



Government of **Western Australia**  
**North Metropolitan Health Service**



# North Metropolitan Health Service

# C<sup>4</sup> Engagement Framework

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**Change Management – Obligation to Consult**

NMHS is cognisant of and committed to the consultative obligations pursuant to the respective Industrial Agreements, the C4 process is not to be used instead of any Industrial Agreement process. Any initiatives that might be identified through the engagement process must be managed according to those obligations.

### Foreword

The North Metropolitan Health Service (NMHS) values the contributions and experiences of their clinicians, consumers and carers. NMHS recognises that there is a role for clinicians, consumers, carers and the community (C<sup>4</sup>) in the planning, delivery, improvement and evaluation of their services.

The framework is designed to guide the planning and delivery of C<sup>4</sup> engagement activities of NMHS hospitals and health services. It has been developed in consultation with clinicians, consumers and carers to help ensure the framework is practical, accessible and meaningful.

As well as being a planning tool, the framework is a reference guide for clinicians and community members wishing to understand the NMHS approach to stakeholder engagement.

There is no 'single way' to engage, the processes utilised will be as diverse as the issues and the people that are part of the engagement.

Engagement is not new to NMHS and this framework seeks to build on our current practice and quality. It offers a way to ensure our efforts deliver the benefits that engagement has been shown to achieve for health services both locally and globally.<sup>1</sup>

The NMHS has chosen to include both clinicians and the community in the one document. While there are specific needs for each group, the fundamental steps and underlying principles of quality engagement are aligned.

### Acknowledgments

The global and local literature is clear about the importance, role and benefits that engagement plays in a successful health service. However, without the clinicians, consumers and carers from NMHS who contributed to this document, its quality and relevance would have been diminished. Thank you.

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<sup>1</sup> Pages 9 and 11 provide some of the research into the benefits of taking this engagement approach.

### Understanding this Document

This document is divided into three main sections:



#### A note about integration with other planning tools

There are a number of different project planning tools utilised within NMHS (e.g. PRINCE 2, LEAN, Six Sigma, Clinical Service Redesign). Each planning tool has the following similar stages of:

- Project Initiation
- Diagnostic Stage / Define, Measure Analysis Stage
- Solution Building Stage / Improve Stage
- Solution Review Stage / Control Stage

The C<sup>4</sup> framework can be incorporated into each of these stages to better inform and assist with engagement planning.

### Glossary of Terms

**Clinician:** All those who provide direct patient care, including medical, nursing and allied health staff.

**Stakeholder:** All those who use, work within, collaborate with or operate alongside or in partnership with NMHS.

**Carer:** People who provide unpaid care and support to family members and friends who have a disability, mental illness, chronic condition, terminal illness or general frailty. Carers include parents and guardians caring for children.<sup>2</sup>

**Community:** Refers to groups of people or organisations with a common interest, including non-government organisations that represent the interests of health care consumers. While some communities may connect through a local or regional interest in health, others may share a cultural background, religion or language or an interest in a specific health issue.<sup>3</sup>

**Consumer:** Potential patients of NMHS

**Engagement:** The process of involving people in decisions that will affect their lives/work. Engagement is a way of recognising that the people affected by decisions bring with them knowledge and understanding that is an important part of decision making. Engagement occurs along a spectrum of potential to influence, depending on the context of each situation.

**Standard:** A statement of the level of performance to be achieved.<sup>4</sup>

**Partnership:** Working together collaboratively to make decisions, sharing responsibility for decisions and collectively owning outcomes.<sup>5</sup>

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<sup>2</sup> Australian Commission on Safety and Quality in Healthcare, (2011) National Safety and Quality Health Service Standards.

<sup>3</sup> Adapted from: Health Consumers Queensland, (2012) Developing a consumer and community engagement strategy: a toolkit for Hospital and Health Services.

<sup>4</sup> The Australian Council on Healthcare Standards.

<sup>5</sup> SA Health (2012) Framework for Active Partnership with Consumers and the Community.

# 1. Understanding engagement

## 1.1 What is Engagement?

Put in the simplest of terms, engagement is about the processes you use to involve people in decisions that affect their lives and/or work.

### **If you are a Clinician....**

There are numerous decisions about your work practice that can feel outside of your control.

There are changes to protocol & procedures that can add complication to the processes you use every day. Or there are changes evident to you that would simplify your role and improve care, but these are not always evident to the people making the decisions.

This is not because decision makers don't care, but because all people only see what they choose.

### **As clinician engagement can be described as...**

The manner in which NMHS involves people who provide direct patient care in the planning, delivery, improvement and evaluation of our health services.

### **If you are a Consumer/Carer...**

There are numerous decisions about your care or the care of someone close to you that can feel outside of your control.

There are changes to protocols and procedures that can add confusion and concern to your care. Or, there may be changes evident to you that would simplify your care, but these are not always evident to the people providing the care.

This is not because clinicians don't care, but because all people only see what they choose.

### **As such consumer/carer engagement can be described as...**

The manner in which NMHS involves people in the planning, delivery, improvement and evaluation of our health services.

## 1.2 The Continuum of Engagement

There is no single way to engage. The way you engage is dependent on a range of factors, such as the context, the issue, the timeline to undertake engagement and the people involved. The outcome is of course also critical and it is useful to remember that outcomes always have two elements the practical, tangible results you are trying to achieve AND the relationships you are left with after achieving the results.

As such, it is useful to think of engagement as occurring along a continuum of ever-increasing influence (empowerment). This level of influence is being offered to the people who are the participants in the engagement and the spectrum below shows the possible levels of influence that can be offered. It

## NMHS C4 Engagement Framework

has been developed by the International Association of Public Participation (IAP2) and is covered in more detail on page 24 for clinicians and page 37 for consumers and carers.

The spectrum does not suggest that one level of influence is better than another, but simply denotes that the level of influence on offer needs to suit the context and the desired outcome. It is the context and desired practical and relationship outcomes that will ultimately determine the most appropriate level of influence.

If all the decisions have been made, then INFORM might be an appropriate level of influence. If there are issues that require the direct guidance of the people you are engaging then EMPOWER might be appropriate. Being able to specify the level of influence reduces the chance of false expectation being created and gives projects a way to check if the influence being offered fits with the desired outcomes (practical and relational).

Based on National Safety and Quality Health Service Standard 2<sup>6</sup> and emerging literature of international examples of 'Consumer directed care'<sup>7</sup>, 'Co-creating'<sup>8</sup> and 'Partnership'<sup>9</sup> are becoming more prevalent across various parts of the health sector. This suggests Health services are being asked to consider models of engagement that deliver to the COLLABORATE and EMPOWER end of the spectrum.

| Increasing level of  |   |   |   |  |
|---|---|---|---|--|
| INFORM  | CONSULT   | INVOLVE   | COLLABORATE   | EMPOWER  |
| This refers to engagement where there is no influence to be had, only information to be shared.           | This refers to engagement where people are asked for their view and then decision makers determine what will occur. | This refers to engagement where people are asked for their view a number of times as options are developed and refined. | This refers to engagement where people are invited 'around the table' to review, discuss and make a final recommendation. | This refers to engagement where people are given the lead to determine the final outcome.                                    |
| This is still considered engagement, as it can be done well or poorly.                                    | The decision is still made away from this process.  | The decision is still made away from this process.  | The final decision is still made away from this process, but typically this is a ratification step.                       | The final decision is made by this group and would carry all the associated responsibility of this level of decision making. |

<sup>6</sup> Australian Commission on Safety and Quality in Health Care. (October 2012) Safety and Quality Improvement Guide Standard 2: Partnering with Consumers. Sydney. ACSQHC.

<sup>7</sup> Rasmussen, E., Jorgensen, K., & Leyshon, S. (2014). Person-Centred Care: Co-Creating a Healthcare for the Future. DNV GL and Monday Morning/ Sustainia 2014: Rosendahls.

<sup>8</sup> Rasmussen, E., Jorgensen, K., & Leyshon, S. (2014). Person-Centred Care: Co-Creating a Healthcare for the Future. DNV GL and Monday Morning/ Sustainia 2014: Rosendahls.

<sup>9</sup> World Health Organisation. (2013). Health 2020: A European Policy Framework and Strategy for the 21<sup>st</sup> Century. Who Regional Office for Europe: Denmark.

### 1.3 Areas of Engagement

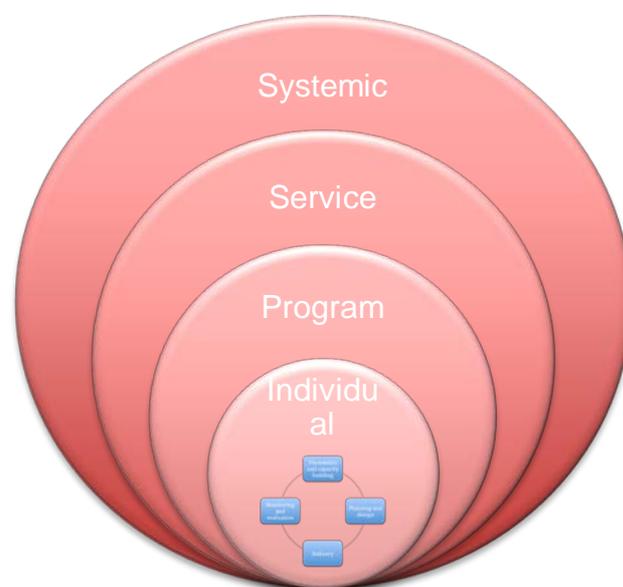
Just as there are different levels of influence that can be offered, there is also a range of Areas that engagement can focus on. At its most basic, engagement is about one or more of the following:

- **Prevention and capacity building:** Engaging to improve peoples ability to self manage. From a consumer engagement point of view, this is about preventing entry into the hospital system
- **Planning and design:** Engaging on the design of services. (Location, priorities, models of care etc)
- **Delivery:** Engaging to improve the consumer experience, efficiency, quality, safety of existing services.
- **Monitoring and evaluation:** Engaging to monitor change, performance and to improve outcomes<sup>10</sup>



The areas of prevention and capacity building, planning and design, delivery and monitoring and evaluation can then be applied to different areas of service provision:

- **Individual:** Development of the individual's experience and how they access and interact with a particular aspect of the provision of care
- **Program:** Development of the operations of a specific program and service within a site
- **Service:** Development of a group of programs and services; including referral pathways, collaboration between services and an individual's transition through programs
- **Systemic:** Development of system-wide policy, processes and priorities.<sup>11</sup>



Note:

- While the above circles imply a distinct areas of focus, the reality of planning and development requires an integration of all areas.

<sup>10</sup> Adapted from; Queensland Government (2012); Consumer and Community Engagement Framework; pg 12

<sup>11</sup> Ibid

### 1.4 Clinician Engagement in More Detail

Clinician engagement has demonstrated itself to be critical to improving health outcomes<sup>12</sup> and essential to the effective running of a well integrated and functioning health system.<sup>13</sup>

NMHS recognises that clinician engagement is fast becoming one of the key priorities for executives and senior managers and a marker of better-performing hospitals.<sup>14</sup> In fact, in some jurisdictions, there is a call for clinicians to go beyond the immediate concerns of their individual professional practice and to engage in the improvement of health care outcomes for entire communities and populations.<sup>15</sup>

Clinician engagement, when done well, is likely to deliver a significant return on investment in terms of improvements in quality, safety, clinical outcomes and value.<sup>16</sup>

There is strong evidence that effective clinician engagement leads to:

- Better clinical outcomes and improved quality of care<sup>17</sup>
- Informed and empowered users and providers of our services<sup>18</sup>
- Increased levels of patient-centred care<sup>19</sup>
- Services that are more responsive to community and clinician needs
- Staff feeling more valued and involved<sup>20</sup>
- Building and maintaining a flexible, motivated and skilled workforce<sup>21</sup>

It has been suggested that without clinician engagement, care will continue to be delivered in isolated clinical pockets, which prevents coordinated action and system-wide improvement.<sup>22</sup>

### 1.5 Consumer, Carer and Community Engagement in More Detail

The process of engagement and participation inherently empowers individuals and communities to understand their own health situations, provide positive input into local health activities and to feel a greater sense of influence over their health service.<sup>23</sup>

*Engaged consumers make better choices, are more likely to avoid negative or*

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<sup>12</sup> Lead Clinicians Groups: Enhancing Clinical Engagement in Australia's Health System

<sup>13</sup> Clark, J. (2012) Medical Engagement: Too Important to be Left Behind. Commissioned by the King's Fund

<sup>14</sup> Guthrie, M. (2005). 'Engaging physicians in performance improvement'. *American Journal of Medical Quality*, vol 20, no 5, pp 235-8.

