

Metropolitan Health Services'
Community Advisory Committees

WORKSHOP REPORT

30 April 2002

**“Consumer and
Community Participation
in Metropolitan Health Services”**

Health Issues Centre

September 2002

ACKNOWLEDGMENTS

This report has been prepared by Health Issues Centre with funding through the Department of Human Service's Community Advisory Committee Support Project.

The Project Team consisted of Meredith Carter, Claire Kelly, Alex Butler and Helena Maher, with administration support ably led by Souzi Markos.

The Project Team would like to thank all the people who participated in the Workshop, the people on the Organising Committee and the people who made presentations to the Workshop. A special thanks goes to Mary Draper and Lesley Thornton from DHS, the CAC Chairs and the Resource Officers for commenting on early drafts of this report.

For further information contact Helena Maher on 03 9479 5827 or h.maher@latrobe.edu.au

Health Issues Centre Inc.
Level 5, Health Sciences 2
LA TROBE UNIVERSITY VIC 3086

 (03) 9479 5827 **Fax:** (03) 9479 5977

Email: hic@latrobe.edu.au

Website: <http://www.vicnet.net.au/~hissues>

TABLE OF CONTENTS

PAGE NO:

Acknowledgments	2
EXECUTIVE SUMMARY	4
INTRODUCTION	6
Background	6
Aims of the Workshop.....	7
CONCEPTUAL FRAMEWORK	8
PRESENTATIONS	10
Minister for Health.....	10
Department Of Human Services	10
Health Issues Centre	10
Community Advisory Committee Member	11
Best Practice Consumer Participation	11
Metropolitan Health Service Management.....	11
Community Advisory Committee Resource Officer.....	12
SCENARIOS	14
Scenario One.....	14
Scenario Two.....	14
Scenario Three	15
Concluding Comments From The Workshop.....	16
FINDINGS	17
Roles and Responsibilities.....	17
Communication.....	17
Membership.....	18
WORKSHOP EVALUATION.....	19
Benefits of the Workshop.....	19
Areas for Improvement	19
Recommendations for Further Activities	19
ISSUES FOR FUTURE DISCUSSION	21
APPENDICES	23
Appendix One: Organising Committee	23
Appendix Two: Workshop Agenda	24
Appendix Three: Evaluation.....	26
Appendix Four: Attendance List.....	28
Appendix Five: Workshop Scenarios	30
Appendix Six: Feedback and comment from CAC members.....	33

EXECUTIVE SUMMARY

This is the report from the workshop “*Integrating Consumer and Community Participation In Metropolitan Health Services*”, which was held on 30 April 2001. The workshop brought representatives from the Executive and Boards of the 12 Metropolitan Health Services together with members of the Community Advisory Committees, their Resource Officers and staff from the Department of Human Services and Health Issues Centre. The program included presenters, small groups working through scenarios and a final plenary session. Rather than developing a set of overall recommendations, the workshop report identifies recurring themes of the day, along with specific recommendations from the scenarios and the evaluation of the workshop. The priority issues have been summarised and arranged under five domains:

1. The community’s capacity to engage

- MHSs need local consumer registers, linked with the Consumer Nominee Program at Health Issues Centre, and more resources, training and support to assist with consultation and advisory processes.
- CACs need to be resourced to strengthen links and networks with the local community, and in particular with disadvantaged and marginalised groups within the population.
- CACs need to develop a Communication Strategy that identifies community needs and priorities and includes processes for reporting back to the community.

2. The skills and competencies of organisational staff

- MHSs undertake an audit of staff skills, and a Resource and Support Package about consumer and community participation in clinical practice and project development be developed for staff.
- Consumer and community participation be included in staff orientation and performance appraisal of all staff, including the Chief Executive Officer.

3. The dominant professional service culture within an organisation

- Communication strategies for planning and development of services include clear articulation of roles and responsibilities of CACs and Boards and relevant staff, and accountability processes of the MHS to the community.
- The development and planning of these strategies needs to include the identification of resources to ensure that they are comprehensive and sustainable.

4. The overall organisational ethos and culture

- CACs assist MHSs to develop guidelines for community consultation processes for planning service developments, and to monitor their implementation.
- MHS Boards be provided with training about the benefits of consumer and community participation and effective processes for integrating community participation into health services.

5. The dynamics of the local and national political systems

- The levels of funding for services, projects, professional development and training for staff determines the ability of MHSs to integrate consumer and community participation into health service development and delivery.
- Ongoing government support for consumer and community participation in health care needs to be secured.

INTRODUCTION

This is the report from the workshop “*Integrating Consumer and Community Participation In Metropolitan Health Services*”, which was held on 30 April 2001. The workshop brought representatives from the Executive and Boards of the 12 Metropolitan Health Services (MHSs) together with the Chairs and Resource Officers from the Community Advisory Committees (CACs), staff from the Quality and Care Continuity Branch, Department of Human Services (DHS), and from Health Issues Centre. The half-day workshop was facilitated by Health Issues Centre and began with a presentation from the Honourable John Thwaites MP Minister for Health.

The report provides a record of proceedings, summarising presentations from speakers, the discussion groups and the final plenary session. It includes practical strategies to guide MHS Boards, CACs and staff as they go about planning and implementing consumer and community participation in their service. The discussion of presentations and group sessions attempts to draw out the important policy issues that were discussed at the workshop. These issues are considered through a theoretical framework provided by a article written by Christine Pickin, and others, from a British perspective, “*Developing a model to enhance the capacity of statutory organisations to engage with lay communities*”. (This article was considered by the workshop’s planning group but was not part of the workshop deliberations.) Although the workshop finished without agreeing on recommendations, the final section of this report pulls together the issues and priorities that were identified at the workshop. CACs have been asked to provide feedback and comment (see *Appendix Six: “Feedback and Comment from CAC Members”*) on what the priorities are for the next stage of developing consumer participation in MHSs. These issues are identified for future discussion by the Department of Human Services, the Boards and CACs of the MHSs, to support the development of sustainable models of consumer and community participation in the Victorian health sector. Finally, the report finishes with five Appendices relating to the workshop program.

Background

The Community Advisory Committees were first established in 2001 as sub-committees of the Boards of Metropolitan Health Services. Non-statutory guidelines for MHSs were developed for the Department of Human Services to improve community participation in the Victorian health care system. Broadly, the Community Advisory Committees have been established to:

- assist MHSs to appropriately integrate consumer and community views at all levels of its operation, planning and policy development; and
- advocate on behalf of the community to the Health Service Board.

