TE POU

Mārama Real Time Feedback

Sector consultation summary report

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Background

Márama Real Time Feedback (Márama) is a consumer experience survey tool that captures the voices of tāngata whai ora and whānau engaging with mental health and addiction services in real time. Márama was initially developed by the Health and Disability Commissioner and CBG Health Research in collaboration with tāngata whai ora, whānau, and service providers.[1] Based on the New Zealand Triple Aim model for quality and safety outcomes, the tool offers opportunities for tāngata whai ora and whānau to share their service experiences and contribute to the development of services (CBG Health Research, 2014). When Márama was developed, mental health and addiction services were required to collect a paper-based satisfaction survey.

Márama asks tāngata whai ora and whānau seven core questions about aspects of support received, such as whether people feel respected and involved in decision making. The development of the core questions was guided by the Picker framework (Picker Institute, 2009), consultation with tāngata whai ora and whānau, and examples of consumer feedback tools used in Australia and the UK.[2]

Since being piloted in 2014, Márama has gathered the voices of over 34,000 tāngata whai ora and whānau. Organisations currently access Márama through an annual base license fee. Márama licenses are currently held by 17 out of 20 district health boards (DHBs), nine non-government organisations (NGOs), and two primary health services. DHBs collecting Márama feedback do so in a range of inpatient and community mental health and addiction settings. Márama is currently offered to tāngata whai ora and whānau through tablet devices available in services and the recently introduced QR codes/URL links.

Aims and objectives

The aim of the sector consultation is to build a better understanding of service experience feedback from tāngata whai ora and whānau in New Zealand's mental health and addiction sector, including Márama and other tools and resources.

Key questions for the review are outlined below.

1. What do people think about Márama?
2. What supports collection of feedback?
3. What supports reporting of feedback?
4. How is feedback used to inform quality improvement?
5. What does the sector want to see in the future of Márama?

[1] The Health Quality and Safety Commission's concurrent work around consumer experience indicators also contributed to the development of Márama Real Time Feedback tool.

[2] For more information about Márama and its development, see hdcrtf.co.nz/

Method

Surveys and interviews were undertaken to build a better understanding of what is currently happening in New Zealand's mental health and addiction sector, along with analysis of Mārama data.

Surveys

Two online surveys were undertaken in September and October 2020 to gather feedback about Mārama and factors important in the collection and use of feedback.

- Forty-four consumer and whānau leaders completed the first survey, including six people with lived experience not working in the sector.
- Twenty people working in mental health and addiction services responded to the second survey. The majority worked in DHB inpatient and community settings, and some worked in NGO community and residential settings. Others worked in a kaupapa Māori health service, prison setting, and other DHB-related roles. Most respondents identified as nurses, managers or leaders, and social workers.

Interviews

A total of 14 interviews were undertaken with 18 people in September and November 2020.

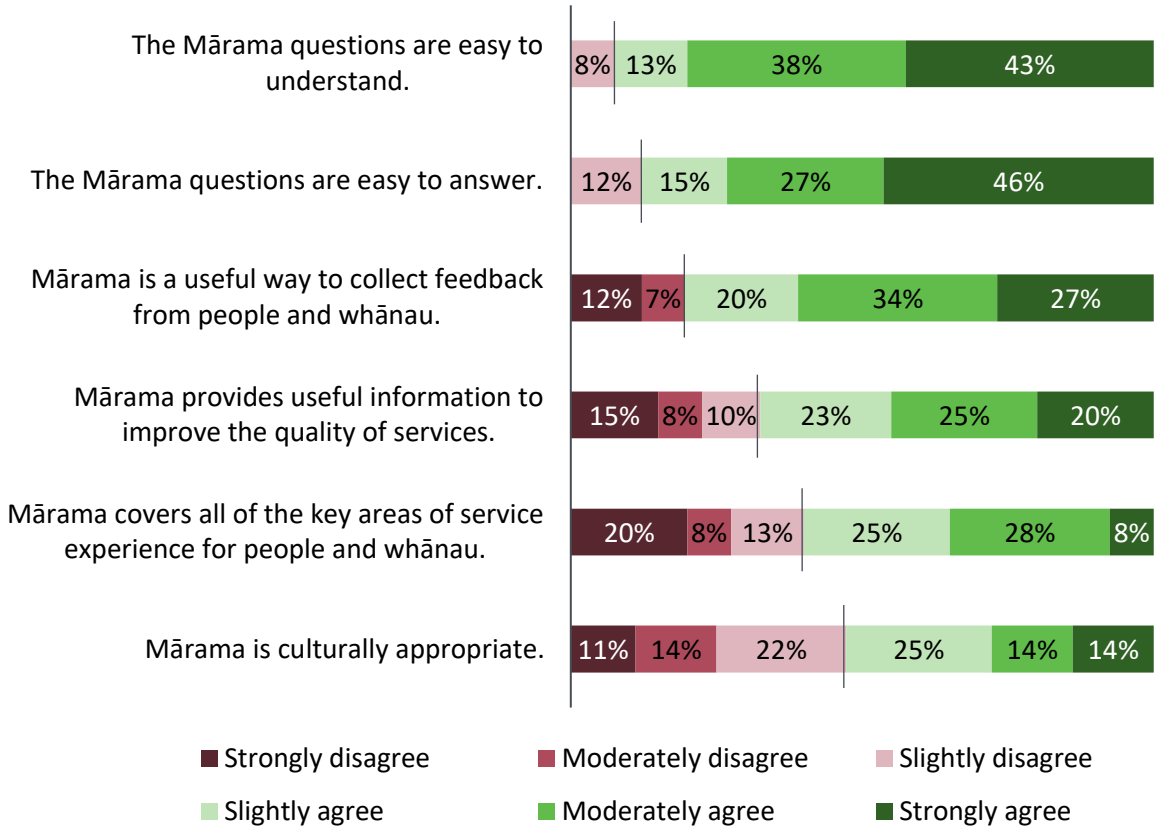
- Six interviews involved people currently using Mārama (four DHBs, two large NGOs).
- Six interviews included people *not* using Mārama in their organisations (three DHBs, three large NGOs).
- CBG Health Research.
- Health Quality and Safety Commission analyst to understand their mental health and addiction patient experience and other patient experience surveys.

