Toward Clinical Excellence
A toolkit to develop consumer participation in credentialling
Foreword

Consumer participation in health and disability sector support planning and evaluation has been described as ‘joint problem solving, joint decision making and joint responsibility’ (Consumers’ Health Forum of Australia 1990). Toward Clinical Excellence: A toolkit to develop consumer participation in credentialling addresses a resource gap identified by the Ministry of Health Medical Credentialling project in 2001 to enable District Health Boards to meet the requirement for public input on medical credentialling committees.

Consumer participation is not a one off event – it is part of the culture that influences the way things are done in an organisation in every aspect of its work. The appointment of consumers to credentialling committees is just one example of consumer participation at this level. For this reason this toolkit has been designed with the dual purpose of providing specific information for credentialling, as well as introductory information for provider organisations looking to develop effective partnerships with consumers to plan and evaluate other aspects of health and disability support services.

Since the Minister of Health introduced the New Zealand Health Strategy in December 2000, a number of initiatives have been developed to support consumer participation in health. I acknowledge the support of the Ministry of Consumer Affairs (NZMCA) in the development of this toolkit, which builds on an NZMCA research project commenced in 2000 and the subsequent development of guidelines for developing consumer representation in New Zealand. Toward Clinical Excellence: A toolkit to develop consumer participation in credentialling provides a resource for the health and disability support sector, one that I hope you will both use and find useful.

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Using this Toolkit

‘Consumer participation’ refers to the ongoing inclusion of consumers in the planning and evaluation of health and disability support services. This toolkit was initially planned to assist provider organisations to establish effective consumer participation in credentialling systems in New Zealand. For some organisations, however, this task will signal the beginning of a journey to develop a new approach to service provision. For this reason we have developed a dual-purpose document: a general resource for those planning to introduce or further develop consumer participation, as well as specific information related to consumer participation in credentialling systems.

This toolkit is divided into three sections:

Section 1 provides background information about consumer participation, in particular the reasons why we need this input to develop an effective health and disability support service in New Zealand.

Section 2 is designed for organisations with little experience of working with consumers at this level. It provides general information to support the development of an effective organisational consumer participation model using a continuous quality improvement approach to deal with the issues of planning, use and evaluation of consumer participation.

Section 3 focuses on the appointment and support of consumer representatives to medical credentialling committees to meet the requirements of the national credentialling framework (Ministry of Health 2001).

We are interested in your ideas and comments. For further information or if you wish to comment, please contact:

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Section 1: Consumer Participation in New Zealand Health and Disability Support Services

1.1 Introduction

This section summarises the case for consumer participation in health and disability service provision. For many organisations this means a new relationship between health professionals and consumers - that of partnership, jointly sharing the responsibility for improving health outcomes with their community. Each community served by a District Health Board (DHB) forms a ‘constituency’. Within this broad constituency there will be sub-groups with specific interests and needs, forming narrower constituencies. The ability to recognise and engage the constituencies within the community is a key requirement of public health and disability service providers (Ray and Hatcher 2000). A service provider may seek input from a number of constituencies, depending on the context.

Each consumer representative must have a constituency they represent. The representative may have experienced a single health event, either as a patient, carer, or family or whānau member. This represents a very narrow perspective - their personal experience with the service. In this instance the constituency is the family and friends of the individual. On the next level, consumer representatives who are ‘expert service users’ have considerable experience in the treatment of a specific disease state, mental health or disability service. They represent a constituency with a similar health or disability problem.

A member of the public representing the community on broader issues has the largest and most complex constituency. This person cannot claim to represent the whole community, since personal contact with everyone in the constituency would be impossible. Rather, this person provides a consumer viewpoint. This requires a broad knowledge of community and national health and disability issues and an ability to consult and communicate with the wider community. The more diverse the constituency, the more time will be required by this person to network, understand and communicate with their constituents. In some cases this will require more than one person. People providing a community viewpoint are described in the British health service as ‘patient advocates’1. These people are not health professionals but are ‘patient specialists whose experience and knowledge is more expansive than those of any single group and have knowledge of issues of concern to patient groups other than their own’ (BMA 2000).

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1 Such usage in New Zealand would create confusion with the advocacy requirements of the Health and Disability Commissioner.
Table 1: The three types of consumer representation in health service planning and evaluation

<table>
<thead>
<tr>
<th>Criteria for participation</th>
<th>Single consumer (patient/family)</th>
<th>Consumer group (‘expert’ in a specific health care need)</th>
<th>Member of the public (‘independent’ consumer voice)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal experience of treatment or care in the service under review</td>
<td>Yes</td>
<td>Most often</td>
<td>Sometimes</td>
</tr>
<tr>
<td>Constituency</td>
<td>Self/family</td>
<td>Specific group</td>
<td>Wider community</td>
</tr>
<tr>
<td>Awareness of local issues of concern to other patients</td>
<td>Not usually</td>
<td>Sometimes</td>
<td>Yes</td>
</tr>
<tr>
<td>Awareness of national issues and ideology of citizens</td>
<td>Not usually</td>
<td>Sometimes</td>
<td>Yes</td>
</tr>
<tr>
<td>Relevance of participation</td>
<td>Patients can talk about individual and provider failures and their impact</td>
<td>Can differentiate between individual and systems problems by consulting with members and tracking failures</td>
<td>Translates consumer experience into proposals for better access, advocacy, equity, safety and redress</td>
</tr>
<tr>
<td>Use of this form of participation by health and disability services</td>
<td>Often used</td>
<td>Sometimes used</td>
<td>Rarely used</td>
</tr>
</tbody>
</table>

Source: Williamson 1998

1.2 Consumers as partners – what can we expect to gain?

A historical perspective: the culture of medical practice

The traditional culture of health services described as the ‘medical model’ is based on a scientific approach, describing the particular signs and symptoms of a health problem in ways that are measurable, generalisable and amenable to technical intervention (Larrabee 1995). This approach largely ignored the uniqueness of individuals in terms of their physical, emotional and cultural response, both to the practitioner and to the treatment. Such responses are qualitative and harder to evaluate. Rather than explore these issues with the consumer, the traditional approach has been for health professionals to decide what is best for the patient at both an individual and a service delivery level.

As the public have become better informed about health matters their expectations of health professionals and the health service have changed from being an unquestioning ‘patient’ to a more knowledgeable ‘consumer’, with increased expectations. Over time this has the potential to develop tension between providers and consumers of health services. Some doctors say they can no longer live up to their patients’ ‘unrealistic’ expectations of medical science and the public health system (BMJ Editorial 2001).
It has been suggested that the dissatisfaction experienced by both parties could be largely eliminated if health professionals and consumers could agree on:

- the role consumers and the wider community should have in planning and evaluating public health and disability support services
- the relationship between health professionals and consumers in terms of rights and responsibilities.

A number of strategies have been and are being developed to clarify what consumers can reasonably expect of health professionals and the health and disability support service in New Zealand. These include the New Zealand Code of Rights (Health and Disability Commissioner 1996), the New Zealand Health Strategy (Minister of Health 2000) and the New Zealand Disability Strategy (Minister for Disability Issues 2001). At a professional level examples include practitioner credentialling (Toward Clinical Excellence: A framework for the credentialling of senior medical officers in New Zealand, Ministry of Health 2001) and the Health Practitioners Competence Assurance Bill.

Exactly how consumers should work in partnership with providers to plan and evaluate health and disability services is less clear. Consumer participation can be defined as any of a broad range of relationships between those who provide health and disability support services and those who potentially or actually receive them. These relationships are illustrated in Figure 1, where at the lowest level consumers and members of the community passively receive information, whereas at the highest level they actively participate in the planning and evaluation of services as a partner with a different, but equally important and respected, viewpoint. This level of partnership has also been described as ‘evidenced-based consumerism’ (Morrison 2001).
Engaging consumers as partners has been described as ‘co-production’ (Donabedian 1992). Co-production covers a broad range of activities, from the contribution of volunteers in the community in health-related work to the efforts made by individuals to keep healthy or recover from illness. The concept of co-production suggests the need for a very different culture from that in the traditional medical model. Specifically, it requires a shift in the balance of power from professional dominance, to a partnership in which professionals and consumers have different but equally valid and valued roles. Co-production can be summarised as ‘joint problem solving, joint decision making and joint responsibility’ (Consumers’ Health Forum of Australia 1990).

