National Safety and Quality Health Service Standard 2:

Partnering with Consumers

Embedding partnerships in health care

November 2014

Contents

Executive Summary

Effective partnerships with patients and consumers are necessary for safe and high-quality care in a sustainable health system. The National Safety and Quality Health Service (NSQHS) Standards are one of the key drivers for the establishment of such partnerships.

NSQHS Standard 2: Partnering with Consumers (Standard 2) aims to create a health service that is responsive to patient, carer and consumer needs. The Australian Commission on Safety and Quality in Health Care (the Commission) has received feedback that some health services have found the implementation of systems to meet Standard 2 challenging. In response the Commission conducted a survey to identify the areas of greatest difficulty.

Actions survey respondents reported as being the most difficult related to the involvement of consumers and carers in clinical training (Action 2.6.2), and in governance (Action 2.1.1).

Accreditation results from 2013 also indicate that some health services experienced challenges in implementing systems to meet Standard 2. In 2013 750 health services were assessed to Standard 2 in 2013; with a total of 11,085 actions assessed. Almost three quarters (73%) of these actions were met, 24% were not met and 2% were met with merit. Standard 2 has the highest proportion of actions that were not met; the average across the other nine NSQHS Standards was 6%. However only four of the actions in Standard 2 are core; the others are developmental and do not need to be met for accreditation to be achieved.

Challenges identified regarding Standard 2 include:

• understanding of the intent and purpose of Standard 2
• executive and management support and leadership
• resources for partnering with consumers
• policy framework for partnering with consumers
• engaging consumers in partnerships
• involving consumers in governance
• strategies for partnering with consumers.

Strategies to embed partnerships in health care need to focus on:

• the purpose of the partnership
• having strong leaders who communicate a strategic vision of partnering with consumers
• identifying and developing strategies for partnering with consumers that are appropriate for the organisation
• working towards the establishment of an organisational culture that values partnering with consumers as part of core business.

1. Introduction

Effective partnerships between consumers, healthcare providers and healthcare organisations have been identified as a necessary dimension of safe and high quality care in national health policy in Australia since 2008.[1-3]

A key driver for improving patient safety and establishing effective safety and quality systems are the National Safety and Quality Health Service (NSQHS) Standards.[4] Within the NSQHS Standards, NSQHS Standard 2: Partnering with Consumers (Standard 2) aims to create a health service that is responsive to patient, carer and consumer needs. It is one of two overarching NSQHS Standards, and health services need to consider how they can partner with consumers in the implementation of all other NSQHS Standards.

The Australian Commission on Safety and Quality in Health Care (the Commission) is responsible for developing and maintaining the NSQHS Standards and developing resources and tools to support good practice. The Commission has received feedback that some health services have found the implementation of systems to meet the requirements of Standard 2 challenging. In response the Commission developed a short survey on Standard 2 to clearly identify areas of difficulty.

The responses to the survey provided information about specific areas of difficulty for health services and areas where the Commission needed to provide additional support and resources. In addition, the responses highlighted many of the wider structural and cultural challenges that will need to be addressed to embed partnerships with consumers into the health system.

Another source of information about the experiences of health services with Standard 2 comes from accreditation processes. Information from accrediting agencies for 2013 – the first year of the new accreditation scheme – identifies where health services did not meet actions, or performed well and received a met with merit rating.

The purpose of this report is to provide a broad overview of how health services are going with the implementation of systems to meet Standard 2 and to highlight the implementation issues that exist with this standard. The report also describes some of the challenges in changing culture and embedding systems so that partnerships with consumers become part of everyday practice in health care. The information in this report will be of use to people responsible for implementing systems or developing policy to establish and support partnerships with consumers.

A note on terminology

Consumers are people who use, or are potential users of healthcare services. When referring to consumers, the Commission means patients, families, carers, friends and other support people.

Standard 2 uses the term 'consumers and/or carers' when specifying actions. These terms are used when quoting or describing the actions in Standard 2.

2. Partnering with consumers

In 1978, the Declaration of Alma Ata stated that 'the people have the right and duty to participate individually and collectively in the planning and implementation of their health care.'[5] Since then, policies have been developed promoting the rights and responsibilities of consumers within the healthcare system, and there has been an increasing focus on consumer participation and collaboration in the planning, design, delivery and evaluation of health care. There has been a slow but steady shift towards the recognition that healthcare providers, health services, and consumers are all partners in the healthcare system.

Effective partnerships exist when consumers are treated with dignity and respect, when information is shared with them and when participation and collaboration in healthcare processes are encouraged and supported to the extent that consumers choose.[6]

There are different types of partnerships within the health system. These different types of partnerships are not mutually exclusive – partnering with consumers at all levels is necessary to ensure that a health service is responsive to consumer input and needs.[7]

- **At the level of the individual**, partnerships relate to the interaction between healthcare providers and consumers when care is provided. At this level a partnership would involve providing care that is respectful, sharing information in an ongoing manner, and supporting and encouraging consumers in their own care.

- **At the level of a service**, **department or program of care**, partnerships relate to the organisation and delivery of care within specific areas. At this level a partnership would involve the participation of consumers in the overall design of the service, department or program. This could be as full members of quality improvement and redesign teams, and participating in planning, implementing and evaluating change.

- **At the level of the health service**, partnerships relate to the involvement of consumers in overall governance, policy and planning. This level overlaps with the previous level in that a health service is made up of various services, departments and programs. At this level, partnerships relate to the involvement of consumers as full members of key organisational governance committees in areas such as patient safety, facility design, quality improvement, patient or family education, ethics and research.

- **At the level of the health system**, partnerships relate to the involvement of consumers in local, state and national policy and program development. This level sets the environment in which health services operate, and the involvement of consumers is important to ensure that this environment supports effective partnerships.

Delivering care that is based on partnerships provides many benefits for the consumer, healthcare provider, organisation and system. Evidence is building about the link between effective partnerships, good consumer experience and high-quality health care.[7-9] For example there is evidence that the existence of effective partnerships is associated with:

- improved clinical outcomes including associations with decreased re-admission rates[10-14]
- decreased rates of healthcare acquired infections[15,16]
- improved delivery of preventive care services[17]
- improved adherence to treatment regimens[18]
- improved functional status.[15]

In addition, studies from the United States have found that delivering health care that is based on partnerships can result in reduced hospital costs, lower cost per case and reduced length of stay.[19,20]

The way that health care is organised and delivered is important to consumers; both as individuals who may be receiving care and as citizens interested in maintaining the efficiency and effectiveness of the health system. There is evidence to show that the involvement of consumers in planning, delivery, monitoring and evaluation can have a positive impact on service planning and development, information development and dissemination, and the attitudes of healthcare providers.[21,22]

In Australia there have been activities in place to support partnerships with consumers for some time. With regard to partnerships at the level of the health service, department or program of care, these activities include:

- legislative requirements for health services to have consumer or community advisory committees in place
- policies and frameworks from state and territory health departments and private hospital groups
- the provision of tools to help health services identify priority areas for action
- the collection of patient experience feedback through surveys and other mechanisms, and use of this feedback for local improvement
- involvement of consumers and the community in the design and redesign of hospitals and other facilities
- a wide range of local activities such as consumer or community advisory committees, conducting open board meetings with the local community, and focus groups with consumers to identify areas for improvement.

3. The National Safety and Quality Health Service Standards and Standard 2

The purpose of the NSQHS Standards is to protect the public from harm and to improve the quality of health service provision. The Commission developed the NSQHS Standards in consultation and collaboration with consumers, clinicians, technical experts, and policy makers, and is responsible for maintaining and updating them.

From January 2013 hospitals and day procedure services needed to be assessed to the NSQHS Standards as part of the Australian Health Service Safety and Quality Accreditation Scheme. In addition, other kinds of health services such as mental health, drug and alcohol, and community nursing are using the NSQHS Standards for quality improvement purposes.

The 10 NSQHS Standards are:

1. Governance for Safety and Quality in Health Service Organisations
2. Partnering with Consumers
3. Preventing and Controlling Healthcare Associated Infections
4. Medication Safety
5. Patient Identification and Procedure Matching
6. Clinical Handover
7. Blood and Blood Products
8. Preventing and Managing Pressure Injuries
9. Recognising and Responding to Clinical Deterioration in Acute Health Care
10. Preventing Falls and Harm from Falls

When organisations are assessed to the NSQHS Standards the accrediting agencies use a three-point rating scale to assess a health service. These ratings are:

- **Not met:** the actions required have not been achieved.
- **Satisfactorily met:** the actions required have been achieved.
- **Met with merit:** in addition to achieving the actions required, measures of good quality and a higher level of achievement are evident. There is a culture of safety, evaluation and improvement throughout the organisation in relation to the action or standard under review.

The accreditation process involves an initial assessment by an external accrediting agency. For those actions that are not met, the health service has up to 90 days to make improvements, at which time it receives a final assessment.