Key findings

What do people think about Mārama?

Around 4 in 5 consumer and whānau leaders agree Mārama is a useful way to collect feedback from tāngata whai ora and whānau, see Figure 1. They also say the Mārama questions are easy to understand and answer. However, there is less consensus around whether Mārama is culturally appropriate and whether it covers all key areas of service experience important to people.

Figure 1. Agreement Ratings from Consumer and Whānau Leaders (40 Respondents)



Four of five people working in mental health and addiction services agree Mārama is a useful way to collect feedback from tāngata whai ora and whānau, see Figure 2. That Mārama is also easy for people to complete and it is useful having multiple collection methods. Active engagement from staff supports people to complete Mārama. There is less consensus around whether Mārama is effective in engaging with high priority populations and a lack of clarity around how to best collect and use Mārama feedback.

Figure 2. Agreement Ratings from People Working in Mental Health and Addiction Services (10 Respondents)

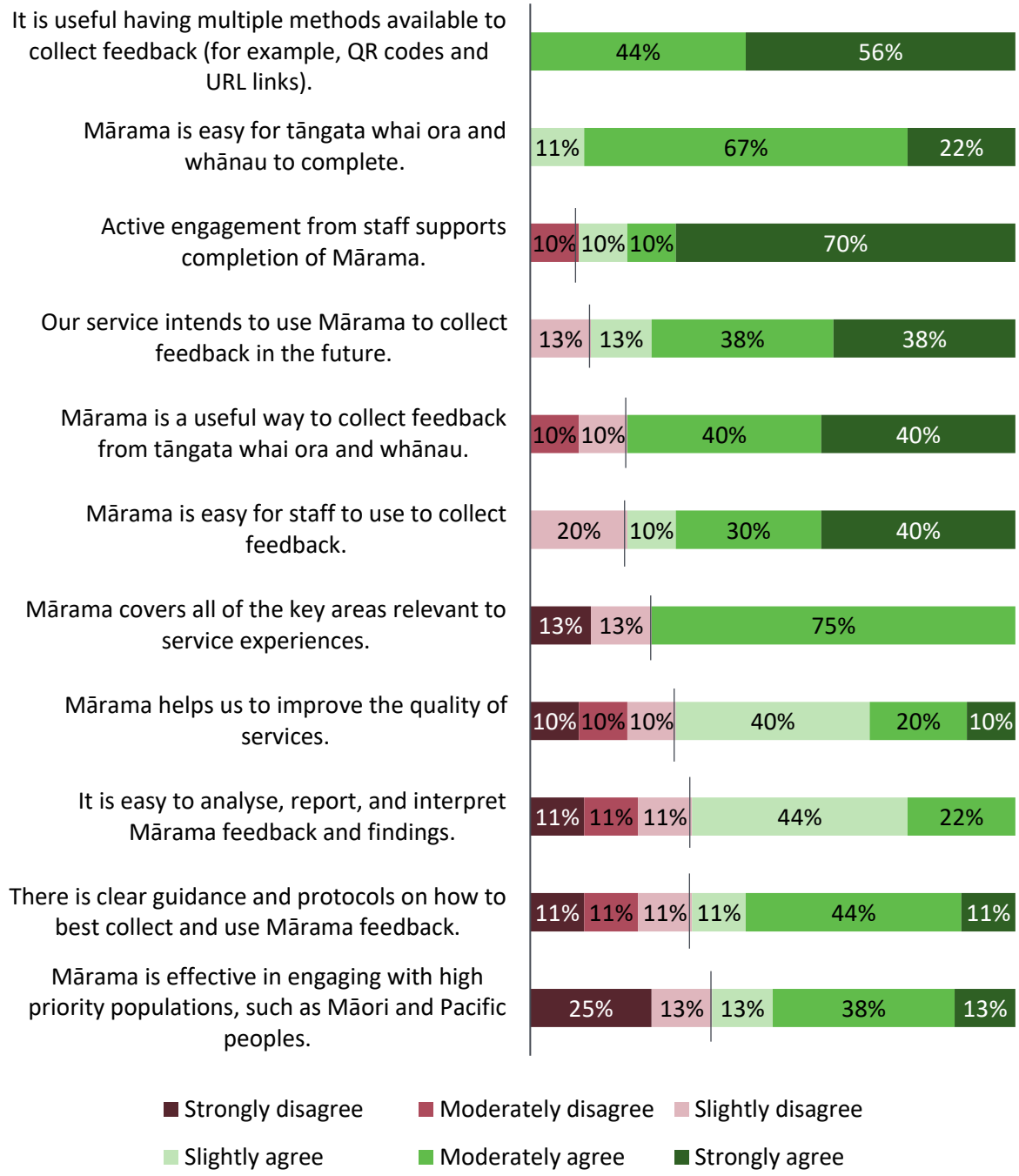


Figure 3 shows the cumulative number of Márama responses continues to grow over time.

Figure 3. Cumulative Márama Collections

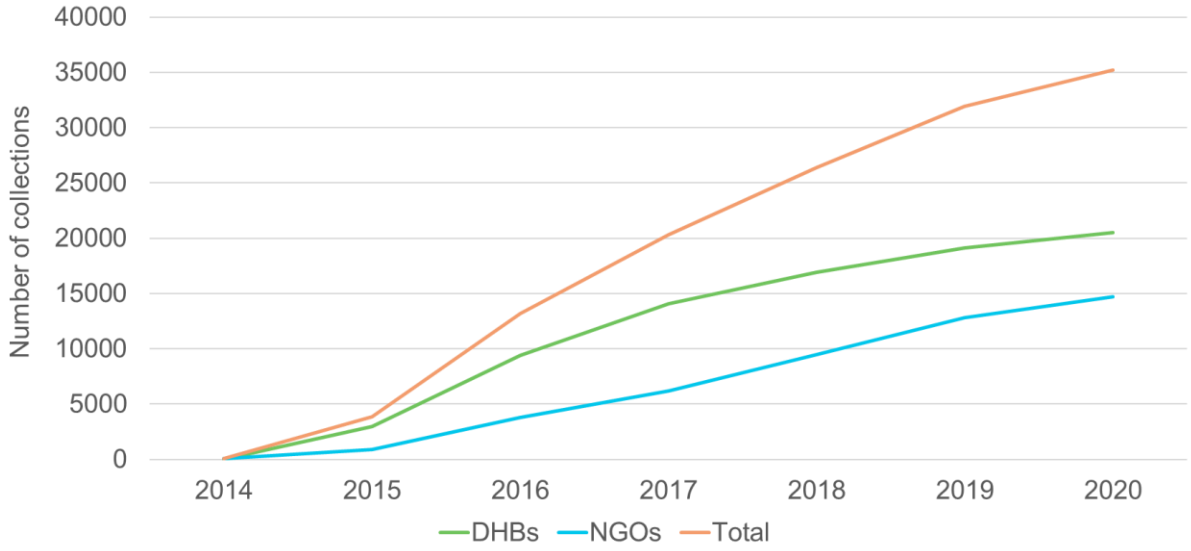
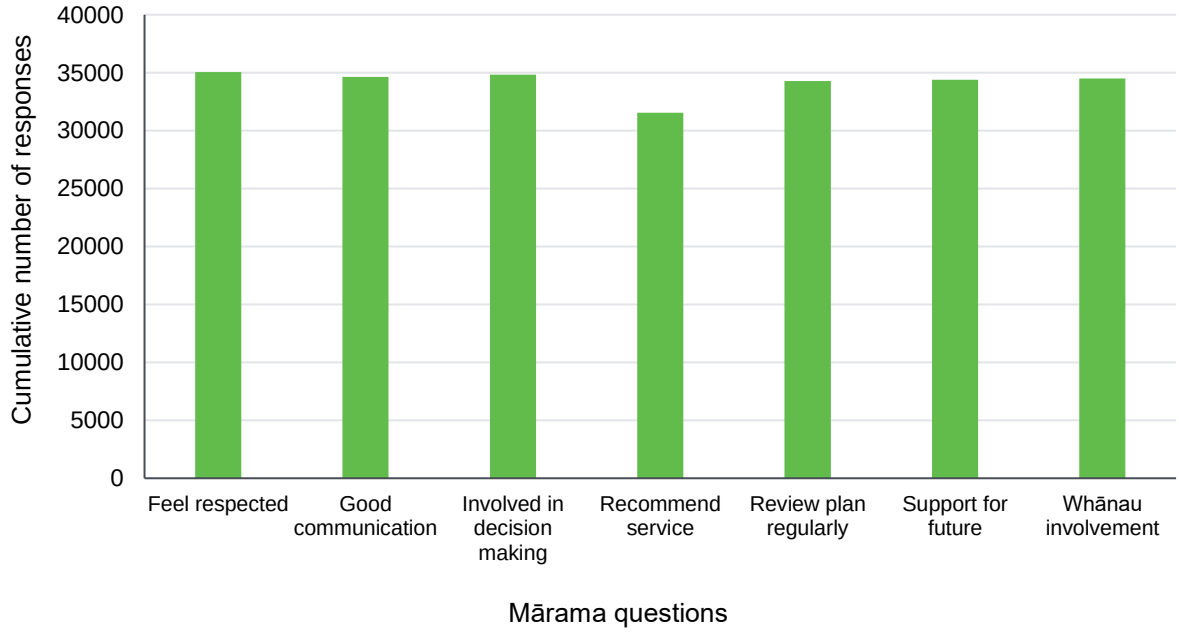