Health and disability service providers seek active consumer participation for two reasons:

- to improve the quality of services provided and make them more sensitive to the needs and preferences of users
- at a higher level, as a strategy to add the unique perspective of consumers to improve the design, management and review of health services (Barnes and Winstow 1999).
1.3 Consumer participation in other publicly funded health systems

A brief look at British, Australian and Canadian approaches to encourage consumer participation in health planning and evaluation suggests that New Zealand lags some way behind other publicly funded health systems. The range of approaches being used by these countries suggests that a customised approach may be necessary for New Zealand, building on their experience.

United Kingdom

More than 20 years’ experience in development, training and support for programmes to promote public participation in the National Health System includes:

- Consumers Advisory Group on Clinical Trials
- Long-Term Medical Conditions Alliance, promoting self-determination and self-management of disease for people with disabilities and chronic illness
- College of Health ‘Voices in Action’ programme, developing training materials in conjunction with a wide range of health service users
- the Kings Fund and Public Policy Research use of concepts such as citizens’ juries to make health policy decisions.

Despite these activities, meaningful consumer participation is described as ‘patchy’, with most attempts to involve the public in the development and evaluation of health services being described as ‘ad hoc, reactive and provider driven’ (Sang and O’Neill 2001). The relationship between patient and health professional is fundamental to the British clinical governance model. Sang and O’Neill suggest that this consumer involvement in clinical governance adds rigour to the process itself and enhances learning by all parties. However, such an approach requires an organisational culture that appropriately values and expects consumer input.

A more overtly consumer-centred approach is currently being advocated based on three core principles: informed dialogue, triangulation, and sharing learning about risk, supported within the organisation by a culture of continuous quality improvement.

- Informed dialogue requires discussion between consumers and clinicians with a view to developing a shared understanding about:
  - the process of clinical governance
  - the substance in terms of clinical practice and the evidence base on which the assessment of clinical effectiveness for a particular condition is established.

- Triangulation requires systematising the informal validation that practitioners engage in through discussion with their colleagues and patients, so that the perspectives of peers, the wider health team and consumers continuously improve clinical knowledge and practice.
• Shared learning about risk requires redefining the implicit contract between patients and practitioners referred to previously. This will require a redefinition of the respective roles of both parties in terms of rights and responsibilities and risk sharing to overcome what has been described as the current ‘mutual expectation deficit’ between the parties.

Australia

More recent developments in Australia provide a number of examples of targeted support for consumer participation. The Consumer Focus Collaboration, established in 1997, is a national body with representatives from consumer, professional and private and public health sector organisations, funded by the Commonwealth Department of Health and Aged Care. The aim of this organisation is to increase consumer focus in health service planning, delivery, monitoring and evaluation in Australia. It produces resource guides, reports and papers, taking a lead in fostering an active partnership between consumers and service providers. A useful publication (Consumer Focus Collaboration 2001) documents evidence supporting consumer participation in health.

The Health Information Commission (HIC) is a national statutory authority, which works with the Commonwealth Department of Health and Aged Care to manage claims and payments for a number of government programmes, including Medicare. HIC identifies its primary customer group as health care consumers. It aims to redress the asymmetry of information between consumers and providers to enable individuals to make informed decisions about their health care. In 2001 this body published the final report of a project it commissioned to identify the current and future needs of Australian health care consumers. Recommendations from this report include the need for a national strategic plan for delivering health information, the establishment of a consumer advisory committee, and the monitoring of process transparency and quality related to consumer information management.

The National Resource Centre for Consumer Participation in Health (National Resource Centre) is an initiative of the Consumer Focus Section of the Commonwealth Department of Health and Aged Care, and is located at LaTrobe University, Melbourne. Established in 1999, the National Resource Centre is a partnership between the Australian Institute of Primary Care, the Health Issues Centre (a body that consults with consumers on health policy) and the Adelaide Women’s and Children’s Hospital. The National Resource Centre board of directors comprises a representative of each of the partners and has consumer representation. A separate advisory board also reports to the funder, which in turn directs the work of the National Resource Centre with regard to targeted projects. The primary role of the centre is to promote and support the development of consumer participation through the collection and dissemination of consumer feedback and participation methodology. It is not a consumer organisation per se, and does not provide a consumer perspective on particular issues. This organisational structure favours policy makers and providers in terms of direct access, with a web site linking consumers to appropriate consumer bodies, and consumer groups to resources and examples of good practice in consumer participation. Despite this considerable investment to enable consumers to participate more fully in health service delivery there is little evidence of provider
commitment to make the changes to organisational culture required for a meaningful partnership.

Canada
The genesis of consumer participation in Canada, as in New Zealand, can be traced to mental health services. In 1983 the Canadian Mental Health Association initiated a nationwide project to promote consumer participation in mental health service planning and delivery. Almost a decade later, in 1992, the Canadian Ministry of Health introduced and funded a partnership model for consumer participation in mental health. Despite government support, consumers have noted lack of commitment by local providers, inability to get beyond the rhetoric to see the value consumers could deliver, and the difficulties of providing input into the ‘sacrosanct’ areas of service planning and provision (Morris 1997). Ongoing consumer input in the health system generally appears to focus on providing information – the lowest level of consumer participation. Macfarlane (1996) suggests that the capacity for genuine collaboration in Canada is underdeveloped and requires more systematic refinement.

1.4 Toward developing consumer participation in New Zealand health and disability support services
In 2000 the Ministry of Consumer Affairs commenced a research project to assist in the development of consumer representation in the New Zealand public sector. Interviews were conducted primarily with consumer representatives across a broad spectrum of public sector activities, including health and disability services. This study found that there was a high level of agreement among participants about the barriers to effective consumer participation in New Zealand, and that the barriers identified were consistent with those reported in international literature. These barriers are as follows.

- Managers and people with decision-making powers are not sure about the purpose and value of consumer representation.
- Consumer representatives find it difficult to be effective, in particular where:
  - ‘generic’ appointments are assumed to represent all consumers
  - consumer representatives feel isolated.
- There are difficulties finding effective consumer representatives because:
  - the qualities of an effective consumer representative have not been clearly identified
  - the requirements of the role are often not clear
  - government agencies are not familiar with the non-government/voluntary sector
  - community organisations are sometimes not motivated to respond.
- Practical difficulties, such as time and cost, mean that the best people are not able to make themselves available as consumer representatives.

The Ministry of Consumer Affairs research and a more specific review of the literature describing consumer involvement in other public health systems suggest the key to
developing effective consumer participation in New Zealand is an organisational culture that supports and resources effective consumer participation. This culture is characterised by:

- clear and public support by board members, the Chief Executive Officer (CEO)/Chief Operating Officer (COO) and management for consumer involvement in all aspects of the work of the organisation
- the development of guiding principles and objectives for public participation that are consistent with the organisation’s values and measurable at a service level
- services within the organisation developing strategies that are consistent with these objectives, accepted by staff, and form part of ongoing individual and service performance requirements
- processes to recruit, manage and remunerate consumer participation that are transparent to both the community and DHB employees
- resources being identified for training, mentoring, networking, evaluation and remuneration of consumer representatives.
Section 2: Developing Effective Consumer Participation at an Organisational Level

2.1 Introduction

Developing effective consumer participation in health and disability support services can be a difficult task when people within the organisation have doubts about what a ‘layperson’ can offer. The New Zealand Ministry of Consumer Affairs research (Ministry of Consumer Affairs 2002) shows that these doubts arise from either not understanding the purpose of consumer representation and the value consumers can bring to the decision-making process, or through experience with consumer representatives who were unable to deliver value. The same research also shows that where consumers represent a defined constituency and are appropriately appointed and resourced, they bring a different but complementary perspective to decision-making - that of the user of services. As such they can predict how the constituency they represent will react to proposed changes or service developments, and help to ensure the right decisions are made, thereby providing lasting solutions.

Literature about consumer participation in the planning and evaluation of health services is increasing and more readily available. This work is a useful resource and demonstrates an international trend toward developing new relationships between health and disability support service providers and the communities they serve. Some Australian examples referred to in this section are included in more detail in Appendix B.

This section of the toolkit gives a step-by-step approach to developing an effective consumer participation model in a health or disability support service with little or no previous experience. It is based on a provider of health services, but the same principles apply to disability support service provision. The section has four parts, which together form a quality improvement cycle for consumer participation:

1. start with a plan
2. put the plan into action
3. review progress to date
4. make improvements.

2.2 Start with a plan

2.2.1 Getting started

The following tasks seem obvious, but are surprisingly often overlooked. Consider the following points.

1. Start talking about the need for effective consumer participation in your organisation and enlist the public support of the board, CEO/COO and senior management team.
2. Develop a project brief. This brief provides the boundaries within which the project team will operate, reporting requirements and timeframes.
3. Consider the resources required. The resources available and the degree of change management likely to be required will influence the brief. A well-resourced smaller project is more likely to succeed than one that is ambitious and under resourced.