It is over 18 months since legislation was enacted to require MHSs to establish CACs as the formal structure for providing advice to Boards and senior management on consumer expectations of care in hospitals and other health services. The workshop provided an opportunity to reflect on the work of the CACs to date. The agenda was organised to provide an opportunity for people to discuss different approaches to how CACs identify and advocate for the needs of the community that they represent, and then to debate the issues and challenges of assisting MHSs to integrate consumer and community participation into health services.

The first stage of development, following the establishment of 12 MHSs, focused on convening the Community Advisory Committees and developing a Consumer Participation Plan for each MHS. As of May 2002, the 12 CACs have completed Draft Consumer Participation Plans to guide the Boards towards greater integration of consumer and community participation in the MHS. The workshop provided an opportunity to review progress to date and look at the next stage of development of consumer and community participation in their respective MHSs.

Aims of the Workshop

The aims of the workshop and its program of activities were developed in conjunction with advice from a Reference Group that included representatives from DHS, Health Issues Centre, health service management and staff, and CAC Chairs, members and Resource Officers¹. The Reference Group approved the following overall aims for the workshop:

1. to clarify the roles of the CACs, Boards and health service management in involving consumers and the community in improving the quality and safety of health care; and
2. to identify the issues that needed to be addressed so that consumer participation in MHSs is comprehensively integrated into health care.

¹ See Appendix One for the membership of the organising committee

CONCEPTUAL FRAMEWORK

In an article discussed by members of the Workshop Reference Group, Pickin (2000) et al. identified some of the challenges of actively involving communities in the decision-making processes of statutory bodies. While there is increasing acknowledgment of the importance of involving communities in health service policy development and implementation, Pickin argues that “the statutory sector appears to lack the organisational capacity to respond constructively to active communities”². The article traces patterns of successful and unsuccessful engagement between communities and health sector organisations and their staff, and the factors that constrain and facilitate effective partnerships. These factors can be grouped into five domains:

1. The community’s capacity to engage,
2. The skills and competencies of organisational staff,
3. The dominant professional service culture within an organisation,
4. The overall organisational ethos and culture,
5. The dynamics of the local and national political systems.³

While the paper is focused on the British context, its findings are relevant to the Australian setting. The elements in organisational change identified by Pickin are consistent with the experience of MHSs and CACs to date. For example, to help with the planning of the workshop agenda, MHSs were asked to identify key issues for the further development of their CACs. The responses can be sorted according to the five factors identified in the British research:

1. The community’s capacity to engage

- how to empower the CAC so it guides the organisation in developing a system that continuously receives consumer views.
- provision of health information and information re health service to the community.
- need to improve the understanding of consumer participation in the broader community.
- training programs for consumers.

2. The skills and competencies of organisational staff

- training for staff (particularly in the acute sector) with regard to the benefits of consumer/community engagement, as well as effective consumer and community participation strategies.

3. The dominant professional service culture within an organisation

- developing protocols for links between the Community Advisory Committee and Quality Committee to enhance continuous quality improvement and ensure duplication of effort is limited.
- how to cultivate an organisational culture that values and promotes seeking and responding to consumer/community views.

4. The overall organisational ethos and culture

- how to translate consumer views into organisational operations.
- education at a Board level.
- how models of effective consumer participation can be integrated into organisational processes.

² Pickin, C., et al. (2002) ‘Developing a model to enhance the capacity of statutory organisations to engage with lay communities’, *Journal Of Health Services Research and Policy*, Vol 7, no. 1, Jan. 2002, pp. 34-35.

³ *ibid.*, p.36.

5. The dynamics of the local and national political systems

- strategic directions for health in the State – policy directions – How does this link with the Health Service? Then the link with the Board and then the CAC?
- funding to employ project worker to focus on the many issues and further development of the CAC and the framework for good consumer participation.
- ongoing cost of supporting the CAC.

The five domains provide a framework for identifying barriers to integrating consumer and community participation into the health services. It is used later in this report to organise the issues identified for future discussion into strategic areas of activity.

PRESENTATIONS

The half-day agenda was organised to review the historical and conceptual framework for consumer and community participation, and then to provide opportunities for the participants to discuss and debate different approaches to embedding consumer participation into MHS. The workshop received presentations from the Minister for Health, the Department of Human Services, Health Issues Centre, a member of a CAC, an example of best practice consumer participation, a Resource Officer and a Chief Executive Officer from an MHS.

Minister for Health

The Honourable John Thwaites, Minister for Health, opened proceedings, reminding participants of the priority that the Victorian government gives to ensuring community needs are reflected in the daily business and long-term strategic planning of health services. The Minister emphasised the importance of having consumers who have direct experience of hospital care and other health services on CACs, and the need to ensure that people in the community know of the existence and work of CACs.

Department Of Human Services

Mary Draper is the Manager of the Effectiveness Unit, Quality and Care Continuity in DHS. Mary Draper reminded the workshop that CACs are only one mechanism for integrating consumer and community participation into health services. Ms Draper spoke about the need to understand the local community and health service when implementing mechanisms for consumer participation, that communities are not homogenous and so there may be disagreement and conflict about the priorities for the committee. At the same time, health services are large and complex organisations with diverse values and varying staff capacity to work in partnerships with consumers. Increased capacity among staff and management is becoming an essential requirement of the health workforce, as accreditation standards now require evidence of mechanisms for consumers to have input into improving an organisation's health services.⁴ Both consumers and staff need opportunities to develop skills and knowledge about how to work in partnership. Integrating consumer participation requires effort at all levels of the organisation, as well as practical and comprehensive communication, participation and reporting strategies.

Health Issues Centre

Meredith Carter, Executive Director of Health Issues Centre, spoke about the recommendations from the Ministerial Review of the Health Care Networks that delivered its report to government in 2000. This Review recommended that the Network Boards be dissolved and 12 MHSs be established with a structure, supported in legislation, that ensured that MHSs were governed as public health care organisations that are accountable to the community. Following the Review, the Health Services Act 1988 was amended to require MHSs to meet the needs of the community and take into account the views of users of health services⁵. The CACs were established as a formal structure for ensuring consumer influence in MHSs' decision-making processes,

⁴ *Australian Council on Health Care Standards EQUIP Standards and Guidelines:*

Guidelines - Leadership and Management

Standard 2.4 – The governing body is committed to consumer participation as a strategy to assist the improvement of quality, safe care and service.

2.4.1 – The organisation establishes mechanisms for involving consumers in planning, provision, monitoring and evaluation of the health service to support improvement

2.4.2 – information is readily available for consumers/patients so that they are informed of their rights and responsibilities

⁵ see s65S of the Health Services (Metropolitan Health Services) Act 1988

recognising that service quality and community accountability are as important as financial accountability and corporate governance in an effective public health system.