Figure 4 shows the response numbers are fairly consistent across the Márama questions.

Figure 4. Cumulative Number of Responses to the Márama Questions (Including Partial and Complete Survey Responses)



People leading the Mārama work in their own organisation see it as a good opportunity to be part of the national landscape of work led by the Health and Disability Commissioner. This group largely intends to continue using Mārama and to keep embedding it into their services' business as usual practices.

Among the DHBs and NGOs interviewed *not* currently using Mārama, several are interested in considering it in the future. One of the DHBs *not* currently using Mārama is using an adapted version of the Mārama questions on their own IT platform. Two other DHBs are currently exploring options to collect feedback. Two NGOs have developed their own tools to collect consumer reported outcomes – one using a tool adapted from Mārama and the other using a more open-ended feedback approach.

A few survey respondents were unaware of, or had not previously heard of Mārama. Some respondents viewed Mārama as a simple and useful feedback tool for services that are not otherwise collecting feedback.

The following themes were identified in the open-ended feedback.

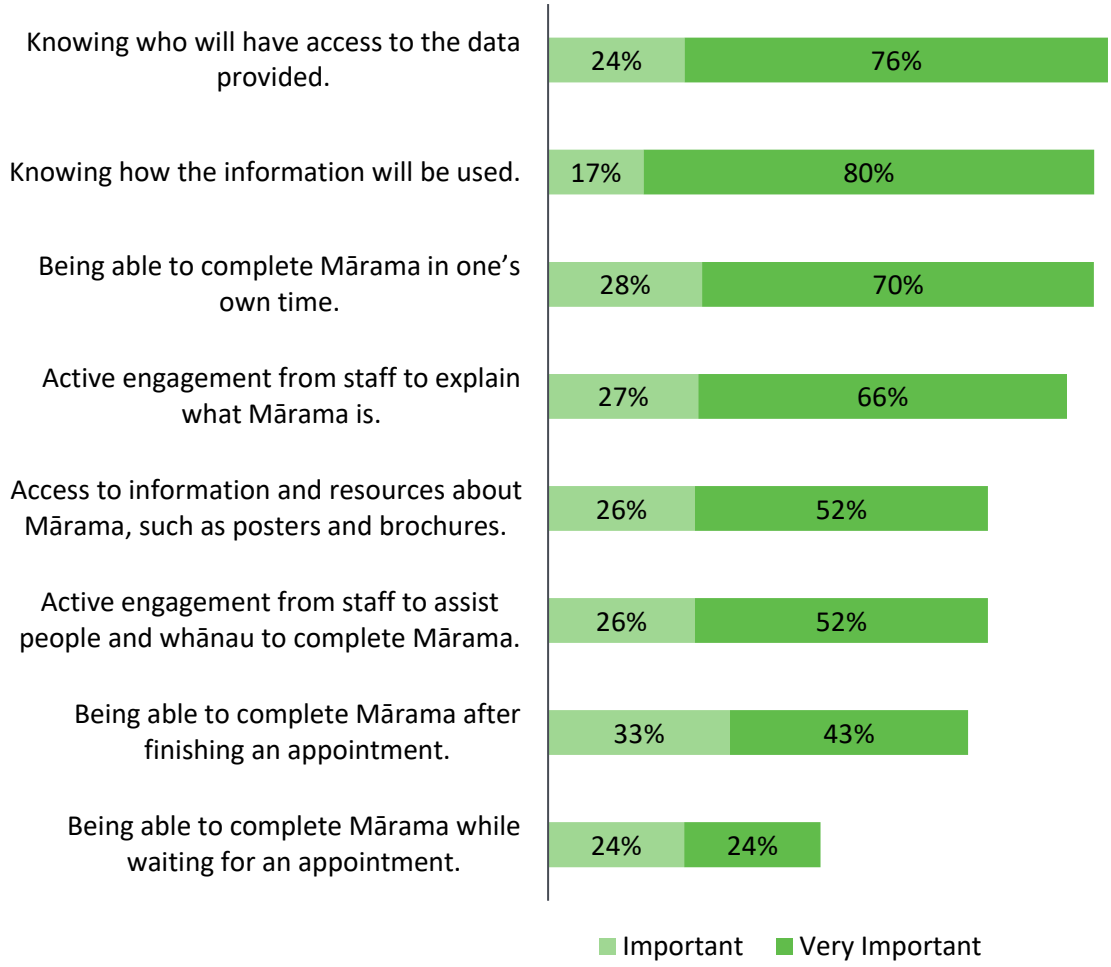
- Mārama is generally preferred over the paper-based questionnaires previously used by DHBs.
- Rationale for choosing Mārama and intentions for future use varied across organisations. Some organisations are committed to continuing with Mārama. Some NGOs are using other methods of collecting feedback, such as adapted versions of Mārama or more open-ended feedback questions, which are working well to meet their organisation's needs.
- There is good leadership commitment and support for the use of Mārama in some organisations. Having dedicated Mārama leads, champions, and senior leadership support means some organisations have had a consistent approach in the use of Mārama and have it well embedded in routine practice.
- The Mārama reference group is seen as a great way to share lessons learned, connect, and collaborate with others, and helps provide a professional profile for Mārama involvement.
- Whilst the cost of Mārama is seen as a worthwhile investment for some organisations, it is a key barrier for other organisations, especially NGOs.
- There is both positive and negative feedback about Mārama content and design. Some organisations include additional customised questions in their Mārama survey, especially around respect for people's culture. There is a need to update the existing question about gender.
- CBG Health Research is seen as a helpful source of technical support and customisation of Mārama surveys and reports.
- The use of technology, such as the Mārama devices and platform, has been challenging for some services and staff. People report technical (tablets being outdated