The focus of Standard 2 is on the involvement of consumers in organisational governance processes, and that is the focus of this report. There are actions throughout the other NSQHS Standards about partnerships for individuals in their own care. Examples of these types of actions include:

- **Action 1.18.1:** Patients and carers are partners in the planning for their treatment.
- **Action 4.15.1:** Information on medicines is provided to patients and carers in a format that is understood and meaningful.
- **Action 6.5.1:** Mechanisms to involve a patient and, where relevant, their carer in clinical handover are in use.
- **Action 10.10.1:** Falls prevention plans are developed in partnership with patients and carers.

Standard 2 has 15 actions (Table 1). Four of these are core and 11 are developmental. Core actions must be met for a health service to achieve accreditation. Developmental actions do not need to be met to achieve accreditation, but health services must demonstrate activity in these areas.

Table 1: Summary of actions for Standard 2: Partnering with Consumers

No.	Action	Action type
Consumer partnership in service planning		
Governance		
2.1.1	Consumers and/or carers are involved in the governance of the health service organisation	Developmental
2.1.2	Governance partnerships are reflective of the diverse range of backgrounds in the population served by the health service organisation, including those people that do not usually provide feedback	Developmental
Planning		
2.2.1	The health service organisation establishes mechanisms for engaging consumers and/or carers in the strategic and/or operational planning for the organisation	Developmental
2.2.2	Consumers and/or carers are actively involved in decision making about safety and quality	Developmental
Orientation and training		
2.3.1	Health service organisations provide orientation and ongoing training for consumers and/or carers to enable them to fulfil their partnership role	Developmental
Patient information publications		
2.4.1	**Consumers and/or carers provide feedback on patient information publications prepared by the health service organisation (for distribution to patients)**	**Core**
2.4.2	**Action is taken to incorporate consumer and/or carers' feedback into publications prepared by the health service organisation for distribution to patients**	**Core**
Consumer partnership in designing care		
Health service design		
2.5.1	Consumers and/or carers participate in the design and redesign of health services	Developmental
Staff training		
2.6.1	**Clinical leaders, senior managers and the workforce access training on patient centred care and the engagement of individuals in their care**	**Core**
2.6.2	Consumers and/or carers are involved in training the clinical workforce	Developmental
Consumer partnership in service measurement and evaluation		
Public reporting		
2.7.1	**The community and consumers are provided with information that is meaningful and relevant on the organisation's safety and quality performance**	**Core**
Safety and quality performance information and data		
2.8.1	Consumers and/or carers participate in the analysis of organisational safety and quality performance	Developmental
2.8.2	Consumers and/or carers participate in the planning and implementation of quality improvements	Developmental
Patient feedback data		
2.9.1	Consumers and/or carers participate in the evaluation of patient feedback data	Developmental
2.9.2	Consumers and/or carers participate in the implementation of quality activities relation to patient feedback data	Developmental

4. Survey about Standard 2

In response to feedback from health services about the challenges associated with Standard 2 the Commission developed a short online survey to identify areas of difficulty. This section provides an overview of the method used, the participants, and results obtained.

Purpose

The survey was designed to investigate the experiences of health services in meeting the actions required in Standard 2. The survey aimed to identify:

- which actions in Standard 2 were causing particular problems or confusion for health services and why this might be occurring
- which actions in Standard 2 were the easiest to implement
- which supporting tools and resources health services were aware of, their level of usage, and their usefulness
- preferred options for future tools and resources.

Process

The survey was created online using Survey Monkey and promoted by email. The primary contact lists used were the Commission's distribution list for partnering with consumers, and lists compiled by the Accreditation Advice Centre regarding people who had previously sought advice or participated in network teleconferences. The email was sent to approximately 1,150 addresses. In addition to these distribution lists the email was sent to jurisdictional representatives, the private hospital sector, the Australian Day Hospital Association, the Australian Private Hospitals Association and accreditation agencies. Recipients were encouraged to forward the email on to other interested parties.

The survey was open for five weeks from 26 July 2013 to 30 August 2013.

Content

The survey consisted of 36 questions and used a mixed-method approach. Twenty-three open questions and 17 closed questions were used. Skip logic was used to avoid asking participants about resources that they had not used.

Questions in the survey covered the following issues:

- the easiest and most difficult actions in Standard 2 to understand / achieve, and reasons for this response
- knowledge about the availability, uptake and usefulness of various resources supplied by the Commission to support Standard 2
- suggestions for the development of future resources, and in particular, case studies to support Standard 2.

Participants

The intention of the survey was to investigate the experiences of health services undergoing, or preparing for accreditation.

Four hundred and fifteen people completed the survey. Of these, 338 (81%) reported that they worked in public hospitals, private hospitals, day procedure services or community-based services (Table 2). The responses from these health service participants are the focus of the information reported in this section.

The remaining 77 respondents reported that they worked for an organisation for which the NSQHS Standards are relevant, but for which assessment against the NSQHS Standards is not required. These organisations included Medicare Locals, general and private practices and aged care. Their responses are not discussed in this report.

Most respondents worked in metropolitan areas (59%) (Table 3), and the state with the highest proportion of respondents was New South Wales (31%) (Table 4).

Table 2: The types of health services in which respondents worked

Health service	Number of respondents (%)
Public hospital	178 (58%)
Private hospital	53 (16%)
Day procedure service	65 (19%)
Community-based service	42 (12%)
Total	**338**

Table 3: The number of respondents, by region

Health service	Metropolitan	Regional	Rural	Remote	Other (mixed)	Total
Public	95	45	36	2	0	178
Private	40	9	4	0	0	53
Day procedure	46	14	4	0	1	65
Community-based service	18	15	3	4	2	42
Total	**199**	**83**	**47**	**6**	**3**	
					Total	**338**

Table 4: The number of respondents, by state and territory

Health service	ACT	NSW	NT	SA	Tas	Qld	Vic	WA	Total
Public	3	55	0	9	5	21	50	32	175
Private	2	19	0	6	1	9	9	7	53
Day procedure	0	18	0	7	1	13	17	7	63
Community-based service	0	14	1	1	0	3	14	8	41
Total	**5**	**106**	**1**	**23**	**7**	**46**	**90**	**54**	
							No response		6
							Total		**338**

Limitations

It is not possible to know how many people received an invitation to participate in the survey because of the way in which it was promoted. Therefore it is not possible to determine an overall response rate.

Of the 338 respondents on which this report is focused, only 106 responded to the questions about the three hardest actions for Standard 2, and a similar number provided reasons for these rankings. This needs to be taken into account when considering the results of this survey. In addition, the potential for bias needs to be noted, as it may be that people who were struggling with Standard 2 were more likely to complete the survey.

It should also be noted that the survey did not require respondents to distinguish between difficulties in understanding the actions in Standard 2, and difficulties in implementing the actions.

Results

This section provides an overview of the responses received to the survey, with a focus on the most difficult and easiest actions in Standard 2, and suggestions that were made about tools and resources that could be used to better support Standard 2.

Most difficult actions in Standard 2

Overall the two most difficult actions for health service respondents to understand / achieve were the involvement of consumers and carers in clinical workforce training (Action 2.6.2) and in governance (Action 2.1.1) (Figure 1).

The most difficult actions for each type of health service were as follows:

- **Public hospitals:** involvement of consumers in clinical workforce training (Action 2.6.2).

- **Private hospitals:** consumer engagement in strategic and/or operational planning (Action 2.2.1), and the involvement of consumers and carers in governance (Action 2.1.1) and clinical workforce training (Action 2.6.2).

- **Day procedure services:** involvement of consumers and carers in governance (Action 2.1.1).

- **Community-based services:** the responses were more evenly distributed across all the actions but consumer engagement in strategic and/or operational planning (Action 2.1.1) and clinical workforce training (Action 2.6.2) were identified as the most difficult.

