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Shared or brokered care: A paradigm shift for clinical governance frameworks

Sandy Thomson
Director GovernancePlus
E: info@governanceplus.com.au

ahha
australian healthcare & hospitals association

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Acknowledgements

Clinical governance is a topic which has been the subject of many publications and research over time but, as this paper identifies, this has largely focussed on health service organisations as a single entity for ensuring effective clinical governance oversight for the services they provide.

In today's health care systems, care is now being shared amongst multiple professions and providers in the acute public, private, community, primary care, not for profit, aged, and disability sectors.

The work of GovernancePlus in the pre-accreditation support services in these sectors has highlighted the difficulties consumers face when care is being shared to the extent it is today. This experience has provided the impetuous for the development of a clinical governance framework which addresses shared or brokered care.

Much of the approach taken for the development of this framework has been adapted work by Cathy Balding (Qualityworks, 2018). My sincere thanks to Cathy for her guidance and support as with support and guidance from Dr Grant Phelps and Dr Simon Towler.

Introduction

Clinical governance is an essential component of a health service's broader organisational governance system and ensures that there is a clear understanding of accountabilities for care outcomes from staff to the Board, who are responsible for ensuring services for every consumer are person-centred, connected, safe, and effective. Effective clinical governance is now also expected in aged care, disability, and primary care. However, as this paper identifies, care for individual consumers is being increasingly shared amongst multiple providers. And yet, there is not a single view of clinical governance in a shared care model of care that can be used to ensure care is seamless and well-coordinated.

With increasing demands on the system including managing the COVID19 pandemic, along with an aging population with more complex comorbidities, models of care are moving rapidly to address these challenges. Virtual care, remote monitoring, hospital substitution programs, brokered care using community providers, integrating digital technology, and traditional face-to-face care are requiring more innovative and targeted approaches to be used. This is further emphasized in the Deeble Institute Evidence Brief no: 24 "*Avoiding hospital readmissions: the models and the role of primary care*".

These drivers for change need to ensure that all providers engaged in shared care consider the clinical governance accountabilities that impact on consumers and that their safety is integral to design processes - with specific attention to be given to the care outcomes that we want our consumers to experience. This is a fundamental concept of good clinical governance, along with engagement of consumers through co-design processes to ensure services reflect consumer and carer needs and preferences.

The Consumers Health Forum (2017) clearly confirm the risks of fragmented and disconnected care which result in a lack of communication and efforts to connect care between providers, and which fail to focus on the needs of individual consumers.

The Quadruple Aims of Health also seek to optimise health system performance by proposing that health care providers simultaneously pursue four dimensions of performance (Figure 1):

- Population Health: Improving the health of populations
- Patient Experience: Enhancing the patient experience of care
- Reducing Costs: Reducing the per capita cost of health
- Provider Satisfaction: Improving the experience of providing care

