer involvement in the delivery and evaluation of the plans.

Residential aged care facilities: Public sector residential aged care services resident and family satisfaction surveys.

Community health services:

Strategy 1.3: Results to questions 2.11 and 2.12 of the Service Coordination Survey. These question numbers are relevant to the 2009 Survey. From time to time the Service Coordination Survey will be restructured, resulting in a different numeration. Up-to-date information on numeration of questions for use in this activity can be found at:

www.health.vic.gov.au/pcps/coordination/ppps.htm

Strategy 1.7: Results to Questions 2.1, 4.2, 4.8, 6.8, 6.11, 7.10 and 8.2 of the Service Coordination Survey. The numbers of the relevant questions in the Service Coordination Survey may vary from year to year when it is restructured. Relevant questions for use in this activity will be listed at:

www.health.vic.gov.au/pcps/coordination/ppps.htm

***Doing it with us not for us* policy level**

- Individual care level
- Program level
- Organisational level

Recommendation for implementation

Victorian public health services: begin collecting data from 1 January 2010.

Community health services: The registration criteria set out in the *Health Services Act 1988* are that the community health centre has links with the local community to which it provides, or will provide, at least one community health service; demonstrated, for example, by:

- a member of the local community being a member of the applicant's board of directors; or
- a partnership between the applicant and another local agency; or
- having the capacity to meet the specific health needs of certain classes of persons living in the local community (*Health Services Act 1988*).

While items 1.4 and 1.5 are not specific requirements of community health centres, policy around Demand Management requires community health centres to prioritise access to Aboriginal and Torres Strait Islander communities, refugees, homeless persons and persons with complex needs.⁴ Similarly, while 1.6 is not a mandated requirement on community health centres, certain community health centres have responded to their local community needs by developing a Disability Action Plan.

All public health services report on annually in the Quality of Care Report from 2010-11.

4 To outline the level at which these priority groups were engaged, agencies may prepare a report from their client management system stating the:

- Number of registered clients against each of these characteristics (from quarter to quarter, or year to year)
- Number of Community and Women's Health occasions of service delivered to clients with these characteristics (noting that homelessness status is captured in Alcohol and Other Drug episodes but not Community and Women's Health activity).

Standard 2

Consumers, and, where appropriate, carers are involved in informed decision-making about their treatment, care and wellbeing at all stages and with appropriate support.

Rationale

When consumers and carers are involved in decision-making, evidence from rigorous studies demonstrates that they achieve better health outcomes.

For example, a Cochrane review shows that the use of decision aids for screening or treatment decisions improves people's knowledge of the options, creates accurate risk perceptions of their benefits and harms, reduces difficulty with decision-making, and increases participation in the process. Patient decision aids increase people's involvement and are more likely to lead to informed values-based decisions. They reduce the use of discretionary surgery without apparent adverse effects on health outcomes or satisfaction (O'Connor et al 2003).

Evidence also exists to argue that people's involvement in decision-making should be facilitated by the provision of evidence-based, understandable and accessible information and support. Consumer involvement in the development of information can improve the clarity and relevance of materials, and can improve people's knowledge without increasing their anxiety about medical procedures (Nilsen et al 2006).

Indicator 2.1 Acute and subacute

A consumer participation indicator (CPI) score on the Victorian Patient Satisfaction Monitor of at least 75.

Target for acute/subacute is 75 (index)

Indicator 2.2 Maternity services

Numerator: The number of women who said they thought they were given an active say in making decisions about what happened during their labour and/or birth

Denominator: The total number of respondents to the Maternity Module's question 2 of the Victorian Patient Satisfaction Monitor

Target for maternity services is 90%

Indicator 2.3 Community health services

Numerator: The percentage of clients/carers satisfied or highly satisfied with their involvement in decisions about their care or treatment

Denominator: The total number of clients/carers who participated in consumer/carer surveys

Target for community health services is 90%

Indicator 2.4 Mental health

Numerator: The number of achievements derived from the suite of evidence for engagement

Denominator: The three items in the suite of evidence as listed (in the terminology)

Target for mental health is 75%

Indicator 2.5 Residential aged care facilities

Numerator: The number of residents/families/carers satisfied with their involvement in decision-making about their care or treatment

Denominator: The total number of residents/families/carers who participated in survey

Target for residential aged care facilities is 75%

Terminology

Appropriate support: includes evidence-based and accessible information, access to staff/clinicians for advice or guidance, access to advocacy when required, evidence-based and accessible forms and documents to record the decision-making process and the final decision.