Figure 1: Three hardest actions in Standard 2 to understand/achieve
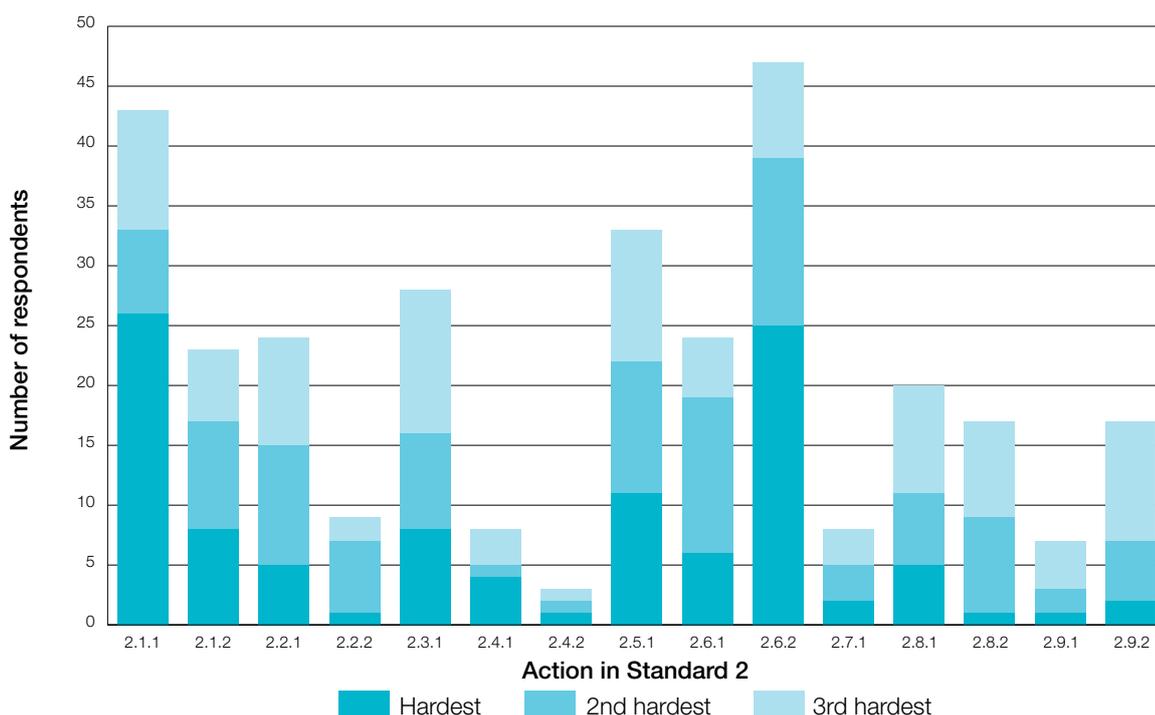
Only public hospital respondents included a core action in their three most difficult actions to implement. This was Action 2.6.1 which requires clinical leaders, senior management and the workforce to have access to training on patient-centred care and the engagement of individuals in their care. All other actions that were identified as the most difficult were developmental.

The reasons why health service respondents found these actions difficult are discussed further in Section 6, and listed in the appendix.

Easiest actions in Standard 2

The survey results indicate much clearer agreement over the easiest actions in Standard 2. More than half the health service respondents named consulting with consumers to provide feedback on patient publications (Action 2.4.1) and incorporating that feedback (Action 2.4.2) as being easier to achieve than the other actions.

Respondents identified resources and mechanisms that contributed to these actions being easier to implement. These resources included:

- seeking information and feedback from a consumer advisory group (a mandatory requirement for hospitals in some states)
- rostering members of the executive to attend consumer advisory group meetings
- making the discussion of consumer-related audits and their results a standing item on meeting agendas
- incorporating a governance framework into an existing consumer and community engagement strategy
- using a post-operative phone call to obtain feedback on services, brochures, and other material and processes
- obtaining feedback from patients and carers while they waited in wards and clinics
- putting up a patient notice board to display information
- providing patients with a 'satisfaction survey' on admission
- providing a checklist for staff to use when developing publications for patients
- incorporating patient-centred care training into performance appraisals
- using 'the MyHealthscope public website'.

Tools and resources that would be useful to support implementation

When looking at the development of further resources by the Commission, fact sheets were reported by all health services to be the most useful resource, with respondents from community-based services wanting both case studies and fact sheets. Podcasts were thought to be of least benefit and e-learning guides were the most preferred resource for private hospital respondents.

Respondents made the following suggestions for specific resources and information to facilitate compliance with Standard 2:

- a comprehensive list of resources including:
  » state-based web sites and programs
  » specific resources for governance
  » entities that run workshops / sessions on patient-centred care
- specific information and resources for small day procedure and rural hospitals, especially doctor-owned facilities
- specific information on how to engage consumers, particularly those consumers who do not usually provide feedback, such as the homeless, low income, mental health patients, non-English speakers, adolescents, and young parents with babies/toddlers
- specific information on how to involve consumers in training the clinical workforce
- case studies demonstrating strategies for consumer involvement in governance and the design, delivery and evaluation of services, and how to demonstrate that this has occurred
- information on how to identify existing processes that can be adapted and formalised to meet Standard 2, such as engaging consumers in existing meetings
- information on how to establish networking opportunities with other facilities undergoing accreditation.

5. Information from accreditation

Further information about the challenges associated with partnering with consumers comes from the experiences of health services who were accredited to the NSQHS Standards in 2013. The accrediting agencies that are approved to accredit to the NSQHS Standards provide information to the Commission about whether each action in the NSQHS Standards has been met, not met or met with merit. In addition, one agency has provided details about the reasons why some health services were awarded a not met or met with merit rating.

Ratings for actions in Standard 2

In 2013 750 health services were assessed to Standard 2; with a total of 11,085 individual actions assessed. Across all of these actions 73% were met at the initial assessment, 24% were not met and 2% were met with merit (Figure 2). At the final assessment improvements had been made so that 77% of all actions were met. All of these health services achieved accreditation, as only four of the actions in Standard 2 are core, and must be met for accreditation.

Across all health services and all 10 of the NSQHS Standards, the average number of actions for which there were not met ratings at initial assessment was 8%, and the average number of actions for which there were met with merit ratings was 2%. Standard 2 had the highest proportion of actions that were not met; the average for the other nine NSQHS Standards was 6%, with a range from 16% to 2%. However Standard 2 also has by far the most developmental actions of all of the NSQHS Standards at 73%. The next closest is 35% for NSQHS Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care.

Figure 2: Ratings received for each action in Standard 2 at initial assessment
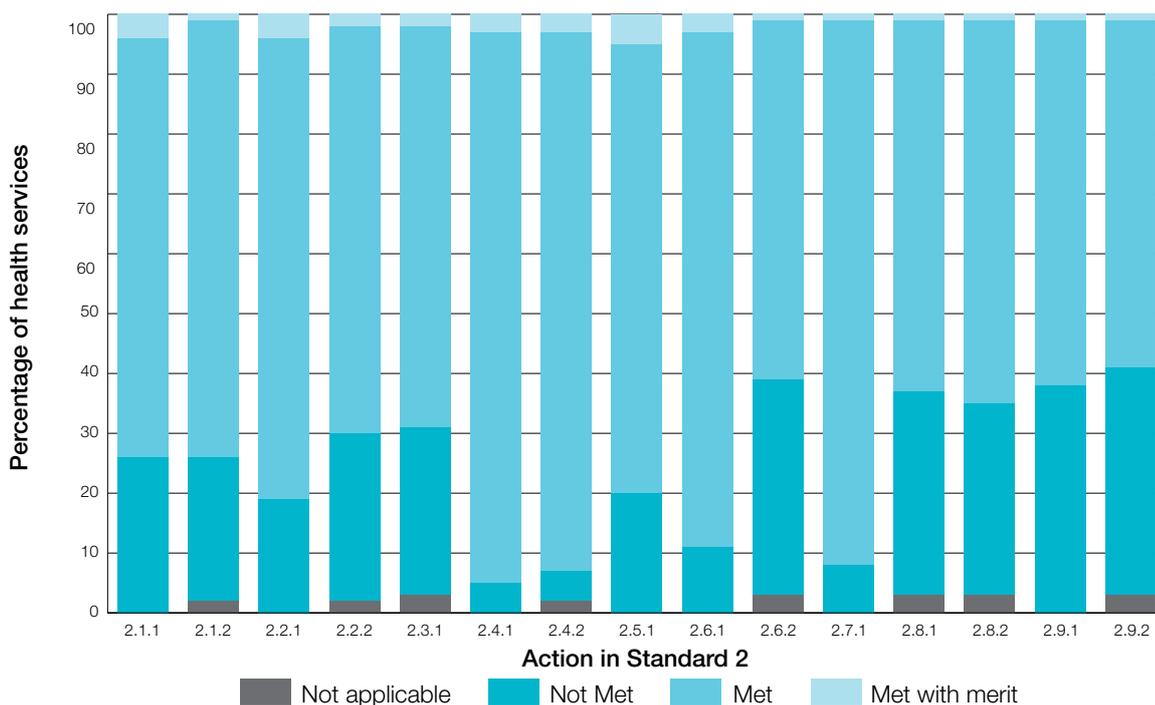
Areas that were more commonly rated as not met included involving consumers in the evaluation of patient feedback data (Actions 2.9.1 and 2.9.2), review of safety and quality performance information (Actions 2.8.1 and 2.8.2), and involving consumers in training the clinical workforce (Action 2.6.2). In private health services, one of the actions that was more commonly not met was providing training for consumers (Action 2.3.1).

Across both public and private health services the actions that were more commonly rated as met with merit related to involving consumers in governance processes (Action 2.1.1), involving consumers in strategic and operational planning (Action 2.2.1), and involving consumers in the design and redesign of health services (Action 2.5.1).

Twenty two health services successfully submitted to their accrediting agency that one or more of the actions in Standard 2 were not applicable to their service. Most of these services were day procedure services. The actions that were most commonly considered to be not applicable related to involving consumers in the evaluation of patient feedback data (Actions 2.9.1 and 2.9.2), the review of safety and quality performance information (Actions 2.8.1 and 2.8.2), involving consumers in training the clinical workforce (Action 2.6.2), and providing training to consumers (Action 2.3.1).