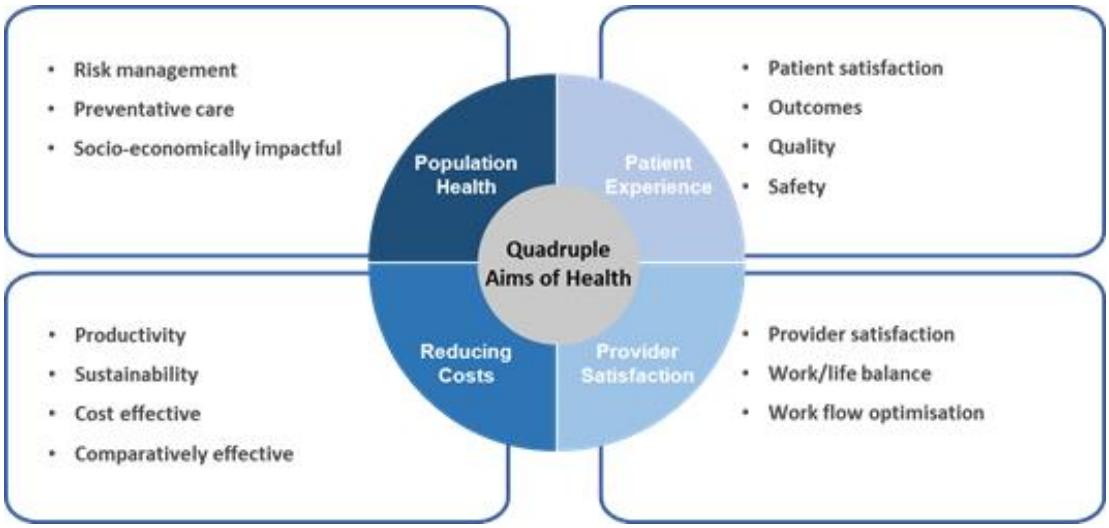

Figure 1: Quadruple aims of health

This framework supports a simultaneous approach to achieve person-centred, connected, safe, and effective care, which can be better operationalised through a shared care model of clinical governance.

In summary, a review of clinical governance frameworks has identified that, to date, there is no formal framework which addresses how a shared model of clinical governance can be effectively achieved; and which will support the objectives of person-centred, connected, effective, and safe care across multiple providers, especially when this occurs in community settings.

While issues relating to shared care are being identified by interested parties, these appear to remain siloed within particular sectors. The objectives of person-centred, connected, effective, and safe care need to bridge multiple sectors and are a fundamental component of a shared care model of clinical governance which is proposed in this paper.

Definition of shared governance in health

Much of the literature for shared care clinical governance focuses on shared governance as it applies to nursing, and not to the broader care provision sector. Nevertheless, it does however provide some guidance. For example,

"*…shared governance is a structure and process for partnership, equity, accountability, and ownership. It puts the responsibility, authority, and accountability for practice-related decisions into the hands of the individuals who will operationalize the decision (*Guanci, 2018)".

"Guidelines for Shared Transfer of Care" developed by Primary Health Tasmania (April 2016) also provide, through case studies, some excellent insight into how transfers of care within and between

health and community services are linked to adverse events and disruptions in the continuity of care. These interface issues faced by consumers and providers present safety risks for consumers and carers represented by poor communication between providers, and avoidable emergency presentations and hospital admissions. The document emphasises that providers must operate in an integrated and collaborative fashion but does not fully address the requirements for a joint understanding and definition of what quality shared care will look like along the consumer journey, with collaboration and communication at all levels and along all service lines.

In developing this shared care clinical governance model, it is important to understand the components of shared care in practice in terms of how these impact on the consumer journey.

Models of shared care

There can be many variations of a shared care model of care. The following examples are provided but are not intended to cover all shared care models.

General practice

General practice is a critical entry point into the health system. General practitioners (GPs) can organise care treatment needs which can include referrals to the acute sector, allied health, radiology, other medical specialties, My Aged Care, etc. General practice relies on information from these providers to be communicated back to the GP in order to provide an overarching view of the care that the consumer has received. This remains fragmented, however the use of My Health Record as a central information point offers excellent opportunities to improve knowledge about services consumers are involved with.

Nursing homes including residential facilities

These facilities provide the daily clinical and support requirements including facilitating referrals for specialist services such as medical, allied and mental health needs. Medical support needs rest with the resident's GP who may be either "attached' to the facility, or who provides care as an external provider. This arrangement is the resident's choice, with choice being a key component of the aged care standards.

For those GPs attached to the facility, information is documented within the resident's record.

For external care providers, the resident's clinical information may not always be available to the facility.

Residents can transfer between the acute and residential setting with hospital avoidance being a key consideration. Shared care in these settings becomes more complex when residents are also in receipt of NDIS packages, where residents can choose providers as part of their funding packages. In these cases, different care plans can be in place.

Disability residential providers

Disability residential providers also provide daily clinical and support requirements, including facilitating referrals for specialist services such as medical, allied, and mental health needs. As per the aged care arrangement, choice is a fundamental right. While hospital avoidance is also a key objective, residents in disability facilities can have complex health issues which often need to be managed in acute services. This requires effective and efficient collaboration and communication with the resident's GP, the acute service, and carer who may also be an authorised guardian.

Acute facility to hospital in the home

When a consumer is discharged from an acute facility to hospital in the home (as an extension of the acute facility), clinical governance accountability remains with the acute facility. The discharge plan informs ongoing care needs for the care providers. At the completion of care the consumer is then transferred back to their GP.

Acute facility to an external provider for nursing or personal care needs.