Evidence-based: Current best evidence is up-to-date information from relevant, valid research about the effects of different forms of health care, the potential for harm from exposure to particular agents, the accuracy of diagnostic tests, and the predictive power of prognostic factors (Cochran Collaboration 2009).

Cochrane: Cochrane reviews produce combined results of the world's best medical research studies and Cochrane reviews are recognised as being of a high standard in evidence-based health care.⁵

⁵ Cochrane reviews can be seen at <http://www3.interscience.wiley.com/cgi-bin/mrwhome/106568753/HOME>

Mental health

Evidence of engagement is detailed within:

- Completion of the consumer self-rated measure
- Consumers' co-signatory on individual service plans, treatment and care plans or recovery plans
- Evidence of consumer held records.

Treatment and care: these terms are generally used within clinical environments.

Rehabilitation and support: these terms are generally used within the psychiatric disability rehabilitation and support services.

Data sources

Acute/subacute (including maternity services):

Victorian Patient Satisfaction Monitor reported on a six-monthly basis.

Mental health: Evidence of engagement is included in the consumer and carer participation plan and the appropriate scope and targets are determined by the mental health services in collaboration with the Department of Health. The file audit holds the data.

Residential aged care facilities: Public sector residential aged care services' resident, carer and family satisfaction surveys.

Community health services: Consumer/carers surveys undertaken by agency as a requirement of accreditation.

Doing it with us not for us policy level

- Individual care level
- Program level
- Organisational level

Recommendation for implementation

Victorian public health services: begin collecting data from 1 January 2010.

All public health services report on annually in the Quality of Care Report from 2010-11.



Standard 3

Consumers, and, where appropriate, carers are provided with evidence-based, accessible information to support key decision-making along the continuum of care.

Rationale

Providing consumers and carers with information in ways that it is accessible to them ensures they are able to make informed decisions. There is strong evidence that consumers and carers benefit from receiving evidence-based and understandable information and that they should receive this information at key stages along the continuum of care (Health Issues Centre 2009).

Indicator 3.1

Services rated “Yes” on at least 30 items of the *Checklist for Assessing Written Consumer Health Information* (Currie et al 2000); including at least five for section D.

Numerator: The number of new information resources produced, revised or adopted over last year which met at least 30 of the 40 items on the *Checklist for Assessing Written Consumer Health Information*, including at least five items from section D

Denominator: The total number of new consumer, carer or community information resources produced, revised or adopted in last year

Target for all Victorian public health services is 85%

Indicator 3.2 Acute and subacute (including maternity services)

The rate of respondents to consumer and carer surveys who rate the information as being 'good' to 'excellent'.⁶

Numerator: The number of respondents who rate the written information on how to manage your condition and recovery at home, Question 16b) on the Victorian Patient Satisfaction Monitor, as being 'good' to 'excellent'

Denominator: The total number of respondents to Question 16b) on the Victorian Patient Satisfaction Monitor

Target for acute and subacute is 75%

Terminology

Accessible: Information that complies with the 40 criteria included in the *Checklist for Assessing Written Consumer Health Information*.

Continuum of care: includes screening, diagnosis and referral, determination of treatment and/or care, initial care and/or treatment, ongoing treatment and/or care, discharge planning, and end of life or palliative care (Department of Human Services 2006c).

Data sources

Victorian public health services: internal review of new information resources.

Acute/subacute: Victorian Patient Satisfaction Monitor

Residential aged care facilities: Public sector residential aged care services' resident and family satisfaction surveys.

⁶ Respondent numbers are available from your health service's Victorian Patient Satisfaction Monitor web site data.