The alignment between these results and the results of the survey was limited. The only area of overlap was Action 2.6.2, which was rated as being one of the most difficult actions to achieve, and was also frequently not met. For some of the other actions that were not met (including Actions 2.8.1, 2.8.2, 2.9.1 and 2.9.2) it is possible that respondents to the survey did not find these difficult as their health service had not yet begun to consider how they would be implemented.

Not met ratings

Reasons why health services were awarded a not met rating were similar across all of the actions in Standard 2. Most of the items in Standard 2 are developmental, and not met ratings were much more common for these developmental items than for the core items. (The highest not met rating for a core item at initial assessment related to training for the clinical workforce (Action 2.6.1), which was not met for 11% of health services.) For developmental items health services need to demonstrate activity in these areas, but they do not need to meet them fully to achieve accreditation.

For some health services accreditation surveyors reported that they could find no evidence that there was any activity in place for specific actions. It was more common that there was some activity underway, but it was not formalised, fully embedded or did not extend across the organisation. Examples of comments from surveyors included:

- *The Executive has a plan to involve a group of consumers in the governance committees but this has not been activated to date.*
- *Currently there is a Community Advisory Group for Mental Health Services which does not cover the other services provided [in the organisation].*
- *The components of a consumer/carer participation strategy in services planning were noted, however the framework and policy are yet to be formalised.*
- *There is a commitment to further involve consumers in governance. However the means of achieving this are still under discussion.*
- *[The health service] has engaged a consumer advocate to be involved at the governance level… However this is in its infancy and will benefit from further development and embedding through the governance committees of the organisation.*

Meeting the actions in Standard 2 appeared to present particular difficulties for day procedure services. Of all the actions that were not met by private health services, 74% related to day procedure services. Over one third (36%) of all actions for day procedure services were not met at initial assessment, higher than the average across all types of services of 24%.

The issues reported by surveyors as reasons why not met ratings were awarded also applied to day procedure services. In addition, it was noted for some services that the highly specialised nature of the service (such as a hyperbaric wound centre) made it more difficult to establish mechanisms to address Standard 2. The need for mechanisms to meet the needs of small private practices was also identified by surveyors.

Met with merit ratings

Health services that achieved met with merit ratings tended to have a comprehensive strategy that applied across many of the actions in Standard 2. It was clear from the comments of surveyors that they valued a coordinated approach that was built into the fabric of the way the organisation operated so that partnering with consumers was not an added extra, but part of the way that business was done.

There were many activities and approaches that were noted by surveyors, and health services that achieved a met with merit rating tended to have several of these in place. Examples included:

- involvement of consumers at different levels of the organisation, with strong linkages with the board
- active consultation with the wider community, including holding community forums
- good knowledge of their local community with a focus on engaging people who are typically not involved
- strong policies and procedures, and clear statements of the role of consumers in planning and decision-making
- collection of feedback from patients and consumers through multiple formal and informal channels
- comprehensive processes to identify consumers to be partners with the organisation and provision of appropriate training for them
- formal processes to obtain consumer input on all relevant publications, policies and documents, with a mechanism to indicate where this has occurred (such as a logo with a tick for publications that have been approved by consumers)
- active involvement of consumers and the community in design and redesign processes using a range of different methods to obtain input
- providing staff training about patient-centred care that places the information being taught in the context of the impact on the patient
- having consumers present at all staff orientation sessions
- involving consumers in root cause analyses.

6. Challenges implementing systems to meet Standard 2

Across all types of settings there are many health services that have a strong commitment to partnering with consumers and have been doing excellent work in this area for some time. However the process of implementing the NSQHS Standards has identified that some health services and individuals are struggling.

The Commission conducted an online survey to identify which actions health services were finding difficult, and the reasons for this. The method used to disseminate this survey means that it is not possible to generalise the findings across the health system. However the results of the survey do align with anecdotal feedback received by the Commission, and with the results of the accreditation processes for Standard 2 for 2013, in terms of the relatively high proportion of actions that were not met.

This section discusses the challenges identified in implementing systems to meet Standard 2. It is based predominantly on the information collected in the survey, supported by information from one of the accrediting agencies about reasons for not met and met with merit ratings.

The issues discussed in this section are:

• understanding of the intent and purpose of Standard 2
• executive and management support and leadership
• resources for partnering with consumers
• policy framework for partnering with consumers
• engaging consumers in partnerships
• involving consumers in governance
• strategies for partnering with consumers.

Quotes from survey respondents are used to illustrate some of these issues. A complete list of all comments is provided in the appendix.

Understanding of the intent and purpose of Standard 2

Some of the survey respondents questioned the value of Standard 2. Some stated that they did not see that Standard 2 would benefit their health service, and as a result found the related actions difficult to implement.

> *I struggle to understand this criterion. What is the benefit?*

> *Do not believe in this standard.*

Some respondents expressed concerns about staff not 'understanding the need for consumer engagement in quality activities' and 'difficulty getting buy-in from the staff'. The need to have staff see the importance of partnering with consumers was also mentioned as a requirement for changing health service culture to focus on partnering with consumers.

In addition, some of the comments made by survey respondents indicated that they had a different understanding of some of the actions in Standard 2 from that intended by the Commission. Where this occurred it tended to indicate that respondents assumed that Standard 2 required a specific type of action (such as having a consumer on the board), rather than the more flexible approach that is recommended by the Commission (see Section 7).[23]

Executive and management support and leadership

Difficulties associated with a lack of executive and management support and leadership were reported by respondents across all types of services. Issues raised included executive/owner resistance to involving consumers, managers finding reasons not to involve consumers, the need for executives to agree to give consumers a voice, and the need for a cultural shift so partnering with consumers is seen as core business.

> *Health service organisations' managers often find this prospect confronting and so find reasons not to involve consumers and carers.*

> *The Board are not really interested and we might have trouble finding someone who wants to be bothered.*

This issue also emerged in the accreditation process. One surveyor noted that the 'owner operator/surgeon opposes having a consumer involved in his organisation based on various beliefs including privacy issues.'

Resources for partnering with consumers

Resources were mentioned by a number of survey respondents as a barrier to implementing systems to meet Standard 2. Comments about budget restrictions and the lack of funding were most commonly associated with the actions that required training for consumers (Action 2.3.1) and staff (Action 2.6.1).

The resources that were seen to limit action were not always financial. The limited time that staff have to undertake training (particularly in the context of the introduction of the NSQHS Standards) and be involved in policy development was also mentioned.

Requires organisational culture change and investment in consumers, including $$$.

Finding time and resources to support clinical staff to be educated about the standard as we are benchmarked and under extreme stress with [organisational structure] changes.

Policy framework for partnering with consumers

Some respondents mentioned that the lack of a policy framework made it difficult for them to implement systems to meet Standard 2. Where there was no policy framework for partnering with consumers in place, respondents mentioned that it was difficult to engage consumers or determine how they should be involved in the health service.

Other policy issues that were mentioned were the need to review policies to ensure that they reflect the need to partner with consumers. The time to do this was identified as a barrier, as was the need to have people with experience and understanding of how to partner with consumers involved in this process.

Formal processes didn't exist. We needed to develop these up from scratch. Again, another significant project.

Getting support and time and resources to attend to policy / procedure / protocol documents.

One of the issues identified by accreditation surveyors was that while health services might have activities underway to meet the requirements of Standard 2, these were not always formalised or documented within policies and procedures.

Engaging consumers in partnerships

Survey respondents identified a range of issues associated with the engagement of consumers.

These included:

- difficulties identifying appropriate consumers to be involved in partnerships, including in health services with highly diverse communities
- establishing partnerships that are reflective of the diversity of the population in health services where there is a low level of diversity, such as some day procedure services
- difficulties identifying consumers who are interested in being involved in some types of partnerships, such as quality improvement activities or reviewing performance data
- consumers not having sufficient knowledge to be able to contribute effectively to partnerships
- the complexity of the health service environment making it difficult for consumers to contribute effectively
- the lack of training and support for consumers who are involved in partnerships.

Need to find people with skills and knowledge to do this. We attract [the] same people, need to change the way we do this as the voiceless and disengaged always miss out.

Very difficult to fully engage meaningfully to the point of empowerment with a high number of consumers in a very complex multidimensional organisation and be able to accommodate wide ranging views of wide ranging number of health issues and conditions etc.

Most of our consumers are elderly and are not interested in being involved in any way with how the facility is run.
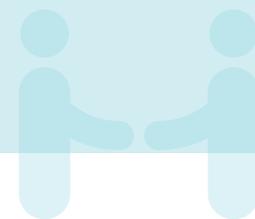
Involving consumers in governance

A number of survey respondents mentioned difficulties involving consumers in governance (Action 2.1.1). Comments were made about the uncertainty of what the term governance meant or what level of involvement was required to meet Standard 2.

Respondents from both the public and private sectors mentioned that their governance models meant that it would be difficult for consumers to be meaningfully involved. Concern was expressed, particularly for small owner-operated facilities, that consumers would be privy to commercially sensitive and other confidential matters at board and executive level meetings.