Upon discharge from an acute facility and following an assessment of needs via My Aged Care, care can be transferred to an external provider of home and community services. This option allows consumers to remain in their own home with appropriate support which can involve nursing, allied health, mental health, and personal support services along with support from the consumer's GP.

Discharge from an acute facility to a broker of community services

Care is transferred to a broker of community services who then organises care with a number of contracted providers[1] depending on need. In this scenario, the broker should maintain the overarching clinical accountability for care. This option also allows consumers to remain in their own home with appropriate support including communication and collaboration with the consumer's GP.

Acute facility to a community mental health team

Care is transferred to the community health team who then take on clinical governance accountability for the consumer. Ongoing communication with other parties including the consumer's GP occurs as required.

In providing these examples, the intent is to demonstrate the complexity and challenges that shared care clinical governance creates. With more and more care being shared, a joint understanding and definition of what quality shared clinical governance should look like for consumers and providers is needed.

[1]This tripartite model is more evident where health funds are engaged in brokering services.

Building a framework for shared clinical governance

Proposed policy statement

The objective and purpose for an effective and efficient model of shared clinical governance is that everyone involved in shared care is accountable to consumers and the community for the delivery of services that are safe, effective, integrated, and person-centred. This also relies on having a culture of quality and risk management embedded at all levels of the organisations involved in shared care.

The consumer journey and the National Safety and Quality Health Service standards

To better understand the components of shared care involving multiple providers, the Australian Commission on Safety and Quality in Health Care (ACSQHC) National Safety and Quality Health Service (NSQHS) standards have been applied to the framework (Figure 2). However, the aged care, general practice, and disability standards can be equally applied to the journey.

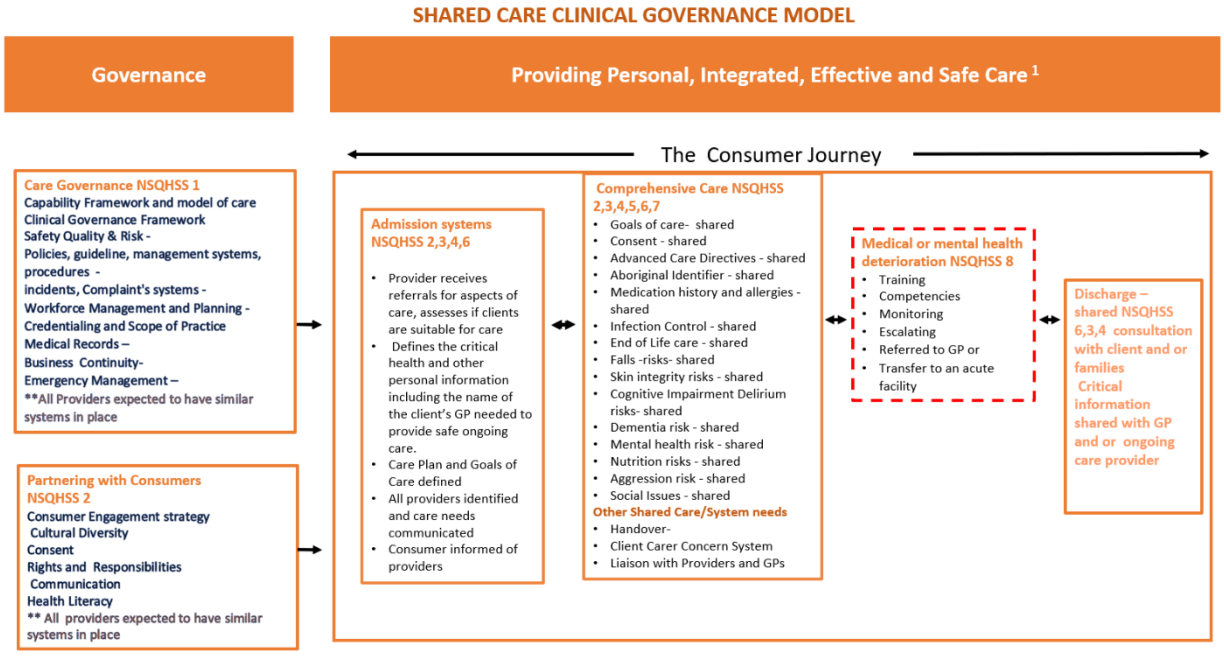

Figure 2: Shared care clinical governance model (adapted from [1]Balding, 2022).