or not working), accessibility (not having enough tablets), and visibility (needing to lock tablets away) issues with tablets. Challenges in using the platform for reporting were also experienced.

What supports collection of feedback?

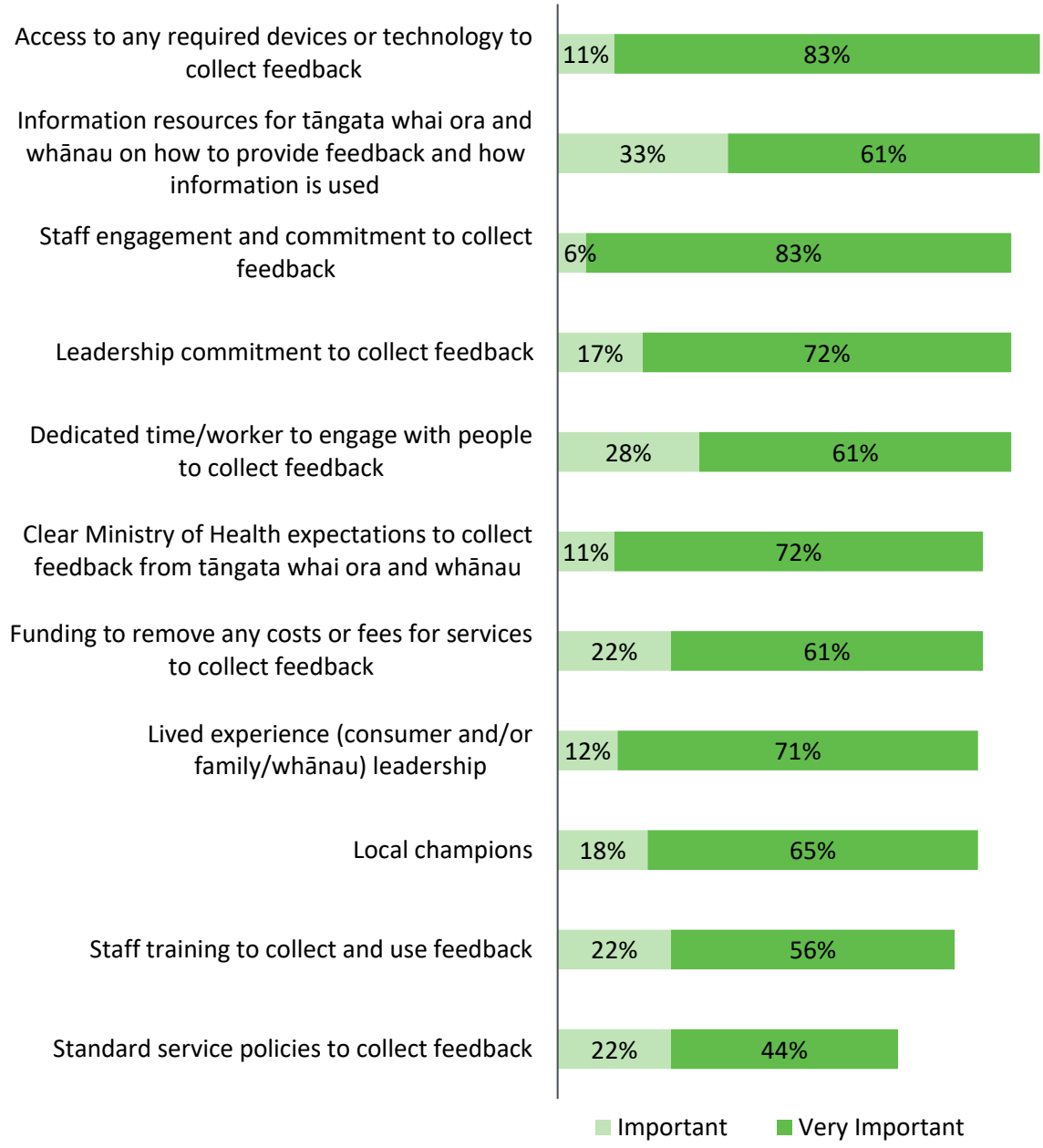
Consumer and whānau leaders say when asking people to provide feedback that it is important they know who will have access to the data and how the information will be used, see Figure 5. They also say being able to complete Márama in one's own time is more important than completing it before or after an appointment.

Figure 5. Collection Factors Rated as Important by Consumer and Whānau Leaders (42 Respondents)



People working in mental health and addiction services say it is important to have access to required devices or technology and information resources to share with tāngata whai ora and whānau, see Figure 6. Having leadership commitment, clear Ministry of Health expectations, lived experience leadership, and local champions are all perceived as similarly important.

Figure 6. Collection Factors Rated as Important by People Working in Mental Health and Addiction Services (19 Respondents)



The following themes were identified in the open-ended feedback.

- Although services vary, both clinical and non-clinical staff have been involved in the collection of Mārama. Staff engagement can be a key barrier for organisations, particularly understanding the value and concerns about what people may say and how information will be used.
- The way staff engage with tāngata whai ora and whānau is seen as a key influencing factor in whether people choose to provide feedback. Active engagement from staff

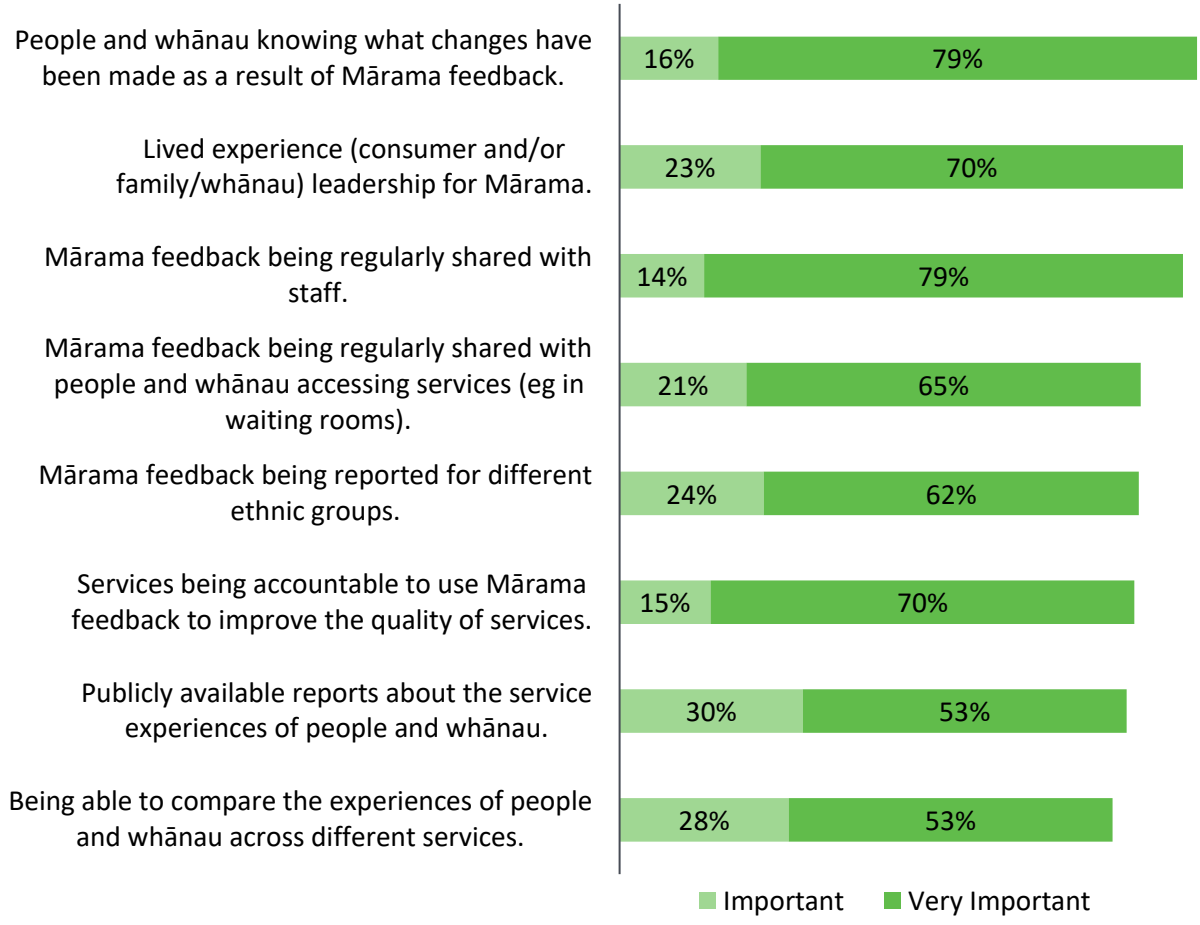
using positive language to explain the purpose and how to complete Mārama is important, along with tāngata whai ora and whānau feeling safe to provide feedback.