Community Advisory Committee Member

In the following panel session Mike Zafiropoulos, a CAC member from the Victorian Eye and Ear Health Service, took up the issues of accountability and transparency about advisory and decision-making processes. Mike Zafiropoulos reminded the workshop that in order to be successful, consumer and community participation needs to be recognised and valued by the Boards and senior management of MHSs. CACs are not the only mechanism for ensuring that a consumer perspective influences the decisions that are made about the health care system. While CACs are an important formal structure, they should not be seen as fully representing the diversity of community views. They could only reflect these views to a degree that varies, depending on the experience and linkages of the CAC membership. Like Ms Draper, he emphasised that communities are not homogenous and that consultation with different groups, such as young people or migrant communities, requires varying strategies. Therefore, it is important to develop community consultation processes that are wide-ranging and sustainable. Effective communication and consultation processes also require that the roles and responsibilities of CACs in MHSs are clearly articulated and capable of being implemented, and that their resource and training needs receive ongoing funding and support. In addition, there needs to be clear lines of accountability between Boards and CACs, including regular feedback on responses to the CAC's advice and recommendations, and between CACs and the community, so that consumers see the benefits of making a contribution.

Best Practice Consumer Participation

Lyn Swinburne is the National Coordinator for Breast Cancer Network Australia (BCNA). The BCNA's role is to empower, inform, represent and link together Australians personally affected by breast cancer. BCNA has developed a program of consumer involvement in decision-making about breast cancer services, policy and research. The Program, called "A Seat at the Table", recruits, appoints, trains and supports women with breast cancer to work with organisations seeking consumer input. The program includes a three-day advocacy and science training course to assist women to be effective and credible representatives. Lyn Swinburne discussed the challenges of recruiting representatives that reflect the diversity of the community of women affected by breast cancer. She said that some women have been keen to provide input and advice on their experiences and expressed interest in varying levels of involvement. In response to this, BCNA's consumer representative database distinguishes the different levels of involvement that women would like to have, such as committee involvement or becoming a spokesperson. Funding is crucial to the sustainability of involvement by consumer representatives. BCNA pays its consumer representatives to attend the training and coordinates a Consumer Education Grants Program to support women to develop their knowledge and skills. With this training and support, women can provide quality input and are more likely to be effective advocates, and organisations see the benefits in changing clinical practice and services.

Metropolitan Health Service Management

Stan Capp, the Chief Executive Officer of Southern Health, opened his presentation with a reminder that involving consumers in decision-making processes is empowering for the community and for professional staff. Southern Health's Community Participation Plan recognises that consumers form a continuum from patients, entitled to have a say in their health care, to the families, partners and carers of patients, and citizens with concerns for protecting and promoting health services in the public interest. Community participation has been integrated into Southern Health's operational plans, and clinical programs have been asked to identify areas where relationships with the community and consumers can be enhanced. Consumers are involved in:

- acute pain management program
- renal dialysis reference group
- project groups including ulcer prevention, falls prevention, breast services Young Person's Reference Group

- mental health services

Information and communication mechanisms are being evaluated in partnership with consumers, and processes for pre-admission, stomal therapy education and vascular surgery are under review. Stan Capp described the elements of Southern Health's Consumer and Community Participation Plan, where the strategic directions include:

- consumer participation in a range of clinical programs and projects
- orientation and training programs for consumers
- skills enhancement and cross-cultural awareness training for staff
- consumer and community participation is one of the performance indicators in staff appraisals, including that of the CEO.

Community Advisory Committee Resource Officer

Jennie Mullins was the Resource Officer for the Community Advisory Committee on Women's Health at the Royal Women's Hospital until June of 2002. Jenny Mullins reported on the consumer participation audit that was undertaken earlier this year at Women's and Children's Health (WCH). The audit was designed to identify areas of need and level of staff activity and support for consumer participation, while at the same time raising staff awareness of consumer participation. It also provided baseline data to evaluate changes in the health service's responsiveness to consumers.

A survey tool was developed with input from the respective site's CACs. Using a checklist format, staff were asked about recent and planned consumer participation activities and the benefits, drawbacks and barriers to involving consumers. All survey respondents could identify at least three consumer participation activities, even though these could be viewed at the passive end of the consumer participation continuum, typified by information-providing activities. During the previous 12 months, consumer feedback was mostly conducted informally or acquired verbally. Staff indicated that for the next 12 months they were most interested in using:

- written surveys of consumers
- focus groups
- forging closer community links.

The majority of respondents agreed that the main benefit of consumer participation was improved service delivery through development of services that are more responsive to consumers' needs. The main drawbacks related to slowing down more important clinical activities that staff believed take precedence, and fears that consumers' expectations are unrealistic and that they will not be able to meet these expectations in the current environment. Staff showed a strong commitment to wanting to improve their skills in this area, despite the main barriers to consumer participation being identified as:

- limited resources, staff time, budget allocation and other resources such as administrative support, costs for consumers;
- staff attitudes which don't hold it as central to service delivery and a perceived lack of skill;
- limited access and protocols for recruitment of consumers;
- language and cultural barriers; and
- the absence of a centralised coordinating program and integrated consumer feedback system.

The most frequently requested resources were for staff development in relation to consumer participation strategies, especially in the form of feedback from others on useful strategies. In addition, a high proportion of staff indicated the need for adequate budget allocation to conduct such activities, and time specifically set aside to do so. A designated support role within the hospital was strongly supported, as was building criteria into quality improvement processes for all programs. WCH has used the findings gained from the audit to guide the priority areas for their Community Participation Plan and to inform resource allocation decisions in the health service.

The Presenter's Session provided participants with an overview of the policy environment for consumer and community participation in Metropolitan Health Services, and some of the complexities that follow from the CAC initiative. The practical examples of training consumers, undertaking audits in hospitals and integrating community participation into the development of projects and programs will be a useful reference for MHSs and CACs, as they consider strategies for implementing their consumer participation plans.

SCENARIOS

In order to discuss and debate issues around the roles and responsibilities of CACs, the Workshop Organising Committee developed three scenarios for participants to work through. Everyone was allocated to a small group, which was made up of a mix of MHS Board and CAC members, as well as DHS and Health Issues Centre staff. The scenarios presented situations and problems that might confront an MHS and its CAC. The scenarios addressed:

1. Consumer nominees to committees within the health service.
2. Complaints and adverse events.
3. Resource allocation and service planning.

Scenario One

The first scenario prompted people to think about the role of a CAC, and how it works with the Board and with service development processes in the health service. In doing so, it opened up debate about the parameters of the CAC's advisory role, and the relationship between the CAC and the community.