4. Select the project team. Include people with influence at all levels - they will be your ‘champions’ in the organisation. Identify a skilled person to liaise with the community and to be the contact person for consumer representatives.

5. Involve the community at the earliest possible stage. Include consumers in your project team – a 50:50 representation indicates that you are really serious about partnership. They will be your ‘champions’ in the community.

6. Don’t try to reinvent the wheel – build on consumer activities in your organisation that work well and learn from the experience of others.

2.2.2 Understand the organisational environment and capacity to develop effective partnerships with consumers

‘Capacity’ is the ability of an organisation to effectively ask for, support and use consumer advice. For many organisations the initial focus of consumer participation activities will be on building capacity to ensure effective partnerships in the future. Capacity is determined primarily by factors in the internal environment, but external factors can also be important. For example, some community groups may be tired of being ‘consulted’ and feel that no one listens when their advice is ignored. This will make it difficult for them to take seriously talk about collaboration and partnership – the two key components of empowerment (Holosoko et al 2001).

An organisational assessment is a good place to start the planning process. Within your organisation there are likely to be examples of effective consumer participation, and staff members committed to developing relationships with consumers that you may not be aware of. These examples and role models are invaluable. Similarly there may be issues that need to be addressed before you start to ensure that the organisational environment or ‘climate’ will be supportive. An organisational assessment should consider both external and internal factors that may influence the development of a consumer participation strategy. These are summarised in Table 2.

Table 2: Factors in the external and internal environments of an organisation that influence effective consumer participation

<table>
<thead>
<tr>
<th>External environment</th>
<th>Internal environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer interest and expectations in health and disability issues in the local community and nationally</td>
<td>Organisational documentation such as values and expectations, policies, systems and processes that govern consumer participation</td>
</tr>
<tr>
<td>Government policy and direction to include consumers in all aspects of service planning and delivery</td>
<td>Support and resources provided by Board, CEO/COO and management</td>
</tr>
<tr>
<td>Health reforms that provide opportunities to use consumer contributions in new ways</td>
<td>Attitudes and skills of staff at all levels to engage in effective partnerships with consumers</td>
</tr>
<tr>
<td>Examples of consumer participation developed in other organisations in New Zealand and overseas</td>
<td>Examples of effective consumer participation already in place</td>
</tr>
</tbody>
</table>
You may wish to develop your own audit form based on these factors, or use one of the examples in Appendix B.

The information collected through this assessment process will have a number of uses. These include:

- developing objectives for consumer participation in your organisation
- informing the strategies you need to plan to achieve your objectives
- providing a baseline for future reassessment.

### 2.2.3 Clarify the principles and policies that govern relationships with consumers in your organisation

If your organisation does not have written principles and policies that govern relationships with consumers, a key task will be to develop them. The principles developed should be consistent with the organisation’s mission and value statements. In some cases it may mean that the mission statement will need to be changed to reflect this new relationship with the community (Holosoko et al 2001). Principles and policies influence the development of short and longer-term objectives and the strategies you develop to achieve these in your plan, and provide a yardstick to measure both individual staff and service performance. (See the Illawarra Area Health Service example in Appendix B.)

### 2.2.4 Develop short and longer-term objectives for consumer participation

Research shows a strong link between the reasons why consumer participation is supported in an organisation, the objectives developed, and the specific strategies employed (Draper 1997). To be effective the process of developing objectives needs the involvement of all staff. The concerns of staff and management and the eventual approach taken by your organisation will be unique.

One way to get staff involved is to make consumer participation an additional agenda item for meetings at all levels of the organisation over a set period of time. Ask the following questions:

- What would this group need to do to develop a partnership (shared responsibility) with consumers to plan and measure the effectiveness of the service we provide?
- What are the benefits of such a partnership?
- What are the risks?

Analysis of this information by the project team will provide more in-depth data about the receptiveness of the environment at different levels – board, management team and services. This information, together with the environment assessment previously discussed, provides the basis from which to develop your objectives for consumer participation. Consider asking the same question of consumer groups and include them in the process.
2.2.5 Establish strategies to achieve your objectives

Strategies form the plan of action you will use to achieve your objectives. Initially they may focus on the lower-level, capacity-building activities. These could include:

- getting support and the necessary resources from the board and CEO/COO
- staff consultation, information and education
- developing and communicating your principles of consumer participation
- putting in place policies and structures to support consumer participation, building on existing activities that work well.

Once this foundation is in place, specific strategies can be developed to enable consumer participation activities in a particular service. Here the strategies become more focused on the needs of the partners in the process (health professionals, consumers and managers) and the service in question. At this level strategies may include:

- determining the readiness of the service to develop active partnerships with consumers to plan and evaluate their work (rather than impose a requirement for all services to engage in consumer participation, it might be more useful to use one of two services with smaller projects and get some quick ‘runs on the board’ to publicise and generate enthusiasm in other services)
- identifying the activities for which consumer participation will be sought
- determining the qualities of consumers required (see 2.2.1, Table 3), which will include whether these people have experience as a patient, represent a special interest group or have a wider consumer viewpoint, as well as personal qualities
- recruitment, orientation, support and remuneration of consumers
- making time for health professionals to become involved and develop skills in partnership activities.

The Improving Health Services through Consumer Participation: A Resource Guide for Organisations (Consumer Focus Collaboration 2000) identifies 43 strategies and gives in-depth information about their use, providing a useful resource. Further information about this and other Australian resources can be obtained through the National Resource Centre for Consumer Participation in Health (http://rccph.latrobe.edu.au).

2.2.6 Prioritise tasks

The number of tasks to be undertaken and the order in which you do them will depend on your objectives and the resources allocated to develop consumer participation activities. Discussion across the organisation therefore needs to occur at two levels – the service level, where health professionals and managers will put the plan into action, and at the board and CEO/COO level, where resourcing and support will be critical to the success of the plan.

2.2.7 Allocate resources

The availability of resources will determine the number and priority of tasks that can be addressed at one time. It is better to do fewer tasks well than spread resources too thinly and achieve poor results. This is particularly important where you are asking staff to come...
to meetings where attendance may conflict with clinical responsibilities. The budget developed in the planning stage provides the basis for the allocation of project-specific resources. Some resources, such as facilities and support for consumer representatives, may be less obvious but they are equally important.

2.2.8 Decide how you will measure progress

The final task in project planning is to decide how you will measure progress towards achieving your objectives. This includes consideration of when and how you will evaluate the evaluation process, as over time the frequency and type of evaluation may need to change.

Evaluation of ‘people’ activities is a complex task. Evaluation criteria should be clear and objective, focusing on process and outcomes rather than individuals. Consider the following questions:

- What is the purpose of evaluation (depending on the stage of development you may be focusing on capacity-building activities or specific consumer partnerships)?
- What will we measure?
- Whose perspective will we use (consumer, management, health professionals)?
- How formal should the process be?
- How often will evaluation occur?
- Who will do the evaluation?
- Who will interpret the results?
- How will the results be reported?
- How will we use the results to make positive changes?

Evaluating capacity-building activities

The need to develop capacity for consumer partnerships has already been discussed. Since organisational capacity is a critical success factor, we need an evaluation process to measure this capacity and re-evaluate to ensure capacity endures over time. Capacity building is generally much easier to evaluate than partnership effectiveness. The audit tool used to measure the organisational environment initially will give ongoing comparative information. Indicators that capacity exists within the organisation to support consumer partnerships include:

- documented principles, objectives and systems to guide consumer participation
- board and senior management support
- availability of resources, including staff with skills in co-ordinating and supporting consumer activities
- uptake of staff education to facilitate development of consumer partnerships
- documented policies and procedures for the recruitment, orientation, support and remuneration of consumer representatives
• evidence of interest in the use of consumer involvement in a wide range of activities, including organisational and service planning and evaluation.

Evaluating partnership activities

Effective consumer participation is more likely when the consumer becomes an accepted and valued member of the group. This requires health professionals, managers and consumer members to develop the ability to work together as equals, recognising that each has a different, but equally important perspective to bring to service planning and evaluation. Groups typically go through a number of stages before they can function in this way, and this can take time. Ongoing evaluation and support to monitor progress is important in the early stages. Informal discussion with the group can:

• help achieve agreement as to where the group is at and where it needs to go
• assist in developing cohesion and trust between members.

