

Evaluation of South Australia's Metropolitan Domiciliary Care Consumer Participation Strategy

Abridged Final Report

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Executive Summary

South Australia's Metropolitan Domiciliary Care Strategic Plan 2003-2006 committed the organisation to the development and implementation of an organisation-wide consumer participation strategy to broaden opportunities for consumers to be involved in planning, decision-making and organisational improvement. This commitment was strengthened when consumer participation was incorporated into sections of the MDC Operational Business Plan 2003-2006 and a Consumer Participation Coordinator was employed to oversee the planning, implementation and ongoing evaluation of a consumer participation strategy. The Consumer Participation Strategy was endorsed by the MDC Board of Directors on the 2nd June 2004. The Strategy has begun to be implemented over the past 2 years in line with Priorities for Implementation identified in the Strategy document.

Evaluation was considered a vital part of the Consumer Participation Strategy. The evaluation was required to consider the quality and extent of consumer involvement achieved to date and to recommend future directions and priorities.

Participation in the evaluation was sought from the following stakeholder groupings within MDC :

- Governance, strategic view: Board, CEO, and General Manager (Client Services).
- Participants in the 'formal' participation mechanism: Members of the four regional Consumer Reference Groups, and the MDC staff who support/coordinate these groups.
- General view: Wider client population and client services staff who have direct contact with clients.
- Strategic and operational overview: Consumer Participation Coordinator,

using a variety of methods including interviews, questionnaires, focus groups and telephone surveys. In addition MDC documents related to the Consumer Participation Strategy implementation were also examined.

It was evident that most of the 10 priority areas identified within the Consumer Participation Strategy have begun to be implemented over the past 2 years, and are at varying levels of achievement.

MDC is a large and complex organisation and as with any organisational change, in a health service of this size change is slow and often difficult to achieve. However, there was a perception from the Board, CEO and General Manager (Client Services) that the implementation of the Consumer Participation Strategy has moved rapidly in terms of becoming embedded into the organisation. From the Evaluators' perspective, this has been due to the strong commitment from the Board, senior management, client services staff and consumers to ensure consumer participation is an integral part of the organisational decision making. There has been strong leadership and facilitation from the Consumer Participation Coordinator, which has been integral to the progress to date. There has also been strong leadership from several consumers involved in the formal participation mechanisms (CRG and CAC).

This evaluation report urges MDC to give ongoing support to the Consumer Participation Strategy and to build on current work through the continued and additional allocation of resources. The report recommends the implementation of 21 recommendations in the key areas of:

- Overall strategy development.
- Partnership in service delivery
- Consumer feedback
- Consumer consultation
- Building all consumers capacity to participate

Introduction

The Consumer Participation Strategy was endorsed by the MDC Board of Directors on the 2nd June 2004. The Strategy has begun to be implemented over the past 2 years in line with Priorities for Implementation identified in the Strategy document.

For action within 6 months:

- **Consumers in governance:** recommend one Consumer Board Member on the new MDC Board and support the appointment of the new Board member.
- **Consumer Reference Groups:** Establish four functional groups working to agreed common Terms of Reference.
- **Client Service Delivery:** Participate in the development of a client focused care planning process.
- **Complaints:** Participate in the implementation of MDC complaints policy and record keeping.
- **Consumer Communication:** Involvement of consumers in imminent client communications (a) preparation for MDC consumer newsletter and (b) informing clients about changes to service delivery/case management.
- **Resources:** Strengthen staff support for relevant consumer participation by ensuring recognition of commitment in allocation of work roles and client caseloads.

For action in 2005

- **Consumer Advisory Committee:** Establish Terms of Reference, consult with representative consumer bodies about membership, recruit and train membership, establish administrative support.
- **Service Evaluation:** Integrate consumer feedback mechanisms in all service evaluation planning and coordinate feedback methods. Link to Organisational Improvement.
- **Staff Development:** Integration of 'Client Centres Practice' focus into staff development program.
- **Recognition and Reward:** Develop strategy.

The Strategy was seen as a formative document and during the early implementation of the above activities; they were conceptually grouped into three main consumer involvement streams, plus a capacity building and support process. The following four strategies evolved into the Key Strategies:

1. **Partnership in Service Delivery**
Client centred service delivery with all consumers
2. **Consumer Feedback:**
 - Complaints
Coordinate monitoring of informal feedback and formal complaints.
 - Evaluation and Planning
Utilise consumer experience in service delivery evaluation and organisational improvement by deliberate surveying.
3. **Consumer Consultation:**
 - Interactive consultation
Ongoing consultation with local communities via consumer reference groups.
 - Consumers advise and provide direction
Consumer member - MDC Board of Directors
Consumer Advisory Committee
4. **Build all consumers capacity to participate**
Information, communication and training.