People identified CACs as important to changing the culture of hospitals in relationship to consumer and community participation. This requires that all stakeholders (CACs, Boards, MHS staff and other advisory bodies such as the quality committees), are clear about the role of CACs. It is important to understand that CACs are not the sole source of advice to the Boards, and that it is not necessary for CAC members to personally try to fill all high level consumer/community nominee requirements. CACs provide a formal structure and planning to support and facilitates consumer perspectives in decision-making throughout the organisation. CAC members provide an important contribution to MHS service design and development, through identifying gaps in service delivery, for making a strategic contribution to planning in the early stages, and for identifying areas that would benefit from increased cooperation and assistance. Consumer Participation Plans provide a framework for this to happen in a strategic rather than ad hoc fashion. CACs have an important role in being a conduit between the community and MHS decision-making processes. They complement and reinforce the value of consumer voices — on the Quality Committees, for example — but do not replace these appointments on committees. A formal structure is also important to the process of increasing MHSs' accountability to the community.

The discussion emphasised that responsibility for ensuring that the decisions of a hospital take account of community needs and perspectives rests with the Board, not the CAC. Following clarification of the role of CACs, the discussion identified several mechanisms for integrating the works of CACs with pre-existing committees that include consumer representatives. These mechanisms include:

- participating and advising on a Communication Strategy
- developing protocols between key committees, in particular the CAC and the Quality, Primary Care and Population Health Advisory Committees
- holding joint meetings, where appropriate
- participating in joint planning sessions.

One group said it was important to retain some flexibility with decisions and mechanisms for making appointments. The final suggestion from the discussion of this scenario was to develop or link into a "bank" of consumers within health services who would be willing to serve on committees, or to replace retiring consumers.

Scenario Two

Scenario Two also focused on the importance of clarifying the roles of all stakeholders in MHSs. In considering adverse events and complaints processes, all the groups agreed on the need to define the roles of MHS Boards and CACs in responding to these events. This work needs to be done before, rather than in reaction to, a crisis. One group thought that the CAC needed to

facilitate good relations between health services and the community. Another group commented that many people were motivated to join CACs to try and address issues such as inadequate services, access problems or discourteous care in health services.

The management of the complaints process drew attention to the important role of CACs in facilitating communication between a community and its MHS, and the underlying assumption that the CAC will advocate consumer needs and expectations to the Board. Complaints processes are an important element in improving the quality of hospital care and other health services. The groups that discussed Scenario Two recommended that:

- MHSs seek CAC advice and input into the complaints process.
- CAC members be well informed of complaints processes, trends in complaints and the responsiveness of MHS to consumer concerns.
- MHSs seek CAC advice and input into its risk management strategies.
- MHSs seek CAC assistance in identifying the issues of priority to consumers and advice on the appropriateness of proposed responses.

In addition, the discussion recommended that CACs and MHSs develop a document about the roles of CACs and Boards and how they will communicate and manage crises, including adverse events, at the hospital. This needs to include a statement of commitment to two-way communication between the CAC and Board, commencing at the earliest stages of the planning process, and processes for consulting with and reporting back to the community.

Scenario Three

The third scenario led to group discussion about planning and consultation processes, and the training needs of the different stakeholders in the process. There was a clear view that resource allocation decisions should be made on the basis of the needs and priorities of the community. Changing demographics, burden of disease data and feedback from consumers all need to be taken into account in resource allocation and planning decisions.

The groups agreed that major changes, such as the relocation of a service, should be discussed with users, and other consumers and community groups as well as service providers, before any decisions are made. The resources and time required to undertake these consultations should be built into the planning processes. MHSs need to have a process whereby communities can inform CACs about what the priorities are, and that the needs of specific groups in the community, such as young people, receive particular attention. There was some discussion about whether CACs have a purely advisory function, or if the role includes an implementation component. This discussion raised questions about the need for CACs to be, for example, resourced to meet with the community and to research priority issues. Other groups were clear that the CAC's role was advisory and that the MHS was responsible for consulting the community about its decisions. It is important that CACs have strong links to different community groups to guide MHSs' communication and consultation process, and to evaluate these processes. There are many ways of consulting with the community, including:

- targeting specific service users and their carers
- consulting service providers and peak bodies
- outreach consultations to ensure the health needs of all groups in the community are understood
- conducting focus groups to identify the needs of, for example, young people in the community.

The discussion also identified a range of forums for communicating with the community:

- local papers, radio
- local services/groups

- local government
- public meeting and meetings with existing community groups.

The groups agreed that CACs and Boards need to have mechanisms for reporting and feedback, and that a consumer “bank” may help with facilitating community consultations.

The role of the CAC in planning and implementation should include focusing on the needs of the population. The CAC needs to provide information to the Board about access problems, or the range of services that are available outside the MHS. Again, the scenario discussion reiterated that CACs are not the only mechanism for consumer participation. The CAC can provide important, but not necessarily comprehensive, links to the community and information about quality of care and community expectations. The Boards, CEOs, CACs and staff rely on accurate and timely information, communication and feedback in order for consumer and community participation to be integrated into the MHS. Training and support was important for staff, to implement change at an organisational level. Health Issues Centre was identified as a possible provider of training, and participants were interested in learning from other models of engagement in the mental health and community health sector.

In summary, it was clear from the scenario discussions that there are significant differences in the stages of development of CACs. Participants were concerned to ensure that the committees are sustainable, and were very interested in different examples of tools and activities that build consumer and community participation in health services. The issues raised in discussion of the scenarios are addressed in the findings section of this report.

Concluding Comments From The Workshop

Judith Couacaud-Graley, (Chair of Peninsula Health CAC), Colleen Pearce (Northern Health CAC) and Mary Draper provided concluding comments to the workshop. People involved in integrating consumer participation must recognise that change involves a commitment of effort, resources and time from all players. CACs should be part of the core business of MHSs, and they need to focus on achieving practical results for the community. The three speakers affirmed the need for training for CAC members and health services staff.

FINDINGS

Roles and Responsibilities

The issues debated in the group discussion of the scenarios suggest that there is still some confusion about the role of the CAC. For example, does the CAC represent the community and speak on behalf of the community or is it a conduit between the MHS and the community? A related question is whether the role of the CAC is to advise or to implement decisions?

Under amendments to the Health Services Act, MHSs are required to respond to community needs, priorities and perceptions in developing and delivering health care. CACs provide a formal structure to help this to occur, and they have an important role in increasing the accountability of MHS to the community and transparency of MHS decision-making. However, CACs cannot provide comprehensive consumer and community representation, and must be regarded as only one process of facilitating consumer input into MHSs.