It has been suggested that there are three indicators that a group is working as an effective partnership: meaningful dialogue, triangulation and shared understanding and responsibility for risk (Sang and O’Neill 2001). These could form the basis for the evaluation of group effectiveness. Specifically:

• meaningful dialogue and mutual understanding of both process information – the basis for fair and robust governance, and substantive information, where consumers are able to appreciate aspects of clinical practice and the evidence base by which clinical effectiveness is assessed
• triangulation – where clinical performance is validated from three complementary perspectives: professional peers, service team and consumers
• shared understanding and responsibility for risk, both in terms of the impact on the community and other health services and financial responsibility.

Developing effective consumer partnerships is a progressive development – the key step is to start the journey! Success is more likely if you:

• begin with the end in mind – to develop effective partnerships with consumers that will result in making good decisions that will improve the health of the community
• start small, building on existing effective consumer involvement
• review progress regularly and make improvements based on this experience.

2.3 Put the plan into action

This section assumes that work will need to be done at an organisational level to ‘build capacity’ to enable the effective use of consumer representation. Developing a ‘package’ to recruit and support consumers is a key capacity-building task that is common to all provider organisations and is explained as an example of ‘putting the plan into action’.
2.3.1 Developing policies and processes to ensure the effective recruitment and support of consumer representatives

What do you want consumers to do?

One of the ‘lessons’ from Australian hospitals (Draper 1997) is that developing trust between consumers and providers is important because both parties have doubts and concerns about the role of consumers (see Appendix B.) One of the first steps toward developing trust is to be very clear about what consumers will do and the process of their appointment. Input from the health professionals with whom consumers will work is important to clarify the consumer role and appointment process, and to work through any initial concerns staff may have before the consumer is appointed. Consider the following questions about appointing a consumer representative.

Position description

- What level of consumer input is required?
- What constituency will this person/s represent?
- What are the key tasks?
- How will performance be measured?
- Who will this person have as a point of contact in the organisation?
- What time commitment is required?
- How will they be remunerated?
- What is the length of tenure?

(For examples of consumer position descriptions see resources Appendix B.)

Person specification

The person specification accompanying the position description will depend on the level of input and the skills required. The more detailed the description (as in the example in Table 3, the easier it will be for individuals and consumer organisations to respond with appropriate candidates.

Table 3: Qualities required of consumer representatives

<table>
<thead>
<tr>
<th>Knowledge and experience requirements:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- a track record of achievements for the community (they have taken an initiative and seen it through to the end) – the quality of track record matters more than the length</td>
</tr>
<tr>
<td>- the community they have worked in and will represent respects their integrity</td>
</tr>
<tr>
<td>- knows the realities of ordinary people's lives (especially those who are disadvantaged), knows the issues, the community thought processes, how decisions are made, and the community's wisdom and ignorance, its breadth and its contradictions</td>
</tr>
<tr>
<td>- knows what is practical, possible, sensible, rational, realistic and probable in the community.</td>
</tr>
</tbody>
</table>
### Networking requirements:
- broad community networks they consult regularly
- accessible to the community - not someone who works alone
- demonstrates a comprehensive understanding of confidentiality.

### Essential attributes:
- ability to appreciate the common good
- stable and acts consistently
- understands group processes and can work constructively within them
- addresses issues from the perspective of the consumer
- strong communication skills and will be assertive and persistent if necessary
- strategises effectively from a minority stance and finds solutions and common ground with others
- exercises good judgement
- excellent at developing and maintaining appropriate relationships
- respects cultural differences.

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**Important note:** This list of qualities should be used as a general guideline in which the individual statements modify each other. For example the statement ‘strong communication skills and will be assertive and persistent if it is necessary’ is modified by other statements such as ‘understands group processes and can work constructively within them’, ‘exercises good judgement’ and ‘excellent at developing and maintaining appropriate relationships’. In other words, representatives need much more than strong communication skills.


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**The recruitment process**

Consumers may be recruited through agencies in the community or appropriate persons may respond to a public advertisement. An approach to a community agency for nominations should be made within the wider context of the organisation’s relationship with that agency. DHBs will already have contacts with these groups through their community consultation processes.

Consider the following points before approaching a community agency.

- **Identify the staff member representing the provider organisation who will be responsible for this task.** Effective consumer liaison requires specific skill, time and continuity to build relationships.

- **Prepare information with the agency in mind.** The ‘package’ should include the job description and person specification. Ensure that the material provided is jargon-free and includes sufficient background information to make the purpose of the request and the ensuing process clear.

- **Personal contact is important.** The Ministry of Consumer Affairs research shows that the most effective approach to community/voluntary organisations is to:
  - phone and talk to the appropriate contact person, explain the request and offer to send an information package

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Toward Clinical Excellence:
A toolkit to develop consumer participation in credentialling
follow up the information package with a visit to discuss the request and provide additional information if required.

Appointment process

The appointment process is an opportunity to develop a working relationship between consumer groups, health professionals and management. One way to do this is to ensure that stakeholders are represented on the appointment panel, especially members of the constituency this person will represent. The appointment process should be clear to all parties and follow both procedural and substantive due process. The size of the group interviewing potential candidates, the venue and cultural requirements such as the ability to have support persons present are important considerations.

Remuneration

Remuneration should include reimbursement for reasonable expenses and a meeting fee that recognises work required for preparation and consultation with the constituency.

Remuneration is a complex issue and there is often a discrepancy in payment to individuals ostensibly fulfilling the same role, but from different employment circumstances. It is therefore important that the basis on which remuneration is paid is documented and freely available. The following advice comes from a guide produced by Consumers in NHS Research (2002).

- All expenses should be reimbursed as a matter of principle. Payment for the time and expertise of consumers should be considered best practice.
- Paying for specific pieces of work, such as meeting attendance, reinforces consumer independence.
- Remuneration can be used to clarify the expectations and responsibilities relating to consumer involvement.
- Setting the rate of payment for consumers should consider the following questions:
  - Does the principle of equity apply?
  - What level of skill and experience are we expecting?
  - What time commitment will be involved?
  - What are the comparative levels of pay and responsibility for participating professionals?
  - What level of responsibility will the consumer representative have?
  - How are similar consumer roles remunerated locally and nationally?
- Consumer choice needs to be considered when offering remuneration. There may be reasons why consumers may wish to be paid differently; for example, consumers on benefits; those who wish their payment to be donated to a particular cause.
- Make it clear from the outset when and how consumers will be paid. For consumers on low incomes it may be necessary to pay expenses in advance.
Confidentiality and indemnity

It is a reasonable requirement that consumer representatives sign a confidentiality agreement, although this should not limit their ability to communicate appropriately with their constituency. Confidentiality agreements for consumers should make explicit the purpose and justification for the agreement along with any other conditions, such as time limitations. Such agreements will be situation-dependent. For example, a consumer member on a credentials committee has a responsibility to the community to ensure the process of credentialling is fair and that it protects consumers. While process issues may be a matter for discussion, information related to individual practitioners must always be entirely confidential. At a broader level, where consumers work in partnership with health professionals to plan and evaluate health and disability support services, the need for informed dialogue is critical. Here consumer representatives must be able to consult freely with their constituency.

Consumer representatives also need protection. Consumers working within their agreed position description in good faith should expect to be included in organisational indemnity insurance cover.

Orientation and ongoing support

Ideally the main point of contact for the consumer representative will be a person with a delegated responsibility to be their contact person, rather than just the service in which the person is involved. This contact person provides continuity in terms of managing day-to-day requirements for consumer representatives and support at an organisational level. The chair of the project working group has a particular responsibility to ensure that the consumer voice is heard and valued, and that specific support is provided, such as explanation of technical matters if this is required.

Getting to know the physical environment is important both to become familiar with the geography and to meet key people. Consumer representatives should be identifiable – name badges and business cards are important.

‘Informed dialogue’ requires that the consumer representative is well briefed on background and current information that relates to their role, as well as receiving more general information at an organisational level that has relevance. This may require the consumer representative to do a lot of reading. Ensure that technical terms and abbreviations are explained, and provide tapes and videos as alternatives to reading where possible.

Consumer representatives are not staff. While they are remunerated for their services their primary responsibility is to their constituency. If this allegiance changes so that the consumer identifies primarily with the organisation, consumer ‘capture’ is said to have occurred and the person can no longer effectively fulfil their role. The ability to network with other consumer representatives reduces the likelihood of consumer capture.

Informal feedback in the form of debriefing following meetings is an important support mechanism. Where the consumer is a sole voice, the chairperson may effectively assume this role, providing an opportunity for the consumer representative to discuss issues and seek clarification outside the wider forum. This does not replace constituency networking.
and networking opportunities with other consumer representatives, which have a different purpose.