Responsibilities of a shared care model of clinical governance

The Australian Commission on Safety and Quality Clinical Governance Framework (ACSQHC, 2017) outlines responsibilities that have been adapted to the shared care model of clinical governance (Table 1 below).

Table 1: Responsibilities been adapted to the shared care model of clinical governance.

Australian Commission on Safety and Quality Clinical Governance Framework	Shared care model of clinical governance
Governing bodies establish strategic and policy frameworks, lead organisational culture, oversee management performance, monitor organisational performance, and ensure organisational accountability.	Governing bodies involved in shared care agree on a common and simple definition of high-quality care, to be pursued by all parties via their clinical governance, quality, and risk systems. This will also then provide oversight of performance outcomes, which ensures accountabilities of all parties can be demonstrated. While separate governance systems including committees, policies, management of risk, and continuous improvement are maintained; all parties are working to a single objective of safe, effective, integrated, and person-centred care. Contracted second and third-party providers will also need to demonstrate that they have the required components in place which will provide a framework for sustainability of their services, as without these providers the primary holder of accountability cannot achieve the objectives of shared care. **Outcome** **There is an agreed definition of shared care that is safe, effective, integrated, and person-centred. All parties involved in shared care demonstrate and deliver a sustainable service model.**

Australian Commission on Safety and Quality Clinical Governance Framework	Shared care model of clinical governance
Consumers are partners in the delivery of care. They are confident that when components of their care are transferred to, or shared with, a second- or third-party provider that the primary holder of accountability will effectively coordinate care that is safe, effective, integrated, and person-centred.	Consumers are fully involved in and in agreement with the decision to move to a shared model of care for their ongoing care. Care is respectful to the consumer's needs, preferences, circumstances, and values. The consumer and/or carer is supported to participate in shared decision-making and self-management. Consumers will be provided with information including contact details of their shared care provider team(s). Individuals are supported to make positive lifestyle choices which promote health and prevent deterioration. The consumer's home or community facility is where care is delivered; risks for the consumer and staff are assessed to ensure a safe environment. **Outcome** **Consumers are involved in the design of care systems. Care is seamless and safe. Consumers are informed and understand the model of care and can choose the care that best suits their needs.** **Staff are supported to deliver care needs.**

Australian Commission on Safety and Quality Clinical Governance Framework	Shared care model of clinical governance
The primary accountable organisation ensures through integrated quality and risk management systems that the second- and third-party providers deliver safe, effective, integrated, and person-centred care.	The collection and utilisation of key performance data, including consumer experience and outcome data, supports the delivery of holistic shared consumer care, management of clinical risk and continuous improvement in care. Appropriate action is taken to mitigate the potential for unwarranted variation of outcomes of care leading to adverse events. Data is shared and used collaboratively with all stakeholders including consumers to improve care outcomes. **Outcome** **Well designed and well-coordinated systems of shared care are implemented and assessed for efficiency and effectiveness. Unwarranted variation is identified, and action is taken to reduce the impact of variation.** **Outcomes are shared and used to support continuous improvement.**

Fundamental principle and components for a shared care model of clinical governance

For all providers, the fundamental principle for a shared care governance model must be to put the safety of the consumer first.

The best interest, agreement, and preferences of the consumer are at the centre of this model of care. Included components are detailed in Table 2.

Table 2: Components for a share care model of clinical governance

Governing bodies involved in shared care establish and commit to a strategic shared care clinical governance framework which provides oversight of performance outcomes, and which ensures accountabilities of all parties is demonstrated.
This is achieved by: • An alignment of vision, mission, values, and governance systems. • Governance systems that define roles and responsibilities of all parties. • Governance systems which include policy management, risk, continuous improvement, incident, and complaint management. • Jointly established metrics being developed and implemented to support measurement, monitoring of outcomes and which address unwarranted variation. • Management of risks and the continuous improvement associated with delivery of the shared care model is jointly owned and managed.
The consumer and/or carer is at the centre of all decision making regarding shared care arrangements; care is person-centred.
This is achieved by: • Consumers being fully involved in, and in agreement with, the decision to move to a shared model of care for their ongoing care. • Care which is respectful to their needs, preferences, circumstances, and values. • Support for the consumer and/or carer to participate in shared decision making and self-management. • The provision of information to consumers, including contact details of their shared care provider team(s).
Coordination of care; care is integrated.
This is achieved by: • Care coordination that is enhanced through timely and effective communication. Roles and responsibilities of care providers are clarified. • The collection and sharing of appropriate clinical data and information that supports continuity of care and integration between providers • The primary provider retaining overarching clinical governance responsibility for the care of the consumer; this includes accountability for delivering best practice care in the community.