Doing it with us not for us policy level

- Individual care level
- Program level
- Organisational level

Recommendation for implementation

Victorian public health services: begin collecting data from 1 January 2010.

All public health services report on annually in the Quality of Care Report from 2010-11.

Standard 4

Consumers, carers and community members are active participants in the planning, improvement, and evaluation of services and programs on an ongoing basis.

Rationale

Consumer, carer and community participation has been linked to quality improvement. Involving consumers, carers and community members as active participants in planning, improvement processes and evaluation of services ensures that organisations are responsive to the views, opinions and needs of the communities they serve. There is strong anecdotal and some evaluation evidence, as well as an implicit rationale behind a range of existing indicators/standards, to support this (Health Issues Centre 2009).



Indicator 4

Numerator: The number of dimensions or specified activities where consumers, carers and community members are active participants

Denominator: The six dimensions or specified activities

The six dimensions or specified activities are:

- 4.1 Strategic planning.
- 4.2 Service, program and community development.
- 4.3 Quality improvement activities.
- 4.4 Developing and monitoring feedback, complaints' and appeals' systems and in the review of complaints.
- 4.5 Ethics, quality, clinical and corporate governance committees.
- 4.6 Consumers, carers and community members are involved in the development of consumer health information.

Target for all Victorian public health services is 75%

Terminology

Programs: includes, for example, health promotion and health education programs.

Data sources

Victorian public health services: Strategic planning processes, quality improvement reports, complaints resolution mechanisms, development of the Quality of Care Report and quality and safety committee reports/minutes.



Acute/subacute scheduled public health services⁷:

Community Participation Plans.

Mental health: Dimensions or specified activities of participation are to be included in the consumer and carer participation plan.

Residential aged care facilities: Public sector residential aged care services resident and family satisfaction surveys.

Community health services: Primary Care Partnership Integrated Health Promotion Plan, including relevant performance measures.

Doing it with us not for us policy level

- Individual care level
- Program level
- Organisational level

Recommendation for implementation

Victorian public health services: begin collecting data from 1 January 2010.

All public health services report on annually in the Quality of Care Report from 2010-11.

⁷ The scheduled health services are the six regional services (Albury Wodonga Health, Ballarat Health Services, Barwon Health, Bendigo Health Care Group, Goulburn Valley Health and Latrobe Regional Hospital) and 13 metropolitan health services (Austin Health, Bayside Health (Alfred Health), Eastern Health, Melbourne Health, Northern Health, Peninsula Health, Peter MacCallum Cancer Centre, Royal Children's Hospital, Royal Women's Hospital, Southern Health, Dental Health Services Victoria, Royal Victorian Eye and Ear Hospital and Western Health) plus St Vincent's Health who choose to participate in this process.

Standard 5

The organisation actively contributes to building the capacity of consumers, carers and community members to participate fully and effectively.

Rationale: There is evidence in existing standards and the literature of the value of supporting participating consumers, carers and community members through enhancing their knowledge and skills to participate effectively (Health Issues Centre 2009).

Indicator 5.1

Descriptive reporting for all Victorian public health services

Target not applicable (descriptive reporting)

Indicator 5.2 Mental health

Numerator: The number of in-service training and orientation programs that demonstrate evidence of consumer and carer involvement in delivering orientation/ in-service training

Denominator: The total number of orientation and in-service training programs conducted by the mental health service for its staff

Target for mental health is 75%

Data sources

Victorian public health services: Quality of Care Report development process

Acute/subacute scheduled public health services⁸: Community Participation Plans.

Mental health: A training register should be maintained by the mental health service with an indicator of consumers and carers delivering training. It is recommended that as far as practicable, elements of consumer and carer participation are integrated into the training curriculum. Consumer and carer participation plans are also a source of data.

Residential aged care facilities: Public sector residential aged care services resident and family satisfaction surveys.

Community health services: Primary Care Partnership Integrated Health Promotion Plan.

Doing it with us not for us policy level

- Individual care level
- Program level
- Organisational level

Recommendation for implementation

Victorian public health services: begin collecting data from 1 January 2010.

All public health services report on annually in the Quality of Care Report from 2010-11.