- There is a potential need for clearer guidance and protocols for Mārama as there is some confusion and uncertainty around when and how to best collect feedback. Some organisations are collecting feedback at any time to collect as much feedback as possible.
- There is interest and support for multiple collection methods which enable tāngata whai ora and whānau to choose how to provide feedback. The inclusion of QR codes and URL links is viewed positively by services and reduces the reliance on tablets.
- Some organisations have developed their own posters and pamphlets to support the collection of Mārama feedback. This can require significant time and resources and contributes to delays in implementation for some services.

What supports the reporting of feedback?

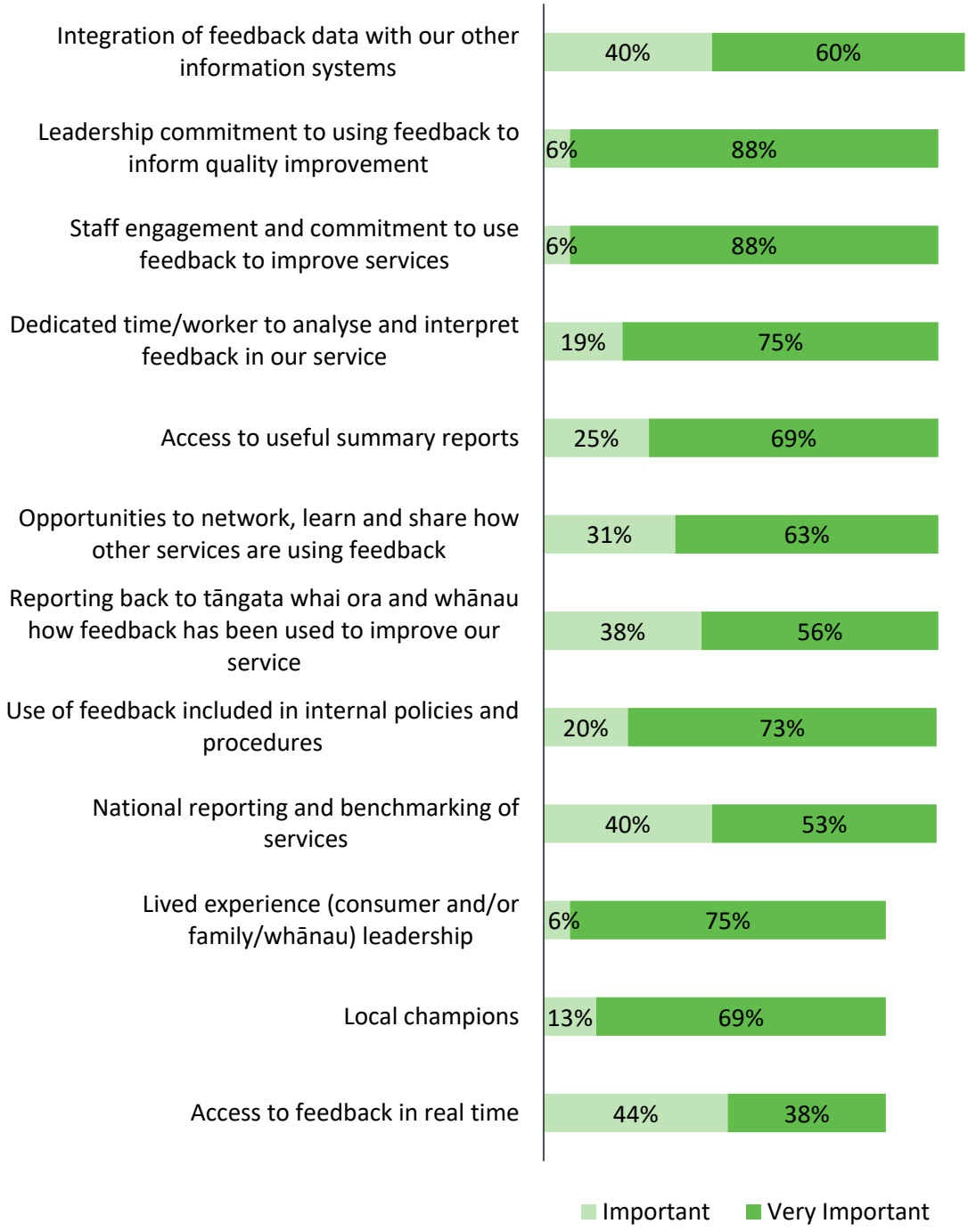
Consumer and whānau leaders say it is important there is lived experience leadership for Mārama. That feedback is also regularly shared with staff, and tāngata whai ora and whānau know what changes have been made in response to feedback, see Figure 7.

Figure 7. Reporting Factors Rated as Important by Consumer and Whānau Leaders (43 Respondents)



The factors perceived as most important for people working in mental health and addiction services are the integration with other information systems and having engagement and commitment from leadership and staff, see Figure 8. They say access to useful summary reports is more important than access to real time feedback.

Figure 8. Reporting Factors Rated as Important by People Working in Mental Health and Addiction Services (16 Respondents)



The following themes were identified in the open-ended feedback.

- The built-in Mārama reporting system is yet to reach its full potential and larger organisations require more flexibility and function to view their data at service and team levels. The reporting dashboard is only accessible via login which means most staff do not have access to real time data. Most larger organisations have developed their own reporting systems to meet this need, which also enables wider staff access to results.
- There are challenges in terms of time in analysing open-ended feedback. Also some uncertainties around how to report and share open-ended feedback,[3] the amount of data required to make meaningful reports and interpretations, and the usefulness of Mārama feedback to inform service improvement.
- The ability to share information collected through Mārama is perceived as an important factor for ensuring transparency and showing the value of people's feedback.

How is feedback used to inform quality improvement?

Over two-thirds of consumer and whānau leaders agree Mārama provides useful information to improve the quality of services, see Figure 1. A slightly higher proportion (70 percent) of people working in mental health and addiction services agree Mārama helps to improve the quality of services (see Figure 2).

The following themes were identified in the open-ended feedback.

- Organisations using Mārama are currently at different stages of implementation. Many are still focused on the initial stage of data collection and have not yet used Mārama for quality improvement.
- The current under-utilisation of Mārama in quality improvement is more likely due to organisations' focus on collection rates, capacity to analyse open-ended feedback, and need for support in how to use the feedback collected, rather than the tool itself.
- The 'You said, we did' reporting approach to sharing feedback and subsequent actions is seen as a positive approach to support the ongoing use of Mārama.
- Some organisations recognise the benefits of matching Mārama results with other forms of feedback (such as consumer focus groups or complaints). Multiple sources of feedback are perceived as complimentary to each other and increase the potential for making service improvements

[3] CBG Health Research estimates about one-third of people who complete Mārama provide open-ended feedback.

What does the sector want to see in the future of Márama?

The following themes were identified in the open-ended feedback.

- Some participants express an interest for increasing leadership and a clear direction from the Ministry of Health around the Márama work. There is also some uncertainty around expectations for collecting service experience feedback.
- The need for the Márama governance group and terms of governance was highlighted.
- There is interest in more accountability around the use of Márama.
- There is support for more visible and transparent reporting of Márama feedback as well as benchmarking at the national level.
- There is some support for aligning and linking Márama with other datasets or programs of work, such as the mental health and addiction key performance indicators (KPIs), the Health Quality and Safety Commission's projects, and the new Mental Health and Wellbeing Commission's framework of measures.
- There is support for growing the use of Márama in NGOs and beyond mental health and addiction services, however, the cost of Márama is seen as a key barrier. Some DHBs report use or interest in Márama by other health services including ED, older person's allied health, child development, community nursing, diabetes, and older persons.

Limitations

A key limitation in this sector consultation is the representation of NGO perspectives. Interviews were undertaken with large NGOs, of which two are using Márama and two are not. NGOs have different and more varied needs compared to DHBs. This is related to the range of people with different wellbeing needs supported by NGOs, multiple funders, organisational size, level of resourcing, and data analysis capability. The sector consultation did not capture the views of smaller NGOs who may have different needs and barriers around the collection of feedback from tāngata whai ora and whānau.

The surveys captured feedback from a few people working in cultural health, iwi provider, kaupapa Māori, and Pasifika mental health services. However, this was not enough to build an understanding of what cultural services are likely to require around the collection of feedback from tāngata whai ora and whānau.

Whilst efforts have been made to engage with DHBs and NGOs not currently using Márama through interviews, only a small number of people working in mental health and addiction services responded to the survey. Therefore, survey results may not be representative of all perspectives.

Future consultations will benefit from targeting these gaps to further build an understanding of service experience feedback collection from tāngata whai ora and whānau.

Conclusion

In summary, many people in the mental health and addiction sector are showing some level of positive support towards Mārama. All the interviews with DHBs and NGOs currently using Mārama favour continuing with this tool, and some of the DHBs and NGOs *not* currently using Mārama show an interest in considering it in the future. This finding indicates it will be beneficial to support the continued use of Mārama. However, sector feedback highlights Mārama has scope for improvement to increase adoption and use.

To support the continued use of Mārama, there is potential for it to grow in relation to leadership and funding, technology, support and guidance around implementation and reporting, alignment with other programs of work, and its use in quality improvement. Sector feedback also indicates a review of Mārama content and design would be beneficial. There is some interest in using Mārama alongside other service experience feedback approaches and in other settings outside of mental health and addiction.

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