Performance review
A formal review of performance forms part of the ongoing support and development of consumer representatives. How performance will be measured should be agreed as part of the appointment process. Typically this will include:

- a review of the person’s ability to meet the requirements of their contract with the organisation
- feedback from the constituency as to their satisfaction with the quality of representation
- an opportunity to identify the need for ongoing support and training.

2.3.2 Tell staff and the community about your plan and progress
Communication is a key task for the designated consumer contact person working with the organisation’s communications staff. This task needs to be carefully managed to establish two-way communication with key groups, including consumer representatives, the various constituencies in the community, the board, management and staff, and key contacts in the wider health sector. Included in this communication plan will be some of the strategies identified to educate and update staff, such as a column in the staff newsletter and intranet updates and resources.

2.4 Review progress to date – did we achieve what we set out to do?
Deciding how and when progress will be reviewed is sometimes overlooked in the project planning stage. In quality improvement terms, these ‘closing the loop’ activities are critical to ensure continued progress toward meeting the objectives of a project.

During the planning stage we asked the following questions:

- What is the purpose of evaluation?
- What will we measure?
- Whose perspective will we use (consumer, management, health professionals)?
- How formal should the process be?
- How often will evaluation occur?
- Who will do the evaluation?
- Who will interpret the results?
- How will the results be reported?
- How will we use the results to make positive changes?

It was agreed that we would need to evaluate two areas:

- capacity-building activities
• consumer partnership activities.

These headings can be used as a format to develop the detail of the evaluation plan. This process is illustrated in Table 4.

Table 4: Sample consumer participation project evaluation

<table>
<thead>
<tr>
<th>Evaluation question</th>
<th>Capacity-building activities</th>
<th>Consumer partnership activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the purpose of evaluation?</td>
<td>Ensure the ‘inputs’ are in place for effective consumer participation: • organisational climate • resources • community relationships</td>
<td>Review process and outcomes of existing partnership activities</td>
</tr>
<tr>
<td>What will we measure?</td>
<td>Compliance with organisational climate audit used previously</td>
<td>• Group process and outcomes • Adequacy of resources • Comfort and effectiveness of individuals within the group</td>
</tr>
<tr>
<td>Whose perspective will we use?</td>
<td>• Consumer representatives, management • Health professionals across the organisation • Community consumer fora</td>
<td>• Consumers • Management • Health professionals involved in the current partnership</td>
</tr>
<tr>
<td>How formal should the process be?</td>
<td>Formal audit</td>
<td>Informal review</td>
</tr>
<tr>
<td>How often will evaluation occur?</td>
<td>Six-monthly until compliance reached, then annually</td>
<td>• Informal debrief after each meeting • Quarterly report</td>
</tr>
<tr>
<td>Who will do the evaluation?</td>
<td>Consumer contact person</td>
<td>• Chairperson – debrief and feedback • Report – co-ordinated by service manager</td>
</tr>
<tr>
<td>Who will interpret the results?</td>
<td>Project team</td>
<td>Service manager/project team</td>
</tr>
<tr>
<td>How will the results be reported?</td>
<td>• Full capacity report to board, CEO/COO management team, service managers • Summary of results and planned actions freely available to staff and community</td>
<td>• Informal reviews involve all members • Quarterly report to CEO/COO to update board</td>
</tr>
</tbody>
</table>

2.5 Make improvements – what have we learned, what could we improve?

The final step in the cycle involves acting on the information received through evaluation activities. This should be both ongoing as a result of informal debriefing meetings and periodic as a result of formal evaluation. Consider the following questions when reviewing progress and making improvements.
• Are the organisational principles that underpin your consumer partnership activities documented and being employed consistently?
  – Are the principles themselves adequate?
  – Are there some principles we have difficulty achieving, and if so, why?

• Have we met the objectives we were working to achieve?
  – Are the objectives appropriate and achievable?
  – Were the strategies employed appropriate?
  – Were resources adequate for the work we planned to do?

• How should the strategies be amended?
  – What worked well and why?
  – What didn’t work and why?
  – Are there other things we should do?
  – Are we doing unnecessary things we shouldn’t do?

• How can we use what we have learned to make improvements?
  – How can we make consumer participation more effective in the areas we have targeted to work on?
  – Should we transfer this learning to other areas of the organisation?

• What and how will we communicate the results of this review to consumers, staff and management?

Once these questions have been answered the four steps of the cycle are complete. The information is used to adjust the plan, and continue the journey toward developing effective partnerships with consumers that result in effective decision-making and, ultimately, a healthier community.
Section 3: Consumer Participation in Credentialling Systems

3.1 Introduction

Consumers provide a perspective that helps to ensure we make the right decisions. The value consumers bring to the decision-making process includes:

- providing a viewpoint on aspects of clinical care from the perspective of a service user (this complements the perspective of health professionals, which is often more focused on the technical aspects of clinical practice)
- predicting how their community will react, so that decisions made by the credentialling committee will stand up to public scrutiny.

The national framework defines credentialling as:

A process to assign specific clinical responsibilities (scope of practice) to health professionals on the basis of their training, qualifications, experience and current practice within an organisational context. This context includes the facilities and support services available and the service the organisation is funded to provide. Credentialling is part of a wider organisational quality and risk management system designed primarily to protect the patient. It is an employer responsibility with a professional focus that commences on appointment and continues throughout the period of employment (Ministry of Health 2001).

The requirement to involve consumers is an integral part of the credentialling framework. Section 2.8 of the same document states that:

Public input must be demonstrable and show progressive development toward inclusion of independent public appointments to credentials committees, within a specified timeframe. The role of the public as consumers of health care is evolving. If we accept that the primary purpose of credentialling is to improve health outcomes for patients, the role of the patient as a consumer of medical care must be identified and strengthened. This includes, but is not restricted to - responding to the particular needs of Māori and our responsibility under the Treaty of Waitangi to develop effective partnerships to improve health outcomes for Māori (Ministry of Health 2001).

Each provider will have a different way of organising their credentialling system depending on the size and complexity of services provided. In general, each organisation will have a permanent structure that holds delegated authority from the Chief Executive Officer (CEO) or Chief Operating Officer (COO) for the over-arching organisational credentialling system, to service-specific committees constituted for a particular credentialling review. The consumer representative should have input at both levels.
This section provides specific information to assist organisations to appoint and support consumer members of credentialling committees. Information about more general issues related to consumer participation is contained in Section 2, which should be read in conjunction with this section. The following information gives a step-by-step account of the process of appointing a consumer to a medical credentialling committee.

3.2 Consumer appointment process

Take time to discuss the role and tasks of the consumer with the clinical team, to develop agreement on the purpose and process of developing effective consumer participation on credentialling committees.

Step 1: Agree the purpose of consumer participation committee

Consumers provide a different, but equally valuable, perspective to health care decision-making processes from the perspective of an actual or potential service user. They can also predict how the constituency will react to decisions and recommendations made by the credentialling committee.

Table 5 summarises the way consumers can contribute to the evaluation of aspects of clinical quality.

Table 5: Consumer contribution to quality improvement in key aspects of health and disability support provision

<table>
<thead>
<tr>
<th>Aspect of quality</th>
<th>Consumers can do alone</th>
<th>Consumers can do with clinicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Appropriate care (choice, shared decision making)</td>
<td></td>
<td>Predict how the constituency will react</td>
</tr>
<tr>
<td>Clinical effectiveness</td>
<td>✗</td>
<td>Needs clinical expertise</td>
</tr>
<tr>
<td></td>
<td></td>
<td>By adding consumer experience</td>
</tr>
<tr>
<td>Patient experience</td>
<td>✓</td>
<td>Provide personal/constituency perspective</td>
</tr>
<tr>
<td>Health outcomes</td>
<td>✓</td>
<td>Provide personal/constituency perspective</td>
</tr>
<tr>
<td>Efficiency</td>
<td>✓</td>
<td>Provide personal/constituency perspective</td>
</tr>
</tbody>
</table>

Source: BMA Clinical Audit Committee March 2000
Step 2: Identify the constituency the consumer will represent

In general the constituency served by the overarching credentialling structure is the entire community, whereas the constituency for a particular service review will be much more specific (e.g., a maternity or mental health service). From a practical perspective it may be better to have the continuity of a single consumer representative who has the ability to co-opt specific consumer expertise for a particular service review in consultation with the chair, in much the same way as clinicians are co-opted for their particular specialty expertise.