Evaluation was considered a vital part of the Consumer Participation Strategy and it was planned to be undertaken in 2006. The evaluation needed to consider the quality and extent of consumer involvement achieved to date and to recommend future directions and priorities (Consumer Participation Strategy 2004, p 8).

Evaluation Methods

The aim was to:

1. Evaluate the Metropolitan Domiciliary Care Consumer Participation Strategy endorsed in by the Board of Directors in June 2004, and
2. To develop recommendations to inform future directions and priorities for consideration by the MDC Board.

The Objectives were:

1. To evaluate each of the four Key Strategies against the following questions:
 - Has the consumer strategy been developed and implemented?
 - How well has this been developed and implemented?
 - Has the implementation of this consumer participation strategy made a useful contribution to organisational planning, improvement and evaluation?
2. To evaluate the progress of the 10 'Priorities for Implementation' against the timelines nominated in the Strategy.

Participation in the evaluation was sought from the following stakeholder groupings within MDC:

- Governance, strategic view: Board, CEO, and General Manager (Client Services).
- Participants in the 'formal' participation mechanism: Members of the four regional Consumer Reference Groups, and the MDC staff who support/coordinate these groups.
- General view: Wider client population and client services staff who have direct contact with clients.
- Strategic and operational overview: Consumer Participation Coordinator.

In addition MDC documents related to the Consumer Participation Strategy implementation were also examined.

Ethics approval was gained from the Social and Behavioural Sciences Ethics Committee at Flinders University and ethical procedures were followed during the course of the evaluation.

Findings and Discussion

Part One: Strategic overview from members of the Board, CEO and General Manager (Client Services)

Members of the Board, CEO and General Manager (Client Services) considered in their strategic overview that the Consumer Participation Strategy had been effective for MDC. With regard to commenting if the Consumer Participation Strategy had benefited clients and carers, some people interviewed felt that they couldn't speak on behalf of consumers as to how participation benefited them.

By far the most impactful aspects of the Strategy to date appeared to be the:

- appointment of the Consumer Participation Coordinator;
- the establishment of the more 'formal' participation strategies (regional CRG, CAC and the consumer representative on the Board);
- the improved communication with clients and carers, and the
- inclusion of consumers in the strategic planning process.

There was a strong view that there was now a more meaningful two-way communication process between the Board, senior management and consumers involved in the various groups/committee, which was created through a greater understanding of issues from both perspectives. This clearly has had an impact on the types of issues that were now being prioritised for consideration at Board level and by senior management. It also appeared that there was a more constructive working relationship between the Board, senior management, and the consumer representative on the Board, the CAC and the four CRG, though there were still

tensions with one of the regional groups, however these had improved. There appeared to be a strong commitment by senior management to communicate with the various CRG and CAC on a regular basis, and work to increase trust.

There appeared to be a strong belief that the development of the consumer participation group/committee structure elevated the importance of consumer participation in decision making within MDC and was more representational of broader consumer issues, though work still needed to be done to enhance representation. It also formed what was perceived to be an effective consumer network within MDC.

The following range of outcomes was identified

- Increased staff awareness about consumer issues.
- Significant changes in the way MDC manages waiting lists and communication with clients. This issue was identified as a priority by consumers.
- Changes to the (brokerage) tender document
- Consumer involvement in the current strategic plan
- The development of client information packs edited by the consumer groups.
- Processes established for consultation with consumers on any new consumer publications
- Influential consumer consultation has been provided in a broad range of client services policy and procedure development (complaints policy, privacy practice, dress code for staff, brokerage contracts, etc)
- Action has been initiated on issues of concern to consumers (fee payment methods review)
- Consumer group members have nominated critical information to be targeted to other MDC consumers via the newsletter
- MDC submissions to funding and policy bodies have been strengthened through engaging consumer opinion (eg funding for equipment program, exemption from government Common Branding policy, future of the Day Rehab Centre),
- MDC has contributed to a wider understanding of consumer perspectives of care through consumer involvement in an MDC research project and presentation of a conference paper.
- MDC consumers have been able to have a voice as wider change agents (eg transport issues lobby, compression stockings concerns).