The CAC should not represent the sole response of the health service to its responsibility to engage the community. The CAC should not displace existing structures and processes for consumer and community involvement.⁶

The responsibility for integrating consumer and community participation in an MHS rests with the Board, who has delegated development, monitoring and evaluation functions to the CACs. Consumer and community participation is core business for MHSs, and this needs to be reflected in the resources allocated to integrating consumers into decision-making processes. CACs are not resourced to undertake community consultations. CAC's work will consist of:

- Responding to MHS requests for advice and direction on specific policy, planning and service delivery issues currently being considered by the health service.
- Representing community views and advocating community priorities to the MHS.
- Reporting back to the community about the MHS's work in addressing community concerns.

It is likely that some CACs are still clarifying their roles in relation to the MHS staff and Board. Some CACs are confident to provide advice on consumer and community issues to their Boards, and a few CACs are actively setting agendas for the strategic development of health services.

Communication

The work of CACs is both proactive and responsive. It relies on timely access to information to facilitate effective decision-making. The guidelines describe CACs as having a responsibility to "assist with two way communication between the health service and the community."⁷ The effectiveness of the CAC will depend on its credibility with the community, its engagement with the Board and Executive of the MHS, and its ability to facilitate good communication between hospitals, consumers and the community. It is clear from the workshop that health service Boards and executive staff are supportive of the work of CACs. The range of relationships that the 12 CACs have with the communities they represent is less clear, as is the impact of their work on increasing the accountability of MHSs to the community. Finally, formal processes for ensuring systematic information exchange between CACs, Health Service Quality Committees, Primary Care and Population Health Advisory Committees, and other consultation processes involving consumers and the community in health service decision-making processes, were identified as lacking.

⁶ Health Issues Centre & Corrs Chambers Westgarth (2000) *Community Advisory Committee Guidelines Non-Statutory Guidelines for Metropolitan Health Services* Acute Health Division, Department of Human Services, Victorian Government, p.3

⁷ *ibid.*, p.7.

Membership

CAC membership involves a specific set of skills and knowledge about the health service, the community that it serves and a familiarity with meeting processes, advocacy and advisory requirements.⁸ Some CACs report difficulty in attracting and retaining members. The need for training and support was a recurring theme throughout the workshop. It is not clear how many MHSs have formal orientation programs or mentoring arrangements to support their CAC members. There was a suggestion that MHSs need their own consumer “banks” with links into the Consumer Nominee Program at Health Issues Centre. There is a concern among some CACs to ensure that their membership reflects the diversity in the community. The guidelines for CACs make it clear that while members need to have the capacity to link health services with community networks, speakers at the workshop reiterated the importance of MHSs undertaking comprehensive consultation processes that were broader than simply seeking advice from the CAC membership.

⁸For a description of the skills and expertise required for effective consumer participation see Carter M., & Maher H., (2002) Issues Paper on Consumer Payments, available from Health Issues Centre

WORKSHOP EVALUATION

An evaluation form was developed and included in the folder of papers given to all participants before the workshop began. The evaluation had a return rate of 42 from a possible 92 participants (46%).

Benefits of the Workshop

Results from these evaluations indicate that most people found the workshop to have been “useful” (22) or “very useful” (13). Each of the four sessions was mentioned in people’s feedback about the most useful aspects of the day, and the scenarios were the most popular. People also enjoyed the opportunity to:

- network
- share information
- hear a broad range of views
- discuss the practical issues around representation, training and consumer participation.

These results were reinforced in the evaluation of each of the sessions.

	Very useful	Useful	Undecided	Not useful
Overview	22%	55%	7%	17%
Speaker’s panel*	41%	48%	7%	2.4%
Discussion groups	50%	24%	12%	5%
Plenary^	29%	57%	7%	2.4%

(*one response & ^two responses not given to these questions)

Areas for Improvement

When asked to nominate the least useful aspect of the day, some participants (13) either gave no answer or made comments such as “ all useful”. The other (25) responses volunteered a range of critical comments about the workshop:

- a half day was too long, too short, or it started too early
- not clear why presentations covered information that was already known
- very professional oriented and not interesting for average “punter”
- insufficient time for discussion in the groups, not sure what the aim of the discussion was, or went over familiar ground
- the speakers’ panel was unfocused.

As well as helpful feedback about the lack of focus of some presentations, the other criticisms reinforce the impression of different levels of familiarity with and confidence to manage issues of consumer participation among the members of Boards and CACs.

Recommendations for Further Activities

People made wide-ranging suggestions in answer to the question about other information, training or support issues that could be addressed by Health Issues Centre. The suggestions covered:

- Representative membership and supporting diversity on CACs, educating the community about rights, involving consumers and the community in MHS.
- Training and support for CAC members, for example negotiating with Boards, input into service planning, understanding the way decisions get made in hospitals.
- Training for staff and Board members.
- Information about the funding and support available to CACs, responsive administrative processes for paying consumers for attendance.

- More information about Consumer Nominee Programs and how to develop registers of people prepared to serve as consumer/community members on MHS committees.
- Information about models of successful consumer participation.
- Opportunities for CACs to meet.
- More formal guidelines.
- Access to relevant information in the ACHS Health Care Standards and Guidelines and the Health Services Act.
- Information about roles and responsibilities of Minister, CEO, Boards, Department of Human Services.

There were 30, of a possible 42, responses to the question about how to address these issues, and some people gave multiple suggestions. The majority indicated that they would like these issues to be addressed through:

- More training and information, either as presentation/discussion with staff/board/consumers on site at MHS, or another workshop, or a formal training program.
- People also wanted information by mail or email or both. Three responses supported a telephone support helpline.

These issues will be taken up in the final section of the report.

In summary, the evaluation responses suggest that participants found the workshop useful. The sessions raised or clarified important issues around consumer and community participation in the MHS. Through the process of debate and discussion, participants recognised that the community, CACs, MHS Boards, management and staff need further information, training, funding and support to ensure that consumer and community participation is integrated into the health system.

ISSUES FOR FUTURE DISCUSSION

The issues and priorities from the workshop have been grouped according to the five domains identified by Pickin et al. (2000), referred to earlier.