Types of participation

PARTICIPATION TYPE	OBJECTIVE	KEY TOOLS	MAKE SURE
Information (needed for participation)	<ul style="list-style-type: none"> To support participation To convey facts To educate 	<ul style="list-style-type: none"> Public information campaigns Health consultation (pre-admission, hospital admission, discharge, outpatient clinic or at community health centre and rehabilitation setting) 	<ul style="list-style-type: none"> You have a distribution strategy researched with your target consumers, carers or community. Try hard to use common words and pictures for medical and technical words. Train and educate staff in patient-centred communication.
Consultation	<ul style="list-style-type: none"> To gauge reaction to a proposal/care plan/treatment plan and invite feedback Consultation is only participation when information gathered can influence subsequent policy, care and treatment choices. 	<ul style="list-style-type: none"> Key contacts Surveys Interest group meetings, focus groups Public meetings Discussion papers Public hearings Consumer (patient) and carer (family) meetings Health consultation 	<ul style="list-style-type: none"> Let all stakeholders know how their input will be used and the outcomes of their participation. If input has not been used, let stakeholders know why. When clinical decisions have to be made quickly, explain why and how as soon as possible. Educate staff in patient-centred communication skills.
Partnership	<ul style="list-style-type: none"> To involve consumers, carers and representatives in aspects of government or health service organisational decision making To involve consumers, carers and representatives in health care or treatment decision making 	<ul style="list-style-type: none"> Advisory boards Community advisory committees Policy community forum Shared decision making Community development Patient-centred care 	<ul style="list-style-type: none"> Talk with the stakeholders and decide if you should have members, representatives or nominees. Consider having a balance between community organisations and individuals. Can you use a variety of partnership opportunities to achieve your aim? Alternate meetings to suit the range of stakeholder needs. Educate and train staff in shared decision making and patient-centred care.
Delegation	<ul style="list-style-type: none"> To hand control to a board of community representatives within a specified framework To ensure policy options are formulated at arms length from partisan politics 	<ul style="list-style-type: none"> Public enquiries Impact assessment studies Health service boards Ethics committee 	<ul style="list-style-type: none"> Hold briefing sessions for new members to meet and learn the systems. For people from a diverse range of backgrounds to feel confident to participate have a long-term training and mentor program in place.
Control	<ul style="list-style-type: none"> To hand control of an issue to the electorate To hand control to the consumer of health care 	<ul style="list-style-type: none"> Referenda Community-elected board of management Advance care planning 	<ul style="list-style-type: none"> Develop your budget and leave time for planning with your stakeholders. Provide a wide range of information on the issue to the public. Regularly advertise the processes to check for advance care plans and for staff to respect consumer choices.

* Based on the work of Bishop and Davis (2002) and Shand and Amberg (1996), as outlined in Bishop and Davis (2002). Inclusion of patient-centred care and shared decision making informed by the work of Wensing et al. (2002) and Bauman et al. (2003).

Glossary

Carers – families and friends providing unpaid care to consumers. Carers may often be receiving a government benefit or allowance.

Communities – defined as groups of people who have interest in the development of an accessible, effective and efficient health and aged care service that best meets their needs.

Community member – a member of a health and aged care service community.

Consumers – people who are current or potential users of health services. This includes children, women and men, people living with a disability, people from diverse cultural and religious experiences, socio-economic status and social circumstances, sexual orientations health and illness conditions.

Indicators – are numerical measures, with a numerator and a denominator. They help an organisation to track its progress and may help it compare itself with other like organisations as a way of improving what it does.

Participation – occurs when consumers, carers and community members are meaningfully involved in decision-making about health policy and planning, care and treatment, and the wellbeing of themselves and the community. It is about having your say, thinking about why you believe in your views, and listening to the views and ideas of others. In working together, decisions may include a range of perspectives.

Standards - are general statements against which organisations can audit their performance. The Australian Council on Healthcare Standards (ACHS) defines standards as “a statement of the level of performance to be achieved”.

Victorian public health services - includes a hospital, health service (acute/subacute), community health service, mental health service and residential aged care service unless otherwise indicated.



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