Finding a person to provide a consumer perspective for an entire community is a difficult task. Within the community there will be a number of constituencies that need to be considered. These include:
- specific health and disability needs
- ethnicity, gender and age
- geographic location
- relative economic advantage/disadvantage.

A clear definition of the constituency the consumer will represent is important to ensure the person specification developed reflects the characteristics of the constituency and/or the ability of the person to network with specific groups. In some instances more than one person may be required.

Step 3: Develop a job description and person specification

The job description should reflect the:
- terms of reference of the credentialling committee
- specific contribution expected of the consumer as a committee member
- key people the consumer will relate with, including functional relationships with staff outside the credentialling committee
- expectation that the consumer representative will engage in appropriate networking activities within the community
- length of tenure
- remuneration.

A person specification should accompany the job description. A clear person specification makes it more likely that suitably qualified people will apply. See Section 2, Table 3 for an example of a person specification for a consumer representative. Appendix B provides an example of a job description for a credentialling committee consumer representative (Hutt Valley District Health Board), more generic example (Wellington City Council Disability Reference Group).
Step 4: Approach the community for nominations
A single consumer representative on a credentialling committee will need to be able to provide a broad community perspective. There are three ways to source consumer nominations:

- by approaching local consumer groups/voluntary organisations
- inviting individuals to self-nominate through public advertisement
- seeking advice from a central agency such as the Ministry of Consumer Affairs (see Section 2.3.1 for information about approaching community agencies for nominations).

Step 5: Appoint the consumer representative
The appointment process is an opportunity to develop a working relationship between consumer groups and health professionals. One way to do this is to ensure consumers are represented on the appointment panel, in particular members of the constituency this person will represent. The process should be clear and made known in advance to all parties. The size of the group interviewing potential candidates, the venue and the ability of applicants to have support persons present are important considerations.

The appointment ‘package’ should include a confidentiality agreement that protects the organisation and the individual without impeding the ability of the person to liaise appropriately with their constituency. Indemnity insurance should also be included in this package (see Section 2 for more detail about these topics).

Once the successful candidate is appointed, everyone involved in the process should be advised of the person’s name, background and contact details. If this is the first time a consumer member has been appointed, consider how patients and the community will be told of this appointment.

3.3 Orientation and ongoing support of consumer representatives
General comments about orientation and support of consumers are made in Section 2 and should be read in conjunction with this section, which contains more specific information related to credentialling. Most credentialling committees are small and will usually only have one consumer member. In this case particular attention needs to be paid to assisting consumer members to ensure that the consumer voice is heard and that they have appropriate support.

3.3.1 Orientation
The role of a consumer on the credentialling committee, like that of the other health professional members, carries with it a responsibility to be well prepared and mindful of the consequences of committee recommendations to which they have input. Specific orientation should consider:
• prerequisite knowledge of the national credentialling framework (Ministry of Health 2001); the Medical Practitioners Act 1995, particularly implications of Part VI; and other relevant legislation such as the Privacy Act 1993

• information that puts the consumer on a ‘level playing field’ with other practitioner committee members, including:
  – organisational credentialling policies and procedures
  – the background to the development of credentialling in the organisation
  – any input consumers have previously had in developing the credentialling system
  – the response of practitioners and services to credentialling to date

• support required, including:
  – meeting the CEO/COO, service managers and others with whom the person may have functional relationships
  – identifying physical requirements such as office space
  – assistance with networking requirements initially, such as identifying speaking opportunities within both the organisation and the community
  – assistance in researching health-related topics and resources, if required.

3.3.2 The role of the chair in supporting consumer members

Research conducted by the Ministry of Consumer Affairs in New Zealand in 2000/01 showed that the committee chairperson can and often does create an environment that encourages effective input from consumer representatives. The main points from this guideline are as follows.

Consumers identified four factors that reduce their effectiveness:

• cost – time lost from work and the expense of meeting attendance
• confidentiality agreements that inhibit representatives networking with their constituency
• ability to stay in touch with a large and diverse constituency
• isolation, because they are a lone voice on a committee, through conflict arising within the group and through their inability to have contact with other consumer representatives.

The Ministry of Consumer Affairs guidelines recommend that chairpersons:

• ensure that the needs of their consumer representative are considered in planning meetings and setting credentialling budgets
• ensure confidentiality agreements take into account the need for the consumer representative to network and consult (chairpersons can assist by reviewing with them at the end of the meeting items that are confidential and those that can be discussed publicly)
• identifying with the committee ways in which they can assist the consumer representative to stay in touch with the community they represent
• reduce consumer isolation by:
  – using a participative leadership style where everyone’s contribution is equally valued and decisions are jointly made by all members
  – making sure everyone has access to the same information
  – encouraging the group to work together by building trust and respect and dealing effectively with conflict.

3.4 Evaluating the performance of consumer representatives
Consumers value recognition and constructive comment on their input. This feedback can be given informally at the end of each meeting in a debriefing with the chairperson. A more formal evaluation should also be considered periodically to check that the individual is comfortable with their role and to ensure that the credentialling committee is receiving effective, independent consumer input. This review should not be limited to the consumer and should include the wider group, based on the Credentialling Committee Terms of Reference.

Consider the following questions:
• What things work well from the consumer’s perspective? What things don’t work and how could this be changed?
• What things work well from the practitioner’s perspective? What things don’t work and how could this be changed?
• What things work well from the chairperson’s perspective? What things don’t work and how could this be changed?
• What impact has consumer representation had on the deliberations of the committee?

3.4.1 Continuous improvement
The implementation of the credentialling framework in New Zealand has been described as a process that is expected to develop by ‘evolution’, not ‘revolution’. One of the most controversial aspects of this framework has been the use of consumer participation on credentialling committees. The reason for this is often better explained by the organisational environment in which the framework is being implemented than the framework itself. Using consumers as partners in health service and disability support service planning and evaluation requires a new approach to working with communities.

Currently there are few service providers with a consumer member on their credentialling committees. This development will take more time for some organisations than for others. Those organisations that have commenced this partnership in New Zealand report that initial concerns about consumers being ‘out of their depth’ have been unfounded, and that well oriented and supported consumers provide a unique and valuable perspective to the task of medical credentialling.
### Appendix A: Reference Group Membership

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization/Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frances Acey</td>
<td>Disabled Persons Assembly</td>
</tr>
<tr>
<td>Gillian Bohm (project sponsor)</td>
<td>Principal Advisor, Quality Improvement and Audit, Ministry of Health</td>
</tr>
<tr>
<td>Lesley Harwood</td>
<td>Ministry of Consumer Affairs</td>
</tr>
<tr>
<td>Hazel Hodgkin</td>
<td>Women’s Health Action</td>
</tr>
<tr>
<td>Celia Murphy</td>
<td>Consumers Institute</td>
</tr>
<tr>
<td>Dr Peter Leslie</td>
<td>Chair, Council of Medical Colleges</td>
</tr>
<tr>
<td>Evan Ng</td>
<td>Credentialling Committee Consumer Representative, Hutt Valley District Health Board</td>
</tr>
<tr>
<td>Barbara Robson</td>
<td>Federation of Women’s Health Council</td>
</tr>
<tr>
<td>Tania Thomas</td>
<td>Director of Advocacy, Health and Disability Commissioner</td>
</tr>
<tr>
<td>Robyn Woodward</td>
<td>Consultant, Project Co-ordinator</td>
</tr>
</tbody>
</table>
Appendix B: Resources

B1. Lessons from Australian hospitals
B2. Principles and processes of consumer participation
B3. Examples of audit tools
B4. Consumer job descriptions

Appendix B1: Lessons from Australian hospitals
In 1997 the Australian Department of Family and Health Services funded a project to demonstrate how consumer partnership can be used to improve the quality of patient care. The results of this work are summarised in the following 15 evidence-based ‘lessons’ from Australian hospitals.

Evidence-based lessons from Australian hospitals
1. Consumer participation is about creating the kind of organisations that get and use consumer feedback.
2. Consumer participation needs senior management support to be effective.
3. Consumer participation needs to have the involvement of the staff right across the organisation.
4. Change and engagement occur when direct dialogue takes place between health professional and consumer.
5. Hospitals need to use a range of ways of getting feedback from consumers and involving consumers in participation.
6. Consumer councils and advisory bodies have an important role to play, but are unlikely to be effective unless participation processes are in place at a service planning and delivery level, and there are processes in place to consult with consumers. These high-level committees need to have a process of consumer representation.
7. Developing trust is important in establishing consumer participation because providers and consumers bring doubts and anxieties to the process.
8. Get some runs on the board by identifying areas where there is common ground and where problem solving can produce solutions.
9. Consumer representatives have an important role to play in establishing processes for broader consumer participation, by tapping into community views, and by providing a process of two-way exchange of information.
10. There are a number of barriers to consumer participation that need to be managed as part of the process.
11. Consumer participation is a continuous process, not a one-off event.
12. Managing consumer participation is a skilled task and these skills need to be present in the organisation.
13. Consumer participation and feedback need to be adequately resourced.
14. There are many benefits for staff and health services from consumer participation.
15. Consumer participation is a process of establishing working partnerships.
### Principles of consumer participation

1. Participation of community members is an essential component of continuous quality improvement and the management of the Illawara Area Health Service and is highly valued.