> *Governance is an incredibly broad issue. As an organisation that has major corporate fiduciary responsibilities it is not appropriate to delegate some governance responsibilities so the challenge is in finding what governance can be shared etc, so that consumers aren't expected to be involved in something, provide advice or input that an organisation can never act upon if it is to be ultimately responsible, and therefore not engage in non-authentic tokenism towards consumers.*

> *Due to multi-layered governance model at work, there have been few opportunities for consumers to be involved.*

Feedback from the accreditation process regarding actions that were not met indicated that many health services were struggling to identify how to involve consumers in their governance processes in a way that fitted with the nature and context of their organisation.

Strategies for partnering with consumers

There was also a wide range of issues raised about strategies that were or could be used to partner with consumers. These issues included:

- the need to focus on outcomes, rather than compliance
- the potential for tokenism and 'one size fits all solutions'
- the time that is needed to develop productive partnerships
- the difficulty of spreading pockets of activity to get engagement across the organisation
- the difficulty of engaging meaningfully in complex health organisations
- the need to have strategies for partnering that apply in specific settings, such as day procedure surgeries.

> *We have a consumer participation committee – one size fits all approach seems a little tokenistic – not sure about its outcome and ability to engage with the voiceless or disengaged.*

> *Cultural change needed. Developing frameworks that meet the needs of the organisation and also meet standards [is] quite difficult.*

> *I think we have a long way to go here to increase the consumer activity. We may do enough to get us through but I think we could do more.*

7. Embedding partnerships in health care

The comments provided by respondents to the Commission's survey about Standard 2 indicate that there is not yet a consistent culture across the health system that recognises consumers as true partners in all aspects of health care. The potential for bias in these comments needs to be recognised, in that respondents to the survey may be more likely to be struggling with Standard 2. However they also represent voices at the coal face within health services that may not normally be heard, and the feedback that they provide needs to be examined and acted on.

From an organisational and a system perspective, the results from the accreditation of health services to Standard 2 in 2013 also indicate that health services are having difficulty. Of all of the NSQHS Standards, Standard 2 had the highest proportion of actions that had a not met rating; this is likely to also be associated with the relatively low number of core actions in this standard.

Partnerships with consumers have been part of the national safety and quality policy framework since 2008,[1] and for much longer in some states and territories.[24] Some private hospitals have had long-standing programs in place to engage consumers and involve them in governance processes.[25] Despite this, there is evidence that an approach to health care that is based on partnering with consumers is not always present at a local level. In addition to the results reported here, there is information from complaints,[26] surveys of the general public about their experiences of being involved in decision-making,[27] and anecdotal feedback from consumer advocates and consumer groups.

Challenges in partnering with consumers

The challenge of changing practice in health is well known.[28] This has most frequently been studied in the context of the introduction of new treatments or procedures, or changing practice in the face of changing evidence, and there is a large body of research about implementation science and the translation of research into practice.[28]

Having an explicit focus on partnering with consumers in governance processes is relatively new within health care, and it is not surprising that there would also be challenges when trying to change the way that healthcare providers and managers work with consumers. In addition to the challenges identified in this report, others include:[29-36]

- The time taken to change culture to one that is based on partnerships with consumers. This often takes many years, and needs to be seen as an ongoing 'journey', rather than a project that will end in six or 12 months.

- The need to have clear roles for consumers and clear expectations about how they will be involved in the organisation. There are many ways that partnerships can occur, and when the purpose of the partnership is not clear this can lead to frustration on the part of both consumer and health service participants.

- Whether consumers are 'representative'. Health services often want to involve consumers who are representative of their communities, and there can be criticism when this does not occur. Rather than seeking an ideal of representativeness that may not be achievable, it may be more useful to seek input from different people in different ways to provide a range of perspectives.

- Understanding the value of consumer input. The input that consumers provide to health services is often based on personal experience. This is a different model from the clinical/technical sources of information that are generally valued in health care. It can be difficult for healthcare providers to understand how this type of input can be used to help them improve their services.

- The complexity of the clinical and technical issues that health services deal with. This complexity can limit the capacity of consumers to provide input to discussions unless they are supported and their roles are clear.

- Structuring opportunities to partner with consumers in ways that are appropriate for the organisation and consumers.

Strategies for success

While there are challenges when partnering with consumers, there are many health services in Australia and internationally who have successfully embedded partnerships within their organisations. Characteristics of these organisations include:[7,31,37]

- having strong committed leadership, with leaders communicating a strategic vision of partnerships throughout the organisation

- engaging consumers as partners throughout the organisation

- routinely collecting data about the experience of consumers, and feeding these data back to the governing body, managers and healthcare providers

- being responsive to changes proposed by consumers and supporting the improvement of care delivery and the environment

- sharing information about board activities and health service performance with consumers and the general community

- building the capacity of healthcare providers, managers, executives and board members and having a supportive work environment

- having clear lines of accountability for partnerships with consumers at all levels within the organisation

- having an organisational culture that strongly supports learning and improvement.

Suggested approaches for meeting Standard 2

The Commission recognises that partnering with consumers is a new way of working for some health services, and it is for this reason that many of the actions in Standard 2 are developmental.

The evidence base about how to partner with consumers in governance processes is building, and there is not yet an agreed 'best practice' approach about how this should be done. For this reason there is no one way to meet the requirements of Standard 2; the strategies and activities that will be needed will vary according to the characteristics and circumstances of the health service. Issues that should be considered include:

- the type of health service, whether it is public or private, a small or large hospital, a day procedure service or a community-based service

- whether there is an identified community that is served

- any requirements or initiatives that may exist in the state or territory in which the health service is located

- the availability of local consumer groups or individuals who are interested in being involved with the health service.

The range of different strategies that can be used means that it is important to keep focussed on the purpose of partnering with consumers. In essence, the purpose of these partnerships is to improve the health service, and experiences and outcomes for consumers and staff, by using the knowledge, skills and experience of people who are using, have used, or may use the health service in the future.

The *Safety and Quality Improvement Guide* for Standard 2,[23] released by the Commission in 2012, contains detailed information about strategies that can be used to implement systems to meet Standard 2, and resources and organisations that can assist in this process. For health services that are just starting on this journey, it is important to:

- recognise that time that will be needed to establish effective partnerships; this is not a short term project, but a change to the way that the health service operates

- identify champions in different parts of the organisation, including among the executive and different clinical disciplines

- provide evidence of the benefits of partnering with consumers to executives

- use stories and draw on the personal experiences of staff within the organisation where possible

- start small and identify discrete projects where gains can be made

- think about what is already happening within the organisation, and how existing activities could be adapted

- think about the nature of the organisation, and the way in which partnerships with consumers might be most effectively developed

- talk informally with consumers to get ideas about what they think about the health service and possible areas for initial focus

- not be limited by traditional ways of partnering with consumers; there are many new technologies and approaches that could be used to involve people.

What the Commission will do

The Commission has an ongoing role to support health services to meet the NSQHS Standards, including Standard 2. Based on the results of the survey and feedback from the first year of accreditation, the Commission will:

- review and update information about Standard 2 to ensure that the intent of each action is clear

- develop short resources to address specific actions in Standard 2 that are reported to be particularly difficult, such as involving consumers in governance processes (Action 2.1.1) and involving consumers in training (Action 2.6.2)

- develop short resources for health services in specific settings and for particular audiences, particularly day procedure services, and services in rural and remote areas

- identify and report on case studies and examples of policies, programs, tools and resources that Australian healthcare organisations have developed to foster partnerships with consumers.

The Commission will also use this information to review the structure and content of Standard 2 in the future.

Appendix: Reasons why Standard 2 actions were reported to be difficult

This appendix provides comments from the respondents to the survey about why they reported specific actions in Standard 2 to be particularly difficult to understand or implement.

The comments from respondents have been copied directly from their survey responses and may be repeated, as per their actual response.

The respondents have been grouped according to the type of health service that they work for, and the number of respondents for each health service type indicates the number who provided reasons for their ratings.

Public hospital (47 respondents)

Consumer partnership in service planning

Governance

Action 2.1.1: *Consumers and/or carers are involved in the governance of the health service organisation*

- Most consumers do not have sufficient knowledge to contribute to the planning of health care facilities.
- We have community participation committees but one size fits all seems tokenistic not outcomes focused.
- Resistance at the Executive level.
- Health service organisations' managers often find this prospect confronting and so find reasons not to involve consumers and carers.
- Getting the balance in getting appropriate consumer engagement/participation on peak committees and policy development is very difficult – lack of formal consumer training program to assist participants. An ethnically diverse and CALD local population brings its own challenges.
- No overarching framework to guide in appropriate consumers, HR checks, etc.
- Governance can be a hard term to define exactly what is wanted and or meant.
- Framework for engaging consumers in governance doesn't exist currently. Hard to find suitable consumers who can participate constructively, huge culture shift.
- We have consumer participation committee – one size fits all approach seems a little tokenistic – not sure about its outcome and ability to engage with the voiceless or disengaged.
- Due to multi-layered governance model at work, there have been few opportunities for consumers to be involved.
- Getting management support and commitment.