Overall there was a very positive view of progress to date and a valuing of the contribution of consumer perspectives to the decision making within MDC. The Board and CEO and General Manager (Client Services) all saw the potential for further development of the Consumer Participation Strategy to be more inclusive of clients and carers who do not participate in the various formal groups/committees. The need to do consumer surveys, conduct forums, and provide more regular information to the broader client population of MDC were seen to be priority areas for the next stage of development. Two of Board members indicated that there needed to be serious thought to ensuring equitable input from consumers who don't feel comfortable providing input through the more traditional methods of surveys and forums. This was considered to be an important part of any future strategy as it is widely reported from many commentators and researchers within the literature that one approach to gaining input from consumers is not adequate, and in fact can mean that people most in need of a voice are not heard due to inappropriate or inadequate participation methods used (Consumer Focus Collaboration 2001, 2000a and 2000b). It is important to have a real understanding of the client population of an organisation so that specific strategies can be employed in order that traditionally marginalised groups can still have a voice, and that processes are monitored to ensure an inclusive approach is achieved.

'As the system and structures around consumer participation are a prominent part of the organisation, you can't ignore what consumers are saying and it does make you think about priorities.'

'For any new systems or procedures that we put in place we are easily able to consult consumers.'

'There is a need to tap into a wider consumer base.'

Further development of the consumer feedback processes needs to be addressed. This includes ensuring the changes made as a result of feedback needed to be included in reports to the Board and increasing the profile of consumer issues on the Board agenda.

Two Board members suggested that resources need to be increased so that future developments could be adequately funded and the Consumer Participation Coordinator be supported in her role.

It was evident that MDC has some tough issues to contend with in the not too distant future and it will be a challenge to get meaningful consumer participation in areas where there are choices about what is possible to change. However, there was an acknowledgement that often decisions were taken out of the hands of the Board and senior management and made by the Minister and Cabinet, which may mean that consumers could feel alienated and distrustful of the organisation if they had unrealistic expectations of how they may be able to influence decisions. However, if consumers are informed and know the realities of the issues and constraints, they can be part of the process of working through the issues that are within their ability to influence. Even though there was a strong commitment to strengthening consumer participation within MDC, it was raised by one Board member that a strategic decision needed to be made about the extent to which consumer participation is sought and used as a driver for change in MDC and the degree to which it is further embedded throughout the organisation.

It was clear that the Board saw that they had an integral role in ensuring consumers continue to have a voice in MDC which continues to challenge the Board and senior management.

Part Two: Input from clients and staff

What was evident in this consultation was the overwhelming positive regard with which many consumers, who participated in this evaluation, had towards MDC and the appreciation of the services they received. Many consumers had not had the opportunity in the past to pass on this type of feedback to MDC and wanted to ensure that it was passed on through this evaluation.

Key Strategy 1 Partnership in Service Delivery

Partnership in care was described to the staff participants as incorporating the following features

1. clients able to fully participate in care,
2. clients are made aware of these processes,
3. clients are aware of their rights and responsibilities,
4. staff are aware of and trained in protocols and procedures for enabling client participation in their care
5. client participation in improving safety and quality is an accepted part of MDC culture and functioning .

Staff surveyed felt that these features have been achieved to the following degree

	<i>Responses</i>
Processes established and working effectively	Approx 32 - 41%
Processes in place but need enhancement	Approx 50%
Processes under development	Approx 7-9%
No processes in place	Approx 5-7% (*)

(*) This could imply that relevant information and the resultant requirements for practice change were not known by these staff.

These results indicate the majority of staff are aware of the changes which are being implemented to support a more client focused approach to care and service delivery, and feel these changes are

progressing well. However, as is typical with any major organisational change processes it is clear that work needs to continue to ensure all staff become aware, and that practice changes linked to the new processes are integrated into the practice of all staff so that consumers receive a consistent approach to care and service delivery.

Most staff thought that clients wanted to participate in their own care and realised that staff needed to be flexible in the way they approached negotiations with clients so that clients' preferences were respected in the care processes. This was coupled with concern about the way MDC services are 'menu driven' so any flexibility was difficult. This raises concerns about conflicting policies coming into play within the service delivery area.