- The transfer of clinical responsibility to second- or third-party providers for delivering services only being considered when the consumer meets agreed and defined criteria. The primary organisation which has clinical governance accountability for the consumer is given the right to refuse to take a consumer if the criteria for admission cannot be met.
- Shared care protocols are approved agreements between providers and operationalised only when formally agreed between the parties.
- Clinical protocols are developed to assist providers to understand local accountabilities.

Care is delivered according to best practice; care is safe and effective.

This is achieved by:

- Care provision that is in accordance with nationally agreed standards and is outcomes-focused.

Support for consumers; care is integrated and personalised.

This is achieved by:

- Support for individuals to make positive lifestyle choices which promote health and prevent deterioration.
- An individual's supportive care needs (physical, psychological, social, cultural, informational, and spiritual) are assessed with appropriate referrals and management to promote optimal health and quality of life.

Care is informed and improved by data. Improvements in shared care are data-driven; care is safe and effective.

This is achieved by:

- The collection and utilisation of key performance data, including consumer experience and outcome data which supports the delivery of holistic shared consumer care, management of clinical risk, and continuous improvement in care.
- Appropriate action is taken to mitigate the potential of unwarranted variation to outcomes being achieved.
- Data is shared and used collaboratively with all stakeholders including consumers to improve care outcomes.

The environment in which care is delivered; care is safe.

This is achieved by:

- Care is delivered in the consumer's home. Providers cannot influence the environment other than to assess any risks of an unsafe environment which places both the consumer and/or staff at risk.

The provider workforce has the skills and capacity to meet required care outcomes; care is safe and effective.

This is achieved by:
• The primary provider ensuring that the second- and third-party providers workforce has the right qualifications, skills, and supervision to provide safe, high quality health care to consumers.
• Second- and third-party providers having systems in place to support and protect a skilled, competent, and proactive workforce, including:
  ○ Planning, allocation, and management of the workforce
  ○ Skills Matrix and Training Needs Analysis
  ○ A Professional Development Program
  ○ An annual recertification program
  ○ Promotion and support of multidisciplinary teams (MDT); and teamwork as the basis of providing high-quality care
  ○ Clear communication of role expectations, responsibilities, and standards of performance is provided to all staff; employees are supported and held accountable for meeting these expectations
  ○ Mentoring and supervision are used to support, monitor and develop staff
  ○ A defined system for managing complaints or concerns about staff is in place and is regularly reviewed for its effectiveness
  ○ A safe and fair workplace based on a 'just' culture and mutual respect is provided, with systems in place to address issues (for example, Speaking Up for Safety); emotional wellness programs are in place

The consumer voice

The nature of the consumer journey, which often commences in an acute setting, means that they will be interacting with different systems and providers; noting that the primary provider must maintain overarching accountability for care and care decisions that the consumer may make.

The voice of the consumer and carer is integral to ensuring care is safe, effective, integrated, and person-centred.

Table 3: Components, strategies, and outcomes of consumer sentiment

Domain	Governance
Consumer Sentiment	My care is person centred. I am confident that the shared care model of clinical governance places me at the centre of governance and decision making.
Components	• There is alignment of vision, mission, values, and governance systems • Governance systems define roles and responsibilities of all parties • Jointly established metrics are developed to support measurement and monitoring of outcomes • Management of risks associated with delivery of the shared care model are jointly owned and managed • Management of continuous improvement of the shared care model is jointly owned and managed • External review is valued and is an integral component of the quality management systems • External review reports are available for public review • Incidents and complaints are reported, and timely action is taken to address these reports • If something goes wrong with my care, there is a system in place to openly report, investigate and fix the underlying problems so that others are not harmed; I will be told openly and honestly what went wrong and receive an apology • Reassurance that there is an external body evaluating the safety of care provided and that providers are working to improve quality and safety outcomes
Applicable NSQHS Standards	NSQHS Standards 1 – 8.
Strategies	• Agreed governance model (MOU) including organisation and committee charts • Consolidated risk register • Consolidated strategic quality plan • Consolidated metrics to support monitoring of outcomes