1. The community's capacity to engage

- MHSs and CACs develop a selection criteria for membership of CAC and other consultation and advisory processes within the health service.
- CAC membership selection criteria should include recruiting people with direct experience of hospital care.
- MHSs include consumer participation strategies in the planning of clinical programs and projects, as well as the larger strategic infrastructure and policy developments.
- Consumer participation in MHSs be enhanced through the development of local consumer registers and that MHSs' develop links with the Consumer Nominee Program.
- MHSs develop resources, training and support to increase the capacity of members to voice consumer and community priorities and needs to MHS.
- Health Issues Centre develop training programs for consumers and expand its Consumer Nominee Program.
- MHSs develop an orientation program to the health services for consumers and advisory committee members that includes information about the legislative amendments that created the MHS.
- CAC members be given resources to strengthen links and networks with the local community, and in particular with disadvantaged and marginalised groups within the population.
- A Communication Strategy be developed to fulfil public accountability requirements, including processes for identifying community needs and priorities, and annual reporting.
- CACs be updated on the work of consumer participation strategies within the MHS and that there be formal opportunities for joint meetings and information sharing sessions.
- CACs advise MHSs on comprehensive community consultation processes.
- Regular meetings of CAC and MHS Board members, including DHS and HIC participation, be convened to network, discuss and debate developments in the integration of consumer and community participation in health services.
- DHS sponsor meetings between CACs and other "models of engagement" in the mental health and community health sector.

2. The skills and competencies of organisational staff

- MHSs/DHS develop a resource and support package for staff development of consumer and community participation in clinical practice and project development.
- MHSs undertake an audit of consumer and community participation.
- MHSs undertake an audit of staff skills in working in a cross-cultural environment and of community development methods for planning and consultation.
- MHSs improve staff capacity to support consumer and community participation in their recruitment and professional development.
- Orientation for new staff include information about:
 - policy and processes for consumer and community participation in health services
 - accreditation requirements and standards
 - complaints process and adverse events
- Consumer and community participation be included in performance appraisal of all staff including the CEO.

3. The dominant professional service culture within an organisation

- Communication strategies for planning and development of services include clear articulation of roles and responsibilities of CACs and Boards and relevant staff.

- These strategies need to include the identification of resources to ensure that they are comprehensive and sustainable.
- A document be prepared by MHSs in consultation with the CACs that sets out the roles and responsibilities of CACs and MHSs when crises, complaints and adverse events occur.
- That communication protocols be developed between consumer advisory bodies within health services.
- A document be developed that describes the information, participation and accountability processes of the MHS to the community.
- Resource and development requirements to support consumer and community participation in health services are identified in annual health service budgets.

4. The overall organisational ethos and culture

- Resource allocation decisions be made on the basis of need and priorities of the community.
- CACs assist MHSs to develop guidelines for community consultation processes for planning service developments and processes to monitor implementation.
- Boards need training, and this may include:
 - the policy basis, governance issues and evidence for effectiveness of consumer and community participation
 - inviting members from specialist CACs (e.g. BreastScreen, maternity services) to discuss membership and representation issues with MHS CACs
 - presentation from the National Resource Centre for Consumer Participation in Health
 - boards and CACs working through each of the scenarios from the workshop
- MHSs report annually to the Minister and the community regarding consumer and community participation activities in the health service.
- Chief Executive and/or senior managers attend CAC meetings.
- MHSs develop clear processes for reporting back to CACs on advice and issues that have been raised.

5. The dynamics of the local and national political systems

- Funding for health services, and especially for hospitals, is subject to negotiations between the Commonwealth and states under the Health Care Agreements.
- There are major public health debates going on around private health insurance, public liability, quality and safety, and the impact of an ageing population on service delivery
- Consumer and community participation needs to be integrated into the education and training of health professionals.

APPENDICES

Appendix One: Organising Committee

- Mary Draper - Manager, DHS
- Lesley Thornton - Project Officer, Effectiveness Unit, DHS
- Kathy Alexander - CEO, Women's and Children's Health
- Fiona Smith - CAC Chair, Royal Victorian Eye and Ear
- Stan Capp - CEO, Southern Health
- Jeni Lee - CAC Chair, Bayside Health
- Antoinette Mertins - Resource Officer, Northern Health
- Jane Gilchrist - Resource Officer, Melbourne Health
- Judith Couacaud-Graley - CAC Chair, Peninsula Health
- John Rasa - Chief General Manager Acute Services, Eastern Health
- Meredith Carter - Executive Director, Health Issues Centre
- Claire Kelly - Project Officer, Health Issues Centre

Appendix Two: Workshop Agenda

8.45 am *Registration and Coffee*

9.00 am *Welcome*

Meredith Carter, Executive Director, Health Issues Centre

9.05 – 9.15am The Honourable John Thwaites, MP, Minister for Health

9.15 - 9.45am Mary Draper, Manager, Effectiveness Unit Quality & Care Continuity Branch, Metropolitan Health and Aged Care Services, Department of Human Services

- overview of Workshop aims and objectives
- conceptual overview of consumer/community participation

Meredith Carter, Executive Director, Health Issues Centre

- Networks Review Panel recommendations for Community Advisory Committees

9.45 - 10.45am **Panel : Embedding consumer and community participation in core business**

- This session aims to explore the strategic role of CACs in planning and organisational change in Metropolitan Health Services

Panel Chair: Jeni Lee, CAC Chairperson, Bayside Health

Mr Mike Zafiropoulos, CAC member, Royal Eye & Ear Health Service

- Expectations of CAC members of their role, relationship to the MHS Board and Strategic Planning

Lyn Swinburne, Chair, BreastCare Victoria Advisory Committee

- Potential roles for CAC's in changing clinical practice

Stan Capp, CEO Southern Health

- Adopting a strategic approach and considering Community Participation in Resource Allocation

Jennie Mullins, Resource Officer, Royal Women's Hospital

- Learnings from the Audits undertaken at Royal Women's and Children's Hospitals

Questions from the floor

10.50 - 11.05 am *Morning tea*

11.05 - 11.50 am *Discussion Groups*

This session aims to provide an opportunity for Community Advisory Committee Members, Board Members and CEOs to work together to explore issues and possible outcomes raised by one of three scenarios based on the Workshop theme and the issues noted by Health Services.

11.50 - 12.45 pm *Plenary*

Chairperson : Noala Flynn, CAC Chair Peter MacCallum

- This session will incorporate feedback from each small group (approx 3 mins per group x 9 groups each identifying 3 key points)

12.45 - 12.5pm *What have we learned?*

Judith Couacaud-Graley, CAC Chair Peninsula Health

Colleen Pearce, CAC member Northern Health

12.55 - 1.00 pm *Where to from here?* Mary Draper, DHS

1.00 pm *Lunch*

Appendix Three: Evaluation

Q1. Overall, how useful did you find the workshop? (please tick)

Very useful	Useful	Undecided	Not useful
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q2. What did you find the most useful aspect of the day, and why?

Q3. What was the least useful aspect of the day, and why?