'I think clients are certainly of the belief that their input is important, as they as consumers, are the people best placed to know what they need – something which clients will often say to me – although I'm not sure that they necessarily see that this input will be valued at a higher organisation level'

'Many clients are far too burdened to actively participate in decision making. However, it is important to provide this option'

'Some are overwhelmed and confused by processes and information – if they don't understand they will be reluctant to make a decision and will rely on workers to make educated, informed decision.'

It is of concern that less than half of the client participants reported receiving information about their rights and responsibilities. This information is meant to be disseminated to all clients, so either there has been a break down in the distribution, or clients had not remembered receiving it. Most who received the information found it to be meaningful and only three had referred back to it. This is congruent with staff perspectives that processes are in place but need to be enhanced.

However, there was an overwhelming view from clients that staff were respectful, or very respectful, of their rights and the way they provided care and services.

'If I won the lottery DOM care would be the first to get some of it'

'Just tell Dom Care that they are a fantastic organisation. I can't give a bigger prize to them'

'Never met one person that hasn't been helpful or respectful'

Staff perceived that the majority of clients prefer to have input into decision making about their care, with most stating they wanted either a reasonable amount of say, a lot of say or to feel as though they are a partner. However, other than stating that they felt staff were respectful or very respectful in the way they provided care and services, it wasn't clear whether clients actually felt as though they did have a say or felt as though they could work in partnership with all staff. Comments from the focus groups with the CRGs indicated that they did not think there was a consistent approach to the way care and services were currently provided. Some issues that were raised related to clients not having the information to know what to ask for, or clients being scared to speak up and have a say for fear of losing the service. Staff suggested other reasons why clients may not participate, such as cognitive impairment (dementia), frail and sick clients, people of non-English speaking background with language difficulties, those who didn't feel the service was culturally appropriate, and those who feel they are a burden.

It is clear that as the Client- Services Model continues to be implemented more detailed evaluation needs to occur to ensure consistent client focussed practice across the organisation. It is important for MDC to ensure the protocols and processes are in place to support staff practice change and that where conflicts arise this is identified and amendments are made so that there is consistency in policy direction.

The key elements of an effective client feedback system were identified to staff participants as

- clients feedback is regularly sought via a number of channels and integrated into improvement activities
- clients are invited to give feedback on their care and identify areas for service improvement
- clients are consulted to review and improve current services and plan new ones
- clients know how to make a complaint or a compliment
- complaints are managed respectfully and effectively and information fed into systems improvements

A significant number of staff thought these processes were in place and needed enhancement, or were under development. Only 2% of staff indicated they did not know of these processes were in place. This is consistent with any organisational change process in a large and complex organisation where new processes are introduced and often require attention over a prolonged period of time to ensure effective implementation and integration.

Concerns were raised by some staff about the link between consumers giving feedback and then that feedback informing policies or processes. In addition there were concerns that complaints were dealt with at the local regional level but many of the issues raised were related to organisational issues (policies and procedures). There needs to be better reporting mechanisms from the local regional level to the central organisational level so that a strategic approach can be taken to address some organisational issues which are of concern to consumers. Also, concerns were raised that the response loop to clients who provided that feedback is not consistently in place.

'Complaints are handled well individually – but don't effectively inform policies or information to clients/staff or general processes. Constructive feedback doesn't seem to go beyond immediate service providers to the policy makers'

The majority of clients who responded said that they felt comfortable or very comfortable giving feedback to MDC, with 54% saying that they had had the opportunity to give feedback to MDC in the past and 46% saying they hadn't. Feedback appeared to be directly to staff, with very few (n=3) using more formal mechanism (attend a meeting or write a letter of appreciation). The majority of clients felt that their feedback had been acted upon. Due to no clients indicating they were aware of, or had used, the complaints process no comments can be made on how effective they found this process.

The members of the CRGs who participated in the focus groups had varied perspectives with some saying a resounding yes that clients are able to have a say in improving MDC services, through to MDC needing to take the initiative and seek information from all clients, rather than expecting clients to speak up. There was a feeling that if MDC proactively sought feedback from clients that this promoted a more open culture within MDC, as opposed to expecting clients to give feedback when they were unhappy with the service. It was also noted that not all criticisms are complaints, but suggestions for how the organisation can improve services. There needed to be a mechanism in place for 'suggestions for improvement'.

'When daughter contacted MDC to give feedback, she was told that her mother should have contacted them if she wasn't happy. Taken as a complaint, when in fact it was feedback'.