	• Consolidated incident management and open disclosure systems • Consolidated complaints management system
Outcomes	• Consumer needs are met and demonstrated though agreed performance measures • Care and services delivered reflect consumer choice • Advanced care plans are in place
Measures of success	• Ongoing contracts for delivery of care • Sustainability of shared care model

Domain	**Person First**
Consumer Sentiment	• My care is person centred; I am at the centre of decision making about my care choices • I understand the risks and benefits of my care options
Components	• Jointly we deliver person-centred care and services based on individual needs and goals • Incidents and complaints are reported, and timely action is taken to address these reports • Appropriate services for my needs are provided • Consumers will be treated with respect and have easy and honest communication with the doctors, nurses and other health care professionals and support staff who are providing care to me. • If there are concerns consumers will be able to talk to someone immediately and have their concerns addressed to their satisfaction
Applicable NSQHS Standards	NSQHS Standards 1 – 8.
Strategies	• Needs and goals are identified and these guide decision-making • Comprehensive and ongoing assessment and care planning information is provided to consumers • Anticipatory care planning, including advanced care plans, is provided • Spiritual, religious, cultural, and diverse needs and desires are identified and incorporated into care planning

	• Communication support, including interpretation support, is identified, and obtained when required • Communication can be in multiple modalities as preferred by the customer • Incidents and complaints are monitored, and action is taken as required
Outcomes	• The consumer is in control throughout their journey • Consumers are actively engaged with care delivery • Goals are identified collaboratively between providers and the consumer • Care and services delivered reflect consumer choice • Advanced care plans are in place • Effective communication between the shared care team(s) is achieved
Measures of success	• Consumer/carer satisfaction • Number of complaints

Domain	**Coordination of Care**
Consumer Sentiment	• My care is integrated and seamless • I know who my care team is and am assured they can communicate effectively • If my needs change, I can be assured that changes are effectively communicated and co-ordinated • In the event of an emergency such as a COVID outbreak, I am confident that my continuing care needs will be met

Components	• Care coordination is enhanced through timely and effective communication, and clarification of the roles and responsibilities of the care providers • Incidents and complaints are reported, and timely action is taken to address these reports • Consumers will be looked after by clinicians and staff who have the necessary clinical and support skills for the work that they do • Provider staff are well-supported and part of effective teams, and have access to the resources (including equipment and information) they need to do their work
Applicable NSQHS Standards	NSQHS Standards 1, 2, 5 and 6.
Strategies	• Goals are identified and these guide decision-making • There is a multidisciplinary approach to care planning and ongoing assessment of needs • Ongoing care planning considers end-of-life requirements • Business continuity and emergency plans are in place and tested • Incidents and complaints are monitored, and action is taken as required
Outcomes	• The consumer is in control throughout their journey • Consumers are actively engaged with care planning and review • Care and services delivered reflect consumer choice • Advanced care plans are considered • Effective communication between the shared care team is achieved • Continuity of care in an emergency is achieved
Measures of success	• Consumer/carer satisfaction • Number of complaints • Number of emergency transfers to acute settings • Number of times when business continuity plan is activated

Domain	Care is delivered according to best practice
Consumer Sentiment	My care is safe and effective and is grounded in evidence-based practice.
Components	• Evidence-based practice is an integral component of care • Where new or emerging technologies are available these will be considered for implementation and delivery to consumers • Variation from use of best practice guidelines is monitored • Action is taken to reduce unwarranted variation • Incidents and complaints are reported, and timely action is taken to address these reports • The best possible care is provided at all times, based on the latest evidence
Applicable NSQHSS Standards	NSQHS Standards 1 and 5.
Strategies	• Clinical governance systems ensure best practice guidelines are used at all times • Guidelines are reviewed as per audit schedule • Audit program confirms application and use of best practice guidelines • Peer review program confirms application and use of best practice guidelines • Incidents and complaints are routinely monitored, and action is taken as required
Outcomes	• Treatment is in accordance with best practice guidelines
Measures of success	• Limited or minor unwarranted variation to best practice

Domain	Care is informed and improved by data
Consumer Sentiment	As a key stakeholder, I am provided with data that assists me to understand care outcomes at an individual and organisational level.
Components	• The collection and utilisation of key data, including consumer experience, incidents complaints and outcome data, supports the delivery of holistic consumer care, management of clinical risk and continuous improvement in care
Applicable Standards	NSQHS Standards 1, 2 and 5.
Strategies	• Clinical governance and partnering with consumer systems ensure data capture and monitoring systems meet best practice • Key performance indicators (KPIs) are developed and implemented to support data monitoring • Monitoring systems can detect unwarranted variation • Quality Improvement (QI) and risk systems support taking action on unwarranted variation • Benchmarking is used as part of QI and risk systems • Consumers are involved in how they would like communication on outcomes to be delivered/displayed (newsletters, web site etc.)
Outcomes	• Data supports treatment outcomes to meet best practice • Consumers are involved in developing communication systems for sharing data • Unwarranted variation is reduced/mitigated
Measures of success	• Limited or minor unwarranted variation to best practice • Consumer satisfaction with data information • Quality activities are aligned with data outcomes • Benchmarking meets or exceeds best practice

Domain	The environment in which care is considered
Consumer Sentiment	My care is safe. I need to feel safe in my home where care is delivered.
Components	• Providers ensure that risk assessments of the home environment are undertaken • Staff are screened for risk factors • Home modifications are considered and organised • Incidents and complaints are reported, and timely action is taken to address these reports
Applicable Standards	NSQHS Standards 1, 3 and 5.
Strategies	• Consumers are engaged in the risk assessment of their home environment • Routine environmental audits are undertaken • Referrals for home modifications are timely and appropriate • Monitoring of incidents and complaints routinely occurs
Outcomes	• Consumers feel safe
Measures of success	• Consumer satisfaction

Domain	Support for managing my health needs
Consumer Sentiment	My care is person-centred. I receive support and encouragement to participate in my care needs. I am aware that my life choices can impact on my wellbeing.
Components	• Individuals are supported to make positive lifestyle choices which promote health and prevent deterioration • The individual's supportive care needs (physical, psychological, social, cultural, informational, and spiritual) are assessed with appropriate referrals and management to promote optimal health and quality of life • Incidents and complaints are reported, and timely action is taken to address these reports • Consumers will be treated with respect and have easy and honest communication with the doctors, nurses and other health care professionals who are providing care • Consumers will be looked after by clinicians and staff who have the necessary clinical and other skills for the work that they do
Applicable Standards	NSQHS Standards 1, 5 and 6.
Strategies	• Support needs are identified on admission • Support needs are provided as part of the model of care • Social activities are organised • Support needs are reassessed when condition changes are detected or raised by the consumer • Multi-disciplinary team meetings consider support needs • Incidents and complaints are monitored and addressed in a timely manner
Outcomes	• Deterioration is avoided due to good lifestyle choices
Measures of success	• Avoidable hospital or residential care admissions

Domain	Workforce skills capacity and capability
Consumer Sentiment	My care is person-centred. I receive person centred care from staff who have the appropriate skills and qualifications.
Components	• Culture is aligned with vision, mission and values • Appointment processes ensure alignment with the vision, mission, and values of both organisations • Position descriptions outline roles, accountabilities, and responsibilities • Training and professional development programs are aligned to care, cultural and spiritual needs • Consumers are involved in training the clinical and support service workforce • Incidents and complaints are reported, and timely action is taken to address these reports • Consumers are well-supported and part of effective teams, and have access to the resources (including equipment and information) they need to do their work
Applicable Standards	NSQHS Standards 1 and 3 – 8.
Strategies	• Strategic Workforce Plans • Engagement of consumers in selection and recruitment processes • Training needs analysis is aligned to service requirements • Collaboration with training providers and colleges is in place • Using consumers to train the clinical and support workforce through use of lived experiences • Incidents and complaints are routinely monitored, and action is taken as required
Outcomes	• The workforce is trained and competent to deliver required services • The workforce demonstrates person centred care in all interactions with consumers and carers • The workforce is supported with professional development and other support needs

	• The consumer's lived experience informs training programs
Measures of success	• Staff attraction/retention ratio • Staff satisfaction • Consumer satisfaction

Signs of success

Evaluating effectiveness

Primary, secondary, and third-party providers should jointly evaluate the effectiveness of the framework as part of the quality and risk management program with reports to accountable authorities. This requires critical reflection of how the service is being managed and delivered such as described in Table 4.