2. The Illawara Area Health Service will provide opportunities at the local and regional level for health consumers to have input into: policy development, identifying priorities, planning of health services and quality issues in the delivery of health services.

3. Health consumers are encouraged to provide direction to the participation processes. The Illawara Area Health Service will support this through consumer access to the Board.

4. Communication links between the Illawara Area Health Service and health consumers are an effective two-way process. Information is shared and exchanged with health consumers to enable them to participate effectively.

5. A range of networks between the Board, health services and the broader community be established and maintained and accessible to health consumers.

6. The Board recognises the need for resources and support for the consumer participation process to enable effective participation of consumers and consumer groups.

7. Opportunities are provided for relevant training and education for health consumers to assist in their effectiveness as consumer representatives.

8. The Board recognises that some communities within the Illawara have special needs and their input into the health service will be supported.

9. Consumer participation in consultation processes will occur prior to final decisions being made with feedback on decisions being provided to the community.

10. Health managers are encouraged to establish and with their staff be involved in health consumer participation processes aimed at establishing active partnerships.

11. Individual health consumers are acknowledged as advocates from the community as well as being representatives of groups.
Processes for consumer participation

1. The Illawara Area Health Service will support a network of health consumer forums based on geographic areas.

2. A consumer health council will be supported by the health service. The Council’s roles will be to:
   - act as an advisory body on consumer issues to the Board
   - act as a co-ordinating body for consumer forums and consumer advisory committees.

   The Council will meet at least twice a year with the Board.

3. Board members will be informed of local health forum meetings and invited to attend.

4. The Illawara Area Health Service will support consumer and/or community advisory committees, which advise specific areas of the health service, such as the Psychiatric Services Community Consultative Committees (example).

5. Health consumers will be involved in identifying the needs of the community and be members of service planning committees from the outset.

6. Health consumers will be invited to participate in annual planning processes such as business and quality plan preparations.

7. The Illawara Area Health Service widely promotes the consumer participation processes it supports.

8. An annual workshop/conference will be held for health consumers.

9. Training programmes for consumers will be developed and provided on a regular basis.

10. Individual health units will be encouraged to involve health consumers in their service and will be recognised for their effort (eg, a quality award for consumer involvement).

The protocol will be reviewed at least every two years by consumers and health staff.

Appendix B3: Examples of audit tools

The following tools are taken from Consumer Focus Collaboration, Improving Health Services Through Consumer Participation: A resource guide for organisations, Canberra: Commonwealth Department of Health and Aged Care, 2000.

Example 1: Organisational capacity assessment

This tool enables you to audit your organisation’s consumer participation focus. There are some options for how you reflect on these questions. You may prefer to answer the questions as a group and in that case you should consider using a facilitator. If you cannot answer the questions, before you move on, spend some time thinking and talking with your colleagues about participation, your motivations, skills and values and the organisation in which you work.

With staff and community members/consumers (separately or together), review the extent to which the following critical factors for effective participation are present or absent in your organisation.
Decide on a rating (0–10) for each. A rating of 0 would indicate that factor is completely non-existent in you organisation. A rating of 10 would indicate that there is no need for improvement for that factor. Mark your score for each item.

1. Is there a policy commitment to consumer participation?
   | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
   | low | medium | high |

2. Are there appropriate organisational structures for consumer participation?
   | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
   | low | medium | high |

3. Are there identifiable processes and procedures for policy development and decision-making?
   | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
   | low | medium | high |

4. Are consumers/community currently involved in the organisation?
   | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
   | low | medium | high |

5. Are there adequate resources to support participation?
   | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
   | low | medium | high |

6. Are time lines long enough to allow consumer participation to develop (minimum of two years?)
   | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
   | low | medium | high |

7. Is there a two-way flow of information between consumer groups/communities and organisations?
   | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
   | low | medium | high |
8. Does the organisation have a willingness to share power?

1  2  3  4  5  6  7  8  9  10

low medium high

9. Does the organisation provide attitude and skill development - management for staff and community/consumers?

1  2  3  4  5  6  7  8  9  10

low medium high

10. Is there a critical mass of enthusiastic people who support consumer participation in the organisation?

1  2  3  4  5  6  7  8  9  10

low medium high

11. Are there appropriate measures of effectiveness used for consumer participation strategies?

1  2  3  4  5  6  7  8  9  10

low medium high

What your score means

Your total score gives an indication of your organisation's capacity for enhancing consumer participation. Scores on individual items provided a guide as to where you may need to concentrate your efforts:

• 110 and over - theoretically possible. Have you talked with the consumers involved in your service?
• over 80 - your organisation is already well focused on consumer participation and has an environment that is likely to support new consumer participation initiatives.
• 60 to 80 - it is likely that there are some measures in place and plenty of opportunities to do more.
• 40 to 60 - while there may be opportunities for initiating new consumer involvement, there may still be some significant work to do in improving the capacity of the organisation for consumer participation.
• below 40 - the organisation is not supportive of consumer participation in its current state, and the focus should be on organisational development efforts.
Example 2: Draft community and consumer participation audit tool for hospitals

Preamble
Community and consumer feedback and participation is increasingly being advocated as an important component in decision-making for health service managers and providers. The term ‘consumer’ is defined as users of a health service or potential users. They can be individuals or a group of consumers with a collective interest. The term ‘community’ is broader and can refer to either a particular community group (e.g., culturally determined group, disease-oriented group, or an interest group), place where the hospital is located, or catchment area for the hospital. Participation can be at different levels of a hospital (of network/area health board/region) such as in strategic planning, service and facilities planning, policy development, service delivery and care processes, and review and evaluation of care and services. Also, the degree of participation can range from low degrees of participation (information giving and information seeking) through to higher degrees of participation (consultation, partnership and consumer control).

There are various methods and models that can be used to involve the community and consumers. There is no one right way of enabling the community of consumers to participate. However, what is important is that a hospital clearly identifies who its community and consumers are, and what the purpose and mechanisms are for involving them. What is also important for maximum benefit to the hospital, its staff, and those community members and consumers who participate, is that community and consumer participation is part of an overall organisational strategy, rather than a series of ad hoc projects. As such, it is important that community and consumer participation is seen as part of an organisational management strategy as well as part of care processes between individual providers and consumers.

Purpose of the audit tool
Many hospital staff have asked for an easy-to-use tool to gain an indication of the level of commitment to community and consumer participation in their hospitals. This Audit Tool has been developed for that purpose. The focus is on management issues at an organisational level, as well as at the department/ward level, rather than assessing the practice of individuals. The design of the Audit Tool has been based on the ACHS’s EquiP format, as many hospital staff have indicated that they are familiar with this format. Community and consumer participation is an integral part of the EquiP standards and criteria. Most of the criteria contained in this Audit Tool bear a relationship to the standards and criteria in the EquiP Guidelines (ACHS 1998).

This Audit Tool can be used by hospitals to determine:

- the level of organisational management commitment to community and consumer participation
- the range of activities being implemented at organisational and departmental/ward levels
- where to go next.
How to use the tool

How you use this Audit Tool will depend on how your hospital is structured and the resources you have available to undertake activities such as this. Some hospital staff have said that their quality manager or quality improvement consultant would undertake the organisational level (part 1) audit and co-ordinate the activity across the hospital, with each department/unit head being responsible for completing part 2 of the tool for their own area. Others have said that it could be part of the patient representative or project officer’s role, and they would expect that person to interview the relevant people across the organisation to complete both organisational and department/ward levels. Another person said that they would co-ordinate the activity in their role as quality improvement consultant, but would get staff in each of the departments/wards to complete the audit from their own perspectives. They were also considering asking some consumers who had a long-term relationship with the hospital and different departments/wards to complete some of the criteria that they thought would be relevant to their level of contact with the hospital. In this way they would have staff and consumer perspectives of key management issues. Others have said they would do the organisational level audit and then randomly select some departments/wards and work with them to complete the Audit Tool.