What was interesting was that the majority of clients preferred to give feedback over the phone (61%) or to a lesser degree fill in a satisfaction survey (27%). Very few wanted to participate in an organised group or write a letter of compliment or complaint. Much of the effort to date has been put into establishing structures for 'formal' or organised group participation in MDC and the "External Feedback Management Policy". These strategies whilst important do not appear to appeal to the wider client population as methods for participation. Regular surveying via phone is

a strategy which appears to be a popular approach with most clients, followed in preference by a written survey. Based on perspectives of the coordinators of the CRG, the recently introduced practice of phoning new clients 6 weeks after their initial assessment does not yet appear to be consistently implemented – however, this appears to be one method of contact that clients would prefer (though not necessarily just at 6 weeks, but as a method of ongoing contact for feedback).

Members of the CRGs who participated in the focus groups recognised the difficulty in getting people involved in the more ‘formal’ groups and suggested a range of ways to involve the wider client population. These ranged from surveys (though it was important to ensure the questionnaires were appropriate for the clients being surveyed), staff providing feedback on behalf of clients, having a Letters to the Editor section in the Newsletter, to sheets inviting feedback in the Newsletter.

The range of strategies raised by clients and members of the CRGs appeared congruent with the range of strategies identified by the staff coordinating the CRGs. This group of staff indicated that one strategy that may be useful would be to give all service providers a list of people to contact at random and to have a question sheet that would take about 5-10 minutes to complete. They also supported the strategy of follow-up with new MDC clients by phone.

Key Strategy 3 Consumer Consultation (CRG, CAC and Board consumer representative)

It was evident that this strategy of consultation through more ‘formal’ participation structures had been one of the key planks of the Consumer Participation Strategy and a lot of attention had been given to ensuring the effectiveness of this structure and that relationships were developed with the consumers, staff and senior management.

There were now four regional CRGs which had members represented on the one CAC. One member of the CAC was now the consumer representative on the Board. Most members of the CRGs that attended the focus groups were supportive of this new structure and felt as though their experiences were very positive, as members of the CRG, having pathways within the organisation to progress issues (eg to CAC and Board), and to have issues raised with them via these pathways. There were also some negative comments which mostly related to the changes from the past structure, where some members felt as though they were not as autonomous and that there should be more consumers on the Board.

There were strong feelings that MDC efforts to involve them in decision making were not tokenistic, in fact they felt that having the new structure meant that there was now a pathway from each regional group to the advisory group and onto the Board and that they were now able to have more of an impact within the organisation. Comments indicated that most members felt as though they were able to make a good contribution to MDC and felt as though they made a difference. Coupled with this were the benefits of being more informed, as well as having the social support and friendship with other group/committee members.

‘In the CRG forum we are heard and feel we make improvements for all clients. We are also persistent and follow through over a long period of time. Because of the group, we don’t go away!’

These views were also echoed by the coordinators of the CRGs who felt that the groups had a fair amount of power within MDC. Having the formal groups meant that there was greater ability for management and clients to have a better two-way communication process and ensure consumers were well informed about key issues, as well as management being better aware of consumer issues.

‘Everybody is made to feel important’

‘All feel free to bring up issues at meeting. It is a relief to be able to talk about issues’

'Less tokenism when work together'.

'Can discuss issues – not necessarily just MDC but broader issues'.

'Group is small but good. Nothing is just rubber stamped here – we discuss and give opinions'.

'Coming to the group is good. You meet other people and feel satisfied that what you learn from being a client/carer of MDC can be passed on to help others'

'Partnership between clients and staff'

'Ideas well received by MDC and action is taken. We also get feedback that input is valued'.

'Pathway from our group to advisory group and then onto the Board is good'.

'Because staff involved – learn more of limits of MDC and what is possible to achieve'.

'Consumers need to be informed of resource issues'.

'Positive relationships between group and management. We bring a reality check to management and decisions they make'

'It has been hard to get new people involved in the group'

The Southern CRG raised the issue of their group being quite large and how the geographical region was also quite large. This meant that the outer southern consumers had to travel long distances to the Parkholme office for meetings. They identified that they felt the time had come for a second southern group to form and meet in the outer southern areas. Whereas the staff coordinator also recognised this need, resourcing this was an issue.

Key Strategy 4 Build Consumers Capacity to Participate

With the exception of providing training for consumers involved in CRG and CAC and Board members being raised in one of the focus groups with a CRG, most of the feedback to this key strategy tended to be focused on information to clients. This was to enhance clients' ability to be better informed and able to participate in decision making about their care and service provision. This may have been a fault in the design of the evaluation, or the fact that most people who responded tended to have a client focus and saw the need for clients to have more information and be involved in the development of that information.