Action 2.1.2: *Governance partnerships are reflective of the diverse range of backgrounds in the population served by the health service organisation, including those people that do not usually provide feedback*

- Resistance at the Executive level.
- When health service organisations engage people in governance partnerships they usually select people whose views are consistent with their own.
- Governance can be a hard term to define exactly what is wanted and or meant.
- Although policies and procedures often refer to informing consumers/carers about their care, they are frequently written without the author/s having an understanding of the diverse range required to meet multiple needs.
- Little diversity exists in our rural community.
- Meaningful partnerships develop over time and with effort.
- Variability across sites to different cultural needs.
- Engaging with people who do not normally engage is not easy! It becomes difficult to actively seek diversity while upholding anti-discrimination culture.
- Consumer rep availability from diverse community.

Planning

Action 2.2.1: *The health service organisation establishes mechanisms for engaging consumers and/or carers in the strategic and/or operational planning for the organisation*

- Resistance at the Executive level.
- Health service organisations often consider that they know what consumers want from the health service and that they cannot afford the level of service.
- No overarching framework to guide in appropriate consumers, HR checks, etc.
- No framework for engagement and not sure how to find relevant consumers.
- Consumers generally do not wish to be involved in strategic direction of the organisation.
- Getting senior executives to agree consumers have a voice.
- Debate over requirements for genuine versus token involvement in these processes. Not yet agreed to by organisation's executive managers.

Action 2.2.2: *Consumers and/or carers are actively involved in decision making about safety and quality*

- Consumers can disrupt committee progress due to ignorance of the wider picture and own narrow view.
- Never seen.
- I think we have a long way to go here to increase the consumer activity. We may do enough to get us through but I think we could do more.

Orientation and training

Action 2.3.1: *Health service organisations provide orientation and ongoing training for consumers and/or carers to enable them to fulfil their partnership role*

- Hard to find time to train staff moving to e-learning. Managers need to see this as part of core business. Requires cultural shift.
- Budget restrictions.
- Previously no training was provided to our consumers or volunteers. Convincing them of the benefits has been difficult. Many did not want anything formal, they just wanted to come in and help when it suited them.
- Not seen as core business.
- Organisation is difficult including access and expectation.
- Operationalising this criteria and getting consumer engagement to complete has been hard.
- Not yet agreed to by organisation's executive managers. Resourcing considered an issue.
- Getting management support and commitment.

Patient information publications

Action 2.4.1: *Consumers and/or carers provide feedback on patient information publications prepared by the health service organisation (for distribution to patients)*

- No system in place to either collate all of the health services publications or get relevant feedback.

- This happens infrequently and often externally to the facility, ie LHD level.

- There is a large volume of publications developed by the organisation and to ensure useful and constructive feedback is provided by consumers is a mammoth task.

- Too many existing brochures, a big project to identify them all and modify to include consumer involvement in a short timeframe.

- We have over 1000 consumer publications. We first needed to collect and collate all of the publications into a central electronic repository, and then we needed to start reviewing them with consumer input. This is a huge body of work that has taken over a year to do.

- Very ambiguous. What sort of publications? We have thousands. What sort and type of consumer involvement? Felt this was a massive task without sufficient clarity and real and achievable examples. The issue of externally produced publications was immensely challenging.

Action 2.4.2: *Action is taken to incorporate consumer and/or carers' feedback into publications prepared by the health service organisation for distribution to patients*

- I don't see much communication or publicity around feedback to consumers. I hope there is work happening here.

- Need to develop mechanisms for this.

Consumer partnership in designing care

Health service design

Action 2.5.1: *Consumers and/or carers participate in the design and redesign of health services*

- The difference between want, need and feasibility is often not appreciated by consumer reps.

- Redesign processes already well established but missing consumer voice.

- Need to develop mechanisms for this.

- The high complexity of the hospital's activity makes it difficult to involve consumers in service redesign.

- Not a great deal of involvement from consumers undertaken.

- Getting engagement and participation is difficult.

- Although intention clear, action extremely broad and ill defined. Difficult to action within such a large scope.

- Currently evolving process.

- Multiple policies, procedures, TOR, systems to be reviewed to ensure this happens

- Dearth of consumers willing to participate at this level.

- Often difficult to determine the process around how this happens.

Staff training

Action 2.6.1: *Clinical leaders, senior managers and the workforce access training on patient centred care and the engagement of individuals in their care*

- No overarching patient centred care e-learning packages locally, no local policies procedures or guidelines to refer to. Don't have the capacity or resources to designate a person to design an e-learning package for staff.
- Tough competition for training time with new standards (multiple needs); belief that 'I already do consumer centred care'.
- Too similar to 2.8.2 & 2.8.2.
- New training packages needed to be developed and delivered. Very difficult getting medical staff to engage in this sort of training. Again, another significant project.
- Ambiguous again. How does patient centred care differ from consumer partnership and engagement? Did we have to complete it pre-survey or just schedule it? What about other staff? Surely it's not just about Executive and senior clinicians! What proportion of staff?
- There are no specific resources or training that have been developed which provides meaningful training on patient centred care, and time to involve consumers and develop these are not prioritised.
- Not sure of process or what had been initially undertaken.
- Staff buy-in.
- Lack of availability of flexible training resources nationally, eg e-learning program.
- 'Patient centred care' isn't always explicit in training for clinicians.
- Training not frequently accessible.
- Significant amount of change of documentation and staff acceptance of process change.
- Remote and difficult to make this training worthwhile rather than just ticking a box.
- Requires $$$.
- Because we haven't yet put the system in place to deliver this.

Action 2.6.2: Consumers and/or carers are involved in training the clinical workforce

- Sadly, we are far off having a system-wide embedded culture in public health whereby clinicians truly value patient/carer engagement in care management, so the idea of them (carers/consumers) being involved in training the clinical workforce is admirable but not a reality for mainstream acute care health services in the near future!
- All the remaining actions are equally hard – don't have robust systems set up to engage consumers and hard to find suitable consumers. 2.6.2 – staff need extensive training prior to involving consumers.
- Inability to get consumers involved.
- Limited to a CAC member meeting new staff at orientation.
- The time expectation of this is demanding to consumers.
- Need to develop mechanisms for this.
- Training is normally the function of those with specific expertise. It will involve a radical new approach.
- No process is available in organisation.
- Not sure of process or what had been initially undertaken.
- Still to develop policies and mechanisms to support this; access to and availability of consumers in rural areas.
- Training is becoming a luxury; staff time-poor; e-learning seems to replace face to face learning. Such training days are an exception rather than the rule. Yet so powerful.

- Hard to demonstrate evidence at local level for ongoing training programs (of which there are multitudes at specialist care delivery levels) developed and delivered in hospitals. Easier at state/tertiary level in curriculum design, a little ambiguous.

- Not yet agreed to by organisation's executive managers.

- Because we haven't yet put the system in place to deliver this, ie 2.6.1 is 'stage 2'.

- Process not established, ensuring the information is relevant and consumer has the ability to train.

- New and tricky to get your head around.

- Still a work in progress. Difficult to access given our regional location.

- Dearth of consumers. Action challenging to define. What does it actually mean?

- This action is at the centre of the change management processes that the organisation must go through to engage staff on the journey.

- Difficult to get consumers to commit to regular training sessions for staff.

- Requires organisational culture change and investment in consumers, including $$$.

- Requires significant support for staff to implement training and also reduce anxiety about consumer involvement.

Consumer partnership in service measurement and evaluation

Public reporting

Action 2.7.1: *The community and consumers are provided with information that is meaningful and relevant on the organisation's safety and quality performance*

- These indicators are only now being standardised [referring to the 18 Accreditation Outcome indicators] and not yet available in meaningful format for consumers to understand.

- Don't believe quality of care reports are read by the community, therefore just a tick the box exercise.

- No process is available in organisation.

Safety and quality performance information and data

Action 2.8.1: *Consumers and/or carers participate in the analysis of organisational safety and quality performance*

- Requires training for which budget allocation is difficult.

- Formal processes didn't exist. We needed to develop these up from scratch. Again, another significant project.

- Again the data can be provided for consumers, but for this data to be meaningful and useful to the community requires a lot of explanation to place the data in perspective and then to ensure there is constructive participation by the consumer will require education and training, as this should not be tokenistic but outcome based.

- Difficult to have consumers with skills in such analysis.

- Often difficult to find evidence that consumers have been actively involved in analysis.

- Resourcing issue.

- Aged population presents limitations for participation.

Action 2.8.2: *Consumers and/or carers participate in the planning and implementation of quality improvements*

- Need to find people with skills and knowledge to do this. We attract same people, need to change the way we do this as the voiceless and disengaged always miss out.
- No current involvement.
- Areas don't understand need for consumer engagement in quality activities.
- Difficult to provide the resources and training which would allow this to occur in a way which would truly meet the intention of the action.
- Easier for large well-funded projects, more difficult for smaller initiatives due to availability of consumers.
- This work is only just starting across the HHS – evidence is not always available.
- Resourcing issue.
- Difficult to get consumers involved in actually undertaking quality activities.
- Consumer reps are used within committees but not in quality activities.