Q4. Individual Sessions:

Session 1 : Overview

Very useful	Useful	Undecided	Not useful
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Session 2 : Speakers Panel

Very useful	Useful	Undecided	Not useful
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Session 3 : Discussion groups

Very useful	Useful	Undecided	Not useful
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Session 4 : Reporting back and Plenary

Very useful	Useful	Undecided	Not useful
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q5. Have you identified any other information, training or support issues you would like addressed by Health Issues Centre in relation to consumer participation? If yes, please specify.

Q6. How would you like these issues addressed?

- Information by mail?
- Information by email?
- Telephone support helpline
- Presentation / discussion with staff / Board / consumers on site at MHS?
- Other or detail re above ? Please specify

Thank you for taking the time to complete this Evaluation and Feedback Form.

**Claire Kelly
Research and Policy Officer
Health Issues Centre**

Appendix Four: Attendance List

NAME	ORGANISATION
Lyn Swinburne	BreastCare Victoria
Marie Ellis	Austin & Repatriation Medical Centre
Mark Petty	Austin & Repatriation Medical Centre
Sue De Gilio	Barwon Health
Alison Duncan-Marr	Bayside Health
Christine Petrie	Bayside Health
Mike Kennedy	Bayside Health
Jeni Lee	Bayside Health
Linda Sparrow	Bayside Health
Natalie Savin	Dental Health Services Victoria
Sue Sestan	Dental Health Services Victoria
Mary Draper	Department of Human Services
Laure Graham	Department of Human Services
Kate Silburn	Department of Human Services
Lesley Thornton	Department of Human Services
Robert Chong	Eastern Health
Glenice Freeman	Eastern Health
Graeme Kelly	Eastern Health
Andrea McCance	Eastern Health
Alison Rule	Eastern Health
Grace Tham	Eastern Health
Gabrielle Hickey	Eastern Health
Claire Kelly	Health Issues Centre
Souzi Markos	Health Issues Centre
Gillian Halliday	Health Issues Centre
Marilyn Beaumont	Melbourne Health
Bill Deveney	Melbourne Health
Frank Fisher	Melbourne Health
Chris Gibbs	Melbourne Health
Jane Gilchrist	Melbourne Health
Paul Kent	Melbourne Health
Melanie Raymond	Melbourne Health
John Thwaites	Minister for Health
Jim Berg	Northern Health
Kaye Cole	Northern Health
Lucy Isivic-Miklic	Northern Health
Koon Leung	Northern Health
Claire MacKinlay	Northern Health
Colleen Pearce	Northern Health
LeeAnne Clavarino	Peninsula Health
Judith Couacaud-Graley	Peninsula Health
Andrea Delahoy	Peninsula Health
John Jukes	Peninsula Health
Jim Kerrigan	Peninsula Health
Peter Turner	Peninsula Health
Elizabeth Wilson	Peninsula Health
Noala Flynn	Peter Mac Cancer Institute
Geoffrey Conrad	Peter Mac Cancer Institute
Heather Scovell	Peter Mac Cancer Institute
Heather Lampshire	Peter Mac Cancer Institute
Joanne Moss	Peter Mac Cancer Institute

Alan Nicholls	Peter Mac Cancer Institute
Kate Parke	Peter Mac Cancer Institute
Robyn Quigley	Peter Mac Cancer Institute
Cathy Balding	Royal Victorian Eye & Ear Hospital
Trish Hall	Royal Victorian Eye & Ear Hospital
Graeme Houghton	Royal Victorian Eye & Ear Hospital
Graeme Ryan	Royal Victorian Eye & Ear Hospital
Jennifer Shaw	Royal Victorian Eye & Ear Hospital
Reg Shelly	Royal Victorian Eye & Ear Hospital
Fiona Smith	Royal Victorian Eye & Ear Hospital
Mike Zafiroopoulos	Royal Victorian Eye & Ear Hospital
Robyn Batten	Southern Health
Stan Capp	Southern Health
Meredith Carter	Southern Health
Nick Collins	Southern Health
Naim Melhem	Southern Health
Garry Richardson	Southern Health
Cherie Slater	Southern Health
Jan Whitaker	Southern Health
Charles Griss	St Vincent's Hospital/Sisters of Charity
Eileen Hannagan	St Vincent's Hospital/Sisters of Charity
Cathy Jones	St Vincent's Hospital/Sisters of Charity
Mary Pearson	St Vincent's Hospital/Sisters of Charity
Anne Hastie	Western Health
Katrina Kincade	Western Health
Phong Nguyen	Western Health
Kathy Alexander	Women's & Children's Health
Elaine Canty	Women's & Children's Health
Tricia Greenway	Women's & Children's Health
Stephanie Lagos	Women's & Children's Health
Joan McMeekan	Women's & Children's Health
Christine Minogue	Women's & Children's Health
Sue Morrell	Women's & Children's Health
Jennie Mullins	Women's & Children's Health
Cas O'Neill	Women's & Children's Health
Christine Walker	Women's & Children's Health

Appendix Five: Workshop Scenarios

Scenario 1

The purpose of this scenario is to discuss issues in relation to the effective functioning of the Community Advisory Committee and to clarify the role of the committee and its relationship with the Health Service Board and Executive Management.

Background

The Big City Health Service Community Advisory Committee has been in place for 12 months. The first meeting of the Committee was held in April 2001. The Committee has been meeting bimonthly with the first 2 -3 meetings being predominantly taken up with orientation. The Committee now feels it has a reasonable understanding of how the health service operates and is keen to contribute. At the last meeting the chair of the CAC reported back to the committee on the Boards response to recommendations made by the committee. The committee was informed that the Board had decided not to appoint a member from the Community Advisory Committee to each of the key committees within the health service such as the ethics committee, the quality committee and others. In responding to the recommendation the Board pointed out that a number of these committees already have consumer representation.

Questions for discussion

- a. What value do you see in having a Community Advisory Committee member on the various committees?
- b. Given the Board's decision, what should be the relationship between the Community Advisory Committee and the various committees?
- c. How could the work of the Community Advisory Committee and the pre-existing consumer representatives on the various committees be integrated?
- d. When the existing consumer representatives retire, should they be replaced by CAC representatives?

Scenario 2

The purpose of this scenario is to discuss issues in relation to the effective functioning of the Community Advisory Committee and to clarify the role of the committee and its relationship with the Health Service Board and Executive Management.