<sup>15</sup> Brook, R. (2010) Medical Leadership in an Increasingly Complex World. *Journal of the American Medical Association*, vol 304, no 4, pp 465-6.

<sup>16</sup> Clark, J. (2012) Medical Engagement: Too Important to be Left Behind. Commissioned by the King's Fund

<sup>17</sup> Dimitria Bonias, Sandra G. Leggat, & Timothy Bartram (2012). Encouraging Participation in Health System reform: Is Clinical Management a Useful Concept for Policy and Management? *Australian Health Review* 36, 378-383

<sup>18</sup> Robert Wood Johnson Foundation. (2011). Improving Quality Health Care: The Role of Consumer Engagement

<sup>19</sup> Ktpatzer Consulting. (2006). A Review of the Trends and Benefits of Community Engagement and Local Community Governance in Health Care. Community-Centred Primary Health Care: Toronto

<sup>20</sup> John Clark & Vijaya Nath (2014). Medical Engagement: A Journey Not an Event. King's Fund Report

<sup>21</sup> Clark, J., & Nath, V. (2014). Medical Engagement: A Journey Not an Event. King's Fund Report

<sup>22</sup> Stoll, L., Swanwick, T., Foster-Turner, J., & Moss, F. (2011). 'Leadership development for junior doctors: what can we learn from "Darzi" Fellowships in clinical leadership?' *The International Journal of Leadership in Public Services*, vol 7(4) 273-86.

<sup>23</sup> NMHS Board (2017), (*Adapted from Health Consumers Qld 2010*)

*sub-optimal outcomes, and are better able to recognize and stop inappropriate or poor-quality care.*<sup>24</sup>

Effective engagement has shown its ability to achieve better health outcomes for both individuals and communities by increasing empowerment and social capital.<sup>25</sup> Social capital refers to benefits that can be harnessed through reducing the isolation, increasing the sharing of information and building trust networks in communities (of staff or consumers and carers)<sup>26</sup>. It has also delivered more responsive and innovative programs, where programs are developed by and for diverse populations which are matched to their specific needs.<sup>27</sup>

Other benefits of consumer and carers' engagement in healthcare include:

- Improved transparency and accountability for the service and programs<sup>28</sup>
- Restored and strengthened trust in democratic processes<sup>29</sup>
- Ability to meet needs within a diverse, multicultural society through responsive and flexible programs and services<sup>30</sup>
- Better resource allocation and more appropriate health service utilisation based on the values, strengths, resources and expectations of the community<sup>31</sup>
- Increased consumer engagement that leads to increased cooperation and the individuals commitment to their own health (eg: high rates of consumers following through with treatment regimes)<sup>32</sup>
- Enhancement of patient satisfaction, trust, confidence and quality of life<sup>33</sup>
- Increased ability to navigate the healthcare system, as engagement promotes understanding<sup>34</sup>
- Enhanced patient satisfaction as well as quality of life and many improvements to the health system itself when patients are involved in decision-making about their treatment<sup>35</sup>
- Decreased readmission rates<sup>36</sup>
- Improved delivery of preventive care services<sup>37</sup>
- Reduced hospital stays<sup>38</sup>

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<sup>24</sup> Ibid

<sup>25</sup> Ktpatzer Consulting. (2006). A Review of the Trends and Benefits of Community Engagement and Local Community Governance in Health Care. Community-Centred Primary Health Care: Toronto.

<sup>26</sup> <http://www.bettertogether.org/socialcapital.htm>

<sup>27</sup> Ibid.

<sup>28</sup> Ktpatzer Consulting. (2006). A Review of the Trends and Benefits of Community Engagement and Local Community Governance in Health Care. Community-Centred Primary Health Care: Toronto

<sup>29</sup> Church, W.J.B. Technical Report. Citizen Participation Partnership Project. 2006.

<sup>30</sup> Ibid.

<sup>31</sup> Ktpatzer Consulting. (2006). A Review of the Trends and Benefits of Community Engagement and Local Community Governance in Health Care. Community-Centred Primary Health Care: Toronto

<sup>32</sup> Robert Wood Johnson Foundation (2007). Improving Quality Healthcare: The Role of the Consumer. Academy Health Issue Brief, October 2007.

<sup>33</sup> Australian Commission on Safety and Quality in Healthcare, (November 2011), Australian Safety and Quality Goals for Healthcare Consultation Paper

<sup>34</sup> Ibid

<sup>35</sup> Health Consumers Queensland (2012) Community Engagement: Evidence of Improved Health Outcomes, Services and Systems.

<sup>36</sup> Ibid

<sup>37</sup> Ibid

<sup>38</sup> Ibid

Other benefits include a more open culture and team functioning, improved illness management, improvements to service delivery, more flexible and responsive services, greater individualised support, greater quality and safety of health services, reduction of medical errors, improved health policy and improved health environments as a whole.<sup>39</sup>

However, engagement need not be just about focusing on an individual's care. Some health services have begun exploring the engagement of the wider community. This includes exploring models for community governance in policy, planning and decision-making.<sup>40</sup>

### 1.6 What are the Drivers for Focusing on Engagement?

Aside from the clinical, community and efficiency benefits of engagement, NMHS has a role, as part of the National Reform Agenda, to engage with the community and clinicians and to incorporate their views into the day-to-day operational planning of our hospitals, particularly in the areas of safety and quality of patient care.<sup>41</sup>

This is a role taken seriously by the NMHS Board, who are keen to influence, review, endorse and monitor initiatives that ensure appropriate clinician, consumer, carer and community engagement in service planning and development, delivery, improvement and evaluation across NMHS.<sup>42</sup>

At the clinical level, *Clinical reform and reconfiguration – NMHS A Framework for Reform*<sup>43</sup> is our plan for system-wide reform; it recognises that without engagement from clinicians and the community, this reform would not be possible. This includes but is not limited to achieving lower costs per patient, reduced length of stay and increased workforce satisfaction and retention rates.<sup>44</sup>

Engagement also forms a prominent part of the National Safety and Quality Health Service Standards (NSQHS). These standards provide a nationally consistent intention to develop health services that are responsive to patient, carer and consumer input and needs.<sup>45</sup> See Appendix 1 on page 54 for this Standard.

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<sup>39</sup> Ktpatzer Consulting. (2006). A Review of the Trends and Benefits of Community Engagement and Local Community Governance in Health Care. Community-Centred Primary Health Care: Toronto

<sup>40</sup> Ibid.

<sup>41</sup> Council of Australian Governments (2011) National Health Reform Agreement, Schedules D, E.

<sup>42</sup> GC C&CE Sub-Committee Terms of Reference Nov 2012

<sup>43</sup> NMHS A Framework for Reform: 2013, NMHS Strategy and Planning Unit

<sup>44</sup> Charmel P, Frampton S. (March 2008). Building the business case for patient-centred care. *Healthcare Financial Management* 62 (3):80-85

<sup>45</sup> Australian Commission on Safety and Quality in Health Care. (October 2012) Safety and Quality Improvement Guide Standard 2: Partnering with Consumers. Sydney. ACSQHC.

### 1.7 Principles for Quality Engagement

NMHS already engages with clinicians and the community on many levels, but as with any process it is important to continually refine the quality of how it is delivered.

Regardless of what you do to engage people (meetings, surveys etc), quality is determined not just by what is done, but how it is done. Poorly delivered engagement can alienate and disenfranchise the very people you are trying to engage and can result in increased cynicism towards current and future initiatives.<sup>46</sup> As such, while time and work pressures are ever present, the risk of NOT engaging well are high. The following principles are adapted from the relevant WA Health Policy<sup>47</sup> and underpin what quality engagement means to the NMHS.

#### NMHS Principles for Quality Engagement

|                       |   |
|-----------------------|---|
| <b>Meaningful</b>     | A clear purpose is supported by the allocation of sufficient time, resources and leadership to ensure participation is meaningful.  |
| <b>Responsive</b>     | The engagement approach is chosen based on an understanding of the needs of those being engaged and aligned with any social, political, economic and environmental changes. |
| <b>Open</b>           | Information is accessible and transparent. Participants know the level of influence on offer and any decisions already made.  |
| <b>Respectful</b>     | Building trust through respecting the confidentiality of information shared, valuing the contribution and different perspectives people offer.                              |
| <b>Accessible</b>     | The selected engagement methods make it easy for people to participate and match their preferred participation needs.   |
| <b>Participatory</b>  | Sufficient opportunities are provided for people to participate to the level of influence offered.  |
| <b>Follow Through</b> | Clear communication back to participants on how input has influenced the decision and provision of updates on the progress of implementation.                               |
| <b>Evaluation</b>     | Transparent monitoring and evaluation of the outcomes lead to developing practice service-wide.   |

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Please see pages 28 or 51 for indicators linked to these quality principles.

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<sup>46</sup> Hanneke van der Meide, Gert Olthuis, Carlo Leget (2014). Patient Participation in Hospital Care: How Equal is the Voice of the Client Council? Springer Science: New York.

<sup>47</sup> WA Health, (2007). Consumer Carer and Community Engagement Framework.

## PART 2A: GUIDE TO CLINICIAN ENGAGEMENT

Clinician engagement is the manner in which NMHS involves people who provide direct patient care in the planning, delivery, improvement and evaluation of our health services.

### 2. Do I need to engage?

Use the following guide to see if something you are working on could be a candidate for clinician engagement.

| Do I need to engage? |   |          |
|----------------------|---|----------|
| Impact               | <ul style="list-style-type: none"> <li>• Will the change/decision affect the work of other people?</li> <li>• Will other people influence what possible options can be considered/implemented?</li> </ul>                         | Yes / No |
| Perspective          | <ul style="list-style-type: none"> <li>• Is there value in considering other perspectives on the best way to approach the situation?</li> </ul>   | Yes / No |
| Buy In               | <ul style="list-style-type: none"> <li>• Will the implementation of the change/decision require the support and backing from others?</li> </ul>   | Yes / No |
| Reaction             | <ul style="list-style-type: none"> <li>• Could people react negatively to the proposed change/decision?</li> <li>• Is there a possibility that your perspective is different to those affected by the change/decision?</li> </ul> | Yes / No |
| Empowerment          | <ul style="list-style-type: none"> <li>• Will making the decision in isolation, prevent others from learning and developing, thus weaken the service overall?</li> </ul>  | Yes / No |

Resource I: Do I need to engage Clinicians?

If you have answered yes to one or more of these questions, then your project or service improvement is a candidate for engagement.