Patient feedback data

Action 2.9.1: *Consumers and/or carers participate in the evaluation of patient feedback data*

- We have enough challenges getting health care providers to evaluate and act upon patient feedback data – let alone a culture where we actively involve the carers/consumers!
- New systems and processes required to demonstrate how.
- This action is at the centre of the change management processes that the organisation must go through to engage staff on the journey.
- Often difficult to determine a clear process that is in place to ensure participation.
- No involvement to date of consumers in quality improvement activities, requires significant work to support staff in quality improvement and consumer engagement.
- No process is available in organisation.

Action 2.9.2: Consumers and/or carers participate in the implementation of quality activities relation to patient feedback data

- Implementation is another world altogether. What does this actually mean? Examples would have been good.

- Areas don't understand need for consumer engagement in quality activities.

- Involves a significant amount of work to change both practice and culture in order to achieve this.

- Although Consumer reps are sitting on the Peak Committee and review performance data through this vehicle it will be difficult to show meaningful evidence that consumers are assisting in the implementation of quality activities.

- Limited opportunities to date.

- Staff have to see the importance of this.

- Dearth of consumers willing to participate at this level.

- Difficult to get consumers participating in quality activities.

- Consumer reps are used within committees but not in quality activities.

- This action is at the centre of the change management processes that the organisation must go through to engage staff on the journey. Staff have to see the importance of this.

Other comments

- Getting support and time and resources to attend to policy/procedure/protocol documents.

- Finding time in a busy clinical setting to have clinical staff participate in developing protocols and updating.

- Finding time and resources to support clinical staff to be educated about this standard as we are benchmarked and under extreme stress with [organisational structure] changes.

Private hospital (13 respondents)

Consumer partnership in service planning

Governance

Action 2.1.1: *Consumers and/or carers are involved in the governance of the health service organisation*

- As a business, our top management are hesitant about having consumers at top level committees.

- Governance is an incredibly broad issue. As an organisation that has major corporate fiduciary responsibilities it is not appropriate to delegate some governance responsibilities so the challenge is in finding what governance can be shared etc, so that consumers aren't expected to be involved in something, provide advice or input that an organisation can never act upon if it is to be ultimately responsible, and therefore not engage in non-authentic tokenism towards consumers.

- Cultural change needed. Developing frameworks that meet needs of organisation and also meet standards quite difficult.

- The depth of involvement at a governance level is not clearly articulated.

Action 2.1.2: *Governance partnerships are reflective of the diverse range of backgrounds in the population served by the health service organisation, including those people that do not usually provide feedback*

- Private hospitals don't always have a very diverse population.

Planning

Action 2.2.1: *The health service organisation establishes mechanisms for engaging consumers and/or carers in the strategic and/or operational planning for the organisation*

- Cultural change needed. Developing frameworks that meet needs of organisation and also meet standards quite difficult.

- Again – very difficult to fully engage meaningfully to the point of empowerment with a high number of consumers in a very complex multidimensional organisation and be able to accommodate wide ranging views of wide ranging number of health issues and conditions etc.

- Hard to implement.

- As a private facility executives are not supportive.

Action 2.2.2: *Consumers and/or carers are actively involved in decision making about safety and quality*

- Consumers are usually volunteers and are reluctant about being involved in decision making.

Orientation and training

Action 2.3.1: *Health service organisations provide orientation and ongoing training for consumers and/or carers to enable them to fulfil their partnership role*

- There should be some standard packages for this for all hospital consumers.

- Difficult to access relevant learning packages that will appeal to our consumers.

- It is difficult to obtain well produced Australian training packages.

Patient information publications
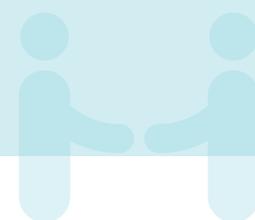
Action 2.4.1: *nil comment*

Action 2.4.2: *nil comment*

Consumer partnership in designing care

Health service design

Action 2.5.1: *Consumers and/or carers participate in the design and redesign of health services*

- Cultural change needed. Developing frameworks that meet needs of organisation and also meet standards quite difficult.
- In private sector, sometimes redevelopments, tenders and strategic developments are commercially sensitive so CEOs reluctant to involve consumers early on.
- Being able to identify opportunities where this can happen.

Staff training

Action 2.6.1: *Clinical leaders, senior managers and the workforce access training on patient centred care and the engagement of individuals in their care*

- Impossible with VMOs.

Action 2.6.2: *Consumers and/or carers are involved in training the clinical workforce*

- Hard to implement.
- As a private facility executives are not supportive.
- There are some resources available but it is difficult to get buy-in from the staff to the need for this criterion.
- Even staff from [the accrediting agency] had different perspectives on what this means and how this can be implemented.
- Difficult to engage consumers in training.
- Education and training undergoing changes, difficult in unstable environment.

Consumer partnership in service measurement and evaluation

Public reporting

Action 2.7.1: *The community and consumers are provided with information that is meaningful and relevant on the organisation's safety and quality performance*

- Having asked consumers – most data /KPI collected they 'don't find meaningful'.

Safety and quality performance information and data

Action 2.8.1: *Consumers and/or carers participate in the analysis of organisational safety and quality performance*

- For review and analysis we need consumers with knowledge, this does not always fit our clientele.
- Information not available in a format consumers can easily understand.
- You need to have a specific type of consumer to be able to put quality performance into perspective and make sense of clinical information.
- Hard to show analysis.

Action 2.8.2: *Consumers and/or carers participate in the planning and implementation of quality improvements*

- Hard to implement.
- Planning for quality improvements can be difficult if the consumer is unable to make sense of the quality cycle and process.

Patient feedback data

Action 2.9.1: *nil comment*

Action 2.9.2: *Consumers and/or carers participate in the implementation of quality activities relation to patient feedback data*

- Not easy to understand to what extent the accountability goes – in the end the organisation and board is accountable so they have to figure out how to implement within the legislative, financial, mission and other constraints an organisation may have, and that may not match with every consumer's expectations.

- Difficult to live out.

Other comments

- Involving patients in strategic planning concepts regarding the attitude of members of the Governing Body – much work had to be done on management attitudes – able to be implemented via the Patient Focus Group.

Day procedure service (23 respondents)

Consumer partnership in service planning

Governance

Action 2.1.1: *Consumers and/or carers are involved in the governance of the health service organisation*

- We are a small day surgery, with one surgeon (who is the medical director). Governance is by monthly meetings. We have approx 150 separations each year. Involving our consumers in governance is unreasonable.
- Most of our consumers are elderly and are not interested in being involved in any way with how the facility is run.
- For a small specialist facility I'm not sure this is even relevant.
- (For all of these) the development of processes where we can involve the consumer and engaging the management levels in this direction.
- Trained consumers not available for small boards and private concerns, board members not open to the inclusion of a consumer.
- Difficult for small organisation to achieve.
- We do not engage consumers directly at a governance level.
- Unrealistic to expect small private day hospitals to want consumers involved in their governance.
- There is no way we can have a consumer on the Board of a small private day facility, often surgeon owned with his wife and Director of Nursing. However, there can still be evidence that consumers can be involved with feedback.
- Small facility so involvement in governance will be difficult.
- The involvement is limited in smaller facilities, with time the consumer reps will be more experienced and more involved, to date feedback has been in low order matters nothing of high order.
- Our monthly meetings are business meetings as well as governance and so it would be hard to invite a consumer to listen in to that also we only have one face to face meeting once every 3 months and email meetings at other times. Also there is strong opposition from the owners/surgeons over this.
- The Board are not really interested and we might have trouble finding someone who wants to be bothered.
- I struggle to understand this criterion. What is the benefit?
- It took several invitations before we found someone who was interested in giving any feedback at this level.

Action 2.1.2: *Governance partnerships are reflective of the diverse range of backgrounds in the population served by the health service organisation, including those people that do not usually provide feedback*

- We are a cosmetic surgery with 95% of patients being healthy Caucasian females with average age of 36 – very difficult to involve 'people from diverse backgrounds'.
- Unrealistic financial burden to be training consumers to comment on procedures, etc.
- Governance partnerships are too difficult to set up with a small and aged population.
- Consumer focus group to be organised.
- 'Diversity' difficult – small organisation, hard to motivate all to be involved.
- There is not a diverse range of backgrounds in our regional area.
- Only have English speaking white people.
- It was difficult enough to get a consumer interested in quality, let alone from a diverse background.

Planning

Action 2.2.1: *The health service organisation establishes mechanisms for engaging consumers and/or carers in the strategic and/or operational planning for the organisation*

- (For all of these) the development of processes where we can involve the consumer and engaging the management levels in this direction.
- Surgeon/owner opposition to this idea and not easy for small single speciality day surgeries to comply with consumer engagement processes.
- Has never been an issue in the past.
- Operational planning is developed and implemented by monthly meetings with medical director, and 3 team managers. Our size, speciality and capacity would not benefit from a consumer focus group in terms of operational planning.
- Including consumers in operational planning and decision making is linked to my earlier comment re trained consumers and inclusion in planning/board meetings.
- Consumer forum including consumer rep on the board.
- Finding the appropriate consumer to involve.
- As a private, for profit organisation, where planning involves some financial knowledge, we found it difficult to involve consumers in strategic planning without breaching the confidentiality of our Directors.