About half of the staff identified that processes were in place but needed enhancement with regard to client participation in information development and clients being able to access information to participate meaningfully in care. 30% felt that both these processes were working effectively and only 5% indicated they were not aware of these processes being in place.

Clients in the North and West rated higher than the South and East with regard to receiving information about MDC services. This could mean that dissemination strategies are more effective in these regions, that consumers in these regions are more aware of receiving this type of information, or might be explained if provision of information has been undertaken in these regions for a longer period under previous management. The small sizes and composition of the client respondent samples may also have contributed to this variation. What was interesting was that 30% felt the information was very useful and about half thought it was useful, and 42% thought they needed to get more information about service options.

'Letters are too complicated, not simple enough'

'Don't know enough so any information is good'.

'I'd like more information about what I am entitled to'

'Would like to know what's going on with DOM care at the moment'

'Complete list of services available would be good'

This was an area which appeared to need greater attention in the future evolution of the Consumer Participation Strategy as it was evident that the range of options for capacity building were not being realised for clients in individual care, and consumers involved in the more formal participation structures.

It was evident that members of the regional CRG received a lot of information about MDC and other issues through their involvement in these groups. This was through the meeting processes and enabled them to be better informed about issues and feel as though they were able to make more considered input into decision making within these meetings. They did not indicate what specific training they required to participate more confidently and effectively within MDC or to take on a broader advocacy role. It was revealed by the Consumer Participation Coordinator that no members of these groups had accessed training by Health Consumers Alliance or COTA as they felt the training of offer did not meet their needs. The need for specific training will need to be further explored with these groups as part of the next phase of the Consumer Participation Strategy.

Conclusions

It was evident that most of the 10 priority areas identified within the Consumer Participation Strategy have begun to be implemented over the past 2 years, and are at varying levels of achievement. One area which had taken priority for action was the development and support for 'formal' structures for participation (four functional CRG, CAC and one Consumer Board Member) which had in effect created a strong network of informed consumers throughout MDC. This is a strength of the Consumer Participation Strategy to date, as unlike many other health services, MDC has recognised the need for forums at the local regional level as well as at a central organisational level, with direct links to the Board. This has meant that no group is isolated, but is connected by formal pathways from the local level to the Board. Members of the regional CRG have perceived this change as mostly positive, though one group feels that their autonomy has been taken away.

Establishing feedback mechanisms and systems within MDC (including informal feedback and complaints) has also been a priority, though it is evident that this area still needs further development to ensure consistency across MDC and that reporting loops are strengthened. It was apparent that there has been a link between feedback and organisational improvement, but the Board would like to see this information reported to them along with the report on consumer feedback (compliments and complaints).

A range of strategies for gaining feedback from the wider client and carer population served by MDC need to be developed and implemented, with consideration given to ensuring that appropriate mechanisms for surveying are implemented to gain equitable input from diverse types of clients with different service needs. This will require an analysis of the different client groupings served by MDC to ensure that the most appropriate mechanisms are developed and implemented.

Consumer communication has been another area of considerable investment of resources and effort, and although the efforts to date have been appreciated by consumers, there is evidence to suggest that this can be further enhanced and resourced by ensuring more frequent communication and that the information provided is more relevant to consumers' information needs.

Supporting a culture of client focus, and integrating a client centred approach into all areas of service, is one of the most challenging and complex tasks of the Consumer Participation Strategy. It was evident that this is the type of care model that clients/carers, CRG members and staff want, and it is evident that substantial progress has been made to date. Participation of the stakeholders is integral to success, and it will take strong leadership and sustained effort to achieve a more consistent approach across the organisation, and it will take time for system changes to become integrated.

It was apparent that there was strong commitment within MDC to ensure meaningful participation at different levels of the organisation. MDC is a large and complex organisation and as with any organisational change in a health service of this size change is slow and often difficult to achieve. However, there was a perception from the Board, CEO and General Manager (Client Services) that the implementation of the Consumer Participation Strategy has moved rapidly in terms of becoming embedded into the organisation. From the Evaluators' perspective, this has been due to the strong commitment from the Board, senior management, client services staff and consumers to ensure consumer participation is an integral part of the organisational decision making. There has been strong leadership and facilitation from the Consumer Participation Coordinator, which has been integral to the progress to date. There has also been strong leadership from several consumers involved in the formal participation mechanisms (CRG and CAC).