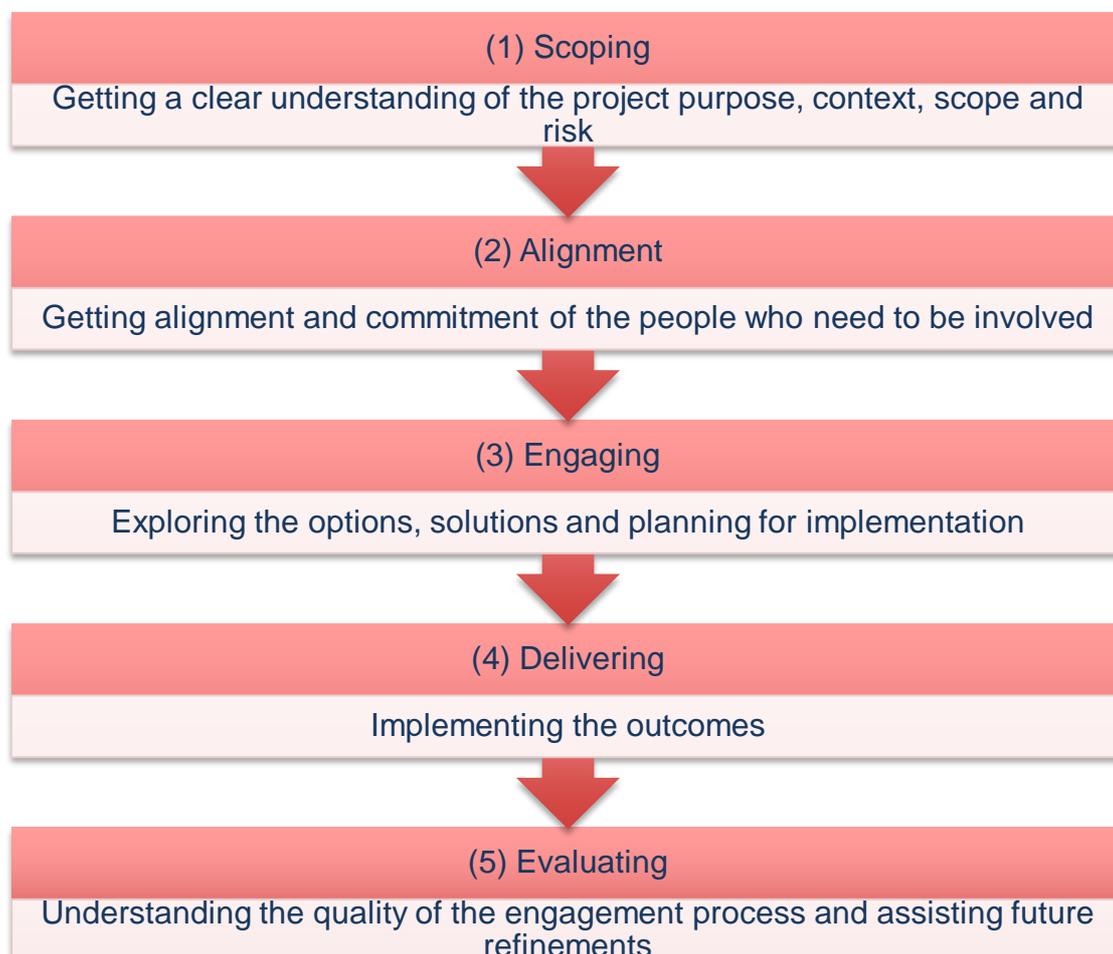
Generally speaking, if engagement is required, the sooner clinicians are engaged in decisions that may affect their work the better, as demonstrated in case studies where clinicians are fostered and encouraged to be active in decision making from the earliest opportunity.<sup>48</sup> This early engagement improves the quality of the decision and builds a sense of shared ownership.<sup>49</sup>

<sup>48</sup> John Clark & Vijaya Nath (2014). Medical Engagement: A Journey Not an Event. King's Fund Report

<sup>49</sup> Niroshan Siriwardena (2009) Engaging Clinicians in Quality Improvement Initiatives: Art or Science? *Quality in Primary Care* 17 303-5.

### 3. Planning to Engage

Like any project, engagement requires some thought and planning. While the level of detail and formality of the planning may vary depending on the size and risk associated with the project, planning will typically follow these steps:



Resource II: Planning Sequence - Clinician

#### 3.1 The Engagement Approach

The following pages will take you through the above process in more detail and offer key questions to consider at each step. As you begin to work through these steps, consider how you are approaching each question.

The traditional clinical medical model is empirical by nature, where the person doing the 'consulting' is often expected to bring with them the solution or at least know where to get it. This approach is important and necessary when considering care and treatment protocols; however, engagement requires a different approach.

The engagement approach requires a willingness to 'consult' and even a willingness to NOT have the answer, it requires more of a relationship focus, where your role is to understand and facilitate the diversity of people, players and systems you are working with and in. This difference of opinion, when

managed well, can open previously unheard perspectives and greatly improve decision making.<sup>50</sup>

### 3.2 Steps of Engagement Planning

|                              |  |
|------------------------------|--|
| <b>(1)</b><br><b>Scoping</b> | <p>This phase is about getting a clear understanding of the project purpose, scope and risk. We don't know, what we don't know, as such it is important to be systematic and open minded when scoping an engagement project.</p> <p style="text-align: center;">“Seek first to understand, then to be understood”<br/>- Steven Covey</p> |
|------------------------------|--|

There are five main elements to understanding project scope<sup>51</sup>:

#### Context

- What is the issue to be addressed?
- Will the timeframe allow for effective engagement?
- What is the purpose of engaging:
  - Practical outcomes
  - Experiential outcomes
- What has happened in the past?
- What commitments and decisions have already been made?
- What do we currently know? What data do we have that supports this, challenges this?



#### World, National, Regional Trends

- What is happening locally, nationally and globally that might have a bearing on this issue, in terms of the options available to us or the way people might respond to what is being considered?
- Are there emerging research or practice examples from elsewhere that would inform our approach?

#### Community (Staff)

- What is happening within this organisation, what other changes or initiatives are occurring at this time?
- What is the culture and mood of the people that would be affected by this change?

#### Organisational

- What are the drivers for this

#### Personal

- Who are the key people and

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<sup>50</sup> James Surowiecki, (2004) The Wisdom of Crowds.

<sup>51</sup> IAP2 (2014). Australasia, Certificate of Engagement [www.iap2.org.au](http://www.iap2.org.au)

- change?
  - What is the organisation's commitment to the change?
  - How well placed is the organisation to implement the outcomes of this engagement?
- decision makers?
  - Who will need to take carriage of the decision once it is made?
  - Who will influence the final decision?
  - Who will be the most affected by this change?
  - What are each group's views on the change?

Resource III: Scoping questions – Clinician engagement

(2)  
Alignment

This phase is about getting the buy in of the people at the executive level, the management levels and with the clinical leaders and teams that will need to implement it.

Change is typically part of any given engagement program. The literature on successful change management is quite clear that any project looking to initiate some form of change requires the backing of the senior people in the organisation, a skilled team, space for people to participate and sufficient time to engage.<sup>52</sup>

This phase is about ensuring there is the required level of internal alignment of people, decision makers at all levels of the organisation and those who need to resource and/or implement these decisions.

### Do I have the backing to commence?

|                            |   |
|----------------------------|---|
| <b>Executive Support</b>   | <ul style="list-style-type: none"> <li>Is there an executive champion or sponsor for this initiative? Yes / No</li> <li>Is there commitment/resourcing to do something with the outcomes/recommendations? Yes / No</li> </ul>   |
| <b>Engagement Team*</b>    | <ul style="list-style-type: none"> <li>Do we have someone with the engagement, communication and interpersonal skills to ensure the people are engaged and heard and diversity of views respected? Yes / No</li> <li>Are there defined roles and clear delegation? Yes / No</li> <li>Does the team have (can they establish) credibility with the people we are trying to engage? Yes / No</li> </ul> |
| <b>Clinical Leadership</b> | <ul style="list-style-type: none"> <li>Do we have the backing of the clinical leadership? Yes / No</li> <li>Do we have or have access to the requisite clinical experience as part of the project team? Yes / No</li> </ul>   |
| <b>Time</b>                | <ul style="list-style-type: none"> <li>Is there a clear project plan with sufficient timelines for the various stages of planning, information gathering, consultation, options assessment, decision making and implementation? Yes / No</li> <li>Is there a risk the people we are consulting will feel that this is tokenistic? Yes / No</li> </ul>   |

Resource IV: Alignment Check list – Clinician Engagement

<sup>52</sup> Sirkin, Keen & Jackson, (Oct 2005), The Hard Side of Change Management, *Harvard Business Review*.

## **NMHS C4 Engagement Framework**

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As part of the development of this framework, the consultation process with clinicians affirmed that successful engagement requires strong credentials to avoid appearing tokenistic or losing traction along the way.

\* There may be value in considering the role of the consumer or carer.

(3)

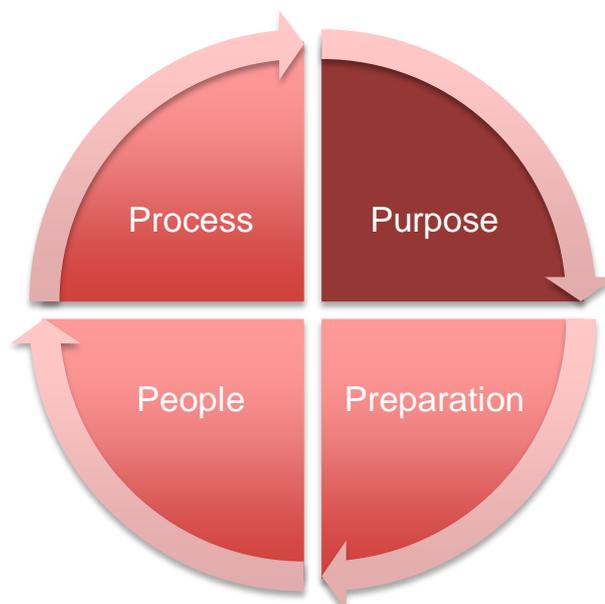
Engaging

This phase is about the process of building the knowledge base, developing the options and having the important conversation.

*“While many fear ‘real’, it is the unreal conversation that should scare us to death.” Susan Scott*

This is a critical stage in the engagement process, because it involves finding ways to bring people together who might have different clinical, social and cultural backgrounds. In a high-pressured work environment it can become easier to have the ‘polite’ conversation and then allow decision making to occur elsewhere where there are fewer people and less room for disagreement. However, this process of consultation and decision making can have negative effects on the quality of the decision.<sup>53</sup>

Many people jump to focusing on the technique that might be utilised (interview, survey, workshop) too early in an engagement project. Prior to considering the process, there are at least three essential steps to ensure the quality of participation and outcome.



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<sup>53</sup> Hanneke van der Meide, Gert Olthuis, Carlo Leget (2014). Patient Participation in Hospital Care: How Equal is the Voice of the Client Council? Springer Science: New York

### Consultation Preparation

|                    |  |
|--------------------|--|
| <b>Purpose</b>     | <ul style="list-style-type: none"><li>• What is the purpose of consulting with these people?</li><li>• What practical outcomes are you looking for?</li><li>• What practical outcomes are the people you are going to consult looking for?</li><li>• What do you want people to understand and/or feel after having been consulted?</li><li>• What level of decision making authority are people being given? (see IAP2 spectrum on page 25)</li></ul>   |
| <b>Preparation</b> | <ul style="list-style-type: none"><li>• Does everyone have the same information about the topic? Is our information plain English and/or easy to follow?</li><li>• What background do they need to be able to participate fully (e.g. training, information, experience)?</li><li>• How much time do they need to provide a considered view?</li><li>• What are the power dynamics or personal opinions that might affect how others get heard?</li><li>• What are the criteria for a quality decision? Is there agreement on this?</li></ul>  |
| <b>People</b>      | <ul style="list-style-type: none"><li>• Who needs to be consulted?</li><li>• What is their preferred method of consultation?</li><li>• What are the best times and dates to undertake the consultation?</li><li>• How can the information be presented so it best suits the individuals' learning styles?</li></ul>  |
| <b>Process</b>     | <ul style="list-style-type: none"><li>• What is the best way to gather the information?<br/>For example:<ul style="list-style-type: none"><li>○ Face-to-face meetings</li><li>○ Focus groups</li><li>○ Workshops</li><li>○ Interviews</li><li>○ Surveys</li><li>○ Social media</li></ul></li><li>• Which process best delivers the level of influence promised?<br/>For example:<ul style="list-style-type: none"><li>○ Surveys are good for one way information collection</li><li>○ Meetings, when run well, can be used for consensus decision making</li></ul></li><li>• Do we have/need someone with enough independence and communication/facilitation skills?</li></ul> |

### 3.3 Level of Influence

It can be easy for people to confuse being involved in consultation with having the decision making authority. While the two are not mutually exclusive, a lack of transparency about what level of influence is being offered can lead to a mismatch of expectations.

As such, part of the alignment process involves becoming clear and transparent about what level of influence you are going to offer people.

The International Association of Public Participation (IAP2)<sup>54</sup> has developed a spectrum that has become an informal industry standard for identifying and communicating the level of influence being offered for any given consultation.

There are five levels of influence described in the chart below. The level of influence offered should be determined by the project scope.



| INFORM   | CONSULT   | INVOLVE   | COLLABORATE   | EMPOWER  |
|--|---|---|---|--|
| <b>Goal:</b>   |   |   |   |  |
| To provide the people with balanced and objective information to assist them in understanding the problems, alternatives and/or solutions. | To obtain people's feedback on analysis, alternatives and/or decisions.   | To work directly with the people throughout the process to ensure that public concerns and aspirations are consistently understood and considered.  | To partner with the people in each aspect of the decision, including the development of alternatives and the identification of the preferred solution.                                | To place final decision making in the hands of the people. |
| <b>Promise:</b>  |   |   |   |  |
| We will keep you informed.   | We will keep you informed, listen to and acknowledge concerns and provide feedback on how public input influenced the decision. | We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision. | We will look to you for direct advice and innovation in formulating solutions; we will incorporate your advice and recommendations into the decisions to the maximum extent possible. | We will implement what you decide.                         |

<sup>54</sup> Used with permission IAP2 International [www.iap2.org](http://www.iap2.org)

| Example Tools:   |   |   |   |  |
|--|---|---|---|--|
| <ul style="list-style-type: none"> <li>• Fact sheets</li> <li>• websites</li> <li>• email circulars</li> </ul> | <ul style="list-style-type: none"> <li>• focus groups</li> <li>• surveys</li> <li>• meetings</li> </ul> | <ul style="list-style-type: none"> <li>• workshops</li> <li>• deliberative polling</li> </ul> | <ul style="list-style-type: none"> <li>• advisory committees</li> <li>• working groups</li> </ul> | <ul style="list-style-type: none"> <li>• citizen juries</li> <li>• ballots</li> <li>• delegated decisions</li> </ul> |

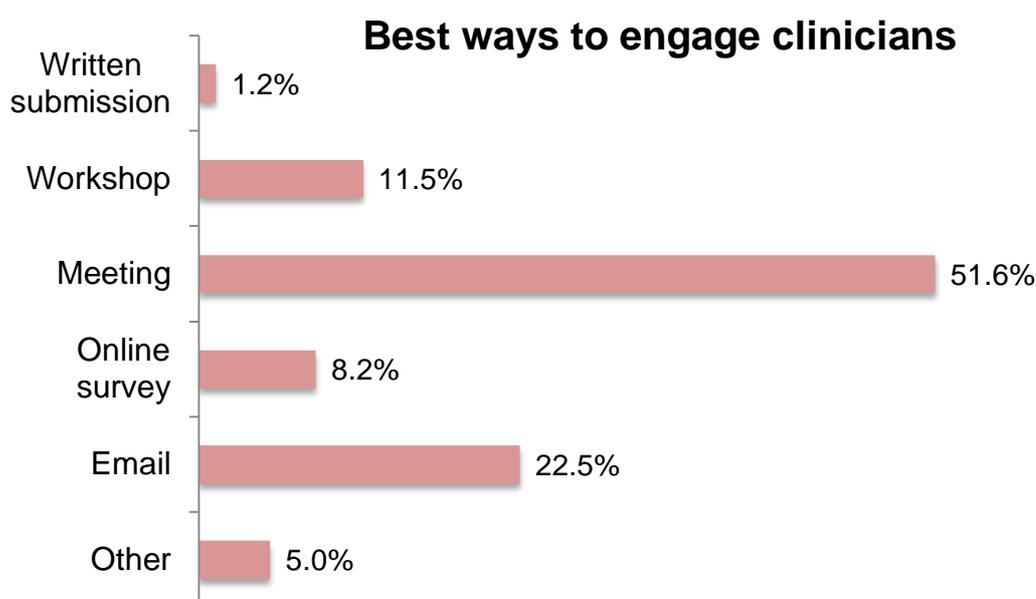
Resource VI:

IAP2 Spectrum

### 3.4 Methods of Engaging Clinicians at NMHS

One aspect of the NMHS consultation that contributed to the development of this framework sought to understand HOW clinicians preferred to be engaged. The results indicated that clinicians would prefer more notice, opportunity and better quality information when being engaged.<sup>55</sup>

On a practical level, the consultation showed that clinicians had a clear preference to deal with matters that affected their work through face-to-face meetings.<sup>56</sup>



Providing the time for clinicians to undertake this face-to-face approach, coupled with allowing the people involved to build the common language required, were essential aspects of successful clinician engagement.

For many clinicians their primary focus is the care of their individual patients. However, this can mean that the relevance and relative importance of involvement in administrative and decision making affecting the broader health service is not always apparent.<sup>57</sup> As such the engagement approach needs to demonstrate the short- or long-term relevance to the care of their patients. See Appendix 2 on page 55 for examples of different types of engagement techniques/processes.

<sup>55</sup> Aha! Consulting (July 2014) NMHS Clinician and Consumer CE Report

<sup>56</sup> Ibid

<sup>57</sup> Glouberman, Mintzberg (1996), Managing the Care of Health and the Cure of Disease

(4)  
Delivering

This phase is about ensuring people understand the outcomes of the consultation and that something is being done with it.

*“However beautiful the strategy, you should occasionally look at the results.”*

*Winston Churchill*

Closing the loop is one of the most important aspects of quality engagement.<sup>58</sup> Closing the loop means that once the conversations have been had, views have been gathered and a decision made, time is taken to ensure that the people engaged know about the outcomes, about how their views have been considered and that something is going to be done with the findings.



A lack of feedback to participants of a consultation and a perceived lack of follow through can have a negative effect on people’s willingness to be engaged in the future.

As such, engagement plans need to include the following two steps:

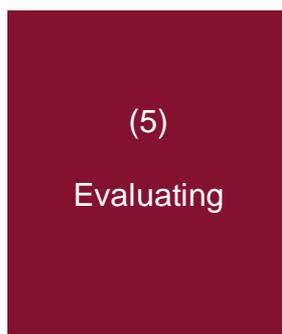
**Closing the loop**

- |                            |   |
|----------------------------|---|
| Communicating the Outcomes | <ul style="list-style-type: none"> <li>• Have you informed the people that were consulted of what the outcomes of the consultation?</li> <li>• Have you made it clear how their views were considered?</li> </ul> |
|----------------------------|---|

- |                           |  |
|---------------------------|--|
| Implementing the Outcomes | <ul style="list-style-type: none"> <li>• What plans are in place to implement the outcomes of the consultation?</li> <li>• Have these plans been communicated to the people involved?</li> </ul> |
|---------------------------|--|

Resource VII: Closing the Loop – Clinician Engagement

<sup>58</sup> IAP2 Core Values ([www.iap2.org.au/about-us/about/core-values](http://www.iap2.org.au/about-us/about/core-values))



This is about a commitment to improving the quality of the process and sharing these learnings across the organisation.

*“ Solving problems is important. But if learning is to persist, managers and employees must also look inward.”*

*Chris Argyris*

Through the development of this guide, clinicians and consumers were asked to define the key indicators of quality for an effective engagement program.

| Quality Principle   | Indicators  |
|---|---|
| <p><b>Meaningful</b></p> <p>A clear purpose is supported by the allocation of sufficient time, resources and leadership to ensure participation is meaningful.</p>  | <ol style="list-style-type: none"> <li>1. There is a clearly communicated purpose for the engagement</li> <li>2. There is a commitment to progressing the project outcomes</li> <li>3. There is support for the project from senior leadership</li> <li>4. Commitments are recorded and progress is reported back to participants in a timely manner</li> </ol>   |
| <p><b>Responsive</b></p> <p>The engagement approach is chosen based on an understanding of the needs of those being engaged and aligned with any social, political, economic and environmental changes.</p> | <ol style="list-style-type: none"> <li>5. Engagement occurs early in the life cycle of the project</li> <li>6. Sufficient scoping ensures an understanding of how to best engage with the participant group/s</li> <li>7. The engagement plan is developed in accord with the current social, political, economic and environmental context</li> <li>8. Participants can communicate with the project team easily and are responded to promptly</li> </ol>                              |
| <p><b>Open</b></p> <p>Information is accessible and transparent. Participants know the level of influence on offer and any decisions already made.</p>  | <ol style="list-style-type: none"> <li>9. Participants have access to information in a format that matches their literacy and learning styles</li> <li>10. Information is provided with time for participants to contribute in a considered way</li> <li>11. Participants understand what decisions have been made and any ‘non-negotiable’ elements of the project</li> <li>12. Participants understand the level of influence being offered (see IAP2 spectrum on page 37)</li> </ol> |

| Quality Principle   | Indicators   |
|---|--|
| <p><b>Respectful</b></p> <p>Building trust through respecting the confidentiality of information shared and valuing different perspectives people offer.</p>              | <p>13. Privacy, confidentiality and anonymity are respected where necessary</p> <p>14. The method of engagement supports people with diverse opinions and backgrounds to participate in a non-threatening environment</p> <p>15. Participants understand the various project roles and communication channels</p> <p>16. The engagement method shows consideration for social, cultural and historical experiences that could be triggered during a consultation</p> |
| <p><b>Accessible</b></p> <p>The selected engagement methods make it easy for people to participate.</p>   | <p>17. Sufficient effort is made to ensure the time, duration and location of engagement aligns with the participants' preferred engagement style</p> <p>18. Sufficient effort is made to mitigate the practical and cultural barriers to participation (e.g. language, literacy, cultural safety, participation costs, child care, existing workloads etc)</p>  |
| <p><b>Follow Through</b></p> <p>Clear communication to participants on how input has influenced the decision and providing updates on the progress of implementation.</p> | <p>19. Participants understand how their input is used to inform the final outcome</p> <p>20. Participants are informed about the progress of the implementation of the project outcomes</p>   |
| <p><b>Evaluation</b></p> <p>Transparent monitoring and evaluation of the outcomes leading to developing engagement practice service-wide.</p>                             | <p>21. Outcome and process evaluation form part of the project planning and data collection</p> <p>22. Participant feedback on the process forms part of the data collection</p> <p>23. Lessons learnt are communicated and distributed in a way that supports development of engagement practice service-wide</p>   |

Resource VIII:

Quality Indicators – Clinician Engagement

## 4. Examples of Clinician Engagement

### 4.1 NMHS Example of Engagement

The following examples of clinician engagement within NMHS were used to help to inform the development of this framework.

| Health Service/Project  | Project Description  | Benefits   |
|---|--|--|
| <b>King Edward Memorial Hospital (KEMH)</b><br><br>Emergency Centre Redesign Project                            | To address National Emergency Access Target (NEAT) by:<br><br>(1) Improving patient flow through the Emergency Centre<br><br>(2) Improving the overall patient experience and enhance access to timely clinical care and decision making | <ul style="list-style-type: none"> <li>• Greater clinician awareness of change and attitude toward change - better relationship with staff in EC and on Ward 6</li> <li>• Better understanding of the processes that occur in each of these areas by the other area</li> <li>• Meeting national targets consistently due to ongoing ownership of project outcomes by staff in EC and on Ward 6</li> </ul>      |
| <b>Osborne Park Hospital (OPH)</b><br><br>Surgi-Centre Re-development   | To address National Elective Surgery Target (NEST) by:<br><br>(1) Improving flow of outpatients through to day of surgery (knife to skin)  | <ul style="list-style-type: none"> <li>• OPH now achieving the NEST for more than a year</li> <li>• Adheres to the state-wide policies and operational directives relating to the service</li> <li>• New structured processes resulted in improved communication and eliminating 'waste' within the service</li> <li>• Structured wait list management process for elective surgery was implemented</li> </ul> |
| <b>Public Health and Ambulatory Care (PHAC)</b><br>Humanitarian Entrant Health Service (HEHS) shared care model | Redesign of the post arrival refugee health assessment program to engage GPs in the process and to provide health care to clients in the community   | <ul style="list-style-type: none"> <li>• Improved communication and collaboration</li> </ul>   |
| <b>KEMH</b>   | Design of a meeting  | <ul style="list-style-type: none"> <li>• Designed with Aboriginal women</li> </ul>   |

## NMHS C4 Engagement Framework

|  |   |  |
|--|---|--|
| Moort Mandja Mia (Family Gathering Place)                            | place for patients, their families and children to come together  | <p>in the community (metro area), departmental staff, artists and funding bodies</p> <ul style="list-style-type: none"> <li>• Delivery of culturally appropriate area the consumers asked for, i.e. artwork and acknowledgement of traditional owners</li> <li>• Connecting clinicians and consumers for the opening, naming and smoking ceremony</li> <li>• High level of utilisation by staff, patients and families/visitors</li> </ul>                                     |
| <b>Sir Charles Gardiner Hospital (SCGH)</b><br>Charles Wait Watchers | To decrease patient waiting times in the Medical Oncology clinic and day chemotherapy unit by April 2014. Thereby, increasing patient satisfaction, improving efficiency and safety, and decreasing cost to the department. | <ul style="list-style-type: none"> <li>• Development of closer relationships between different departments/ professions within the cancer centre</li> <li>• Collaboration, insight into clinician and consumer perceptions of the current service state and where improvements needed to be made</li> <li>• Engaging in multi-disciplinary approach to root cause analysis to determine the actual problems and the development of solutions within the department.</li> </ul> |

Resource IX: Examples of NMHS Clinician Engagement

### 4.2 Another Example of Engagement

| Health Service/Project   | Project Description  | Benefits  |
|--|--|---|
| <b>Salford Royal NHS Foundation Trust</b><br><br>(long-term improvement of clinician engagement) | Fostering a very strong focus and investment on empowering all staff to identify and contribute to safety, quality and service improvements, and an overriding aim to be the safest organisation in the NHS. | <ul style="list-style-type: none"> <li>• Recognised as having the highest consistent rating for service quality coupled with one of the highest sets of patient and staff satisfaction scores. It was also rated as the best place to work in the NHS, according to the annual NHS Staff Survey (2013).</li> <li>• The clinical engagement strategy of Salford Royal has been effective in increasing productivity and safety.</li> </ul> |

Resource X: Examples of Clinician Engagement other services

## PART 2B: GUIDE TO CONSUMER, CARER AND COMMUNITY ENGAGEMENT

Consumer, carer and community engagement is the manner in which NMHS involves people in the planning, delivery, improvement and evaluation of our health services.

### 5. Do I need to engage?

Use the following guide to see if something you are working on could be a candidate for engagement.

| Do I need to engage? |   |          |
|----------------------|---|----------|
| <b>Impact</b>        | <ul style="list-style-type: none"> <li>Will the change/decision affect someone's care or the experience of a carer?</li> <li>Will other people influence what possible options can be considered/implemented?</li> </ul>      | Yes / No |
| <b>Perspective</b>   | <ul style="list-style-type: none"> <li>Is there value in considering other perspectives on the best way to approach the situation?</li> </ul>   | Yes / No |
| <b>Buy In</b>        | <ul style="list-style-type: none"> <li>Will the implementation of the change/decision require the support and backing from others?</li> </ul>   | Yes / No |
| <b>Reaction</b>      | <ul style="list-style-type: none"> <li>Could people react negatively to the proposed change/decision?</li> <li>Is there a possibility that your perspective is different to those affected by the change/decision?</li> </ul> | Yes / No |
| <b>Empowerment</b>   | <ul style="list-style-type: none"> <li>Will making the decision in isolation, prevent others from learning and developing, thus weaken care delivery overall?</li> </ul>  | Yes / No |

Resource XI: Do I need to Engage? - Consumers or Carers

If you have answered yes to one or more of these questions, then your project or service improvement is a candidate for engagement.

Generally speaking, if engagement is required, the sooner consumers or carers are engaged in decisions that may affect care, the better.

This early engagement improves the quality of the decisions and builds a sense of shared ownership.<sup>59</sup>

<sup>59</sup> John Clark & Vijaya Nath (2014). Medical Engagement: A Journey Not an Event. King's Fund Report

### 6. Planning to Engage

Like any project, engagement requires some thought and planning. While the level or detail and formality of the planning may vary depending on the size and risk associated with the project, planning will typically follow this steps:

Resource XII: Planning Sequence - Clinician

#### 6.1 The Engagement Approach

The following pages will take you through the above steps in more detail and offer key questions to consider at each step. As you begin to work through these steps, consider how you are approaching each question.

The traditional clinical medical model is empirical by nature, where the person doing the 'consulting' is often expected to bring with them the solution or at least know where to get it. This approach is important and necessary when considering care and treatment protocols; however, engagement requires a different approach.

The engagement approach requires a willingness to 'consult' and even a willingness to NOT have the answer, it requires more of an relationship focused approach, where your role is to understand and facilitate the diversity of people, players and systems you are working in. This difference of opinion, when managed well, can open previously unheard perspectives and improve decision making.<sup>60</sup>

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<sup>60</sup> James Surowiecki, (2004) The Wisdom of Crowds.

### 6.2 Steps of Engagement Planning



This phase is about getting a clear understanding of the project purpose, scope and risk. We don't know, what we don't know, as such it is important to be systematic and open minded when scoping an engagement project.

“Seek first to understand, then to be understood”  
- Steven Covey

There are five main elements to understanding project scope.<sup>61</sup>

#### Context

- What is the issue to be addressed?
- Will the timeframe allow for effective engagement?
- What is the purpose of engaging
  - Rational
  - Experiential
- What has happened in the past?
- What commitments and decisions have already been made?
- What do we currently know? What data do we have that supports this, challenges this?
- Is the information in plain English, accessible language and visually easy to read?



#### World, National, Regional Trends    Community

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>• What is happening locally, nationally and globally that might have a bearing on the options available to us?</li> <li>• What is the political, social and media sentiment towards what is being proposed?</li> <li>• Are there emerging research or practice examples from elsewhere that could inform our approach?</li> </ul> | <ul style="list-style-type: none"> <li>• What other consultation might be happening within the community?</li> <li>• What other changes are they being asked to consider?</li> <li>• Are there cultural or historical considerations that might affect how/where/when you engage?</li> <li>• What are each group's views on the change?</li> </ul> |
|--|--|

#### Organisational

- What are the drivers for this change?
- What is the organisation's

#### Personal

- Who are the key people and decision makers (internal/external)?

<sup>61</sup> IAP2 Australasia, Certificate of Engagement 2014. [www.iap2.org.au](http://www.iap2.org.au)

## NMHS C4 Engagement Framework

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- commitment to doing something with the feedback?
- How well placed is the organisation to implement any feedback?
- Does the project lead have the required engagement capabilities?
- Who will need to take carriage of the decision once it is made?
- Who will influence the final decision?
- Who will be the most affected by this change?

Resource XIII:

Scoping questions- Consumers or Carers

(2)  
Alignment

This phase is about getting the buy in of the people that need to be involved internally (executive, management, clinical) and externally (community leaders, community members etc). This is also about building the team that will need to implement it.

Change is typically part of any given engagement program. The literature on successful change management is quite clear that any project looking to initiate some form of change requires the backing of the senior people in the organisation, a skilled team, space for people to participate and sufficient time to engage.<sup>62</sup>

This phase is about ensuring there is the required alignment of decision makers at all levels of the organisation, those that need to resource and/or implement these decisions and external leaders.

| Do I have the backing to commence? |   |  |
|------------------------------------|---|--|
| <b>Executive Support</b>           | <ul style="list-style-type: none"> <li>Is there an executive champion or sponsor for this initiative?</li> <li>Is there commitment/resourcing to do something with the outcomes/recommendation?</li> </ul>  | Yes / No<br>Yes / No                         |
| <b>Engagement Team</b>             | <ul style="list-style-type: none"> <li>Do we have someone with the engagement, communication and interpersonal skills to ensure the people are engaged, heard and diversity of views respected?</li> <li>Are there defined roles and clear delegation?</li> <li>Does the team have (can they establish) credibility with the people we are trying to engage?</li> </ul> | Yes / No<br>Yes / No<br>Yes / No             |
| <b>Leadership</b>                  | <ul style="list-style-type: none"> <li>Do we have the backing of community leaders?</li> <li>Do these people speak for the whole community?</li> <li>Do we have the backing of the clinical leadership?</li> <li>Do we have or have access to the requisite clinical experience as part of the project team?</li> </ul>   | Yes / No<br>Yes / No<br>Yes / No<br>Yes / No |
| <b>Time</b>                        | <ul style="list-style-type: none"> <li>Is there a clear project plan with sufficient timelines for the various stages of planning, information gathering, consultation, options assessment, decision-making and implementation?</li> <li>Is there a risk people we are consulting will feel that this is a tokenistic?</li> </ul>                                       | Yes / No<br>Yes / No                         |

Resource XIV:

Alignment Check list- Consumers or Carers

As part of the development of this framework, the consultation process with consumers and carers affirmed that successful engagement requires strong

<sup>62</sup> Sirkin, Keen & Jackson, (Oct 2005), The Hard Side of Change Management, *Harvard Business Review*.

credentials/credibility and to avoid appearing tokenistic or losing traction along the way.

### 6.3 Level of Influence

It can be easy for people to confuse being involved in consultation with having the decision making authority. While the two are not mutually exclusive, a lack of transparency about what level of influence is being offered can lead to a mismatch of expectations.

As such, part of the alignment process involves becoming clear about what level of influence you are going to offer people.

The International Association of Public Participation (IAP2)<sup>63</sup> has developed a spectrum that has become an industry standard for identifying and communicating the level of influence being offered for any given consultation.

There are five levels of influence described in the chart below. The level of influence offered should be determined by the project scope.

| INFORM   | CONSULT   | INVOLVE   | COLLABORATE   | EMPOWER  |
|--|---|---|---|--|
| <b>Goal:</b>   |   |   |   |  |
| To provide the people with balanced and objective information to assist them in understanding the problems, alternatives and/or solutions. | To obtain people's feedback on analysis, alternatives and/or decisions.   | To work directly with the people throughout the process to ensure that public concerns and aspirations are consistently understood and considered.  | To partner with the people in each aspect of the decision, including the development of alternatives and the identification of the preferred solution.                                | To place final decision making in the hands of the people. |
| <b>Promise:</b>  |   |   |   |  |
| We will keep you informed.   | We will keep you informed, listen to and acknowledge concerns and provide feedback on how public input influenced the decision. | We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision. | We will look to you for direct advice and innovation in formulating solutions; we will incorporate your advice and recommendations into the decisions to the maximum extent possible. | We will implement what you decide.                         |
| <b>Example Tools:</b>  |   |   |   |  |

<sup>63</sup> Used with Permission IAP2 International [www.iap2.org](http://www.iap2.org)

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- fact sheets
- websites
- email circulars

- focus groups
- surveys
- meetings

- workshops
- deliberative polling

- advisory committees
- working groups

- citizen juries
- ballots
- delegated decisions

Resource XV:

IAP2 Spectrum

(3)

### Engaging

This phase is about the process of building the knowledge base, developing the options and having the important conversation.

*“While many fear ‘real’, it is the unreal conversation that should scare us to death.” Susan Scott*

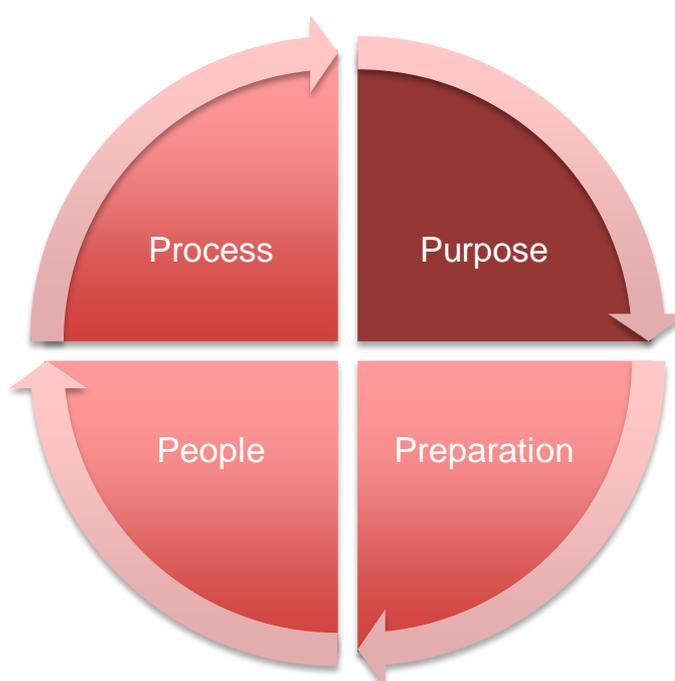
This is a critical stage in the engagement process, because it involves finding ways to bring people together who might have different clinical, social and cultural backgrounds. Engagement does not occur in a vacuum, people’s past experiences, family structure and cultural expectations can all play a role in HOW the people we are trying to engage respond to our approach.

We also need to consider the fact that medical language and terminology can often be alienating to people without clinical training. This means we need to not just consider the information the project wants from consumers or carers but also:

- The information consumers or carers might need
- The best format to present this information in (layout, language etc)
- What else consumers or carers might need to feel able and welcome to participate

Trust and rapport are central to this if there is a desire to move away from the ‘polite’ conversations, where views are heard and little change is affected, to conversations that contribute to quality participation and quality outcomes.

Many people jump to focusing on the technique that might be utilised (interview, survey, workshop) too early in an engagement project. Prior to considering the process, there are at least three essential steps to ensure the quality of participation and outcome.



### Consultation Preparation

|             |   |
|-------------|---|
| Purpose     | <ul style="list-style-type: none"><li>• What is the purpose of consulting with these people?</li><li>• What practical outcomes are you looking for?</li><li>• What practical outcomes are the people you are going to consult looking for?</li><li>• What do you want people to understand and/or feel after having been consulted?</li><li>• What level of decision making authority are people being given<br/>(see IAP2 spectrum on page 37)?</li></ul>  |
| People      | <ul style="list-style-type: none"><li>• Who needs to be consulted?</li><li>• What do we understand about their culture and family structure?*</li><li>• What is their preferred method of consultation?</li><li>• What are the best times and dates to undertake the consultation?</li><li>• What is their capacity/capability to respond/participate?**</li></ul>  |
| Preparation | <ul style="list-style-type: none"><li>• Does everyone have the same information about the topic? Is our information plain English and/or easy to follow?</li><li>• What background do they need to be able to participate fully (e.g. training, information, experience)?</li><li>• How much time do they need to provide a considered view?</li><li>• What are the power dynamics or personal opinions that might affect how others get heard?</li><li>• What are the criteria for a quality decision? Is there agreement on this?</li></ul>   |
| Process     | <ul style="list-style-type: none"><li>• What is the best way to gather the information?<br/>For example:<ul style="list-style-type: none"><li>○ Face to face meetings</li><li>○ Focus groups</li><li>○ Workshops</li><li>○ Interviews</li><li>○ Surveys</li><li>○ Social Media</li></ul></li><li>• Which process best delivers the level of influence promised?<br/>For example:<ul style="list-style-type: none"><li>○ Surveys are good for one way information gathering</li><li>○ Face to face meetings /workshops are better for conversation and deliberation</li></ul></li><li>• Do we have/need someone with enough independence, communication/facilitation skills?</li></ul> |

Resource XVI: Consultation Preparation- Consumers or Carers

\* See 6.4 and 6.5 for more on engagement with Aboriginal people and CALD communities

\*\* See 6.8 on understanding capacity and capability

### 6.4 Engaging Aboriginal People and Communities

There are approximately 12,527 Aboriginal people residing in the NMHS catchment area with residence predominately concentrated in the valley and hills area and Wanneroo.

When considering engagement with the local NMHS Aboriginal community, the following needs to be considered<sup>64</sup>;

1. Each community is different and unique, and while there may be some common interests, what applies in one will not automatically apply in another; The NMHS population are predominately Noongar people of the following groups; Yued, Ballardong, Whadjuk, Gnaala Karla Booja, South West Boodjarah and Wagyl Kaip. Recognition of these differences is important in any consultation.
2. Recognition and respect for the protocol that an Aboriginal person cannot generally speak about or for another person's land, unless given permission by the traditional owner (TO) to do so; the traditional owner is often identified through elder status and will be acknowledge as such in the community.
3. Community members have preference for a time and place for a meeting. Often consultation must 'fit into' the current community priorities. Meetings are not preferred on Monday's and Friday's; Fridays in particular are often set aside for family obligations (funerals). Meetings are preferred during the hours of 10.30am – 2pm, as this coincides with school hours. Meetings are highly attended when location of meeting is easy to access by vehicle or public transport.
4. In some settings, use of Aboriginal languages (including interpreters) may be required to adequately define terms, particularly if the terminology used is of a technical or complex nature; Use simple clear language, free of jargon
  - a. apply Aboriginal English where appropriate
  - b. use local language in verbal communications where necessary and appropriate
  - c. apply a narrative, storytelling approach
  - d. utilise a conversational approach that emulates the idea of 'having a yarn', this use of 'yarning' is not always applicable and will be determined by the knowledge of the community members you ae engaging.
5. Face to face meetings can help to overcome fundamental lack of understandings about Aboriginal ways of life and thus builds trust for sustainable agreements and effective engagement; effective engagement takes time and flexibility. Consulting and engaging with the community may be your priority however it may not be the priority of the community. Community and family priority will take precedent over any engagement process.

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<sup>64</sup> WA Government (2005), Engaging with Aboriginal Western Australians

6. Follow up preliminary contacts with letters or phone calls, as the request to consult may need to be put to other committees or members of the community; always remain in contact with members who you are engaging, consultation and engagement is building a long term relationship.
7. Allow time for discussion, for meetings to be planned and for organisation of meetings whether they are small or large; allow time for decision making in any discussions. Often it is appropriate for a lag time between a meeting and a final decision as this allows information to filter to other community members who for various reasons cannot be at the meeting.
8. Make an effort to give on the spot feedback and follow up feedback reports at consultations or meetings; be honest in your feedback and follow up. If honesty is questioned, this will hinder any further engagement process.
9. Agree to a feedback or follow up process at the meeting or consultation, and confirm decisions of the meeting in writing. Be careful about 'forcing' outcomes; take a break to review and allow discussion before returning to pursue an agreed agenda; consensus from the group will determine outcomes.
10. Don't expect an immediate answer to questions and don't be disappointed or dismissive if the consultation doesn't meet expectations; Stick with agreements made at a meeting - make sure that actions that the agency agrees to are actually carried out.
11. Refrain from committing to any actions which are not or cannot be achieved.

Additional advice can be sought from the NMHS Aboriginal Health Unit, which is part of Public Health & Ambulatory Care.

### 6.5 Engaging Cultural and Linguistically Diverse Communities

Engaging Cultural and Linguistically Diverse (CALD) communities requires an understanding of the cultural make up of each community you want to engage. There is rarely a single approach that can be applied, as consideration needs to be given to:

- **Building trust** – Understanding how long they have been in the country and their possible experiences of people in authority. It might be wise to involve people that are already trusted and not threatening.<sup>65</sup>
- **Allow time** – Sector representatives and community leaders need time to encourage the participation of community members, for trust to build and for information to circulate.<sup>66</sup>
- **Recognise diversity within communities** – Differences exist between culturally and linguistically diverse communities, and also within groups. Take time to understand communities and offer a range of targeted engagement strategies.<sup>67</sup>
- **Understand power dynamics** – Some cultures have stronger power hierarchies, and these consumers, carers or community members may not be comfortable with being involved in decision making. It is important to inform them that their care won't be comprised, and that people wanting to hear their opinions and asking questions is for their benefit.
- **Avoid over-consultation** – Check with others who might also want to engage the same community.<sup>68</sup>
- **Address language issues** – Provide materials in different languages and/or interpreter services.
- **Location** – Hire culturally appropriate venues, consider the catering, child care and if transport support is required.
- **Respect** – Demonstrate respect by acknowledging community protocols, beliefs and practices. Explain engagement rights and responsibilities, especially as some groups may not be accustomed to this experience.

Additional resources and support for CALD engagement:

- Cultural competency training modules are available through the [Cultural Diversity Unit](#).

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<sup>65</sup> Adapted from: Queensland Government (2011) Top 10 Tips for Engaging with Culturally and Linguistically Diverse Communities <<http://www.qld.gov.au/web/community-engagement/guides-factsheets/cald-communities/introduction/top10.html>>.

<sup>66</sup> Ibid

<sup>67</sup> Ibid

<sup>68</sup> Ibid

- Office of Multi-Cultural Interest can provide some guidance on different communities
- Also consult the [WA Health Language Policy and Toolkit for Health Services](#).

### 6.6 Engaging Mental Health Consumers or Carers

Participation and engagement can be an avenue for both consumers and carers to gain empowerment, and for many, it can be part of their recovery journey. As such engagement that respects the lived experiences of consumer and carers in a real and non-tokenistic manner is important.

While the same considerations of respect, openness, transparency etc apply when engaging mental health consumer and carers additional care should be taken to understand the degree to which discussing life or treatment experiences could impact the consumers' and or carer's mental health and wellbeing. This is not to say these conversations are to be avoided, but rather to ensure care has been taken to consider the impacts and appropriateness of the topic of consultation. In planning any consultation consider what supports are required both during and after the consultation project. Supports could range from financial, transport, child care, consulting with more than one consumer at a time so there is greater safety or encouraging them to attend with an advocate or buddy.

The other consideration is to be mindful of the inherent biases and stigma that some people still carry toward people with a mental illness. These biases can affect the openness and genuineness with which an engagement project is planned and implemented. It is also worth being mindful that some consumers and or carers have a long history of being marginalised by professionals for many years, and as such may also come with their own biases about being engaged by people in clinical roles.

Within NMHS Mental Health there are a range of existing consultation avenues<sup>69</sup>:

- **Consumer or Carer Representative/Consultant:** A committee member who voices the consumer or carer perspective and takes part in formal decision making processes on behalf of consumers and carers, and is expected to bring a consumer/carer perspective to matters under consideration.
- **Consumer/Carer Peer Support Worker:** Peer support is a system of giving and receiving help founded on key principles of respect, shared responsibility and mutual agreement of what is helpful. Peer support is about understanding another's situation empathically through the shared experience of emotional and psychological pain.

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<sup>69</sup> NMHS Mental Health (2014), Consumer and Carer Workforce Participation framework

- **Consumer Advocates:** People who have been given the power to speak on their behalf, such as the Council of Official Visitors, who represent the concerns and interests of the consumer, as directed by the consumer, and seek the outcomes desired by the consumer.

### **Additional resources and support for engaging in the Mental Health sector:**

- Consumers of Mental Health WA (Inc)
- WA Association for Mental Health
- Carers WA

### 6.7 Does One Consumer Equal Engagement or Representation?

The term 'engaging consumers/carers' implies that they are a homogenous group of people with similar views and ideas about the type of care that is appropriate, desirable or expected. But the pool of consumers is typically as diverse as the population they come from.

The practice of appointing one consumer to represent all of these voices can place undue pressure on that one person.

It is not expected that a consumer engagement project would be able to consult with all people from across all demographics. The resources required for this would be prohibitive, and as such it is important to recognise the inherent bias and difficulty in asking a sole consumer to represent the voice of all consumers.

Possible considerations to mitigate the situation could include:

- Resourcing the consumer/carer representative to consult more widely between meetings
- Hold 'adjunct' workshops and forums to bring more voices to the meeting room
- Consider the need for direct representation of consumers on committees and explore alternative models of engagement that would include a broader cross section of consumers; e.g. a targeted series of deliberative sessions to inform the strategic direction at the start of the year to link into the planning cycle
- Rotating the role, ensuring there is diversity among consumer representatives

### 6.8 Building Engagement Capacity

The need to fill consumer/carer representative positions on various committees has meant that people who are invited into this role may not be ready to fulfil it effectively.

The pressure of being a consumer/carer representative was acknowledged by many of the people consulted in the development of this framework. They acknowledged that at times, a poorly supported representative can end up making life difficult for staff and limit the benefits gained from engagement, all resulting in both staff and consumers becoming less interested in working together.<sup>70</sup>

As such it is important to consider avenues to support and develop consumer/carer representatives in some of the following areas:

- Being effective in meetings
- Working collaboratively with clinicians and claiming their equal authority

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<sup>70</sup> Aha! Consulting (July 2014). NMHS Clinician and Consumer CE Report.

## NMHS C4 Engagement Framework

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- Being able to communicate their lived experience in a constructive manner
- Managing feedback on topics that might trigger an emotional response
- Being comfortable with one's own opinion – e.g. not needing to be a medical expert to have something worthwhile to say

Beyond the role of the consumer or carer representative, it is important to consider:

- The format of what is being presented (plain English, visually accessible)
- The time people have to consider what is being presented
- The time meetings are held and other commitments consumers may have; while there is a stipend paid, there are often other commitments and responsibilities to be attended to
- The duration of meetings and the travel time required (especially for meetings cancelled without notice)
- An individual's access to printers, computer etc and the expenses incurred
- Accessibility of information and venues (larger type, visually impaired, hearing impaired, disability access)
- Utilisation of alternative forms of communication (e.g. teleconferencing, skype etc)

It is important to note that this development would be equally required of NMHS staff who convene these meetings to ensure the role of representative is valued and delivers maximum benefit.

### 6.9 Ways to Engage

The following list of techniques - developed by the Queensland Government - can be used to reach your stakeholders.<sup>71</sup> They are based on the purpose of the engagement decided in the first step, based on the IAP2 spectrum of participation model.

|         |                                 |                                  |                    |                 |                        |
|---------|---------------------------------|----------------------------------|--------------------|-----------------|------------------------|
| Inform  | Advertising                     | Education and awareness programs | Online information | Briefings       | News conferences       |
|         | Fact sheets                     | Community meetings               | Newsletters        | Displays        | Media stories          |
| Consult | Discussion groups and workshops | One-on-one interviews            | Internet surveys   | Email feedback  | Internet surveys       |
|         |                                 | Informal meetings                |                    |                 |                        |
|         | Open days                       | Polls                            | Discussion boards  | Forums          | Interactive website    |
|         | Road shows                      | Survey research                  | Road shows         | Survey research | Web-based consultation |

<sup>71</sup> Queensland Government (2011) Active Participation Techniques <[Engaging Queenslanders: a guide to community engagement methods and techniques](#)>.

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|                        |                     |                         |                       |                 |
|------------------------|---------------------|-------------------------|-----------------------|-----------------|
| Involve<br>Collaborate | Action research     | Partnerships            | Participatory editing | Focus groups    |
|                        | Advisory committees | Nominal group workshops | Photovoice            | Advisory groups |

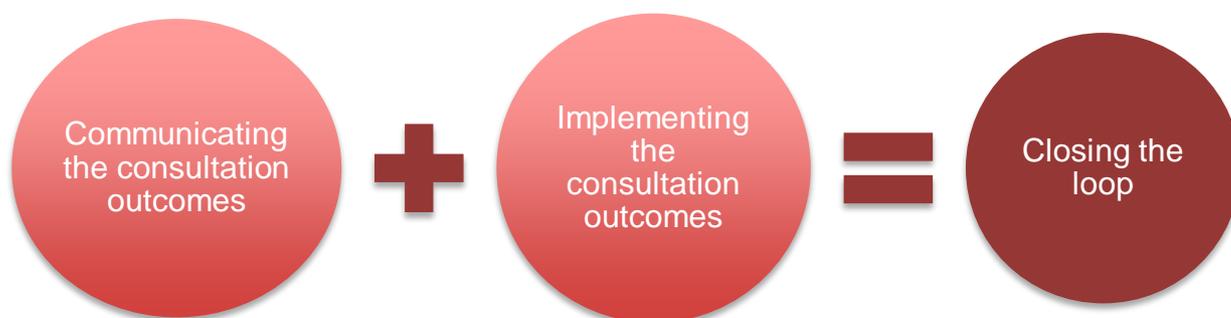
See Appendix 2 on page 55 for examples of different types of engagement techniques/processes.

(4)  
Delivering

This phase is about ensuring people understand the outcomes of the consultation and that something is being done with it.

*“However beautiful the strategy, you should occasionally look at the results.”*  
Winston Churchill

Closing the loop is one of the most important aspects to quality engagement.<sup>72</sup> Closing the loop means that once the conversations have been had, views have been gathered and a decision made, time is taken to ensure that the people engaged know about the outcomes, about how their views have been considered and that something is going to be done with the findings.



A lack of feedback to participants of a consultation and a perceived lack of follow through can have a negative effect on people’s willingness to be engaged in the future.

As such, engagement plans need to include the following two steps:

**Closing the loop**

**Communicating the outcomes**

- Have you informed the people that were consulted of what the outcomes of the consultation?
- Have you made it clear how their views were considered?

**Implementing the outcomes**

- What plans are in place to implement the outcomes of the consultation?
- Have these plans been communicated to the people involved?

Resource XVII: Closing the Loop - Consumers or Carers

<sup>72</sup> IAP2 Core Values ([www.iap2.org.au/about-us/about/core-values](http://www.iap2.org.au/about-us/about/core-values))

(5)

### Evaluating

This is about a commitment to improving the quality of the process and sharing these learnings across the organisation.

*“Solving problems is important. But if learning is to persist, managers and employees must also look inward.”*

*Chris Argyris*

Through the development of this guide, clinicians and consumers were asked to define the key indicators of quality for an effective engagement program.

These indicators can be used as a process evaluation tool for projects.

| Quality Principle   | Indicators  |
|---|---|
| <p><b>Meaningful</b></p> <p>A clear purpose is supported by the allocation of sufficient time, resources and leadership to ensure participation is meaningful.</p>  | <ol style="list-style-type: none"> <li>1. There is a clearly communicated purpose for the engagement</li> <li>2. There is a commitment to progressing the project outcomes</li> <li>3. There is support for the project from senior leadership</li> <li>4. Commitments are recorded and progress is reported back to participants in a timely manner</li> </ol>   |
| <p><b>Responsive</b></p> <p>The engagement approach is chosen based on an understanding of the needs of those being engaged and aligned with any social, political, economic and environmental changes.</p> | <ol style="list-style-type: none"> <li>5. Engagement occurs early in the project life cycle</li> <li>6. Sufficient scoping ensures an understanding of how to best engage with the participant group/s</li> <li>7. The engagement plan is developed in accord with the current social, political, economic and environmental context</li> <li>8. Participants can communicate with the project team easily and are responded to promptly.</li> </ol>                                    |
| <p><b>Open</b></p> <p>Information is accessible and transparent. Participants know the level of influence on offer and any decisions already made.</p>  | <ol style="list-style-type: none"> <li>9. Participants have access to information in a format that matches their literacy and learning styles</li> <li>10. Information is provided with time for participants to contribute in a considered way</li> <li>11. Participants understand what decisions have been made and any ‘non-negotiable’ elements of the project</li> <li>12. Participants understand the level of influence being offered (see IAP2 spectrum on page 37)</li> </ol> |
| <p><b>Respectful</b></p> <p>Building trust through respecting the confidentiality of information shared and valuing different perspectives people offer.</p>  | <ol style="list-style-type: none"> <li>13. Privacy, confidentiality and anonymity are respected where necessary</li> <li>14. The method of engagement supports people with diverse opinions and backgrounds to participate in a non-threatening way</li> <li>15. Participants understand the various project roles and communication channels</li> <li>16. The engagement method shows consideration</li> </ol>   |

| Quality Principle   | Indicators   |
|---|--|
|   | for social, cultural and historical experiences that could be triggered during a consultation  |
| <p><b>Accessible</b></p> <p>The selected engagement methods make it easy for people to participate.</p>   | <p>17. Sufficient effort is made to ensure the time, duration and location of engagement aligns with the participants' preferred engagement style</p> <p>18. Sufficient effort is taken to mitigate the practical and cultural barriers to participation (e.g. language, literacy, cultural safety, participation costs, child care, existing workloads etc)</p> |
| <p><b>Follow Through</b></p> <p>Clear communication to participants on how input has influenced the decision and providing updates on the progress of implementation.</p> | <p>19. Participants understand how their input is used to inform the final outcome</p> <p>20. Participants are informed about the progress of the implementation of the project outcomes</p>   |
| <p><b>Evaluation</b></p> <p>Transparent monitoring and evaluation of the outcomes leading to developing engagement practice service-wide.</p>                             | <p>21. Outcome and process evaluation forms part of the project planning and data collection</p> <p>22. Participant feedback on the process forms part of the data collection</p> <p>23. Lessons learnt are communicated and distributed in a way that supports development of engagement practice service-wide</p>  |

Resource XVIII: Quality Indicators - Consumers or Carers

## 7. Examples of Consumer and Carer Engagement

### 7.1 NMHS Examples of Consumer, Carer and Community Engagement

The following examples of Consumer and Carer Engagement within NMHS were used to help inform the development of this framework.

| Health Service/Project                                 | Project Description   | Benefits  |
|--|---|---|
| <b>SCGH</b><br>Charlie's Wait Watchers                 | To decrease patient waiting times in the Medical Oncology clinic and day chemotherapy unit by April 2014. Thereby increasing patient satisfaction, improving efficiency and safety and decreasing cost to the department.   | <ul style="list-style-type: none"> <li>• Development of closer relationships between different departments/professions within the cancer centre</li> <li>• Collaboration, insight into clinician and consumer perceptions of the current service state and where improvements needed to be made</li> <li>• Engaging in a multi-disciplinary approach to root cause analysis to determine the actual problems and the development of solutions within the department</li> </ul>  |
| <b>PHAC</b><br>Ngulluk Koolbaang - Moorditj lifestyles | The purpose of the Ngulluk (us mob) Koolbaang (moving forward) was to <ul style="list-style-type: none"> <li>- increase the awareness of the link between chronic disease risk and lifestyle related issues, such as physical activity, diet and weight.</li> <li>- To raise the priority of the need for lifestyle changes.</li> <li>- To increase positive attitudes towards adopting a healthy lifestyle and the associated</li> </ul> | <ul style="list-style-type: none"> <li>• Resources were produced under the guidance of the community. For example: The "More Deadly Tucker Cookbook", a pictorial, practical know-how resource for the Aboriginal community highlighting convenience, cost and nutritional information.</li> <li>• Culturally appropriate engagement strategies resource: 'Exploring healthy lifestyle messages for metropolitan Aboriginal people' aimed to develop a public awareness and engagement strategy for culturally appropriate</li> </ul> |

|  |   |   |
|--|---|---|
|  | <p>benefits.</p> <ul style="list-style-type: none"> <li>- To increase confidence in achieving these changes.</li> <li>- To increase trial and adoption of the dietary and physical activity guidelines for adults.</li> </ul> | <p>healthy lifestyle messaging.</p> <ul style="list-style-type: none"> <li>• Production of community champions' video: Community response at the consultations was not supportive of using celebrities, whose use could potentially cause disregard of the message. Instead, community favoured using a regular person whom the community people could identify with, as this would enable the breakdown of the "someone like me can't do this" barrier.</li> <li>• Cook ups: Eleven, for five to ten weeks, cook ups across the metropolitan area in collaboration with local agencies to provide practical know-how information and skills regarding nutrition as suggested in community consultation.</li> </ul> |
| <p><b>KEMH</b><br/>Moort Mandja Mia<br/>(Family Gathering Place)</p> | <p>Design of a gathering place for patients, their families and children to come together.</p>  | <ul style="list-style-type: none"> <li>• Designed with Aboriginal women in the community (metro area), departmental staff, artists and funding bodies</li> <li>• Delivery of culturally appropriate area the consumers asked for, i.e. artwork and acknowledgment of traditional owners</li> <li>• Connecting clinicians and consumers for the opening, naming and smoking ceremony</li> <li>• High level of utilisation by staff, patients and families/visitors</li> </ul>  |

Resource XIX: Example of Consumer or Carer Engagement NMHS

### Appendix 1: Consumer and Carer Engagement Standards

The Standard: Partnering With Consumers from the National Safety and Quality Health Service Standards<sup>73</sup> provides actions for NMHS to undertake regarding community engagement.

The standards focus on service planning, designing care and measurement and evaluation, which align with the NMHS commitment to involve consumers in these aspects of the service. Progress against these standards is routinely assessed by NMHS Safety and Quality.

#### Consumer partnership in service planning

- 2.1.1 Consumers and/or carers are involved in the governance of the health service organisation
- 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 who do not usually provide feedback
- 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
- 2.2.2 Consumers and/or carers are actively involved in decision making about safety and quality
- 2.3.1 Health service organisations provide orientation and ongoing training for consumers and/or carers to enable them to fulfil their partnership role
- 2.4.1 Consumers and/or carers provide feedback on patient information publications prepared by the health service organisation (for distribution to patients)
- 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

#### Consumer partnership in designing care

- 2.5.1 Consumers and/or carers participate in the design and redesign of health services
- 2.6.1 Clinical leaders, senior managers and the workforce access training on patient-centred care and the engagement of individuals in their care
- 2.6.2 Consumers and/or carers are involved in training the clinical workforce

#### Consumer partnership in service measurement and evaluation

- 2.7.1 The community and consumers are provided with information that is meaningful and relevant on the organisation's safety and quality performance
- 2.8.1 Consumers and/or carers participate in the analysis of organisational safety and quality performance
- 2.8.2 Consumers and/or carers participate in the planning and implementation of quality improvements
- 2.9.1 Consumers and/or carers participate in the evaluation of patient feedback data
- 2.9.2 Consumers and/or carers participate in the implementation of quality activities relating to patient feedback data

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<sup>73</sup> Australian Commission on Safety and Quality in Health Care. Safety and Quality Improvement Guide Standard 2: Partnering with Consumers (October 2012). Sydney. ACSQHC, 2012.

## Appendix 2: Ways to Engage

Further information to be considered when deciding on different engagement techniques<sup>74</sup>:

| INFORMATION SHARING              |   |  |
|----------------------------------|---|--|
| Method                           | Strengths   | Weakness   |
| Fact sheets                      | <ul style="list-style-type: none"> <li>• often an efficient way of summarising significant information for dissemination to a wide range of people</li> <li>• can be developed in languages other than English and large text formats</li> </ul>  | <ul style="list-style-type: none"> <li>• may not be accessible to people with low literacy levels or visual impairments</li> <li>• distribution strategies need to be planned carefully to ensure that all those with an interest receive copies</li> <li>• facts may be contested or mistrusted</li> </ul>                                      |
| Online information processes     | <ul style="list-style-type: none"> <li>• electronic processes can reach a large number of people quickly and are generally cost effective</li> <li>• changes to the information being conveyed can be made quickly and are relatively cost effective</li> </ul>   | <ul style="list-style-type: none"> <li>• not all consumers have reliable access to the information and telecommunication technologies needed to share information in this way</li> <li>• some groups within the community may distrust electronic processes</li> <li>• information needs to be kept up to date.</li> </ul>                       |
| Education and awareness programs | <ul style="list-style-type: none"> <li>• very important when seeking to generate behavioural change</li> <li>• can support sustained engagement by contributing to community capacity</li> <li>• some agencies have staff with responsibility for community education and awareness who may support such initiatives</li> </ul> | <ul style="list-style-type: none"> <li>• can be seen as a one-sided, non-consultative process</li> <li>• the 'facts' being disseminated may be contested</li> <li>• can be costly to develop</li> <li>• if processes of engagement are not made transparent, the provision of information can be alienating to some key stakeholders.</li> </ul> |

<sup>74</sup> Developed by the State of Queensland. Available from <http://www.qld.gov.au/web/community-engagement/guides-factsheets/>

## NMHS C4 Engagement Framework

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| <p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Community fairs or events</b></p> | <ul style="list-style-type: none"> <li>• can increase the 'visibility' and 'approachability' of the agency/issue</li> <li>• is often attended by a wide variety of people, many of whom have time to look at displays, ask questions, participate in activities</li> <li>• can support relationship building efforts</li> </ul> | <ul style="list-style-type: none"> <li>• often attended by people beyond the immediate geographic community that may be targeted</li> <li>• can require significant staff resources to establish and maintain</li> <li>• requires good collaborative practice</li> </ul>   |
| <p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Community meetings</b></p>        | <ul style="list-style-type: none"> <li>• particular people/groups/sectors can be targeted and invited</li> <li>• is time limited</li> <li>• the agenda is known in advance</li> <li>• is relatively efficient to implement</li> <li>• can be structured in a number of ways to achieve a number of outcomes</li> </ul>          | <ul style="list-style-type: none"> <li>• may not attract participants who are representative of the community</li> <li>• can frustrate participants as discussion is often artificially constrained to a limited number of government priorities</li> <li>• is not suitable for topics where there is significant controversy or negative opinion</li> </ul> |

| CONSULTATION                    |  |   |
|---------------------------------|--|---|
| Method                          | Strengths  | Weakness  |
| Discussion groups and workshops | <ul style="list-style-type: none"> <li>• targets specific groups</li> <li>• can be structured in a number of ways to achieve a range of outcomes</li> <li>• harnesses community energy and knowledge to generate innovative options</li> <li>• can build capacity, consensus, ownership and relationships</li> <li>• can be iterative or cyclical, evolving in scope over the course of a project</li> </ul>   | <ul style="list-style-type: none"> <li>• participants may not be representative</li> <li>• produces qualitative not quantitative information, which may not be easily understood or valued</li> <li>• consideration regarding the collection and analysis of qualitative data is required and may sometimes require skilled expertise in qualitative analysis</li> </ul>  |
| One-on-one interviews           | <ul style="list-style-type: none"> <li>• people will often provide much more detailed information in a one-on-one interview or discussion than they will in a public forum</li> <li>• is useful to gain views on sensitive or complex issues</li> <li>• can be conducted in languages other than English</li> <li>• is effective when working with people with limited literacy and</li> <li>• has the ability to be empowering and/or therapeutic for the participants because of the narrative response</li> </ul> | <ul style="list-style-type: none"> <li>• expertise in qualitative analysis is required to produce a quality report</li> <li>• it is generally not possible to interview all community members</li> <li>• can be resource intensive</li> </ul>   |
| Survey research                 | <ul style="list-style-type: none"> <li>• can be used to gain feedback from large and diverse groups of people</li> <li>• can often be produced and distributed in large quantities relatively cheaply</li> <li>• enables comparison between groups in the community, or between different stages of the process</li> <li>• can provide large amounts of qualitative and quantitative data</li> </ul>   | <ul style="list-style-type: none"> <li>• many groups in the community feel they have been over-consulted by government and may react negatively to being asked to complete 'yet another survey'</li> <li>• may not be accessible for people with limited literacy, English as a second language or with visual impairments</li> <li>• analysing the data provided via surveys requires time, resources and skill</li> <li>• often only useful for providing and collecting information on a limited number of topics</li> </ul> |

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| <b>Internet based – surveys, websites, email feedback</b> | <ul style="list-style-type: none"><li>• a number of existing ICT platforms exist to support this type of engagement</li><li>• can be very cost efficient, particularly if using established online engagement mechanisms</li><li>• can reach a wide audience quickly</li><li>• people can participate at a time and on a date that suits them</li><li>• may be appealing to people who do not wish to participate in group gatherings</li></ul> | <ul style="list-style-type: none"><li>• the anonymity afforded by online processes may result in some people providing multiple responses to surveys and skewing results</li><li>• resources must be allocated to moderating online discussions and ensuring that questions raised are responded to in a timely manner</li><li>• concerns about privacy and confidentiality may need to be carefully addressed to ensure participation</li><li>• participation is limited to those with access to the internet</li></ul> |
|---|---|--|

| <b>COLLABORATION</b> |   |   |
|----------------------|---|---|
| <b>Method</b>        | <b>Strengths</b>  | <b>Weaknesses</b>   |
|                      | <ul style="list-style-type: none"> <li>• values a wide range of technical and local expertise and knowledge</li> <li>• provides committee members and government with an understanding of a range of perspectives, data sets and other knowledge bases in order to develop informed, agreed and integrated solutions</li> <li>• can support a range of other engagement processes, for example action research</li> <li>• provides opportunities to explore alternative strategies and build on commonalities and alliances</li> <li>• enables information and decisions to be distributed to members of the organisations or community sectors represented on the committee</li> </ul> | <ul style="list-style-type: none"> <li>• participants may not be representative of the various groups with relevant knowledge or skills</li> <li>• it can be difficult to manage the diversity of opinions, data, frameworks and other information provided via committee members</li> <li>• standing committees may lose impetus or relevance</li> </ul> |
| <b>Focus groups</b>  | <ul style="list-style-type: none"> <li>• can be used to gain the views of those who may not respond to other forms of consultation, for example surveys, written exercises</li> <li>• good for in-depth exploration of people's views on an issue/service including their likes and dislikes</li> <li>• can be used at different stages of a consultation process from preliminary planning to the feedback stage</li> <li>• can target specific groups</li> </ul>  | <ul style="list-style-type: none"> <li>• some people may feel inhibited in expressing non-consensus views</li> <li>• risk of 'group think'</li> <li>• not guaranteed to be statistically representative because of small numbers involved</li> </ul>  |

## NMHS C4 Engagement Framework

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| <p style="text-align: center;"><b>Editing</b></p>                   | <ul style="list-style-type: none"> <li>• builds ownership of documents/plans edited in this way</li> <li>• enables people to participate at times and on days which suit them</li> <li>• allows feedback to be received from a cross-section of participants from different geographic locations</li> <li>• can provide the basis for a variety of other engagement techniques</li> </ul> | <ul style="list-style-type: none"> <li>• needs sufficient time, detailed information and briefing material to ensure clarity about the requirements of participants</li> <li>• may be unsuitable for people who speak English as a second language, with low literacy levels or with visual impairments</li> <li>• it is difficult to ensure genuine representation</li> <li>• editing may attract criticism if the final result does not adequately reflect all of the input provided</li> </ul>                    |
| <p style="text-align: center;"><b>Partnerships</b></p>              | <ul style="list-style-type: none"> <li>• harnesses the resources and energy of government and community members to achieve shared outcomes</li> <li>• can be established in a variety of ways to achieve a variety of outcomes</li> <li>• is useful to build longer term relationships and</li> <li>• can build the knowledge, skills and awareness of all partners</li> </ul>            | <ul style="list-style-type: none"> <li>• not all stakeholders have the resources, desire or need to partner government</li> <li>• no matter how well-intentioned partnerships may be, power is often not equal and in some instances it is difficult for some stakeholders to 'let go' of their power</li> <li>• often requires extensive discussion and negotiation to agree on the nature and terms of the partnership</li> <li>• requires significant commitment of resources to maintain partnerships</li> </ul> |
| <p style="text-align: center;"><b>Future search conferences</b></p> | <ul style="list-style-type: none"> <li>• good technique for developing a vision for a community</li> <li>• can drive community and government action</li> <li>• involves a broad range of relevant stakeholders</li> <li>• can develop support and consensus among stakeholders with diverse views early in the planning process</li> </ul>   | <ul style="list-style-type: none"> <li>• there may be difficulties in reaching consensus</li> <li>• the process may be dominated by large interest groups if not carefully planned and facilitated</li> <li>• can be logistically challenging</li> </ul>   |

|                   |   |   |
|-------------------|---|---|
| <b>Photovoice</b> | <ul style="list-style-type: none"> <li>• provides pictorial evidence of community issues</li> <li>• provides an alternative means of expression which may help to include those who prefer visual rather than textual or verbal information</li> <li>• allows detailed information to be collected from participants</li> <li>• can easily be used in the media, including print, television and online</li> </ul>  | <ul style="list-style-type: none"> <li>• can be costly, including cameras, developing and printing photographs</li> <li>• may generate ambiguous information</li> <li>• may be difficult to manage and coordinate</li> </ul>  |
| <b>World café</b> | <ul style="list-style-type: none"> <li>• the method is simple in design</li> <li>• allows a large and diverse group of people to participate</li> <li>• enables information sharing on a large scale</li> <li>• responses do not have to be limited to written material, drawing would be equally as effective in articulating issues</li> <li>• allows cross-pollination of ideas across a large group of people and</li> <li>• is a powerful technique for creating shared knowledge of a community's issues and a subsequent sense of 'community'</li> </ul> | <ul style="list-style-type: none"> <li>• resource intensive (venues, resources, people, marketing)</li> <li>• requires significant planning</li> <li>• requires a number of skilled facilitators, preferably one for each table and</li> <li>• a significant amount of follow-up is required for further action planning</li> </ul> |

- End of Document -

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