Action 2.2.2: *Consumers and/or carers are actively involved in decision making about safety and quality*

- Consumers not interested in decision making for safety and quality.

Orientation and training

Action 2.3.1: *Health service organisations provide orientation and ongoing training for consumers and/or carers to enable them to fulfil their partnership role*

- Small day surgery consumers.
- Objective training in consumer centred care needs to be devised.
- Orientation achievable, ongoing training difficult.
- Hard to find out what you should orientate the consumer on?
- Hard to provide training to the consumer reps, in small facilities to the degree I would like but we are managing in a simplistic way.
- Only do day surgery and limited to no interest shown by consumers and carers to date.
- No time. No allocated funds to incorporate in our facility.

Patient information publications

Action 2.4.1: *nil comment*

Action 2.4.2: *nil comment*

Consumer partnership in designing care

Health service design

Action 2.5.1: *Consumers and/or carers participate in the design and redesign of health services*

- (For all of these) the development of processes where we can involve the consumer and engaging the management levels in this direction.

- Limited scope to achieve in a small organisation.

- No new design or redesign of the facility has been commissioned since the facility was purpose built.

- Not possible, small facilities, council and DHS restraints, etc.

- Consumer focus group minutes.

- We don't redesign many processes, important to educate consumer on our processes.

- No redesigning to be done.

- No projects currently in the pipeline.

- Have not undergone any redesign process.

- Consumers designing health services – an ambiguous question.

- Do not believe in this standard – we are a private company and believe the market will ensure efficient services.

- There are no plans for redesigning or extending our health services in the foreseeable future.

Staff training

Action 2.6.1: *Clinical leaders, senior managers and the workforce access training on patient centred care and the engagement of individuals in their care*

- We do not train consumers or carers as part of the organisation.

- Why would patients in a private clinic be bothered with training staff or executives?

- Training opportunities are virtually non-existent as a manager. It falls on us to research and educate our staff – a laborious process.

- Very difficult to access training.

Action 2.6.2: *Consumers and/or carers are involved in training the clinical workforce*

- Finding suitable consumers to assist with training.

- Not sure how to have training by consumers.

- Because this is so new, the consumer reps are also very new and they have not provided any relevant feedback to date.

- For a small specialist facility I'm not sure this is even relevant.

- No previous involvement.

- Not sure how we as a small facility can implement this with limited resources.

- Not realistic in a day procedure setting, actually quite ridiculous.

- I don't agree this is valuable or achievable. I feel these criteria require creative interpretation to achieve.

- Why would patients in a private clinic be bothered with training staff or executives?

- How is this going to occur !!!!!!!!!!!!

- Do not believe in this standard.

- Members of the Consumer Advisory Group, in general, do not wish to take part in training activities at this stage.

Consumer partnership in service measurement and evaluation

Reporting

Action 2.7.1: *The community and consumers are provided with information that is meaningful and relevant on the organisation's safety and quality performance*

- With the sensitivity of the private sector and funding arrangements, very difficult to publish a lot of data without risk of misinterpretation. Facilities have given patients info about what data they collect and then invited patients to contact them if they wish to have more info, and therefore it can be explained in context.

Safety and quality performance information and data

Action 2.8.1: *Consumers and/or carers participate in the analysis of organisational safety and quality performance*

- For a small specialist facility I'm not sure this is even relevant.

- Why would they analyse our data? That is our job!

Action 2.8.2: *Consumers and/or carers participate in the planning and implementation of quality improvements*

- Not realistic in a day procedure setting, actually quite ridiculous.

Patient feedback data

Action 2.9.1: *nil comment*

Action 2.9.2: *nil comment*

Community-based service (11 respondents)

Consumer partnership in service planning

Governance

Action 2.1.1: *Consumers and/or carers are involved in the governance of the health service organisation*

- It is not so much the standards that are hard to understand or achieve, rather that we have undergone 3 organisational restructures in 5 years. The focus on consumer involvement in the governance area has been very limited due to the continually changing circumstances.

- More work is required for this action as consumers are reluctant to participate in meetings and forum.

- Engaging consumers at a high level is limited due to the forensic nature of the service and confidentiality.

- Depends on what is meant by 'governance'. This can mean being a Company Director/Board member, which brings a range of additional fiduciary responsibilities, or simply involvement at a policy decision level but not the governance of the organisation. So depending at which level of governance is meant this can be problematic.

- Previously no consumers in governance roles.

Action 2.1.2: *Governance partnerships are reflective of the diverse range of backgrounds in the population served by the health service organisation, including those people that do not usually provide feedback*

- Gaining perspective from those who do not readily engage is always difficult, it takes time and dedication to seek out and engage these groups.

- Emerging model in health organisations and numbers of consumers and carers are limited.

Planning

Action 2.2.1: The health service organisation establishes mechanisms for engaging consumers and/or carers in the strategic and/or operational planning for the organisation

- More work is required for this action.

Action 2.2.2: *Consumers and/or carers are actively involved in decision making about safety and quality*

- Have undergone 3 organisational restructures in 5 years – needing to establish overall organisational committee structures, before our part of the organisation can establish our processes, awaiting clear leadership. This standard is often reflected through informal processes on an individual client/clinician level but the formal committee involvement is more difficult.

- More work is required for this action.

Orientation and training

Action 2.3.1: *Health service organisations provide orientation and ongoing training for consumers and/or carers to enable them to fulfil their partnership role*

- It is difficult to facilitate a training or orientation for carers within a secure forensic setting.

- Providing ongoing training to consumers requires funding and specific skills. It also requires busy consumers to attend. These are barriers that are difficult to overcome.

- As our organisation is just starting to increase our number of formalised consumer partners, we are at the beginning of consideration of what is appropriate training for consumer partners.

- Volunteer burnout.

Patient information publications

Action 2.4.1: *nil comment*

Action 2.4.2: *nil comment*

Consumer partnership in designing care

Health service design

Action 2.5.1: *Consumers and/or carers participate in the design and redesign of health services*

- Design and planning of services often involves industrial and organisational structure issues where staff rights and employment contracts are involved.

- Short tenure as consumers (4 days max residential; outpatient 1/2 day sessions) has not supported this element.

Staff training

Action 2.6.1: *Clinical leaders, senior managers and the workforce access training on patient centred care and the engagement of individuals in their care*

- Have undergone 3 organisational restructures in 5 years – because this has been a time of great change, the organisation is still developing this. We will require all staff to undertake this training, and it is being developed/sourced; however to date has not been available to staff.

- Services are undergoing huge clinical reform so we are getting there.

Action 2.6.2: *Consumers and/or carers are involved in training the clinical workforce*

- The clinical workforce are required to meet specific targets and in order for them to achieve these targets they cannot be taken off service to participate in this sort of training.

- Training by consumers is not something that community health practitioners have traditionally considered as important.

- Volunteer burnout.

- Hard to find community/consumers/carers empowered to participate in training for workforce.

- Emerging model in health organisations and numbers of consumers and carers are limited.
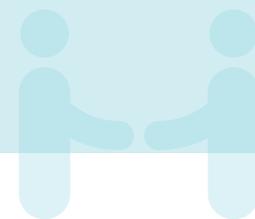
Consumer partnership in service measurement and evaluation

Public reporting

Action 2.7.1: *The community and consumers are provided with information that is meaningful and relevant on the organisation's safety and quality performance*

- Not only do we not have a variety of well-established communication systems with consumers, but defining what quality and safety information interests them, and presenting that in an understandable way is a large piece of work.

- Availability to get to appropriate meetings where discussed.

Safety and quality performance information and data

Action 2.8.1: *Consumers and/or carers participate in the analysis of organisational safety and quality performance*

- We have not been able to facilitate consumer/carer representation into quality performance meetings.

- Historically the culture has not been active in engaging consumers in this way, partly because consumers are short term.

- Difficulty identifying consumers/carers to participate in analysis of performance measures.

Action 2.8.2: *Consumers and/or carers participate in the planning and implementation of quality improvements*

- Difficulty identifying consumers/carers to participate in planning and implementation of changes/improvements.

Patient feedback data

Action 2.9.1: *Consumers and/or carers participate in the evaluation of patient feedback data*

- Ability of consumers to do this work.

Action 2.9.2: *Consumers and/or carers participate in the implementation of quality activities relation to patient feedback data*

- Intrusion of consumers into the clinical service delivery area involves territorial issues between clinicians and consumer responsibility and accountability.

- Consumers' time and availability.

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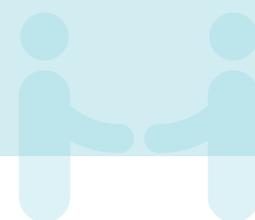
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