However you choose to use the Audit Tool, it is important that you determine beforehand why you are undertaking the audit and how you want to use the results. It is equally important that you clearly describe and justify your method as part of your report.

Rating the activity

This is a self-rating scale and is based on the EQuIP format.

<table>
<thead>
<tr>
<th>LA</th>
<th>Little achievement</th>
<th>EA</th>
<th>Extensive achievement</th>
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</thead>
<tbody>
<tr>
<td>SA</td>
<td>Some achievement</td>
<td>OA</td>
<td>Outstanding achievement</td>
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<tr>
<td>MA</td>
<td>Moderate achievement</td>
<td>N/A</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

What to do with the information

Once the information is gathered from the organisational and department/ward audits, it can be analysed and then reported to the board, senior management, staff and consumer groups you may have involved in the audit to enable them to determine where the organisation is positioned with regard to its commitment to, and activity in, community and consumer participation. The results can be used to identify the organisation’s strengths, as well as where the gaps and limitations are. The organisation will then be able to prioritise where the management efforts need to be directed if it chooses to develop an organisational approach to community and consumer participation.
## Part 1: Community and consumer participation – organisational level

<table>
<thead>
<tr>
<th>No</th>
<th>Criteria</th>
<th>Evidence of achievements</th>
<th>Self-rating</th>
<th>Action required and expected outcomes</th>
<th>By when</th>
<th>By whom</th>
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</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Has community and/or consumer participation been incorporated into the hospital’s vision, values and any other philosophical statements?</td>
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<td>1.2</td>
<td>Has the hospital clearly identified who their community and ‘consumers’ are?</td>
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<td>1.3</td>
<td>Has the hospital clearly identified the purpose and mechanisms for involving community members and consumers at different levels?</td>
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<td>1.4</td>
<td>How has the hospital involved community and consumers in a needs assessment? Are the strategic directions responsive to those identified needs?</td>
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<td>1.5</td>
<td>Who are the leaders, champions, or staff delegated with the responsibility for consumer participation? Are they easily identifiable with the organisation?</td>
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<td>1.6</td>
<td>Does the hospital has key consumer policies in place, such as:</td>
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<td></td>
<td>• consumer rights and responsibilities</td>
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<td></td>
<td>• complaints</td>
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<td></td>
<td>• consumer access to information</td>
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<td></td>
<td>• consumer participation?</td>
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<td>1.7</td>
<td>How do consumers find out about:</td>
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<td></td>
<td>• their rights and responsibilities</td>
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<td></td>
<td>• how to make a complaint or commendation</td>
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<td></td>
<td>• accessing information</td>
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<td></td>
<td>• information about how they are able to participate in the hospital? How are these processes monitored and evaluated?</td>
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<td>1.8</td>
<td>What staff education programmes are in place to support the implementation and maintenance of these consumer policies?</td>
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<td>1.9</td>
<td>What organisational resources have been allocated to support the incorporation of community and consumer views into strategic and service planning and review?</td>
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<td>1.10</td>
<td>What training and supports have been provided or accessed to enable consumers to participate effectively?</td>
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<td>1.11</td>
<td>Does the hospital have a consumer participation evaluation plan in place?</td>
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<tr>
<td>No</td>
<td>Criteria</td>
<td>Evidence of achievements</td>
<td>Self-rating</td>
<td>Action required and expected outcomes</td>
<td>By when</td>
<td>By whom</td>
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<td>1.12</td>
<td>Is consumer participation incorporated into job and position specifications?</td>
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<td>1.13</td>
<td>Are consumer participation effects and achievements incorporated into performance management and staff recognition processes?</td>
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<td>1.14</td>
<td>Is community and/or consumer input a part of key organisational decision-making processes?</td>
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<td>1.15</td>
<td>How does the hospital recognise the contribution of consumers to the organisation?</td>
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<td>2.1</td>
<td>Has the department/ward identified who its consumers are?</td>
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<td>2.2</td>
<td>Has the department/ward identified the purpose and mechanisms for involving consumers?</td>
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<td>2.3</td>
<td>Does the department/ward have a consumer feedback and participation plan in place?</td>
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<td>2.4</td>
<td>How are organisational consumer policies reinforced as part of department/ward management processes?</td>
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<td>2.5</td>
<td>What resources are allocated at a department/ward level for enabling consumer feedback and participation?</td>
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<td>2.6</td>
<td>What types of strategies are used to involve consumers in decision-making about care processes and service improvement at the department/ward level?</td>
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<td>2.7</td>
<td>Does the performance review of staff incorporate attitude towards, and achievements in, consumer participation in care processes and service improvement?</td>
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<td>2.8</td>
<td>Are staff supported to attend staff development programmes about consumer participation and consumer policy issues?</td>
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<td>2.9</td>
<td>What links and feedback mechanisms are in place with other departments/wards and service/groups outside the hospital to ensure consumer satisfaction with continuity of care?</td>
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<td>2.10</td>
<td>How have consumers participated in the development and evaluation of care pathways and consumer education/information resources?</td>
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<tr>
<td>No</td>
<td>Criteria</td>
<td>Evidence of achievements</td>
<td>Self-rating</td>
<td>Action required and expected outcomes</td>
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<tr>
<td>2.11</td>
<td>Does the department/ward have effective working relationships with key support/community groups associated with the consumer profile of their department/ward? Are staff aware of the key consumer issues for these groups, and do they have processes in place to jointly address these issues?</td>
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<td>2.12</td>
<td>How does the department/ward report on its consumer participation activities and outcomes? Has accountability for actioning consumer feedback been built into this reporting process?</td>
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Appendix B4: Consumer job descriptions

Disability Reference Group
Member’s Job Description

The job of the member:
The main job of the member of Council’s Disability Reference Group is to represent the interests of the broad community of people with disabilities in relation to Council’s activities, which includes its services, plans and policies.

The member will need to prepare for and attend the Reference Group meetings regularly (probably monthly) and make sure that information is passed to and from people with disabilities in the community and the Council.

Reference group members will:
• keep in touch with their disability groups
• read and comment on papers, policies and plans, and respond to these when needed
• contribute to submissions to policies and plans when needed
• find people with key skills or information on issues when the group does not have them
• build up a good knowledge of Council services as they relate to people with disabilities and give feedback to the Council or the community.

Reference group members will be able to:
• understand an issue and see the effects it may have on a wide range of people with disabilities
• represent disability issues in a broad sense, ie, more than the interests of a specific group
• build and maintain good relations with people with disabilities and Council staff
• use their knowledge and experience of working with issues of disability
• work co-operatively with the group to achieve agreed goals
• think of creative solutions and options for action on problems.
Glossary

Consumer
There are many terms used to describe the people who use or are potential users of a health and disability support service. ‘Consumer’ is an inclusive term covering those directly involved (patients), as well as carers, family and whānau (indirect consumers). This document uses the British National Health Service (NHS 2002) definition of consumers in health: ‘patients, carers, long term users of services, organisations representing consumers’ interests and members of the public likely to be the target of health promotion programmes’.

Consumer representative
A person nominated by and accountable to a constituency. A consumer representative is responsible for representing the views of the constituency they represent, and is accountable to that group for the position they take (McCrossin and Hyland 2001).

Constituency
Each community served by a District Health Board can be described as a constituency - a group served by a provider organisation. Within this broad constituency there will be sub-groups with specific needs forming more specific constituencies. The ability to recognise and engage the constituencies within the community is a key requirement of public health service providers (Ray and Hatcher 2000). Likewise each consumer representative must have a constituency to represent.

Credentialling
A process to assign specific clinical responsibilities (scope of practice) to health professionals on the basis of their training, qualifications, experience and current practice within an organisational context. This context includes the facilities and support services available and the service the organisation is funded to provide. Credentialling is part of a wider organisational quality and risk management system designed primarily to protect the patient. It is an employer responsibility with a professional focus that commences on appointment and continues throughout the period of employment (Ministry of Health 2001).

Expert service user
A person who has considerable personal experience of a particular service or clinical speciality, either as a patient or as a caregiver/family/whānau.

Layperson
This term has been used more in recent times to make it clear that the consumer representative provides a different perspective; in particular, they do not have the professional knowledge ascribed to health practitioners. This term is used in the Health Practitioners Competence Assurance Bill and highlights the need to clarify the perspective presented by the consumer.

Organisational capacity
The ability of an organisation to effectively ask for, support and use consumer advice.

Participation
Refers to an active relationship between the health and disability support service and the consumer. Rather than just gaining feedback, the process of participation enables consumers to work with providers in the evaluation and planning of services (McCrossin and Hyland 2001).
References