Table 4: Evaluation criteria for effectiveness

Critical reflective questions	Evaluation criteria
Do we have a shared definition/understanding of success?	• Via the agreed shared care model of clinical governance
How effective are our organisational shared care governance systems in supporting our safe, effective, and person-centred goals for every consumer?	• Agreement evaluation • Committee evaluation • Consumer satisfaction surveys • Complaints • Incidents • Results of KPIs and Clinical Indicators
How do we know our shared care is safe and effective?	• Consumer satisfaction surveys • Consumer journey observation audits
How do we ensure the quality and safety of shared care?	• Through use of defined key performance indicators and use of relevant clinical indicators
Do we know what the red flags are?	• Use of agreed KPIs, clinical indicators, and benchmarking will enable flags to be detected
What must we do to increase the effectiveness of our shared care systems?	• Regular and routine monitoring of outcomes with a particular focus on unwarranted variation

How will we fix what we know is not working?	• Through use and application of quality and risk management principles via designated governance committees • Quality initiatives will be registered and evaluated to assess whether changes are effective
What needs to get done to improve the quality and safety of shared care?	• Audit, risk, and quality management systems will identify improvement opportunities
Do we have a 'just' culture to facilitate continuous improvement in quality and safety?	• Annual staff safety culture survey • Outcomes of accreditation assessment processes which focus on just cultures
What actions do we take as a group to ensure that intimidating and inappropriate behaviour is not tolerated?	• Recruitment and selection policies and procedures • Orientation program • Code of conduct • Staff development programs
What actions do we take to ensure consumers are empowered to meaningfully partner in their shared care and the organisational design of the service?	• Consumer Engagement Framework • Consumer representatives • Consumer satisfaction surveys include questions on partnering and shared decision making
Are we frequently evaluating the impact and extent of the consumer voice?	• Via consumer satisfaction surveys • Consumer journey observation audits • Complaint system
Do all staff feel supported to create consistently safe, person-centred, and effective care?	• Staff culture surveys • Attraction and retention KPIs
What must we do to increase support for staff?	• Staff culture surveys • Performance and professional development programs
Are our clinicians skilled, engaged and empowered to provide safe, high-quality, person-centred shared clinical care?	• Position descriptions outline requirements • Recruitment and selection processes • Onboarding and orientation programs

	• Performance and professional development programs
Are we achieving our purpose of providing a safe, person-centred, and effective experience for every consumer? What must we do to make more progress on achieving our purpose?	• Results of all data outcomes will verify safe, person-centred care is being achieved; where variation occurs, active action is taken to improve results
Where is the evidence that our consumers are better off?	• Results of KPIs and clinical indicators relating to: ○ Unplanned emergency transfers ○ Unplanned readmission to hospital ○ Quality of life indicators ○ Unexpected deaths

Internal organisational objectives

Organisational objectives of the primary care providers for a shared care model of clinical governance will demonstrate:

- Systems that are in place are best practice; and systems of shared governance support leaders, managers, and staff to deliver the required services and understand their safety and quality responsibilities.
- System risks for shared care are known and mitigated.
- Leaders partner with providers to evaluate the appropriateness of the shared care safety and quality systems.
- Improvements identified to strengthen culture, leadership, governance, workforce capability, consumer partnerships, safety and quality systems, and manage specific clinical risks are actioned monitored.

External Analysis

The Primary, secondary and third-party providers will meet externally mandated accreditation standards by an approved accreditation assessment provider. This requirement forms part of agreements for shared care.

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Contact:
Adj AProf Rebecca Haddock
Executive Director Knowedge Exchange
Australian Healthcare and Hospitals Association.
Email: rhaddock@ahha.asn.au

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AHHA acknowledge the Aboriginal and Torres Strait Islander peoples as Australia's First Nation Peoples and the Traditional Custodians of this land. We respect their continued connection to land and sea, country, kin, and community. AHHA also pays our respect to their Elders past, present, and emerging as the custodians of knowledge and lore.