Recommendations

Related to the overall Consumer Participation Strategy:

1. Continue to build on the excellent foundation work which has begun to be implemented in the four Key Strategies and consider providing additional resources to support the further expansion of the Consumer Participation Strategy.
2. Continue to support and fund the Consumer Participation Coordinator position and associated budget.
3. Systematise and embed the Strategy across the organisation with particular attention to sharing and delegation of responsibilities and succession planning for the Consumer Participation Coordinator.
4. Clarify the extent to which consumer participation is to be integrated into various levels of MDC decision making.
5. Continue and further enhance the commitment to staff development and training in all aspects of the implementation of the Consumer Participation Strategy. This is especially needed in the key strategy areas 1 & 2 (eg. support of a client centred care model and response to, and management of, consumer feedback).
6. Widely disseminate the results of this evaluation to MDC staff, members of the CRGs, clients and carers.

Related to Key Strategy 1 Partnership in Service Delivery

7. Explore mechanisms for effectively distributing appropriate information about client rights and responsibilities and how to make a complaint.
8. Increase focus on meeting consumers' need for information about MDC to ensure informed decision making about care options. (eg. improve communication to consumers about requirements of HACC Funding and Service Agreements and how this can dictate the type and amount of services available).
9. Review progress towards client centred service delivery and organisational supports required to improve achievement.

Related to Key Strategy 2 – Consumer Feedback

10. Develop feedback and monitoring processes to obtain ongoing random feedback from clients, noting that client feedback has indicated that phone calls were the most desirable mechanism for communication for these types of surveys.
11. Define and target discrete client sub-groups for surveying/or other mechanisms for seeking information (eg. by services types such as equipment, personal care and domestic support ; and/or intensity of use of MDC services; and/or identification of disadvantaged or special needs groups of clients). It was evident that MDC clients are not a homogenous group and it would be more equitable and effective to target each client sub-group with the relevant type of approach, rather than a generic survey to all clients. This would ensure higher response rates, more relevant information and more representational input from diverse client groups.
12. Evaluate the compliance of follow up phone calls and distribution of information packages by staff to all new clients 4-6 weeks after initial assessment. Ensure information from these phone calls and other informal feedback are collated and fed back through a formal reporting mechanism within MDC.
13. Strengthen processes to ensure that data from complaints and compliments enables system issues to be identified and adequately addressed throughout the organisation. Ensure that regular reports to the Board, the CAC and staff indicate how issues have been addressed and any organisational changes that have resulted.
14. Extend the complaints and compliments processes to incorporate opportunities for clients and carers to make 'suggestions for improvements'.

Related to Key Strategy 3 – Consumer Consultation

15. Maintain and continue to develop the consumer participation structure to ensure broad regional representation from a range of client groupings. Consideration should be given to forming and resourcing an outer southern CRG, due to the large geographical area, increasing population and the current CRG size.
16. Consideration could be given of forming sub-groups or working groups within CRG so that consumers in regions can work on specific issues, rather than enlarging reference group membership.
17. Work needs to continue in building and maintaining relationships with members of the regional CRG and to continue to develop strategies that enable links to clients and carers who do not attend these groups.
18. Conduct one off 'issue specific' forums to enable broader consumer involvement.
19. Continue to promote occasions for CRG members from each region to network.
20. Continue to develop the rewards and recognition strategy that was identified in the Consumer Participation Strategy.

Related to Key Strategy 4 – Build all Consumers Capacity to Participate

21. Further develop capacity development strategies for consumers. More specifically information provision to consumers, and training and support for members of CRG and CAC. This program is to be developed in collaboration with these consumers.

References

Consumer Focus Collaboration, 2001, The evidence supporting consumer participation in health, Canberra, Commonwealth Department of Health and Aged Care.

Consumer Focus Collaboration, 2000a, Improving health services through consumer participation. A resource guide for organisations, Canberra, Commonwealth Dept of Health and Aged Care.

Consumer Focus Collaboration, 2000b, Feedback, participation and consumer diversity. A literature review, Canberra, Commonwealth Department of Health and Aged Care.

Metropolitan Domiciliary Care, 2004, Consumer Participation Strategy.

Metropolitan Domiciliary Care, 2003, Strategic Plan 2003-2006.