Background

The Big City Health Service recently experienced an outbreak of *veryinfectiousdisease*, which forced the closure of two surgical wards. The cause of the outbreak was traced back to a member of staff. This was widely reported in the newspapers with considerable criticism of the health services staff screening procedures. A woman whose surgery had been postponed as a result of a recent outbreak approached a member of the Community Advisory Committee member with about the postponement of her surgery and how distressed she was by it. The committee member felt it was important to respond to the concerns and raised the matter at the next Community Advisory Committee meeting. After some discussion at the meeting it was decided to put a recommendation to the board. The recommendation outlined some strategies for improving staff screening procedures and suggested that woman should receive priority in the rescheduling of her surgery. This recommendation was tabled at the next Board meeting. This proved contentious

with some members of the Board finding the recommendation contained some useful suggestions others held the view that this was a management issue and therefore it was not appropriate for the CAC to be making recommendations.

Questions for discussion

- a. With respect to the woman's request that her rescheduled surgery be given priority, what do you think would have been the appropriate response for the Community Advisory Committee to make? To the consumer, the Board, hospital management?
- b. What response do you think the Board should make, to the CAC, to management?
- c. How should the Board have responded to the CAC's recommendations about staff screening?
- d. What arrangements (if any) should be in place to brief and involve the CAC in the case of any future crises at Big City Health Service?

Scenario 3

The purpose of this scenario is to look at:

1. Effective processes for involving communities in planning for service development
2. Building community capacity to respond to requests for input and advice from hospital boards and advisory committees
3. The practical steps involved in MHS' Boards of Management and Community Advisory Committees working together, and
4. The appropriate roles and responsibilities of the Board and CAC in hospital decision-making processes.

BACKGROUND

SeaChange Metropolitan Health is located in the outer suburbs of Melbourne, with a catchment area extending around Port Burke Bay. The service is made up of a mix of three hospitals, drug and alcohol services and an aged care and rehabilitation service that includes two nursing homes. Its Community Advisory Committee has been established for eighteen months, and has had some difficulties attracting members that reflect the diversity of people in the community. SeaChange Health provides emergency, medical, surgical, primary care, aged care and rehabilitation services, as well as being the main provider of drug and alcohol services for outer south eastern suburbs and Bushland. Its catchment area is made up of a mix of people retiring to the peninsula, new communities of migrants and large numbers of unemployed and underemployed young people. Demographic projections show that in five years there will be larger than average increases in residents over 65 and under 18.

St Finnegan's is the largest of the SeaChange hospitals, with 290 beds. The hospital's Emergency Department has the highest number of drug overdoses in Victoria, and the surrounding suburbs have a reputation for drug trafficking and related crime. The hospital has attracted a world-renowned specialist in neurological disorders, including epilepsy and stroke, and wants to build up its neurological department. To do this, the Board of SeaChange Health are proposing that St Finnegan's inpatient drug treatment services be relocated to a community setting. The Board is keen to maintain its high standing in the community and to ensure that there is broad community support for these decisions, and wants to use the Community Advisory Committee in this process.

Questions for discussion

6. How are the health needs of the Port Burke Bay and Bushland communities identified and what are the processes for prioritising resources to meet these needs?
7. How is the Board going to ensure that affected groups are consulted about the proposed relocation decisions and that there is general support from the community for its priorities?
8. What role would the CAC play in the planning and implementation of this relocation?
9. What are the responsibilities of the Board, its Chair and CEO, the CAC, its Chair and its Resource Officer in these processes and what training and support is needed to fulfil these responsibilities?
10. Is there a role for the population health and primary care committee, and/or the local primary care partnership?

Appendix Six: Feedback and comment from CAC members

The April 30th Workshop brought CAC members together with board members and staff from MHS. The workshop was an opportunity to debate and discuss the development of the CACs and issues that are affecting the integration of consumer and community participation in Metropolitan Health Services. Prior to the Workshop Report being finalised, Health Issues Centre is seeking feedback and comment from CACs on;

- What are the priority areas for CACs?
- Suggestions for strategies to address these priorities
- Mechanisms for implementing these suggestions

What are the priority areas for CACs?:

CAC members are asked to provide feedback and comment on which of the following suggestions, proposed at the workshop should be presented to DHS as recommendations for the future development of CACs. Could you please indicate, in the left-hand column of the table below, your views about each suggestion using the following key.

Key for Responses	
✓	I agree with the suggestion
✓✓	I think this should be a priority
x	I disagree with the suggestion

The suggestions from the workshop have been grouped according to five areas, as discussed earlier in this report.

1. The community’s capacity to engage

	In order to improve consumer participation, CACs need to be supported to develop stronger links with the community, and in particular with disadvantaged and marginalised groups within the population
	A Communication Strategy that identifies community needs and priorities and includes processes for consulting with and reporting back to the community
	Training and orientation programs about CACs in MHSs for potential CAC members
	MHSs develop local consumer registers, linked to the Consumer Nominee Program at Health Issues Centre
	OTHER:
	OTHER:

2. The skills and competencies of organisational staff

	MHS dedicate resources to improve staff capacity to develop and implement services and programs in partnership with consumers and the community
	Consumer and community participation be included in staff orientation and performance appraisal of all staff
	MHS orientation programs include information about policy and processes for consumer and community participation in health services
	OTHER:
	OTHER

3. The dominant professional service culture within an organisation

	That a Communication Strategy be developed by MHSs, in consultation with the CACs, that describes community consultation policy and processes within the health service,
	This needs to include the information, participation and accountability processes of the MHS to community
	This needs to include the roles and responsibilities of the CAC and MHS, when crises, complaints and adverse events occur
	The planning and development of services and programs needs to allocate time and resources to community consultation processes
	OTHER
	OTHER

4. The overall organisational ethos and culture

	MHS's Chief Executive and/or senior managers attend CAC meetings
	MHS develop clear processes for reporting back to CACs on advice and issues that have been raised
	MHS Boards be provided with training about the benefits of consumer and community participation and effective processes for integrating community participation into health care
	OTHER
	OTHER

5. The dynamics of the local and national political systems

	The resources required to integrate consumer and community participation in health services be costed out
	The responsibility for funding consumer and community participation under the current federal funding system be agreed on by both governments
	Consumer and community participation be integrated in health professional's education and training
	Ministerial commitment to community as well as consumer participation be secured
	OTHER
	OTHER

General comments

What Strategies Have Already Been Developed (And Are Working Well) And What Strategies Need Further Development?

CAC members are asked to comment on possible strategies for addressing priorities in each of these areas, such as templates for Communication Protocols, Confidentiality Agreements, Best Practice Consumer Participation Plans.

COMMENT:

What Would Assist CACs To Further Develop & Implement Strategies?

Finally, we are asking CAC's to suggest possible mechanisms for implementation. It is possible for example, to have a workshop of CAC members only, workshops by priority area only, and/or workshops with each CAC.

COMMENT: