

# Maternity Consumer Panel Evaluation

2015 - 2018

**Guiding Maternity Services at  
Counties Manukau Health towards an effective  
model of consumer engagement**



*Prepared by Greta Westermann & Brooke Hayward,  
Research and Evaluation Office, Ko Awatea*

**Completed in February 2019**



## Acknowledgements

This evaluation was funded by the Maternity Quality and Safety Programme, as part of the Counties Manukau Health (CM Health) Women's Health division.

Special mention must be made to the evaluation participants – Panel members, key informants and presenters – who contributed to the Maternity Consumer Panel and voluntarily shared their experiences for this evaluation. This information and the resulting evaluation findings are highly valuable for future engagement approaches within the service and the whole organisation. Thank you for making time to participate!

Special thanks go to Amanda Hinks and Lyn Stark for coordinating the Maternity Consumer Panel and supporting Ko Awatea's Research and Evaluation Office (KAREO) with their time and input on this evaluation.

We wish to acknowledge Odette Frost-Kruse for facilitating the Panel and offering valuable insights and expertise for this evaluation.

Finally, thanks to other CM Health staff who contributed to this evaluation, including the library service, Dr Dominic Madell and Dr Lynne Maher.

## Executive Summary

Ko Awatea's Research and Evaluation Office was tasked with leading the evaluation of the Maternity Consumer Panel from its implementation in late 2014 to its suspension in February 2018. The evaluation was requested by the coordinators of the Panel in conjunction with Counties Manukau Maternity Quality and Safety Governance Group in order to evaluate its model, outputs and outcomes, to inform its future direction.

The Maternity Consumer Panel was set up to influence service design and to increase woman-centred care within Maternity Services at CM Health.

This evaluation aimed to answer the following questions:

- 1) What are the topics/subjects that the Panel has considered since the beginning of their work?
  - How can they be described and categorised?
- 2) To what extent is advice or guidance from the Panel being used/applied in the service or project?
  - What barriers to use/application can be identified?
  - What facilitators to use/application can be identified?
- 3) What have stakeholders learnt from their interaction with Panel members?
  - Has their consumer engagement changed?
  - How do they understand the role of the Panel?
- 4) What are key strengths and weaknesses of the Consumer Panel model?
- 5) How were Panel members recruited and supported?
  - What are members' demographics?
  - How and to what extent did the members participate?

In order to answer the evaluation questions, a mixed-methods approach was chosen which included:

- semi-structured interviews with panel members, coordinators, and presenters;
- a survey with panel members and presenters;
- document analysis; and
- a literature review.

Overall, Panel members had a positive experience of Panel membership and felt well supported by CM Health staff and the Panel facilitator. The evaluation

showed that building genuine relationships and effectively valuing consumer input are key factors for successful engagement, especially for Panel members.

While we recommend ongoing operation of a Panel, the Maternity Consumer Panel was not successful in meeting its key aim to design/create more consumer-centred maternity services. Most of the Panel's work could be located on the lower end of the continuum of engagement (see p.22). Evidence has shown that work on this level is suitable to influence resource design and the development of documents. In order to effect change in service design and policy development, engagement needs to reach the stages of 'Involvement' and 'Partnership and shared leadership'. When planning engagement strategies, it is recommended to be clear of the objectives, and the suitable stage of engagement.

Future engagement strategies for Maternity Services should be multi-method i.e. ensure that they use a variety of different approaches, including a consumer panel. Having a consumer panel with consistent members ensures that relationships and trust can be built over time. Nevertheless, other approaches like co-design are needed to engage increasingly diverse groups of consumers in the design of services.

Ensuring a consumer-led approach at all stages of engagement – from planning to evaluation – can enhance involvement and improve the quality of outcomes of the engagement. This evaluation identified considerable gaps in organisational strategy for the use and formation of consumer groups to direct care design.

## **Recommendations**

From evaluation findings, we propose 17 recommendations which are related directly to the panel, service or our organisation more broadly.

### *Panel recommendations*

We recommend continuation of the Panel activity (alongside a broader service strategy for engagement as detailed under service recommendations) with several refinements for improvement:

- 1) Revise the purpose of the Panel to create clarity and consensus across stakeholder groups. Ensure:
  - a. The Panels' purpose is designed in partnership with consumers.
  - b. The Panels' purpose is supported by relevant senior leaders (Women's Health, Maternity Services) and the Patient and Whaanau Centred Care Board.
  - c. Clear documentation of the Panel purpose.
- 2) Refine members' roles. Ensure:

- a. Members' roles are defined in partnership with consumers.
  - b. Advocacy (for community groups/connections) and maintenance of community connections are the main focus of Panel members' roles.
  - c. Clear documentation of members' roles and responsibilities.
- 3) Adopt a consumer-led approach that involves, for example:
    - a. Establishment of a Consumer Panel chair.
    - b. Facilitation of the Panel by a consumer.
    - c. Consumer defined agenda items.
  - 4) Nominate a member of the staff to revise presentations that are meant for the Panel to ensure that they align with the strategic aim.
  - 5) Develop a process to hold presenters accountable for giving updates on their projects.
  - 6) Review coordinators workloads and develop a plan to support them.
  - 7) Develop a toolkit for story-capture (e.g. questionnaires, interviews, photos, or videos).
  - 8) Train Panel members, coordinators and the facilitator on co-design and engagement.
    - a. Assess further training requirements in partnership with consumers.
  - 9) Develop a plan for the leveraging of Panel members community connections to reach out to vulnerable consumers.
  - 10) Develop a template for meeting minutes to ensure consistent documentation of meetings.
  - 11) Regularly assess Panel meeting content and actions to anticipate and address:
    - a. Emerging issues with Panel value.
    - b. Alignment with purpose.
    - c. Panel influence.

### *Service recommendations*

- 12) Increase visibility and support of Panel activity by senior leaders (Maternity Services) ensuring:
  - a. Clear communication pathways between the Panel and Maternity Services senior leadership team.
  - b. Increased visibility/presence of senior leaders at Panel meetings.
  - c. Increased support to action of Panel recommendations/suggestions from senior leaders.
  - d. Increased socialisation of the Panel purpose and scope of influence by senior leaders.
- 13) Increase visibility of the impact of Panel or other consumer activity.
- 14) Train staff on approaches for effective consumer engagement.

- 15) Use a range of consumer engagement approaches in addition to the panel (e.g. co-design, consumers on project groups).
  - a. Ensure consumer input into the planning of these approaches.

#### *Organisation recommendations*

- 16) Develop an organisational strategy for consumer engagement and connect the different services in their approach (Patient and Whaanau Centred Care board).
- 17) Distribute this report to relevant audiences.

# Contents

Acknowledgements.....	i
Executive Summary.....	ii
Recommendations .....	iii
Introduction.....	1
Background.....	1
Patient-centred care .....	1
Patient engagement.....	3
Counties Manukau Health Maternity Consumer Panel.....	4
The Model.....	4
Membership .....	5
Evaluation of the Maternity Consumer Panel .....	6
Methodology .....	7
Literature review.....	7
Document review.....	8
Interviews (individual and shared) .....	9
Survey .....	10
Participant recruitment .....	10
Ethical statement.....	11
Evaluation Findings.....	12
Chapter 1: Characteristics of Panel Membership .....	13
Members attributes and participation.....	13
Support and Recruitment.....	16
Chapter 2: The Panel’s Activity at Counties Manukau Health .....	18
Subjects the Panel worked on .....	18
Time of the engagement.....	20
Continuum of Engagement .....	21
Application of Panel advice.....	22
Stakeholders’ understanding of the Panel’s role.....	25
Chapter 3: Key strengths and areas for improvement.....	27
Key Theme I: Investment in genuine relationships is crucial to effective consumer engagement. ....	27
Key Theme II: Valuing consumers’ time and input is an essential part of successful consumer engagement. ....	31
Key Theme III: Only diverse engagement approaches can accommodate for a diverse group of consumers .....	35

Summary of strengths and areas for improvement .....	38
Discussion .....	40
Purpose .....	40
Diversity .....	41
Relationships.....	42
Valuing .....	43
Conclusion .....	45
Recommendations .....	46
References .....	48
Appendices .....	50
Appendix 1: Interview schedule for individual Panel members.....	50
Appendix 2: Shared interview schedule for group of Panel members .....	51
Appendix 3: Shared interview schedule for CM Health staff involved in running the Panel .....	51
Appendix 4: Interview schedule for external facilitator.....	52
Appendix 5: Interview schedule for Key Informant .....	53
Appendix 6: Interview schedule for Presenters .....	53
Appendix 7: Panel Member survey to be filled out at the individual interview, shared interview, or online .....	54
Appendix 8: Survey for Panel Presenters.....	55
Appendix 9: Participant Information Sheet for Member Interview and Survey .....	56
Appendix 10: Terms of Reference.....	59
Appendix 11: Information for presenters of the Maternity Consumer Panel	61

## Introduction

In New Zealand and globally, there has been increased recognition of consumer engagement and its value in healthcare (Health Quality and Safety Commission [HQSC], 2015). Done effectively, consumer engagement results in patient-centred care and services which are not only associated with increased patient and staff satisfaction, continuity of care, and clinical outcomes, but also with decreased utilisation of services, improved continuity of care and improved clinical outcomes (Kuhn, Mickelsen, Morimoto, & Larson, 2016; Oldfield et al., 2018). In 2015, the Health Quality and Safety Commission New Zealand (HQSC) released a guide on consumer engagement for district health boards (DHBs) which positioned consumer engagement as a “strategic priority” (HQSC, 2015, p. 2).

Patient and whaanau centred care is a key organisational priority at Counties Manukau Health; the organisation is aiming to work in partnership with patients and their whaanau, and local communities, in order to deliver related strategy actions (Counties Manukau Health, 2015). Many different projects and programmes target the increase of consumer engagement within CM Health, one of which is the Maternity Consumer Panel which operated from late 2014 to early 2018. Women’s Health use the term woman-centred care to describe their partnership with women using Maternity Services.

This report presents evaluation findings from the Maternity Consumer Panel, which aimed to increase woman-centred care within Maternity Services at Counties Manukau Health.

## Background

Patient-centred care and patient engagement are central concepts in this evaluation which warrant exploration and definition. Castro and colleagues (2016) point out an “absence of theoretical and conceptual clarity” of words and concepts like patient-empowerment, -centeredness and also participation, which are often used interchangeably (p. 1923). Definitions of patient engagement vary and other terms like patient activation are used to describe similar concepts (Carman et al., 2013, p. 223).

### Patient-centred care

Patient-centred care was mentioned for the first time in the late 1960s by Enid Balint, who developed a guideline for communication between doctors and their patients (Balint, 1969). He believed that every patient “has to be understood as a unique human-being” (p. 269). In the late 1980s this scope of patient-centeredness broadened to include more than just the

communication between clinicians and their patients. For example, this was expressed in the 1987 Picker-Commonwealth Programme for Patient-Centred care which presented “patient centeredness as a comprehensive way of delivering health services” (Saha, Beach, & Cooper, 2008, p. 2). This broader concept of patient-centeredness has been widely accepted. This understanding is reflected in the current definition of the term patient-centred care on the Medline database: [Patient-centred care is the] “design of patient care wherein institutional resources and personnel are organised around patients rather than around specialized departments” (Ovid, 2018, para. 1).

A recent model by Scholl and colleagues (2014) describes the dimensions of patient-centeredness as divided into (i) principles, (ii) enablers and (iii) activities. The principles of the model include the patient-clinician relationship to be based on trust and caring. To make this partnership possible, the clinician needs to have essential characteristics including empathy, respect and honesty, and needs to recognise the patient as a unique person. The biopsychosocial perspective is taken by the physician (Scholl et al., 2014).

Scholl and colleagues (2014) identify several enablers of patient-centeredness including clinician-patient-communication, the integration of medical and non-medical care, teamwork, access to care and the coordination and continuity of care. They locate these enablers not on the micro- (i.e. individual interactions) but on the meso (i.e. organisational processes and culture) level of healthcare. Conversely, the defined activities of patient-centeredness such as patient information and involvement in care, involvement of family and friends and physical and emotional support, are located on the micro-level in the direct interaction of clinician and patient (Scholl et al., 2014).

Dickinson, Water, and Wrapson (2014) deliver a more succinct definition of patient-centred care, describing it as “an approach which allows for the values, experiences, and preferences of patients including involvement in decision-making regarding their treatment” (p. 24).

Carman and colleagues (2013) take this definition a step further and describe patient-centred care not just as an approach but as a broad vision for health with “a partnership among care practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients’ wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care” (p. 223). This definition draws attention to the importance of building health literacy and support role health care professionals have to take to ensure that patients are enabled to actively engage and participate in their own care. This definition by Carman and colleagues (2013) will be the working definition for this report.

## Patient engagement

There are a variety of definitions on patient engagement in the literature. Concepts like patient and consumer engagement are often used interchangeably and add to the confusion (Washington, 2014, p. 56).

To bring more clarity into these concepts, Washington (2014) defined consumers as individuals that are maintaining their own health or are caring for others. Whereas patients, according to Washington (2014), are people that are currently “dealing with an illness or a health challenge” (p. 56). At CM Health the preferred term for both groups – those who are caring for others and those who are experiencing illness themselves – is consumers. Further, when working with consumers, it is good practice to clarify their preferences for how they wish to be identified (for example, previous work with consumers of CM Health mental health services showed their preferred terminology is ‘client’).

Washington (2014) states that consumer and patient engagement involves “enabling people to work with healthcare professionals in full participation of maintaining their own healthcare and making informed healthcare decisions” (p. 56). This definition insists that the responsibility of engagement lies within healthcare services and professionals to enable individuals to build partnerships with healthcare professionals. Other definitions define engagement as actions that are taken up by individuals “to obtain the greatest benefit from healthcare services available to them” (Washington, 2014, p. 56).

Higgins, Larson, and Schnall (2017) offer a comprehensive definition of the concept of patient engagement that involves various antecedents, attributes, and consequences of patient engagement. They ultimately define patient engagement as “the desire and capability to actively choose to participate in care in a way uniquely appropriate to the individual in cooperation with a healthcare provider or institution for the purposes of maximizing outcomes or experiences of care” (p. 33). This definition leaves the initial choice and responsibility of participation and engagement with individual consumers, but also recognises the responsibility of healthcare providers to support engagement and build cooperation.

A definition that gives individuals and health professionals the same stake of responsibility for engagement is the one by Carman and colleagues (2013), which will also be the working definition for this report: “Patient and family engagement as patients, families, their representatives, and health professionals working in active partnership at various levels across the health care system—direct care, organizational design and governance, and policy

making—to improve health and health care” (p. 224). Another difference to other definitions is the inclusion of different levels of engagement into the definition, and reduced emphasis on consumer attributes or skill deficits.

### **Counties Manukau Health Maternity Consumer Panel**

The Maternity Consumer Panel originated from the implementation of the Maternity Quality and Safety Programme in New Zealand DHBs. As part of the implementation, the Ministry of Health identified consumer engagement as a priority area under the programme. CM Health Maternity Services decided to create a Maternity Consumer Panel with volunteer members as their model of consumer engagement.

At the end of 2014 the Maternity Consumer Panel had its first meeting.

#### **The Model**

The aim of the Maternity Consumer Panel as stated in the Terms of Reference (Appendix 10) was to:

*“...provide[s] advice and feedback on maternity services to the management of the Counties Manukau District Health Board (CMDHB). The advice is to inform the DHB and other providers (e.g. self-employed midwives, general practice) on the design and direction of maternity services, how people can access them and how effective services are in providing the services and meeting women’s and family’s needs.”*

To reach this aim, the Panel provided a consumer perspective to the design and operations of maternity services across the Counties Manukau district, including services used by CM residents outside of the district such as regional or national services.

The advice given by the Panel intended to focus on the design and operations of Maternity Services, while three key areas of advice were identified. These included:

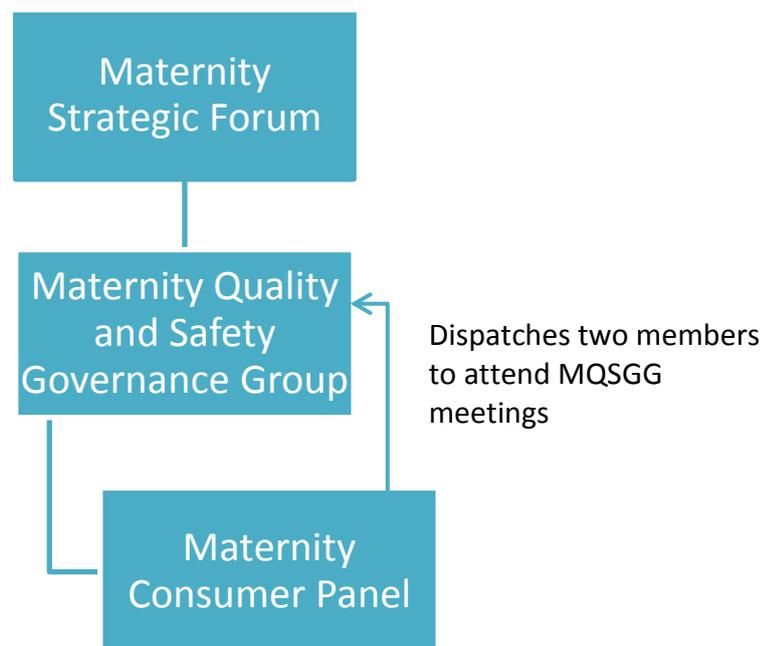
- advice on improving the maternity experience for women and their families,
- advice on sustainability of the services,
- and advice on gaps in services or other necessary improvements.

The Panel met four times a year in March, June, September and December. Two staff members from the Primary Care and Community Health Directorate functioned as Panel Coordinators, their tasks included recruiting new members, organising and attending the Panel meetings, promoting the Panel within CM Health and liaising with presenters to set the meeting agenda.

The meetings were convened by an independent facilitator who also coordinated the agenda, and provided secretariat support.

To ensure accountability, CM Health intended to demonstrate how advice by the Panel had informed services, provided updates of the development and content of information regarding Maternity Services, and also give advice on how this information can be shared with communities.

As visualised in Figure 1, the Maternity Consumer Panel feeds into the Maternity Quality and Safety Governance Group which feeds into the Maternity Strategic Forum. The Maternity Consumer Panel dispatched two of its members to attend the Maternity Quality and Safety Governance Group (MQSGG) meetings.



**Figure 1. The model of the Panel**

### **Membership**

The Terms of Reference proposed two different roles of Panel membership, both of which were volunteer positions:

- General member positions
- General member positions with additional membership in the Maternity Quality and Safety Group

The Panel consisted of a maximum of 15 members and a quorum of seven. Each appointment was intended to have a specified term of one year with the option of a reappointment of an additional year. The women had to have had utilised Maternity Services in CM Health within the last five years, although there was an exception with three of the members.

Panel members had to live in the Counties Manukau district and be residents from the four localities, defined by CM Health as Manukau, Maangere/Otara, Franklin and East. Panel membership had to be representative of the women who utilise the services (geographically). Furthermore, Panel membership intended to be representative of the ethnic diversity and the age mix of women that utilise the services at CM Health.

Attendance at meetings was expected to be face to face and was supported for those who did not have transport. The locations of the meetings were discussed and designed to meet in the local areas and easily accessible. If members were unable to attend the meeting, they received the meeting minutes. Non DHB employed Panel members were remunerated for their attendance with a \$100 Pak 'n Save or petrol voucher, according to CM Health policy.

### **Evaluation of the Maternity Consumer Panel**

Ko Awatea's Research and Evaluation Office was tasked with leading the evaluation of the Maternity Consumer Panel from its implementation in late 2014 to its suspension in February 2018. The evaluation was requested by Maternity Services at CM Health in order to evaluate the model, outputs and outcomes, and consider the future direction.

## Methodology

This section describes the methods used to gain an in-depth understanding of the Maternity Consumer Panel's model, its work, and to identify strengths and areas for improvement. The following key evaluation questions were proposed:

- 1) What are the topics/subjects that the Panel has considered since the beginning of their work?
  - How can they be described and categorised?
- 2) To what extent is advice or guidance from the Panel being used/applied in the service or project?
  - What barriers to use/application can be identified?
  - What facilitators to use/application can be identified?
- 3) What have stakeholders learnt from their interaction with Panel members?
  - Has their consumer engagement changed?
  - How do they understand the role of the Panel?
- 4) What are key strengths and weaknesses of the Consumer Panel model?
- 5) How were Panel members recruited and supported?
  - What are members' demographics?
  - How and to what extent did the members participate?

The evaluation design is a non-experimental mixed methods approach, which as further detailed below, involved semi-structured interviews (shared and individual), a survey, review of programme and service documentation, and review and analysis of relevant literature and similar groups. The design is informed by the Guidelines for Health Research on Maaori (Health Research Council, 2010) and Bridging Cultural Perspectives (Superu, 2018).

### Literature review

Research literature and grey literature was rapidly reviewed to describe similar groups nationally and to compile evidence on best practice. The databases MEDLINE, CINAHL, and NICE Evidence Search were scanned, and the search engines Ovid Discovery, Google Scholar and Google were used to find relevant literature. Search terms in the Medical Subject Headings (MeSH) search were 'community participation', 'maternal health services', 'consumer participation', and 'patient centred care'. A keyword search was conducted for 'consumer-centred', 'services', 'health', 'maternity' and 'review'. The search was limited to publications from 1998-2018.

## Document review

The evaluation team reviewed Panel documents including meeting minutes and the Terms of Reference to describe the model, processes, membership and work done, and to identify presenters.

In order to understand the subjects that the Panel considered, the presentations were categorised into four different groups as follows:

(1) 'General information or upskilling' includes presentations that inform Panel members about new decisions, projects, and other news without asking for their feedback, or presentations that aim to increase or support Panel members knowledge or skills. General discussions between coordinators, the facilitator, and Panel members that didn't result in any feedback on particular services or projects were also grouped in this category.

(2) 'Consults' are presentations that are being held in order to get Panel members feedback or input on a service, project, or resource. This category also contains consults from groups that Panel members are involved in e.g. the Maternity Quality and Safety Group. A Panel member that is also a group member would consult with the Panel on a topic that is being worked on in the group, and bring the feedback back into this group. 'Consults' also include occasions where a presenter returns to the Panel for further input on a project or service that they had already consulted about with the Panel – these are 're-consults'.

(3) 'Updates' are presentations that give Panel members an update on projects that they had earlier given feedback on. This update can be given by the original presenter, but also by the facilitator or the coordinators. This differs from a re-consult as the presentation is informative but does not seek further input/advice from the Panel.

(4) The category 'other' contains all presentations that would not fit within the existing presentation types.

In order to understand Panel members' engagement with presentations and projects, a categorisation of engagement was also used, based on the model by Carman and colleagues (2013).

Carman and colleagues (2013) conceptualise extent of engagement as different stages or levels along a continuum of engagement. In their framework on the lowest end of the continuum, Carman and colleagues

(2013) locate consultation. Consultation is described as health care professionals informing consumers about their plans and getting feedback; the information flows mainly unidirectional from the professionals to the consumers, and consumers can provide their opinion or feedback, but have limited influence. We added the stage of 'subconsultation' to acknowledge the fact that some of the Panel's work did not reach the level of consultation. For example, presentations that informed members about services, projects, or other news, which are not intended for gaining feedback. Furthermore, it includes presentations that we earlier categorised as upskilling.

In the stage of 'involvement' the information flow becomes more bilateral and patients function as advisers during decision making processes. On the higher end of the continuum lies the stage of 'partnership and shared leadership'. Decisions are made based on consumers preferences; they function as active partners and get to set their own agendas and priorities (Carman et al., 2013).

### **Interviews (individual and shared)**

To understand the overall experience of Panel members and of working with the panel, including the strengths and weaknesses members and stakeholders saw within the Panel model, semi-structured interviews were conducted. These were completed with five former Panel members (out of a total of 14), four key informants (two CM Health staff members who coordinated the Panel, and two further who just worked closely with the Panel), and three presenters (out of a total of 15).

Interviews with Panel members explored their experience of Panel membership, the purpose members believed the Panel had and their satisfaction with received support. Three Panel members were interviewed individually and two participated in a shared interview (see interview schedules in Appendix 1 & 2).

Interviews with key informants explored the purpose of the Panel, decisions around its initiation, the model, and the overall experience of working with and coordinating the Panel. The two who were CM Health staff members participated in a shared interview (see interview schedules in Appendix 3, 4 & 5). Finally, two interviews with presenters (people who came and consulted with the Panel) were also completed to collect feedback on their experience using the Panel, understanding of the Panel, and application of Panel advice. Out of the presenters, two were interviewed in a shared interview and one participated in an individual interview (Appendix 6).

The interviews were conducted between the 1<sup>st</sup> of October 2018 and the 26<sup>th</sup> of November 2018 at locations that were convenient for participants.

## Survey

The five interviewed Panel members further participated in a brief, anonymous, online survey hosted by SurveyMonkey (Appendix 7). The survey consisted of open and closed questions on members' demographics and their experiences of being on the Panel. The purpose of the survey was to generate quantifiable information about:

- Motivation to being a Panel member
- Support during Panel membership
- Overall experience of membership
- Key demographics

Seven presenters participated in a different brief and anonymous online survey hosted by SurveyMonkey (Appendix 8). The survey consisted of a mix of open and closed questions in order to produce quantifiable information and understand presenter experiences.

It focused on the following:

- Presenter perspectives of the role of the Panel
- What prompted them to engage with the Panel
- How well expectations were met
- Whether Panel advice had been applied
- Attitudinal change regarding consumer engagement

## Participant recruitment

All women that were listed as Panel members when the Panel stopped operating, in February 2018, were invited to participate in the evaluation (n=14). The evaluation team recruited the Panel members through an email, distributed in September 2018. A reminder was sent out two weeks later and women that hadn't responded by October 2018 were contacted again over the phone. Five women accepted the invitation and participated in the evaluation (36%). After their interviews, participants were asked to also participate in the anonymous online survey hosted by SurveyMonkey.

Key informants and presenters were recruited for interviews through an email distributed in September 2018. All the identified key informants (two coordinators, professional leader of Maternity Services, independent facilitator) could be contacted and participated in the evaluation. Four presenters were invited to participate in evaluation interviews, three of whom accepted the invitation.

For survey participation, presenters (n=15) were collated from meeting minute records and recruited through an email containing the survey link, distributed in October 2018. The link stayed active for four weeks and two reminders

were sent out via email to increase participation. Seven presenters participated in the survey (47%).

All recruitment emails sent by the evaluation team contained participant information sheets, consent forms and the contact details of the lead evaluator.

### **Ethical statement**

All evaluation participants provided free and informed consent to participate in this evaluation. Both verbal and written explanations of the evaluation were provided to participants (Appendix 9). Written consent was obtained. This evaluation was ethically approved by the New Zealand Ethics Committee (REF 2018\_24).

## Evaluation Findings

Evaluation findings are presented in three chapters:

Chapter 1: Characteristics of Panel Membership

Chapter 2: The Panel's Activity at Counties Manukau Health

Chapter 3: Key Strengths and Areas for Improvement

Findings will be followed by a discussion, conclusion and list of recommendations.

## Chapter 1: Characteristics of Panel Membership

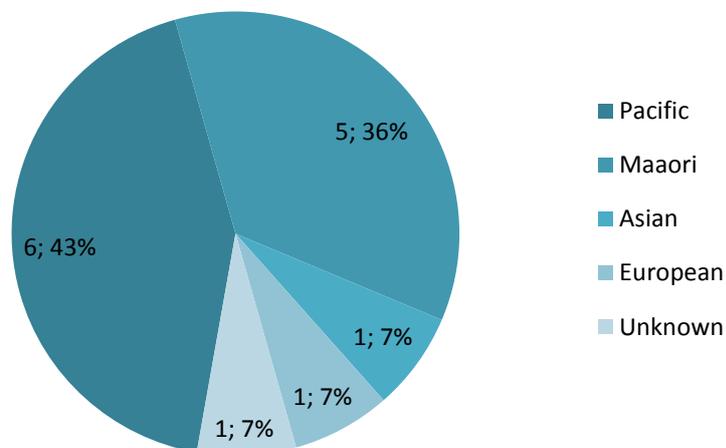
The following section describes what membership within the Panel looked like, including member demographics, skills and where and how they participated during their Panel membership. Recruitment and support of Panel members will also be described.

This section will address the following evaluation question:

- 1) How were Panel members recruited and supported?
  - What are members' demographics?
  - How and to what extent did the members participate?

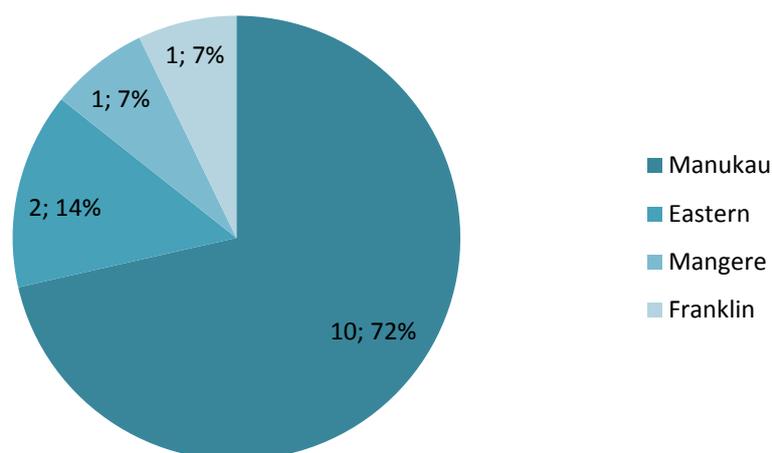
### Members attributes and participation

At the time of Panel suspension in February 2018 the Panel had a total of 14 active members. Some of the women had been on the Panel from the beginning, and others joined along the way. Even though the Terms of Reference limited the length of Panel membership to two years, some of the members had exceeded this without leaving the group.



**Figure 2. Pie chart of membership by ethnicity showing n (number) followed by percent of members.**

Panel members had many different ethnicities, with 43% (n=6) of the women identifying as Pacific, 36% Maaori (n=5), and both Asian and European 7% (n=1) (Figure 2).



**Figure 3. Pie chart of membership by locality showing n (number) followed by percent of members.**

The majority of Panel members resided in the Manukau locality (71%, n=10), while two members (14%) came from the Eastern locality, one (7%) from Maangere and one (7%) from Franklin (Figure 3). Of the five panel members participating in the evaluation, four (80%) were aged between 35-44 years, while the fifth member was between 25-34 years old.

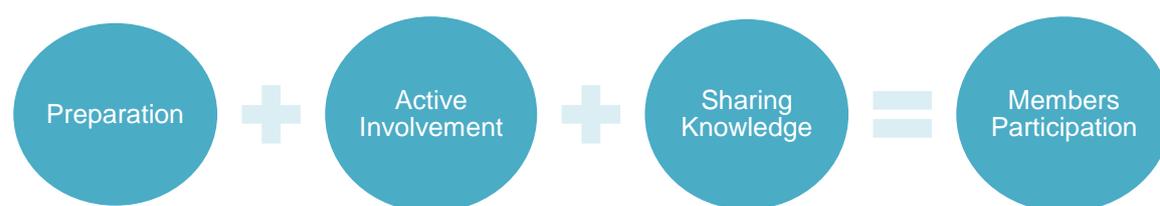
Many stakeholders and Panel members described the Panel as diverse (in regards to ethnicity and skills), however, Panel members emphasised that the membership was not necessarily representative of the women that are using CM Health’s Maternity Services. Key diversity gaps identified by evaluation participants included the need for a consumer that identifies with Indian ethnicity, as well as younger mums (aged 20 or less). Some participants felt like they did not represent the vulnerable population that the Panel intended to serve. The following quote highlights this:

*“[Because] I think the Panel, at the end of the day, the most consistent ones were people who were middle class independent. And we are not really, I mean we are probably the majority of what is served by the DHB, but we are not the vulnerable group that should have been more recognised in this.” Panel Member*

Panel members participating in the evaluation had a broad range of different backgrounds and skills with the uniting connection of motherhood. Many participants had professional experience of working within the healthcare sector in clinical and non-clinical roles. Members also had a variety of community connections with other mothers (including young mums) through

church, Maaori and Pacific communities, coffee groups, home-schooling communities, breastfeeding groups and antenatal groups.

Being a Panel member involved a range of different activities and responsibilities (see Figure 4), some of which were documented in the Terms of Reference, while other responsibilities of being on the Panel were identified by members themselves as a natural result of being a Panel member. Members' main responsibility was to attend and actively participate in the quarterly meetings and to give feedback and advice on presented topics. In order to do this, Panel members had to get familiar with the topics talked about during the meetings. They did this by preparing for the meetings through reading the materials they had received beforehand. On top of the meetings, members had the opportunity to attend several events including Midwifery conferences, the national Perinatal and Maternal Mortality Review Committee conference and the CM Health Women's Health and Newborn Annual Report launches.



**Figure 4. Panel members' participation activities**

As stated in the Terms of Reference, two Panel members worked on the Maternity Quality and Safety Group and gave additional input into this work. As part of their role, they presented about the group's activities in front of the Panel and got feedback from the Panel that they then took back to the MQSG.

Another optional responsibility for Panel members was additional work on certain project groups. Panel members were asked to join groups that they were interested in and become a part of the project team. One of the Panel members took this opportunity and supported a project group.

A responsibility that wasn't part of the Terms of Reference, but came naturally to Panel members, was to share the new information and skills that they gained through meetings with their communities. This sharing happened in informal groups like unofficial networks, groups of friends, family and whaanau. Panel members that participated in the evaluation shared almost

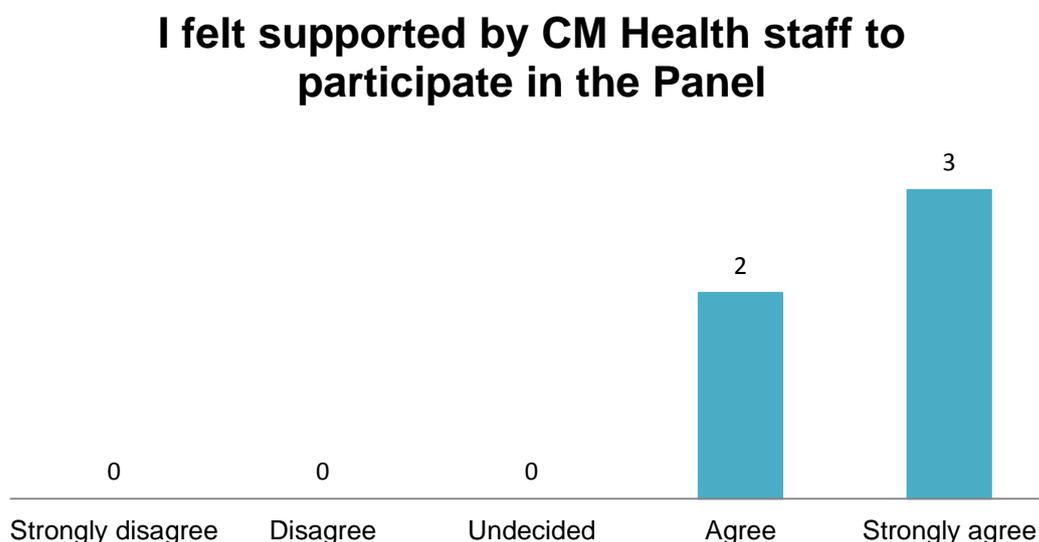
everything they had learned within meetings that they found empowering or useful to know.

Evaluation participants felt that meeting attendance was one of the strengths of Panel members. Revising the meeting documentation, an average absence rate of 25 percent was calculated. According to the coordinators, common reasons for absence from Panel meetings were often work or family related. Despite high attendance, interview feedback from Panel members, key informants, and a presenter, showed that meeting participation varied. During meetings some Panel members seemed more confident to speak up, give feedback and to share their stories than others.

### Support and Recruitment

To be able to contribute in meetings and actively participate while being on the Panel, members received a variety of support. Overall, Panel members felt very well supported by staff members and the facilitator. This conclusion is further supported by the results of the Panel members' survey.

As shown in Figure 5 below, in response to the statement 'I felt supported by CM Health staff to participate in the Panel', 40 percent (n=2) of the participating Panel members agreed, while 60 percent (n=3) strongly agreed. All of the women strongly agreed that they felt supported by the Panel facilitator.



**Figure 5. Panel members' perception of support by CM Health staff**

Table 1 summarises the support that members received from Panel coordinators and the facilitator in the column ‘support provided’. The information for this was taken out of the Panel documents and stakeholders and members interviews. The column ‘support needed’ presents specific actions or steps identified by evaluation participants that could have enhanced members’ roles and experiences.

**Table 1. Provided and needed support for Panel members**

Support provided	Support needed
Koha in form of vouchers for attending meetings	Valuing members input by increasing the visibility of the affected changes
Updates on projects	Remuneration for extensive workload outside of Panel meetings
Catering	Training Panel members on successful communication, different services across CM Health and CM Health and Maternity Services values
Emotional support through building relationships between members, coordinators and the facilitator	
Convenient location of the meetings e.g. parking, distance	Use of different communication and feedback styles to acknowledge diversity
Child-friendly environments	Enhanced relationships through more dedicated time and teambuilding activities
Meeting times	
Resources to prepare for meetings	Enhanced relationships through more transparency
Transport in form of taxi-chits and rides	
Possibility to contact coordinators and the facilitator in between meetings, and to keep in touch through a private Facebook group	
Opportunity to attend regional and national conferences	
Cultural acknowledgement e.g. through greetings	

Different strategies were used to recruit Panel members. Documentation in terms of recruitment strategies was limited, so all information was extracted from interviews with Panel members and other stakeholders.

Most of the interviewed members were recruited through the Panel coordinators. Panel coordinators used their existing relationships and their networks to approach and invite members. In doing so, they were aware of key demographic groups that were still missing among the Panel members.

Some of the women were also recruited through their midwives and Lead Maternity Carer (LMC). It was not possible to determine which criteria midwives and LMCs used to decide whether a woman was suitable for Panel membership or not.

## **Chapter 2: The Panel's Activity at Counties Manukau Health**

The following section presents findings from Panel documentation, qualitative interviews and the presenter survey which offers an overview of the subjects the Panel worked and gave advice on, the depth of the collaboration between the Panel and presenters, as well as how this advice has been applied to their projects and further consumer engagement.

This section will address the following evaluation questions:

- 2) What are the topics/subjects that the Panel has considered since the beginning of their work?
  - How can they be described and categorised?
- 3) To what extent is advice or guidance from the Panel being used/applied in the service or project?
  - What barriers to use/application can be identified?
  - What facilitators to use/application can be identified?
- 4) What have stakeholders learnt from their interaction with Panel members?
  - Has their consumer engagement changed?
  - How do they understand the role of the Panel?

### **Subjects the Panel worked on**

Since the beginning of the Panel's work, many presenters have spoken and a variety of subjects have been considered. As detailed in 'Methodology', we analysed presentation types according to the following categories: general information or upskilling, consults (including re-consults), updates and others.

These presentation categories are summarised in Table 2, together with the presentations that fell under these categories.

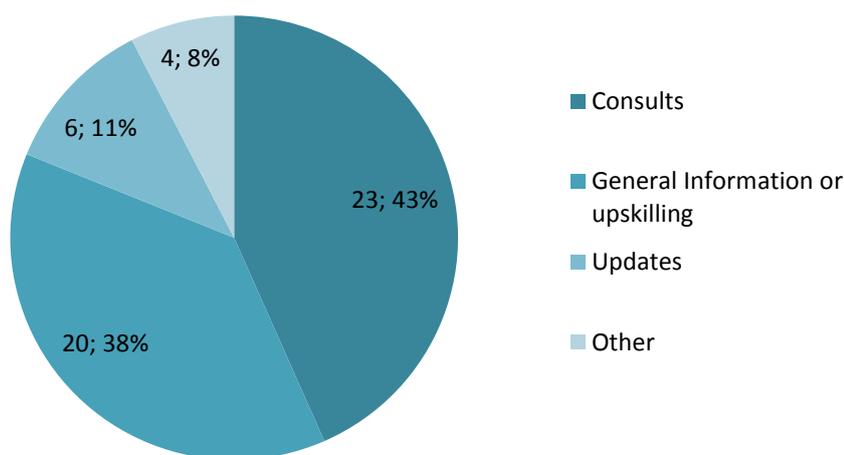
**Table 2. Presentations organised in four different presentation types**

General Information or upskilling	Consults	Updates	Other
Available services within CM Health	Community birthing units	Improving patient experience work	LMC Newsletter
Discussion of latest maternity related news	Developing communication strategies	MQSG updates	Meeting Minute Review
Conference feedbacks	Improving patient experience work		Healthy Mums and Babies Study
ABC study information	Designing the Panels' Terms of Reference and role descriptions		Patient Stories
Living our values work			
Panel related topics	MQSG annual report design		
	How to approach women for research		
	Breastfeeding policy review		
	Te Rito Ora Infant nutrition		
	Wellchild Tamariki Ora		
	Feedback on several resources		

Meeting minute documents from February 2015 to conclusion of the Panel showed that there were a total of 22 Panel meetings, consisting of 53 presentations to Panel members. The majority of presentations were

delivered by internal presenters (within CM Health) (42%, n=22), followed by the Panel coordinators (23%, n=12) and Panel members (21%, n=11). External presenters who work outside of CM Health held minority at six percent of the presentations (n=3).

As summarised on Figure 6, presentation types were mainly ‘Consults’ (43%, n=23) (including two re-consults and two consults from groups that members were involved in) or ‘General information or upskilling’ (38%, n=20). Of all presentations made, six (11%) provided an official update on the work at a later date. All six updates evolved around two different project groups that Panel members were directly involved in. These members would work on the project groups and regularly update other Panel members on this work. During the re-consults, presenters also gave updates on their work and informed how they had incorporated the women’s feedback into their work. The two re-consults were the only officially provided updates on projects where Panel members were not heavily involved in the work. This is also highlighted as one of the key areas for improvement later in the report.



**Figure 6. Pie chart of presentations by presentation types showing n (number) followed by percent**

**Time of the engagement**

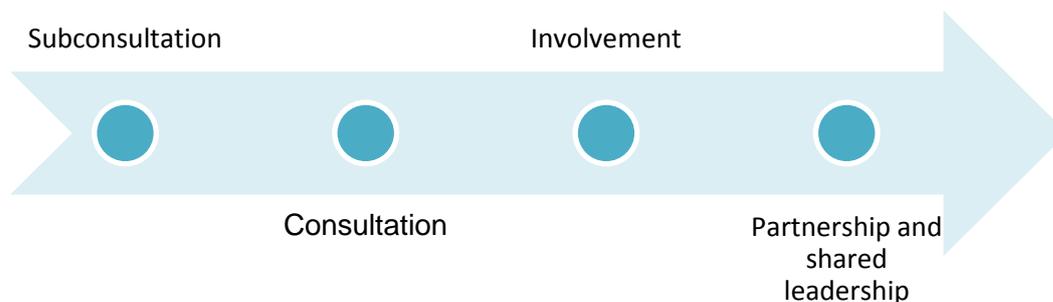
Presenters engaged with the Panel at different stages of their project. Thirteen percent (n=7) of the projects engaged with consumers right from the ‘beginning’, meaning that presenters came proactively at the start of their work to get guidance from the Panel. For some projects and pieces of work, the work had already commenced and the presenters were seeking feedback to progress with their work (8%, n=4). This stage is referred to as the ‘middle’. Presenters frequently presented their projects towards the ‘end’ of their work, as they had already completed the project, but were now looking for a

consumer endorsement or approval of the results (15%, n=8). Majority of the presentations held in front of the Panel were about 'ongoing' projects (21%, n=11) and to 43 percent (n=23) the definitions of the different stages were not applicable or the time of the engagement was unknown. This was especially the case for presentations of the type 'General information or upskilling'.

### Continuum of Engagement

Panel members' engagement in different projects and topics varied. As explained in the Methodology, and shown in Figure 7 below, this can be conceptualised as different stages on a continuum of engagement, based on the work of Carman and colleagues (2013). It is important to state, that the stages are based on their work, but changes have been made to accommodate the comprehensive work of the Maternity Consumer Panel.

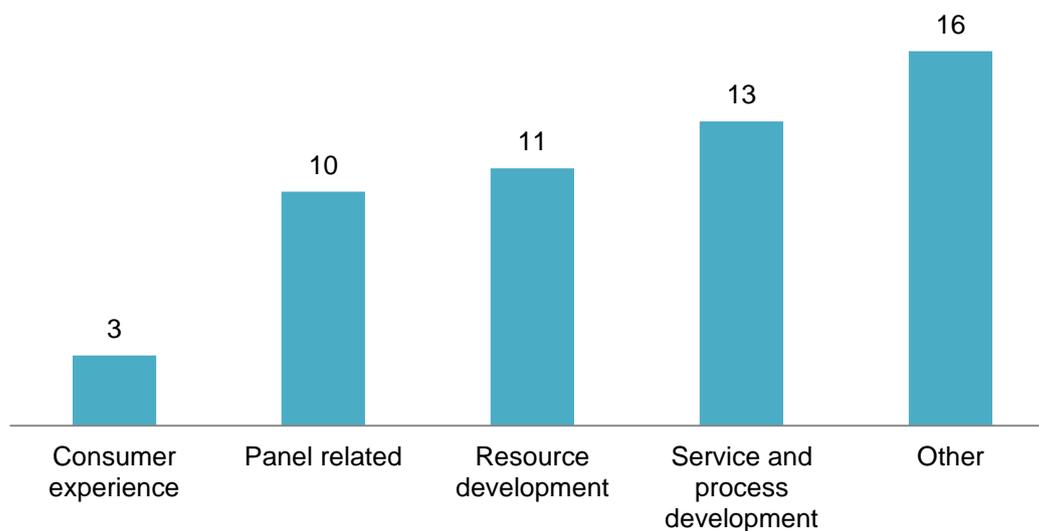
Most of the Panel's work can be located at the stage of 'subconsultation' (43%, n=23) and 'consultation' (38%, n=20). Seven percent (n=3) of the documented presentations were categorised as 'involvement' by the evaluators. There were two examples (4%) where interactions with the Panel met the 'partnership and shared leadership' level of engagement. In one case, evaluators were unable to determine the level of engagement from meeting minute records, whereas in four cases, the continuum of engagement and its definitions weren't applicable to the presentation.



**Figure 7. The continuum of engagement based on the framework by Carman et al. (2013).**

According to Panel documents and Maternity Services leadership, the purpose of the Panel was mainly to influence changes within service design. Figure 8 shows that this theme of 'service and process development' was addressed by 25 percent of the presentations held in front of the Panel

(n=13), while 21 percent addressed 'resource development' (n=11). The majority of the presentations fall under the theme 'other', as they didn't fit under any of the categories or the evaluators were unable to determine the theme of the presentation (30%, n=16). A small part of the presentations also addressed 'panel related' themes or 'consumer experience'. Overall, about three quarters of the presentations did not address the theme of 'service and process development'.



**Figure 8. Summary of the themes of presentations showing n (number)**

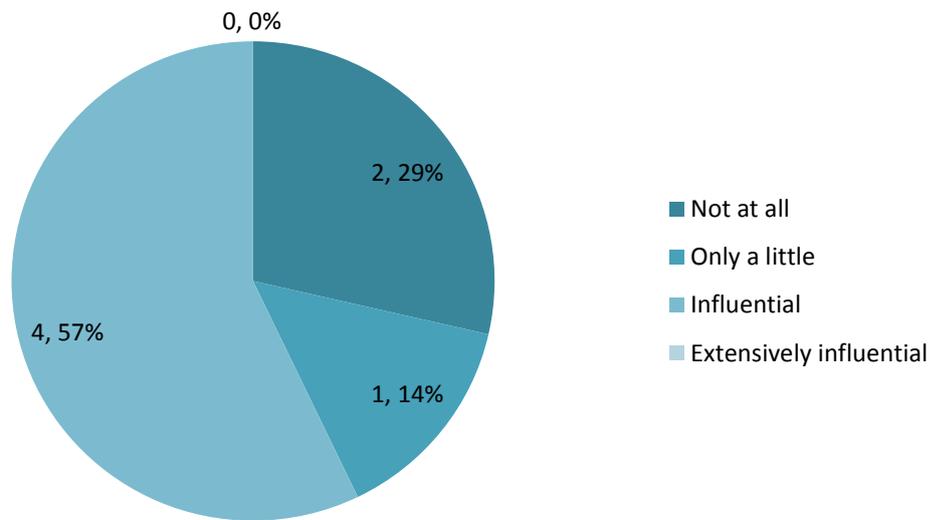
### Application of Panel advice

In order to understand the extent to which advice by the Panel has been applied to projects, presenters were asked to describe the influence through qualitative interviews and the presenters' survey. This section is therefore limited to the perspective of the presenters, given information regarding the Panel's influence could not be confirmed through other methods.

Fifty-seven percent of the participating presenters (n=4) said that working with the Panel has been 'influential' in their project (Figure 9). During qualitative interviews two examples of this influence were provided:

- 1) The Panel gave feedback on a resource which resulted in changes of the included information as well as alterations to the resource design. The Panel also suggested expanding the targeted population, which the presenter did.
- 2) The Panel helped to develop a communication strategy for CM Health. They gave advice on how they want to receive information, and through which channels. This information has been used across a range of programmes and projects, and helped build up an understanding of successful ways of communicating with the population.

As shown in Figure 9 below, out of seven surveyed presenters, two stated that the Panel did not influence their project (29%). Presenters commented that the given feedback was not relevant to the project and that they had already engaged with other consumers. One presenter said that the Panel only had a little influence on their project (14%). Examples for this are minor changes that had been made to a project. Another presenter stated that they used the Panel's advice as a confirmation for their approach.



**Figure 9. Pie chart showing to what extent the Panel influenced projects showing n (number) followed by percent**

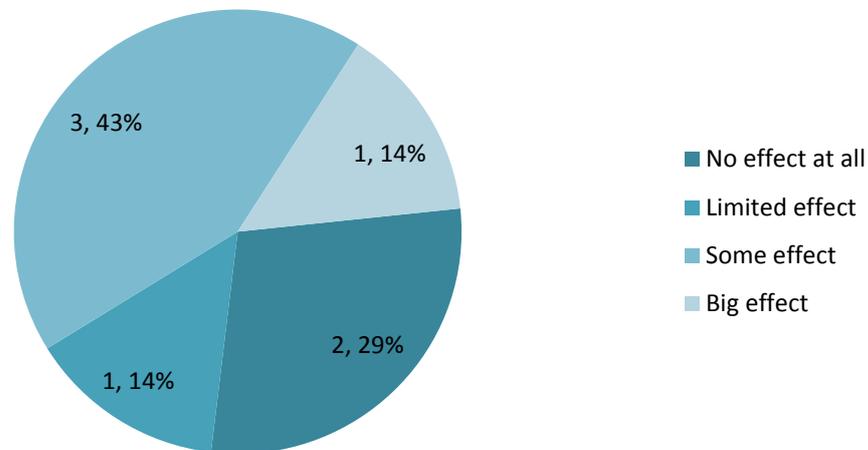
Presenters identified a number of barriers and enablers to the application of advice, which are summarised in Table 3.

**Table 3. Barriers and enablers to application of advice**

Theme	Barriers	Enablers
Membership	Some members had been on the group for too long and were rather 'experts'	Members had an understanding of CM Health and its services
	Some women did not have recent service experience	Members had used Maternity Services within CM Health
	Panel members did not always represent the particular target population for the project e.g. women who had problems breastfeeding, women who had preterm babies, women with gestational diabetes, women who had a caesarean	
Organisation	Limited presentation time and not enough time for feedback	Convenience of engaging with Panel rather than having to find suitable consumers
Professionalism		Members were confident in giving feedback
		Given feedback was constructive and honest
Presenters behaviour	Engaging the Panel at a progressed stage of the project so feedback can't be incorporated	Being clear on what is expected from the Panel and what they are supposed to feedback on

As shown in Figure 10, 43 percent of survey participants reported that the Panel had no or limited effect on how they engaged with consumers to shape

their projects. Conversely, 58 percent of presenters reported that the Panel had 'some effect' (43%, n=3) or a 'big effect' (14%, n=1).



**Figure 10. Pie chart showing the Panel's effect on presenters' consumer engagement showing n (number) followed by percent**

Reported changes in engagement include realising the importance of consulting with the Panel at the beginning of a project, a more realistic approach when making recommendations to consumers and a building a better understanding of the population CM Health serves. One presenter stated that they felt it was impossible to take all advice on board, and that it was imperative to engage consumers with a clear idea and plan. Another presenter reported that their experience of engaging with the Panel discouraged them from further attempts to seek feedback on consumer engagement due to having limited time to present and the lack of feedback as a result.

There is limited evidence to suggest that the Panel influenced the behaviour of individual presenters. However, stakeholder interviews indicate that after having the Panel, the service approach to consumer engagement changed. Instead of having a fixed group of consumers that meet on a regular basis, Maternity Services are now engaging with focus groups, facilitated by an external research provider. This provider assembles a group of women based on the subject that will be discussed.

### **Stakeholders' understanding of the Panel's role**

Stakeholders understanding of the purpose of the Panel is well aligned with the aim defined in the Terms of Reference. The Panel was founded with the intention of supporting and influencing service design within Maternity

Services in order to make some long-term changes. Coordinators and leadership understood this purpose and the focus of the Panel on service design. However, they do not feel like they were able to translate this purpose into the work of the Panel. Rather than driving service design, some stakeholders felt like the focus of the panel evolved around resource design. The following quote highlights this:

*“We used the group (...) as a focus group in a lot of ways. So we would ask people that were doing research or people that were devising a pamphlet or about consumer information.”* Key Informant

Coordinators had another vision of the Panel’s purpose which presents a consumer-led approach. They wanted Panel members to define their own agenda and identify problems within the organisation.

*“[The coordinators] always had the vision that the group would be more of a bringing up our own issues and ideas and things that we want to hold the DHB to account for, and things that we want to be seeing happening.”* Panel Member

The majority of Panel members reported an understanding of the panels’ purpose that is well aligned with its defined aim. Responses referred to making changes and improving Maternity Services, and further having a consumer voice within the services.

Even though the interviewed members understood the purpose of the Panel as influencing change within the system, some members were uncertain whether this was the intended purpose of the Panel. Panel members could sense a lack of alignment between the purpose of the Panel and the work that they were doing. This made them question their formerly firm beliefs, as highlighted in the following quote:

*“If the group [is] there for focus group style feedback in which case turning up, having a certain amount of time for speakers, giving that feedback and going, keeping on task with whatever was supposed to be talked about and then going home, that would be in my mind achieving what the goal was. If that was the purpose of the group then fine, but if, on the other hand, you’re wanting it to be more consumer-led and discussing some of those ideas outside of what the DHB’s kind of goals and aims were, then there needs to be more time (...)*

*I think the purpose of the group was to ensure that there was a consumer voice within the service but I kind of feel like at the end of it, just being a focus group style feedback group.”* Panel Member

Like stakeholders and members, the majority of presenters understand the role of the panel revolving around service design. Responses referred to feedback on services, consumer perspective on the healthcare system, and partnership in changing and improving services and co-design. One of the presenters described the purpose of the Panel as:

*“To work in partnership so that we get feedback from consumers on how we might develop, maintain, or improve our services.”* Presenter

In summary, Panel stakeholders seemed to have understood the role of the Maternity Consumer Panel within Maternity Services and CM Health. Nevertheless, Panel members, coordinators and other key informants didn't see this role reflected in the operation of the Panel, which eventually made them question its role and purpose.

### Chapter 3: Key strengths and areas for improvement

The following chapter draws on information from qualitative interviews to present the strengths and areas for improvement of the Panel that could be identified. Most of these strengths and areas for improvement revolve around the three key themes: (i) Relationships; (ii) Valuing, and; (iii) Diversity. This chapter will address the following evaluation question:

5) What are key strengths and weaknesses of the Consumer Panel model?



#### **Key Theme I: Investment in genuine relationships is crucial to effective consumer engagement.**

One of the key themes from the interviews with the participating Panel members was the importance of genuine relationships for meaningful and effective consumer engagement.

Participating Panel members saw relationship building as the foundation of engagement. By giving feedback and sharing what they had experienced they opened themselves to the group and made themselves vulnerable. Through building genuine partnerships this sharing came naturally to the women.

*“I say to people, I’m a nutritionist<sup>1</sup>, but literally a large part of it is engaging with people, is actually just this relationship building. It’s not about the information; it’s not about all of that stuff. At the beginning,*

---

<sup>1</sup> Identifying information in this quote has been changed.

*it's about relationship building... But in actual fact, when we relationship build and we do that at the beginning, all of that stuff comes just as part of relationship building."* Panel Member

Evaluation participants described the relationship between the Panel members as one of the essential benefits of Panel membership. Genuine relationships full of trust and transparency made Panel members feel comfortable and free to share their stories and experiences. Interviewed Panel members identified sharing and telling their stories of pregnancy, birthing and being a mum as a therapeutic benefit. Furthermore, during meetings Panel members discussed a range of subjects, with lots being personal and sensitive. To be able to share these stories and discuss these topics they needed to feel comfortable within the group and everyone who was present at meetings.

*"It was an amazing group. In terms of the ladies that were a part of the consumer Panel, it was really a positive experience in terms of being able to share and feel like you were listened to."* Panel Member

*"And they worked really well together, and you felt really comfortable in the meetings with everyone there. And you felt like you could say what you wanted to say and that your point of view was heard within the group and between the members. And there were often emotional experiences too that people were sharing, but I think what was really nice was that everyone could kind of, because everyone had kind of been there, done that, everyone could relate and discuss a topic together. It didn't matter who they were or where they'd come from."*  
Panel Member

An essential enabler for genuine relationships, as identified by interviewees, was the environment. A comfortable environment needed to be created for members in order for them to be able to share and build relationships with one another, including the stakeholders. To create these environments, interviewees emphasised the importance of openness and a non-judgemental mentality within the group and the meetings. During the meetings a diverse group of women with many different views and perspectives came together. Being respectful and open to these different views was what created a sense of comfort for members and made them feel free to share. Other factors that made the women feel comfortable in the environment were the location which was chosen to their convenience and the fact that they were able to bring their children to the meetings. Coordinators and facilitators remembered Panel members' names and engaged with them in personal conversations e.g. about their children's school activities.

*“And they were quite aware of what we had been through. We didn’t feel like we were judged.. Not that I care about that. No, they were quite understanding and open to our experiences. They weren’t judgemental...And we were given freedom to share. It wasn’t like someone directed what we said, or asked us closed questions. It was quite of an open forum to share”.* Panel Member

*“Oh they were.. very open and understanding, very patient. You know, not judgemental. Because you know, we were such a big group, different ideas.. but they supported us you know? We were very close to them, so we felt very comfortable with them.”* Panel Member

These quotes highlight how evaluation participants experienced Panel meetings as an open environment and how this contributed to them feeling comfortable and ready to share their views and emotions.

Transparency about the model of the Panel and its organisation is another contributor to this openness. Being honest about occurring problems and the reasons why they occur is crucial. This ensures that both parties can trust each other and continue to be open and non-judgemental. Panel members were able to sense conflicts and problems that were evolving; inconsistent messaging and hesitation made them feel insecure. To improve transparency for the model of the Panel, Panel members should be involved in the coordination and the administrative tasks regarding the Panel. Problems in terms of monetary, staff and timely resources need to be openly discussed with Panel members. Sharing and openness is not a one way street and we can only expect people to be honest with us when we are honest with them too. This is demonstrated in the following quote:

*“[It was] not transparent towards the end, you know? So I think that was just sort of frustrating for us. It was just like...If it comes to an end it comes to an end, it’s not a big deal but you don’t have to be so secretive or like hesitant to be honest with us, because we were quite an honest group, you know? That was sort of the environment that we had created that everyone felt free to share. And then, as it was coming to an end, there was sort of like a, it felt quite strange, like a, instead of just being really forward with us and saying ‘This is the reason it’s starting to come to an end’, but it wasn’t like that, it was sort of, it was weird.”* Panel Member

Many evaluation participants identified time as a necessary resource when building relationships. Even though interviewed Panel members saw sharing their stories as natural, most of them still needed time to get to this stage.

Panel members needed time to feel comfortable in the environment, both with each other and their role. Asking questions and exposing gaps in their knowledge was something they could only do after they had reached a degree of comfort.

*“I think it started off with getting to know everyone. I think it takes a few sessions for people to feel comfortable with each other...So I think there shouldn't be such high expectations in the future that people gonna share freely from [the beginning].”* Panel Member

*“But I think as the Panel moved on, we asked what things were, you know. And we felt comfortable, finally, you know with like: 'Ok, we don't know what this is, could you explain this?'”* Panel Member

When working with a culturally diverse group, another thing to consider when building relationships is to ensure cultural competency within the group and its leadership. Members' cultural needs to be acknowledged and respected and members want to be able to express their own culture. By adapting greetings and other practices, members can feel assured and feel safe to be themselves.

*“I think they often tried to greet...Also letting the ladies be themselves and express our own cultures. Like it wasn't shut down.”* Panel Member

*“They didn't make excuses for what mainstream had done, to us. You know, what we felt that had happened to us. They sort of just allowed us, aye?”* Panel Member

*“I am quite hesitant on greeting people with hugs and kisses, especially if they are non-Polynesian, because...you don't know if they like that kind of greeting. But they always did it! So...those [things] made us feel comfortable.”* Panel Member

In summary, Panel members mentioned having a non-judgemental environment, time, transparency and cultural competency as factors that contributed to them feeling comfortable and being able to build genuine and true relationships. As described in the quotes above, many of these things were provided for the members of the Maternity Consumer Panel. Through genuine and friendly interaction with the coordinators, members felt welcomed and comfortable. Nevertheless, some of the interviewed Panel members expressed that they would have wished to have more dedicated time for relationship building, especially as it is such a crucial part of the Panel membership. Examples like having more in-depth introductions, getting to know each other at a dinner or activity, and having farewells for leaving Panel

members, were given by evaluation participants as ideas to enhance relationships with each other. In order to strengthen relationships with members of the staff and to get to know structures within CM Health, an example was to visit offices and interact with staff outside of Panel meetings. Ensuring transparency was another identified contributor to building relationships.



**Key Theme II: Valuing consumers' time and input is an essential part of successful consumer engagement.**

Successful consumer engagement is a two way street. Through consumers sharing personal stories and emotional experiences, services get valuable insights into their needs and views. To enable and support consumers in doing so, services need to show that they value and appreciate the input and time consumers sacrifice to engage.

There are many different ways to show this appreciation. A common way to value consumers' feedback is remuneration. Panel members received \$100 gift vouchers for every attended meeting and they valued these. Nevertheless, Panel members that participated in the evaluation spoke a lot about other actions of appreciation that empowered them during their membership, or could have enhanced the engagement even more.

For evaluation Panel members it is critical to understand the impact that they are making. They want to be able to see the changes and want to know how they influenced services. Changes and improvements that result from consumer engagement need to be made visible to involved consumers and to the rest of the organisation. It can be frustrating for consumers to share their stories and be involved in projects without seeing the outcome. As highlighted earlier, only eleven percent of presentations held were official updates on work; all of these updates revolved around project groups that Panel members were directly involved in. The Panel coordinators and facilitator need to ensure that pathways and expectations for feedback from presenters and project groups are clearly defined. An evaluation participant describes as follows:

*“..[It's] really powerful stuff for people to know from your Taki or your Kaupapa came this change. That's really powerful stuff, but that doesn't happen...And I don't care if it's a year or two years later, I really don't care. But if you came back and said 'You know what? When you said that, we did this.' That's great. You think [Wow], I made*

*a change...As a consumer, if I know that and I want to create change for something else, am I [going to] engage? Totally, I will! Cause the last time – right, it worked. I put my voice out, I was listened to, and it were actioned. Will I do it again? Yes, I will!” Panel Member*

As the following comment highlights, feedback on their work and input made Panel members feel good and like they were “making a difference”. As reported in the above quote, this can be a very empowering feeling for consumers and makes it more likely for them to engage again. This information can be extremely useful for future panels or other engagement strategies.

*“..The facilitators or you know, the people that are running these Panels, they tell us how valuable what we’re giving, you know, our feedback is. And you know, it’s nice. Cause then it makes us feel...feel that we’re making a difference.” Panel Member*

Even though presenters were supposed to return to the Panel and give an update on their project and how they incorporated the Panel’s feedback, this rarely happened. The following quote highlights how poor experiences of engagement inhibit further engagement – a fundamental issue in healthcare:

*“I would have liked more [feedback] - but we did, we did get it though but it was - we had to ask for it. Like feedback about projects or things that we helped with.. for example.. we gave ideas about pamphlets and we didn’t really hear anything about it until we asked for feedback on it. You know, it would have been nice just to get an update of things that we helped out with.” Panel Member*

Interviewed Panel members reported that they could sense a lack of investment from CM Health into the Panel and its members. It made them question the purpose of their work and got them wondering if the organisation actually supported and cared about their voices. The following quote demonstrates this:

*“And as a group that we were very passionate about improving services, it was a shame to hear and to feel like there wasn’t really an investment in what the consumer...what our people have to say about the services.” Panel Member*

The following section summarises further actions that could be taken to meaningfully invest into the Panel, its members and stakeholders. Through investment, the Panel’s work is valued, and the organisation can show its appreciation of the Panel members’ efforts.

As illustrated in the following quote, evaluation participants reported that they felt training could have helped them to enhance members' roles on the Panel. Offering training to Panel members on presented topics or on organisational issues, systems or processes can show them how much their skills are being valued. This investment enhances appreciation.

*“If that was the purpose, if that was part of our role, then I wonder if we needed some sort of training, to start off with. To serve, whatever purpose they wanted us for, aye?”* Panel Member

Training can be beneficial for both staff and Panel members. Training on effective consumer engagement can give them reassurance for their approach and enhance their confidence. By ensuring staff are appropriately trained, their hard work and input into the Panel will be valued as well.

*“The Ministry had given, as part of the Maternity Quality and Safety Programme, a guide.. about consumer involvement and things there, but I never felt.. confident or comfortable, I suppose, in knowing.. whether we were doing the right thing or is this good for them or are they getting something out of it, are we getting something out of it ...”* Key Informant

Another action that can show consumers how much their time and input is valued, is to enhance clarity around the Panel purpose, consumer roles and the purpose of presentations. In order for consumers to deliver what they are being asked, they need to understand what their roles are and how these fit into the service vision and strategy. It is crucial to be clear about the purpose of presentations that are held in front of the Panel to ensure alignment with Panel purpose, and clarity of what is needed from members in response. Uncertainty about member roles can make members feel insecure and question their involvement.

*“So what I felt my role was, was to offer advice, offer a pacific perspective on the services that maternity health offered to the community. That’s what I thought my role was. That’s what I felt my role was throughout the whole period...I think I would like to know what my real role is... We didn’t really know. I think that would have been good to be clear about ‘Look, these guys are coming in for this purpose.’ And then for us to know, instead of sitting there, wanting to say things and wanting to offer [advice] - when really that wasn’t the whole purpose.”* Panel Member

Defining the purpose of the Panel, of individual presentations that are held in front of it, and also defining members' roles can help Panel members better understand what they are working towards.

This clarity also links back to the importance of transparency for genuine relationships, as it has been illustrated in Key Theme I.

Something that needs to be considered when reimbursing Panel members or investing into them is that the work burden and impact that is expected from consumers needs to be reflected in the support that they are given. If consumers are expected to participate in service design and join projects groups, this will involve preparation and extensive, ongoing commitments to project team meetings. Consumers will have to allocate time to preparing for meetings by reading up on topics and building up background knowledge. It cannot be expected from consumers to do this in their own time. An evaluation participant summarised it like this:

*“It depends on where they see the group going and what they want out of the group. If it’s just a focus group style feedback meeting, and you reimburse people for their time and doing what they’re doing now, great location, parking, kid friendly, that’s fine, but if they are wanting more than that, if they’re wanting people to spend time outside of meetings doing things like reading and or any kind of phone calls, then they’d need to rethink how they reimburse and support that. I think they just, it needs to be something that’s always kept in mind, I guess.”* Panel Member

In summary, this key theme highlights the importance of showing Panel members how much their work is being valued by the organisation and the service. On the Maternity Consumer Panel this happened through a koha and (to some extent) by making changes the group had achieved visible. Nevertheless, evaluation participants reported that the visibility of change and impact could still be improved through increased feedback from presenters.

Panel members reported a lack of investment into the Panel and its work. By training Panel members and stakeholders, and therefore investing into their skills, this perception can be changed. Being clear about the Panel members' roles and the purpose of presentation shows them that their time is being valued. Whenever consumers are remunerated, whether it's through a koha, training or other incentives, it is necessary to consider what amount of work they are expected to do and how meaningful this is to the future of the organisation and its services.



### **Key Theme III: Only diverse engagement approaches can accommodate for a diverse group of consumers**

Consumers of healthcare services are individuals with a variety of different needs and preferences. When a consumer engagement plan is being developed this needs to be taken into account. Some consumers will need more support to be able to engage than others, and for some people it is easy to feel comfortable in a new environment, while others need time and help to do so. Offering women the opportunity to engage with a Panel to effect change within a system is valuable, but it is only one approach. It will most likely attract people who are approachable, who are able to commit to regular meetings and who are comfortable with sharing their experiences and stories in a Panel meeting environment with many other people. This approach does not suit every consumer. By providing a range of engagement and feedback pathways, the diversity of engaged consumers and their experiences can be increased.

*“Depending on the group you’ve got, I guess, their background. Things work well for different people.” Panel Member*

As earlier highlighted, although Panel members were satisfied with the support they received from CM Health and Maternity Services, many emphasised that they did not see themselves as the vulnerable population that could greatly benefit service. Panel members underlined that vulnerable women need more support than what had been given to them. Examples for support included having meetings within the community in an informal space, having coordinators that young mums can relate to, and creating different subgroups to make different cultures and age groups feel comfortable.

*“I think there were women who maybe weren’t as independent but their voice was needed, but were often missing. If it’s because they didn’t have a ride or - especially the younger mums. Like we really wanted.. our teenage mums to be in it. But you know they often depended on a ride to get there or.. And to be honest, I think their voice was probably what was really needed on the Panel.” Panel Member*

Consumers also have different needs when it comes to communication. Evaluation participants reported that for some women it was easy to share their stories and give honest feedback, while others needed more time to do so. Speaking freely in front of a group can be challenging for many people and is only one approach to feedback. Using different communication and feedback options like questionnaires, interviews, photos or videos, and

supporting Panel members to find their preferred methods can help them express themselves and give their opinion. Some Panel members mentioned that it can be hard to listen to lecture style presentations for a long time, and that this can also be difficult for children that are brought to the meetings. Breaking presentations up and trying different approaches like smaller subgroups or interview style conversations can be a welcomed change.

*“Whereas sometimes, you might be sitting there and you might just copy their answer. Just cause, you know.. you think your answer is dumb. Or you’re just too scared to say anything, anyways, you’d be saying ‘Oh, no, no, pretty much I am the same as them.”* Panel Member

*“They were not always family friendly environments, or kiddie friendly environments. And what I mean by that is there’s a huge expectation to sit down, be quiet and listen to the person in the front of the room, you know? And if you’ve got a baby or whatever, that cries and stuff, that’s like ‘What the hell?’ and it’s just continual presentations for two hours.”* Panel Member

When recruiting new members for a panel, approaching women who are accessing maternity care is likely to mean that only women who are already engaged with the services are invited to participate. In order to attract members, existing connections and relationships of current members should be used to extend the Panel reach. Many participating Panel members had connections into different communities, some of which may be considered vulnerable or those with unmet maternity needs. Leveraging existing community relationships could be very helpful in approaching a more diverse group of women.

Another way of ensuring that a Panel is and stays diverse in their membership but also in their views is by having a fixed term membership. The Maternity Consumer Panel had a maximum membership of two years, but it emerged from interviews that this was not executed. Many Panel members felt like their last service experience was in the distant past and that they did not have recent service experiences to inform their work. They expressed the need for new members with fresh views and recent maternity and birthing experiences on the Panel. It is important that rules like this, that are defined in the Terms of Reference, are followed and that coordinators and facilitators are clear about what happens after the two years are reached. This also refers to the sections on transparency in Key Theme I and II.

*“I loved being part of the Panel, absolutely loved it. But I reckon that we should have like a date when we should stop being in it. So like, I think*

*we need to have.. revolving [members] all the time. Like, because when I had my last kid [several] years ago that would be different from my [aunty] who just had a baby [two weeks] ago. You know? So we have fresh ideas and voices of the changes that had happened and their experiences. Because my experiences from ten years ago to now would be completely different, you know? I think that's the only thing that I would ever change of it.<sup>2</sup>" Panel Member*

Presenters also have diverse needs when working with a consumer panel. Some participating presenters reported that they found the group of women on the Panel diverse and helpful to talk to about their project or subject, while for other projects, feedback from more diverse subgroups, like women that had premature babies, would have been needed. While it is hard to combine all stakeholders and subgroups on one Panel, it is important to offer choice and variety in the approaches to attract a diverse group of consumers most relevant to projects.

In summary, consumers are individuals that have a variety of different communication and support needs and preferences. In order to attract and accommodate a diverse group of consumers, CM Health needs to be diverse in their approaches of consumer engagement. Examples for a more diverse approach in engagement can be new ways of recruitment, offering different presentation and communication styles, trying out new ways to capture stories and give feedback. When engaging with a demographically diverse group it also needs to be considered that some consumers will need more support to engage than others. To ensure a group of consumers stays diverse in their views, fixed term membership should be considered.

---

<sup>2</sup> Identifying details in this quote have been changed.

### Summary of strengths and areas for improvement

Many of the operational strengths and areas for improvement have already been highlighted in the three Key Themes above, or in other sections of the report. Table 4 provides an overview.

**Table 4. Operational strengths and areas for improvement**

Theme	Strengths	Areas for improvement
Building meaningful relationships	Creating a comfortable and open environment for Panel members	Dedicating time for relationship building
	Culturally appropriate greetings	Increased cultural competency
		Transparency
Valuing	Koha	Making the Panel's impact visible
	Other types of support like transport, location and time of meetings	
		Increased investment into the Panel and its skills
Membership	Members represented a broad range of views and experiences	Increased ethnic and demographic diversity
		Fixed-term membership
Actions	High demand of the Panel's services	Frequency of the meetings
		Diverse engagement and communication strategies

### Strategic strengths and areas for improvement

The Maternity Consumer Panel had a clearly defined aim in their Terms of Reference. As described in Chapter Two, apart from small variations, most stakeholders and Panel members were familiar with this aim. However, the subjects and projects the Panel worked on did not always align with this strategic aim. Many presentations aimed to inform or upskill Panel members, as opposed to getting their feedback. The Panel often worked on the lower end of the continuum of engagement, with only two projects engaging at the level of 'Partnership and shared leadership'. Stakeholders had the impression that a lot of the Panel's work evolved around resource design rather than service design.

*“And what we found is that...in some instances unfortunately, it almost became a bit of a tick-box approach...the people knew that there was a maternity Panel so what they tend to do was go ‘oh ok, we developed a new resource and now we need to test it... for your acceptability, so we take it to the consumer Panel’ ...and they’d receive feedback around that. And that was part of the intent, but ...that was not really what we put the consumer Panel up for, it was more on service design rather than resource development.” Key Informant*

In interviews, coordinators stated that another objective of the Panel was for them to make it consumer led. They wanted consumers to identify and lead with their own issues, and make their own agenda. This objective had not been documented and Panel members did not refer to this when talking about their views on the purpose of the Panel. Indeed, one Panel member said that they found Panel meetings rather service led:

*“And we never kind of reached the point where the group members were bringing up their own issues that they had with how things were run. It was very much DHB-led, not consumer-led in meetings.” Panel Member*

When reviewing Maternity Services documentation, it was challenging to find documentation around the development of a consumer engagement plan, its objectives and the implementation of the Panel.

Furthermore, Panel members and stakeholders sometimes felt like the engagement had a ‘tick-box’ approach, particularly when the presentations took up most of the Panel’s time without them being able to give feedback. Stakeholders found it challenging to make the Panel’s work meaningful and had problems deciding on which projects to take to the Panel.

Overall, a key strength of the Panel was having a clearly defined aim and scope within its Terms of Reference that was familiar to the majority of Panel members and other stakeholders. However, the work of the Panel did not fully align with its strategic aim. Documentation around consumer engagement within Maternity Services, its objectives, and the set-up of the Panel was scarce. This is a key area for improvement, as well as creating a consumer led Panel.

## Discussion

This evaluation of the Maternity Consumer Panel aimed to assess the Panel's model, its key strengths, areas for improvement and outputs and outcomes of the Panel's work, in order to consider its future direction.

In brief, the evaluation has revealed that the Panel worked on a variety of different projects that addressed a broad range of topics. The majority of the presentations engaged with consumers on the lower end of the continuum of engagement. Panel members had a diverse range of skills and community connections, but we found a need for participation of an increasingly diverse consumer group. During interviews, evaluation participants identified genuine relationships, valuing input, and diversity as key enablers to successful consumer engagement.

The following part of the report will discuss evaluation findings in four different sections: Purpose, Diversity, Relationships, and Valuing.

### Purpose

As presented in the background section of this report, the main purpose of the Maternity Consumer Panel was to influence service design within Maternity Services. However, evaluation findings have highlighted that the purpose of the Panel was not well reflected in its operation. For example, the Panel purpose, and types of presentations at the Panel did not align and there was limited scope for Panel to influence services and processes. Over time, this misalignment made some stakeholders question the role of the Panel.

In order to make consumers feel comfortable with the process and the team, and to maintain their involvement, existing research recommends clarifying “the objectives, roles, and expectations of the engagement for patients...” and to include consumers into “all/most stages of the planning, administration, and evaluation” of an engagement process (Bombard et al., 2018, p. 12-13). These strategies can improve the outcomes of the engagement. This evidence highlights the need for the Panel to review its main purpose and ensure that it is reflected in its operation.

From interviews and a review of meeting minutes, we concluded that Panel meetings were primarily service-led rather than consumer-led. In order to move in the direction of consumers leading the Panel and its meetings, consumers should participate in revising the purpose of the Panel and identifying topics that need to be discussed. This approach reflects the recommendation of Kuhn and colleagues (2016), who advocate that consumers on formal consumer groups should shape their own agendas –

either internally or through feedback from the wider community. Being consumer led results in the increased and ongoing involvement of consumers, and improved quality of engagement outcomes.

When preparing for consumer engagement, the Health Quality and Safety Commission New Zealand recommends being clear on the purpose of the engagement and also on the level of engagement that is needed to achieve set aims (HQSC, 2015). In their systematic review, Bombard and colleagues (2018) highlight that 'discrete products' like patient resources or planning documents are the result of low level engagement, while high level engagement produces process or structural outcomes. This evidence suggests that the Panel needs to work on the higher end of the continuum of engagement in order to fulfil its purpose of affecting service and policy-level design.

A number of presenters engaged with the Maternity Consumer Panel at the end of their project or piece of work. In these cases, Panel members and coordinators had the impression that presenters' engagement with the Panel was a 'tick box' exercise to gain consumer endorsement or approval retrospectively. While this is not necessarily intentional, delayed or late engagement occurring after decision-making can seem tokenistic (Bombard et al., 2018). Revising the Panel's purpose and training staff on successful consumer engagement to support proactive and early engagement of consumers may help to address this issue.

## Diversity

Panel members and coordinators (to a certain extent) expressed their wish for the Panel to be more diverse in composition across ethnicity, age and needs. Evidence suggests that being flexible in approaches used when engaging with consumers can enhance involvement and therefore increase diversity (Bombard et al., 2018). Maher, Hayward, Hayward, and Walsh (2017) conclude that "there is no one size fits all approach to engagement in healthcare" and that different people prefer different ways of communication and story capture (p. 30). Some of the examples given by Bombard and colleagues (2018) on approaches when involving patients include: patient-to-patient interviews, headline generation (patients creating headlines to describe important issues), structured group discussions or written exercises. Other options may be photos, videos or questionnaires.

Ensuring a diverse range of engagement and story capture tools are used points to the need for additional engagement strategies which should be developed to complement the Panel. Examples of different and effective strategies as identified by Johnson (2015) include the involvement of

consumers on existing committees or formal structures, collaborating with consumers over the duration of a project, or practising co-design. Through using a range of these engagement strategies and story capture tools, we would expect a broader variety of consumers to get involved, as we can accommodate and appeal to different engagement and communication preferences, styles, skills and experiences. When deciding on which strategies to utilise, consumers should be consulted to inform decisions, as the community can give insights on how its members want to participate.

One of the evaluation findings concluded that Panel members had a variety of different skills and important community connections. It could be worthwhile to leverage these valuable connections when recruiting consumers for the Panel or other engagement approaches. If this approach is being taken, community connections are a crucial attribute to seek when recruiting new Panel members. This approach is taken with the existing Counties Manukau Health Consumer Council. The Council has clearly articulated Council member roles and responsibilities to support the use of members as key conduits between CM Health and external community/consumer groups.

## Relationships

A persistent theme in interviews (especially with Panel members, but also other evaluation participants), is the importance of genuine relationships for engagement. This finding is supported by an evaluation of the co-design programme 'Partners in Care' at CM Health, which recommends to "focus on building and maintaining relationships throughout, particularly by devoting time to get patients to express their needs and views" (Hayward, 2015, p.7). Time is highlighted as an essential factor when building and maintaining relationships (Hayward, 2015); during the current evaluation, Panel members also highlighted this connection.

The HQSC (2015) identifies openness and honesty as key principles when engaging with consumers and building genuine relationships – enablers that Panel members reported and wished to increase. Other techniques that can help build a partnership between consumers and staff includes valuing and belief exercises, and narratives to "generate consensus" and facilitate a "shared understanding" (Bombard et al., 2018, p. 15). Power imbalances between staff and consumers can prevent genuine relationships, and may be decreased by giving consumers equal voice throughout the engagement process (Bombard et al., 2018).

## Valuing

Evaluation findings revealed a need for increased valuing of Panel members' participation on the Panel. Bombard and colleagues (2018) found that giving consumers regular updates on how their feedback and suggestions had been accepted and implemented can increase involvement. Similarly, learning from co-design emphasises that “visibility of the end result [is] a critical factor in patient engagement and satisfaction with their involvement... [Patients valued] ongoing contact and follow up about how their contributions had been applied, solutions that had been implemented and the impact on other patients utilising health services as a result of their involvement” (Maher et al., 2017, p.29-30). This follow up may be needed beyond the project lifecycle (Maher et al., 2017).

On the Panel, the coordinators informed presenters about the importance of returning and giving updates (Appendix 11); reminding them via email to do so. However, the majority of presenters never returned, and some did not respond to emails. Defining clear pathways for updates and developing a process to hold presenters accountable for giving updates on their work can ensure consumers get the follow up they deserve.

A “key facilitator of successful engagement” that Bombard and colleagues (2018) identify is called “leadership actions” (p. 15). Through specific actions and involvement, organisational leaders can show their support and appreciation and demonstrate that they've recognised the importance of the patient involvement. This can lead to enhanced empowerment and commitment of the group. Such support and acknowledgement can be provided by having ongoing contact to senior management and making sure that key roles are open to changes. By increasing the visibility and support of Panel activity by senior leaders, and defining clear communication pathways between the Panel and Maternity Services leadership team, the service can demonstrate how valuable the Panel is and to what extent it influences the service.

Some Panel members mentioned training as a support that could have enhanced their roles – an action that can have several benefits like providing clarity on roles and enabling consumers to contribute to meetings (Bombard et al., 2018). The Australian Commission on Safety and Quality in Healthcare reviewed the key attributes of high-performing person-centred healthcare organisations and found that they value their consumer representatives and their skills through professional orientation sessions and ongoing training which includes:

- Governance and decision making

- Relevant organisational issues
- Co-design and evaluation processes

(Australian Commission on Safety and Quality in Healthcare, 2018).

Conversely, high-performing person-centred healthcare organisations incorporate the consumer perspective into training for their workforce when offering training sessions on how to engage with consumer and their families for governance and design of services.

## Conclusion

In summary, this evaluation explored model and membership of the Maternity Consumer Panel, its involvement and impact on projects and other pieces of work, and stakeholders' experience of working on and with the Panel.

In order to answer the evaluation questions, a mixed-methods approach was chosen which included:

- semi-structured interviews with panel members, coordinators, and presenters;
- a survey with panel members and presenters;
- document analysis;
- and a literature review.

Overall, Panel members had a positive experience of Panel membership and felt well supported by CM Health staff and the Panel facilitator. The evaluation showed that building genuine relationships and effectively valuing consumer input are key factors for successful engagement, especially for Panel members.

While we recommend ongoing operation of a Panel, the Maternity Consumer Panel was not successful in meeting its key aim to design/create more consumer centred maternity services. Most of the Panels work could be located on the lower end of the continuum of engagement. Evidence has shown that work on this level is suitable to influence resource design and the development of documents. In order to affect change in service design and policy development, engagement needs to reach the stages of 'Involvement' and 'Partnership and shared leadership'. When planning engagement strategies, it is recommended to be clear of the objectives and the suitable stage of engagement.

Future engagement strategies for Maternity Services should be multi-method i.e. ensure that they use a variety of different approaches, including a consumer panel. Having a consumer panel with two year membership ensures that relationships and trust can be built over time. Nevertheless, other approaches like co-design are needed to engage increasingly diverse groups of consumers in the design of services.

Ensuring a consumer-led approach at all stages of engagement – from planning to evaluation – can enhance involvement and improve the quality of engagement outcomes. This evaluation identified considerable gaps in organisational strategy for the use and formation of consumer groups to direct care design.

## Recommendations

From evaluation findings, we propose 17 recommendations which are related directly to the panel, service or our organisation more broadly.

### *Panel recommendations*

We recommend continuation of the Panel activity (alongside a broader service strategy for engagement as detailed under service recommendations) with several refinements for improvement:

- 1) Revise the purpose of the Panel to create clarity and consensus across stakeholder groups. Ensure:
  - a. The Panels' purpose is designed in partnership with consumers.
  - b. The Panels' purpose is supported by relevant senior leaders (Women's Health, Maternity Services) and the Patient and Whaanau Centred Care Board.
  - c. Clear documentation of the Panel purpose.
- 2) Refine members' roles. Ensure:
  - a. Members' roles are defined in partnership with consumers.
  - b. Advocacy (for community groups/connections) and maintenance of community connections are the main focus of Panel members' roles.
  - c. Clear documentation of members' roles and responsibilities.
- 3) Adopt a consumer-led approach that involves, for example:
  - a. Establishment of a Consumer Panel chair.
  - b. Facilitation of the Panel by a consumer.
  - c. Consumer defined agenda items.
- 4) Nominate a member of the staff to revise presentations that are meant for the Panel to ensure that they align with the strategic aim.
- 5) Develop a process to hold presenters accountable for giving updates on their projects.
- 6) Review coordinators workloads and develop a plan to support them.
- 7) Develop a toolkit for story-capture (e.g. questionnaires, interviews, photos, or videos).
- 8) Train Panel members, coordinators and the facilitator on co-design and engagement.
  - a. Assess further training requirements in partnership with consumers.
- 9) Develop a plan for the leveraging of Panel members community connections to reach out to vulnerable consumers.
- 10) Develop a template for meeting minutes to ensure consistent documentation of meetings.

- 11) Regularly assess Panel meeting content and actions to anticipate and address:
  - a. Emerging issues with Panel value.
  - b. Alignment with purpose.
  - c. Panel influence.

#### *Service recommendations*

- 12) Increase visibility and support of Panel activity by senior leaders (Maternity Services) ensuring:
  - a. Clear communication pathways between the Panel and Maternity Services senior leadership team.
  - b. Increased visibility/presence of senior leaders at Panel meetings.
  - c. Increased support to action of Panel recommendations/suggestions from senior leaders.
  - d. Increased socialisation of the Panel purpose and scope of influence by senior leaders.
- 13) Increase visibility of the impact of Panel or other consumer activity.
- 14) Train staff on approaches for effective consumer engagement.
- 15) Use a range of consumer engagement approaches in addition to the panel (e.g. co-design, consumers on project groups).
  - b. Ensure consumer input into the planning of these approaches.

#### *Organisation recommendations*

- 16) Develop an organisational strategy for consumer engagement and connect the different services in their approach (Patient and Whaanau Centred Care board).
- 17) Distribute this report to relevant audiences.

## References

- Australian Commission on Safety and Quality in Healthcare. (2018). *Review of key attributes of high-performing person-centred healthcare organisations*. Sydney: ACSQHC.
- Balint, E. (1969). The possibilities of patient-centered medicine. *Journal of the Royal College of General Practitioners*, 17,269–276.
- Bombard, Y., Baker, R., Orlando, E., Fancott, C., Bhatia, P., Casalino, S., . . . Pomey, M.-P. (2018). Engaging patients to improve the quality of care: a systematic review. *Journal of Implementation science*, 13(98). doi:<https://doi.org/10.1186/s13012-018-0784-z>
- Carman, K. L., Dardes, P., Maurer, M., Sofaer, S., Adams, K., Bechtel, C., & Sweeney, J. (2013). Patient and Family Engagement: A Framework for Understanding the Elements and Developing Interventions and Policies. *Health Affairs*, 32 (2), 223-231.
- Castro, E. M., Van Regenmortel, T., Vanhaecht, K., Sermeus, W., & Van Hecke, A. (2016). Patient empowerment, patient participation and patient-centeredness in hospital care: A concept analysis based on a literature review. *Patient Education and Counselling*. 99, 1923-1939.
- Counties Manukau Health. (2015). Healthy Together. Strategic Plan. Retrieved from: <https://countiesmanukau.health.nz/assets/Uploads/CM-Health-Strategic-Plan-April-2016.pdf> [08/01/2019]
- Dickinson, A., Water, T., & Wrapson, W. (2014). Children’s voices in public hospital healthcare delivery: Intention as opposed to practice. *The New Zealand Medical Journal*, 127, 24-31.
- Hayward, B. (2015). *An evaluation of the co-design programme 2014-15*. Auckland: Ko Awatea.
- Health Quality and Safety Commission New Zealand. (2015). *Engaging with Consumers. A guide for district health boards*. Wellington: HQSC.
- Health Research Council of New Zealand. (2010). *Guidelines for Researchers on Health Research Involving Māori*. Auckland: Health Research Council.
- Higgins, T., Larson, E., & Schnall, R. (2017). Unravelling the meaning of patient engagement: A concept analysis. *Patient Education and Counselling*, 100, 30-36.
- Johnson, A. (2015). *Consumer and community engagement in health services: a literature review to support the development of an evidence*

*based consumer and community engagement strategy for the Women's and Children's Health Network.* Adelaide: Government of South Australia.

- Kuhn, K. J., Mickelsen, L. J., Morimoto, L. N., & Larson, D. B. (2016). The Use of Patient and Family Advisory Councils to Improve Patient Experience in Radiology. *American Journal of Roentgenology*, 207, 965-970.
- Maher, L., Hayward, B., Hayward, P., & Walsh, C. (2017). Increasing patient engagement in healthcare service design: a qualitative evaluation of a co-design programme in New Zealand. *Patient Experience Journal*, 4(1), 23-32.
- Oldfield, B. J., Harrision, M. A., Genao, I., Greene, A.T., Pappas, M. E., Glover, J. G., & Rosethal, M. S. (2018). Patient, Family, and Community in Healthcare and Research: a Systematic Review. *Journal of General Internal Medicine*. doi:10.1007/s11606-018-4565-9.
- Ovid (2018). Scope note for: Patient-Centred Care. Retrieved from: <http://ovidsp.tx.ovid.com.cmdhb.idm.oclc.org/sp-3.32.0a/ovidweb.cgi>
- Saha, S., Beach, M. C., & Cooper, L. (2008). Patient Centeredness, Cultural Competence and Healthcare Quality. *Journal of the National Medical Association*, 100(11), 1275-1285.
- Scholl, I., Zill, J. M., Haerter, M., & Dirmaier, J. (2014). An Integrative Model of Patient-Centeredness. A Systematic Review and Concept Analysis. *PLoS ONE*, 9(9):e107828. doi:10.1371/journal.pone.0107828.
- Superu (2018). *Bridging cultural perspectives*. Wellington: Superu. Retrieved from <https://www.superu.govt.nz/sites/default/files/Bridging%20Cultural%20Perspectives%20FINAL.pdf>
- Washington, L. (2014). Enabling consumer and patient engagement with health information. *Journal of AHIMA*, 85(2), 56-59.

# Appendices

## Appendix 1: Interview schedule for individual Panel members

1. What interested you in being part of the Maternity Consumer Panel?
2. What skills, experience, or community connections did you bring to your role on the Panel?
3. What support did you receive to participate in the Panel and be effective? *Follow up: Ask about relationships with CMH staff and facilitator*
4. Thinking about the whole panel group, to what extent did Panel membership represent the women who use these services?  
*Follow up: Do you think Panel members represented the views of this population of women? How / how not?  
Is there anything you would change about Panel membership?  
Note to interviewer: this is not about specific Panel members per se, but rather their demographics, connections to the community, and skills.*
5. In your view, what is the key purpose of the Panel?  
(i.e. what support or service does the panel provide? What is your understanding of the role of the panel?)
6. What did you think the Panel did well?
7. What sort of projects was the panel consulted about?
8. In your view, to what extent has the panel been able to influence change with maternity services? Could you provide examples of your impact?
9. What could the Panel have done differently?
10. What was your experience of working alongside healthcare professionals?
11. Is there support you would like to have received?
12. Did you participate in any Panel work outside of the group meetings? (Follow up: What was it? How were you supported to participate? Note to interviewer: Probe experiences.)
13. What do you think a future Panel, group, or consumer engagement plan should look like?  
*Note: this doesn't have to be a "panel"- think broadly*
14. Is there anything else you want to say?

## Appendix 2: Shared interview schedule for group of Panel members

1. In your view, what is the key purpose of the Panel?  
(i.e what support or service does the panel provide? What is your understanding of the role of the panel?)
2. What do you think the Panel did well?
3. In your view, to what extent has the panel been able to influence change with maternity services? Could you provide examples?
4. What could the Panel have done differently?
5. What do you think a future Panel, group, or consumer engagement plan should look like?  
*Note: this doesn't have to be a "panel"- think broadly*
6. What was your experience of working alongside healthcare professionals?  
*Follow up: what was good and bad about this?*
7. What support did you receive to participate in the Panel and be effective?  
*(Follow up: Ask about relationships with CMH staff and facilitator)*
8. Is there extra support you would like to have received? (if so, please describe)
9. What skills, experience, or community connections did you bring to your roles on the Panel?  
*Follow up: what skills are missing? What skills are used and not used?*
10. What sort of communities do you belong to?  
*(Follow up: Do you think you brought your communities' voices to the Panel?)*
11. Is there anything else you want to say?

## Appendix 3: Shared interview schedule for CM Health staff involved in running the Panel

1. How (and why) was the Panel established?
2. What are your understandings of the role of the Panel?  
*Follow up: Do you think the Panel fulfilled its role? Why/why not?*
3. What were your roles and responsibilities with the Panel?  
*Follow up: What did that look like? To what extent have you been able to fulfil these.*
4. How were Panel members recruited?
5. Do you think Panel membership reflected and represented the population of women using Counties Manukau Health Maternity Services? *Follow up: Were there any skills missing? Were there any demographics missing? Did Panel members bring their communities' voices?*
6. What was your experience of working with consumers?
7. What sort of projects was the Panel consulted about?

- Follow up: What did the consultation process look like? Who was consulting? What projects or subjects were missing but needed?*
8. In your view, to what extent was Panel advice applied to projects?  
*Follow up: What enabled the application? What made it harder?*
  9. Tell me about Panel members' roles outside of meetings (e.g. Maternity Quality Safety Group).
  10. Did the Panel effect how staff who consulted engaged with consumers to shape projects? *Follow up: How?*
  11. Do you think the Panel had any other impacts? What?
  12. How were Panel members supported to participate?  
*Follow up: Ask about relationships with Panel members and facilitator*
  13. How could they have been supported better?
  14. What were the Maternity Consumer Panel's strengths?
  15. What were the Panel's key challenges? (Barriers is detailed on evaluation questions also)
  16. What were limitations to engaging consumers in this structure?
  17. How could the Panel have been improved?
  18. What do you think a future Panel, group, or consumer engagement plan should look like?

#### **Appendix 4: Interview schedule for external facilitator**

1. What was your role with the Panel?  
*Follow up: What did that look like? What were key responsibilities or tasks?*
2. What was your experience of facilitating the panel?  
*Follow up: lows and highs? Hard and easy parts?*
3. What's your understanding of the purpose of the Panel?
4. What were the Maternity Consumer Panel's strengths?
5. How were Panel members recruited?
6. To what extent do you think Panel membership reflected and represented the population of women using Counties Manukau Health Maternity Services? *Follow up: Were there any skills missing? Were there any demographics missing? Did Panel members bring their communities' voices?*
7. What sort of projects were the Panel consulted about?  
*Follow up: What did the consultation process look like? Who was consulting?*
8. Tell me about Panel members' roles outside of meetings (e.g. Maternity Quality Safety Group).
9. To what extent do you think the panel was able to impact or influence projects (if at all)? What? How?
10. How were Panel members supported to participate?  
*Follow up: Ask about relationships with Panel members and CMH staff*

11. How could they have been supported better?
12. How could the Panel have been improved?
13. What do you think a future Panel, group, or consumer engagement plan should look like?

### Appendix 5: Interview schedule for Key Informant

1. Please tell us about the strategic context in which the panel originated.
2. What were your roles and responsibilities with the Panel?  
*Follow up: What did that look like? To what extent have you been able to fulfil these? What support did you need to deliver?*
3. In your view, what is the key purpose of the Panel?  
(i.e what support or service does the panel provide? What is your understanding of the role of the panel?)
4. Do you think Panel membership reflected and represented the population of women using Counties Manukau Health Maternity Services? *Follow up: Where there any skills missing? Where there any demographics missing? Did panel members bring their communities voices?*
5. In your view, to what extent has the panel been able to influence change with maternity services? Could you provide examples?
6. What is your vision for how maternity services works with consumers?
7. What do you think a future Panel, group, or consumer engagement plan should look like?  
*Note: this doesn't have to be a "panel"- think broadly*

### Appendix 6: Interview schedule for Presenters

1. What's your understanding of the role of the Panel?
2. What project or piece of work did you consult with the Panel about?  
*Follow up: What did the consultation process look like?*
3. What sort of advice did you get?  
*Follow up: How useful was it? How did you apply it? What enabled the application? What made it harder?*
4. What was most valuable about consulting with the Maternity Consumer Panel?
5. What was least useful about consulting with the Maternity Consumer Panel?
6. Did your consumer engagement or your project change?  
*Follow up: If so, how?*
7. What were the Maternity Consumer Panel's, and its members', strengths?
8. Where could the Panel have improved?
9. What were limitations to engaging consumers in this structure?
10. Have you told other people about your experience with the Panel?  
*Follow up: Who? How and where did you disseminate the advice or guidance from the Panel?*

11. What do you think a future Panel, group, or consumer engagement plan should look like?
12. Would you work with the panel again if you had the opportunity?

## Appendix 7: Panel Member survey to be filled out at the individual interview, shared interview, or online

Opening note: You don't have to answer every question – you can give as much or as little information as you want to.

We will be using this information to what sort of people make up the Panel.

1. What inspired you to participate in the Maternity Consumer Panel?
2. I felt supported by CMH staff to participate in the Panel  
*strongly disagree/ disagree/ undecided/ agree/ strongly agree*
3. I felt supported by the Panel facilitator to participate in the Panel  
(*strongly*)  
*strongly disagree/ disagree/ undecided/ agree/ strongly agree*
4. I felt supported to participate in work outside Panel meetings (E.g. Maternity Quality and Safety Group)  
*strongly disagree/ disagree/ undecided/ agree/ strongly agree/NA*
5. Information provided to the Panel was:  
Provided in a timely manner/ Provided in a way that was easy to understand/ Enough to be able to have useful discussions/ Enough to provide useful advice/ Too much information was provided
6. If you wish to provide any further comment on support or information provided to Panel members, please do so here:
7. I was heard and taken seriously  
*strongly disagree/ disagree/ undecided/ agree/ strongly agree*
8. *The Panel was able to influence change with maternity services*  
*strongly disagree/ disagree/ undecided/ agree/ strongly agree*
9. Panel members were a diverse group who represent women from different Counties Manukau communities  
*strongly disagree/ disagree/ undecided/ agree/ strongly agree*
10. Panel members had the right set of skills and experience  
*strongly disagree/ disagree/ undecided/ agree/ strongly agree*
11. Participating as a Panel member was a good use of my time  
*strongly disagree/ disagree/ undecided/ agree/ strongly agree*
12. Given the chance, I would participate in the Panel again  
*strongly disagree/ disagree/ undecided/ agree/ strongly agree*
13. If I were running the Panel, I would change a lot  
*strongly disagree/ disagree/ undecided/ agree/ strongly agree*
14. If you would like to add any further comments on these questions please do so here:
15. How would you describe your ethnicity?
16. What age group do you belong to?  
15-24/ 25-34/ 35-44/ 44+/ I would prefer not to say

17. What suburb do you live in?
18. Which Maternity Services have you used?  
*For example: Lead Maternity Carer (LMC), Primary Birthing Unit, Obstetrician, Maternity Wards, Birthing and Assessment Unit, Neonatal Unit, Follow-up Care, Maternal Mental Health)*
19. When was the last time you used Maternity services at Counties Manukau Health?  
Within the last 12 months/ 12-18 months ago/ 18 months – 2 years ago/ 2 – 3 years ago/ 3 – 4 years ago/ 4 – 5 years ago/ More than 5 years ago
20. What communities are you a part of or represent on the panel?
21. Is there anything else you would like to say about your experience with the Maternity Consumer Panel

## Appendix 8: Survey for Panel Presenters

Opening note: You don't have to answer every question – you can give as much or as little information as you want to.

We will be using this information to understand your experiences with the Panel, what type of work they provided advice on, and what impact it has had.

1. What's your understanding of the role of the Panel?
2. What project or piece of work did you consult with the Panel about?  
(please describe)
3. What did you expect from the Panel?
4. To what extent did the Panel meet your expectations? (please explain)  
*my expectations were not met at all/ my expectations were partially met/ undecided/ my expectations were met/ my expectations were exceeded*
5. Which pieces of work did Panel members work on with you outside of Panel meetings, and what was your experience? (If applicable)
6. How many times have you consulted with the Maternity Consumer Panel on a particular project/piece of work?  
only once/ 2-3 times/ 4-5 times/ more than five times
7. To what extent did the Panel influence your project? (please explain)  
*not at all/ slightly/ moderately/ very/ extremely*
8. Did the Panel effect how you engage with consumers to shape projects?
9. Do you think Panel membership reflected and represented the population of women using Counties Manukau Health Maternity Services?  
*strongly disagree/ disagree/ undecided/ agree/ strongly agree*
10. How and where did you disseminate the advice or guidance from the Panel?
11. What were the Maternity Consumer Panel's strengths?  
*Open response*
12. Where could the Panel have improved?  
*Open response*

13. What do you think a future Panel, group, or consumer engagement plan should look like?
14. Would you consult with the Panel again (if it were currently operating)?  
yes/ no

## **Appendix 9: Participant Information Sheet for Member Interview and Survey**

### **Maternity Consumer Panel Evaluation**

*You have been invited to participate in an interview, and in a survey, about the Counties Manukau Health (CM Health) Maternity Consumer Panel. The interview and survey are part of a broader evaluation of the Consumer Panel. This information sheet provides you with details about the purpose of the evaluation, what the interview involves, what the survey involves, and how the information you provide will be used. If there is anything you don't understand, or if you would like to ask any questions, please contact Brooke from the Research and Evaluation Office at Ko Awatea.*

**Evaluation contact: Brooke Hayward, Senior Evaluation Officer**  
**Brooke.Hayward@middlemore.co.nz**

#### **What is the purpose of the evaluation?**

*The Maternity Consumer Panel Evaluation aims to:*

- *Critically analyse the Panel's aims, model, and membership*
- *Analyse work completed by the Panel and its impact on Maternity services*
- *Identify strengths, opportunities, and areas for improvement*
- *Provide recommendations for the future development and direction of consumer participation in Maternity services*

*This evaluation was requested by CM Health Maternity Services, and is led by the Research and Evaluation Office at Ko Awatea, who are responsible for the evaluation design, data collection, analysis, reporting, and oversight. This evaluation is being completed on behalf of Maternity Services.*

#### **What will my participation in the evaluation involve?**

*All Panel members have been invited to take part in evaluation in order to understand your experience with the Panel. Each Panel member has either been invited to an individual interview, or a focus group. Every Panel member has also been invited to complete a survey.*

##### **1) Interview**

*You are invited to participate in an interview with our evaluation assistant – Greta Westermann. Areas for discussion throughout the interview include:*

- *Your experience with the Maternity Consumer Panel*
- *Panel strengths and areas that could have improved*
- *Support for participating on the Panel*
- *What you recommend for future consumer participation in Maternity services*

*These areas for discussion are intended as a guide. In reality, conversation is fluid and interactive so it is likely we will also discuss other things. You are*

*encouraged to raise anything you feel is really relevant that is not covered by interview questions.*

*We expect that the interview will take up to 1 hour of your time, depending on your availability and how much you have to say. The interview can be completed in person at a Counties Manukau Health site or another location that suits you. If you prefer, the interview can be completed over the phone. We will try to be as flexible and as accommodating as possible regarding interview location, time, and accommodating children within the interview space.*

*The interview will be audio recorded in order to capture the information. A transcriber will then write it up. This is a professional transcriber, external to CMH, who has signed a confidentiality agreement. The audio file of the interview will not be played to anyone else.*

## **2) Survey**

*You are also invited to participate in a survey, which will ask for information about your demographics (so we can understand Panel membership), and for your experiences on the Panel. We expect it will take up to 10 minutes. You can fill this out online, or on a hard copy at the interview (if you choose to participate). If you fill out a hardcopy, the Lead Evaluator will enter that data onto a computer.*

*The audio file of your interview, written transcript of your interview, and your electronic survey data will then be stored on a password-protected shared drive, and any hard copy documents such as a consent form or paper copy of a survey will be stored in a locked cabinet. Both the shared drive and the cabinet are only accessible to Ko Awatea Research and Evaluation team members, meaning that they cannot be accessed by anybody directly involved with the Panel.*

*After four years all raw electronic and hard copy data will be destroyed.*

### **What are my rights?**

*All participants have the right to access information about them collected as part of the evaluation.*

*When the evaluation is complete, you will receive a copy of the written report. You will also be invited to a presentation of the results by the Lead Evaluator.*

***It is your choice** whether or not to participate in this evaluation. **You are free to decline** without this affecting your participation in Maternity services development, or your care at Counties Manukau Health.*

*You may choose to participate in the interview and the survey, neither, or just one of the two.*

***You may withdraw from the evaluation at any time** up until your interview or survey responses are combined with others in reporting, at which point we will be unable to identify which perspectives are yours and therefore would not be able to remove them.*

*You will be provided with a copy of the draft report to review and comment on before the final report is generated and published.*

### **What are the possible benefits and risks of this evaluation?**

*This evaluation will benefit CM Health Maternity Services who access consumer engagement to shape their services, future Maternity Services consumers who provide consultation, and the women who access Maternity*

Services. This evaluation will inform the future direction of Maternity Services consumer participation.

This evaluation is low risk. Only the Research and Evaluation Office will have access to any evaluation data (your interview records and survey responses). Any reports or publications made will not include your name or other personal details. For example, we will call evaluation participants 'members' or 'key informants' or 'consultors' rather than using names. However, if you wish to be acknowledged by name in the final report and to have your comments and opinions credited to you, you may choose to consent to this by ticking the box on the consent form.

There is some risk that those readers who are familiar with the Panel members may be able to identify individuals due to their knowledge of experiences and perspectives presented in the evaluation. If you would like more information about this, please contact Brooke Hayward, or one of the support people listed at the end of this page.

### **Consent**

If you wish to take part in this evaluation, you will be asked to give written consent by signing a one-page form. Brooke Hayward – Senior Evaluation Officer - will discuss the form and the consent process with you before signing.

On the consent form you can indicate whether you wish to participate in the interview, survey or both by circling 'yes' or 'no' for each item.

### **Will I receive a koha for participation?**

If you choose to participate in an interview, you will receive a koha in the form of a \$40 voucher. If you choose to participate in the survey, you will receive a koha in the form of a \$10 voucher. If you participate in both the survey and interview, you will receive a \$50.00 voucher. If you decide to withdraw from the evaluation after the interview or survey, you will still receive the koha.

### **Who do I contact for more information or if I have concerns?**

If you would like to take part in the evaluation, or if you have any questions, concerns or complaints about the evaluation at any stage, please email, phone or text:

Brooke Hayward, Senior Evaluation Officer, Ko Awatea  
027 291 4939, [Brooke.Hayward@middlemore.co.nz](mailto:Brooke.Hayward@middlemore.co.nz)

If you would like support from someone who is involved in the Maternity Consumer Panel, please contact:

Amanda Hinks, Maternity Service Development Manager  
09 2613373 ext 3073, [Amanda.Hinks@middlemore.co.nz](mailto:Amanda.Hinks@middlemore.co.nz)

If you want to talk to someone who isn't involved in the evaluation or Maternity Consumer Panel, you can contact:

Luis Villa, Research and Evaluation Manager, Ko Awatea  
09 250 2065, [Luis.Villa@middlemore.co.nz](mailto:Luis.Villa@middlemore.co.nz)

## Appendix 10: Terms of Reference

### COUNTIES MANUKAU DISTRICT HEALTH BOARD

#### MATERNITY CONSUMER PANEL TERMS OF REFERENCE

January 2015

<b>Scope</b>	To provide consumer perspectives across all maternity services delivered in the Counties Manukau district and those used by CMDHB residents outside of the district as regional or national services.
<b>Functions</b>	<p>To provide a consumer perspective to the design and operations of maternity services across the Counties Manukau district by:</p> <ul style="list-style-type: none"> <li>• Providing advice on how the maternity experience could be improved for women and their families.</li> <li>• Providing advice on the suitability of maternity services provided across the district.</li> <li>• Providing advice on gaps or improvements to maternity services that may be needed.</li> </ul> <p>Maternity services include antenatal, birthing and postnatal services. It also includes services to support the needs of women during pregnancy and 6 weeks after birth.</p>
<b>Aims</b>	The Maternity Consumer Panel provides advice and feedback on maternity services to the management of the Counties Manukau District Health Board (CMDHB). The advice is to inform the DHB and other providers (eg self-employed midwives, general practice) on the design and direction of maternity services, how people can access them and how effective services are in providing the services and meeting women's and family's needs.
<b>Chairperson</b>	<p>No appointment to a Panel Chair will be made. An independent facilitator will convene the group, coordinate the agenda and facilitate the meetings. The independent facilitator is not a Panel member.</p> <p>CMDHB will provide a notetaker for each Panel meeting.</p>
<b>Membership</b>	<p>Individuals will be appointed to the Maternity Consumer Panel by the DHB on the basis of their experience and expertise in maternity services use according to criteria outlined below.</p> <p>Each appointment will be for a specified term of 1 year with the option of a year reappointment.</p> <p>Panel membership will include;</p> <ul style="list-style-type: none"> <li>• The Panel membership will be representative of the ethnic diversity of women who utilise services in the Counties Manukau district.</li> <li>• The Panel must include residents from the 4 localities</li> </ul>

	<p>defined by CMDHB (Manukau, Mangere/Otara, Franklin and East) and the mix be representative of the mix of women who utilise services.</p> <ul style="list-style-type: none"> <li>• The Panel will be representative of the age mix of women who utilise services in the Counties Manukau district.</li> <li>• All Panel members will have utilised maternity services in the CMDHB district.</li> <li>• All members must have used maternity services in the Counties Manukau district within the last 5 years with the exception of three members.</li> <li>• No more than 15 people.</li> <li>• The Panel will appoint 2 people from its membership to the Maternity Quality &amp; Safety Governance Group.</li> </ul> <p>A quorum is 7 persons. Panel members must attend meetings and cannot delegate their responsibilities. Attendance will usually be face to face unless otherwise agreed with the Chairperson. The Panel is expected to meet 4 times a year (February, May, August, and November). Those members missing two consecutive meetings (within the year starting January to December) may be removed from the Panel at the discretion of CMDHB following discussion with the relevant Panel member.</p> <p>The Panel members are not representative of any stakeholders, groups or organisations and participate as individual members of the local community who have experienced the use of maternity services in the Counties Manukau district.</p> <p>DHB staff may attend Panel meetings as ex-officio and provide agenda matters for the Panel to consider.</p>
<b>Parameters</b>	<p>The group provides advice to:</p> <ol style="list-style-type: none"> <li>1. The Child, Youth, Maternity Integration Manager, CMDHB, and</li> <li>2. The Maternity Quality &amp; Safety Governance Group</li> </ol> <p>The group will be expected to acknowledge the Strategic priorities of the Ministry of Health (MoH) and CMDHB.</p>
<b>Accountability</b>	<p>The Maternity Consumer Panel is accountable to the Child, Youth and Maternity Integration Manager, CMDHB.</p> <p>CMDHB will:</p> <ul style="list-style-type: none"> <li>• Demonstrate how advice provided by the panel has informed services.</li> <li>• Provide updates on the development and content of information regarding maternity services, interventions and/or research.</li> <li>• Provide advice on how information may be shared</li> </ul>

	<p>with communities.</p> <p>Minutes of the Maternity Consumer Panel may be shared with other consumer groups for the CMDHB.</p> <p>All those in attendance are required to Conduct during the meeting</p>
<b>Relationships</b>	<p>The Maternity Consumer Panel will be aware of the work of the Maternity Quality and Safety Governance Group and the oversight role of maternity governance groups.</p> <p>CMDHB will provide the group with secretarial support and remuneration for non DHB employed members according to CMDHB policy.</p>
<b>Process</b>	<p>The group will meet every 3 months in the first year and review the frequency of meetings. The secretariat will organise meetings and provide logistical support for meetings, documentation and will liaise with the Chair and DHB management on agenda matters.</p>

## Appendix 11: Information for presenters of the Maternity Consumer Panel

### Welcome to the CMDHB Maternity Consumer Panel Information for speakers

Our story....

We are an invited group of mothers who all reside in Counties Manukau. We are from a variety of cultures, ethnicities and life experiences who meet, along with our children who are aged from newborn to 5 years old on quarterly basis to;

- ✚ Share our own experience and feedback from others using the maternity services in Counties Manukau DHB;
- ✚ Review and provide constructive feedback to health professionals or researchers;
- ✚ Contribute to activities related to special interests we have ;
- ✚ Contribute and participate in the designing of information or services for future users of CMDHB Maternity Services;
- ✚ Contribute to the annual CMDHB Maternity Quality and Safety report;
- ✚ Contribute or present as a member of the Counties Manukau Health DHB Maternity Consumer panel to stakeholders.

Some points to help you make your information or project meaningful to us;

- *Please share your story about who you are and a bit about yourself;*

- *Please provide us with reading time during the meeting as we do not have the opportunity beforehand to read through what you would like us to feedback on;*
- *Please avoid jargon;*
- *We prefer group work-please divide us into groups and ask us what you want answers to;*
- *Consider how this work or project has meaning for us as consumers.*
- *Please provide us with a time when you will come back and let us know how you have used our feedback.*

**CMDHB Maternity Consumer Panel Meeting Dates for 2017**

Please contact Amanda Hinks to discuss coming along to present at a meeting; [amanda.hinks@middlemore.co.nz](mailto:amanda.hinks@middlemore.co.nz) or 021 494 227

*Thursday 23<sup>rd</sup> March - Friends building Auckland Botanical Gardens Hill Road, Manurewa 10-12 midday*

*Thursday 29<sup>th</sup> June - Friends building Auckland Botanical Gardens Hill Road, Manurewa 10-12 midday*

*Thursday 28<sup>th</sup> September - Friends building Auckland Botanical Gardens Hill Road, Manurewa 10-12 midday*

*Thursday 7<sup>th</sup> December - Friends building Auckland Botanical Gardens Hill Road, Manurewa 10-12 midday*

We look forward to meeting you,

**CMDHB Maternity Consumer Panel**