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Leading in Health and Social Care

Leading in Health and Social Care

*Leadership concepts and practices to
strengthen health and social care
services*

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Recommended citation: Lloyd, S., Olley, R., Milligan, E., Aish, K., Barnes, A., Craig, J., Evans, J., Ferrier, J. A., Khalil, H., Lakhani, A., Long, K., McKenzie-Stewart, R., Murray, M., and Sequeira, A. R. (2023). *Leading in Health and Social Care*. Griffith University. <https://dx.doi.org/10.25904/6A38-4917>

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Acknowledgement

A practical text for strengthening and improving the delivery of services in health and social care

SHEREE LLOYD; RICHARD OLLEY; AND ELEANOR MILLIGAN

The editorial team, acknowledges and pays respect to the past, present and future Traditional Custodians and Elders of this nation and the continuation of cultural, spiritual and educational practices of Aboriginal and Torres Strait Islander peoples. We pay our respects to all First Nations peoples.

The editorial team would like to acknowledge the authors who contributed to the text, Kylie Morris of Written Proof editing services, Griffith University Library and all Griffith University Library staff involved in the project, Bonnie Dixon and participating universities. Professor Deborah Parker, University of Technology, Sydney for reading the text and providing the forward.

We would like to acknowledge the Council of Australian University Librarians (CAUL), the peak leadership organisation for university libraries in Australia and New Zealand for their support for projects such as ours.

Introduction

SHEREE LLOYD; ELEANOR MILLIGAN; AND RICHARD OLLEY

This comprehensive textbook captures best international practice and is focused on the practical needs of leaders in health and social care. The text includes chapters that address evolving and innovative practices in leadership, ethics, leading people and human resource management, cultural safety for First Nations peoples, innovation, digital health, finance and resource management, systems thinking, change, evaluation and safety and quality. As an open educational resource, leaders, managers, students, policymakers and all readers interested in improving healthcare systems can access the book. The choice to publish on an open platform demonstrates our commitment to building a strong, transparent, and connected community of practice for health service leaders across many disciplines and across the world. We hope this pragmatic and contemporary textbook will reach a broad audience with an interest in strengthening the discipline of health service leadership and building fit-for-purpose healthcare systems that meet the needs of the diverse communities we serve. To achieve this we want the text to be free and widely available. To achieve the United Nation's Sustainable Development Goals, health and quality education are key and this open educational resource (OER) is available for all to use to guide their practice and the strengthening of health and social care systems.

Our world faces many challenges and climate change poses an existential crisis and will impact the health of populations (IPCC, 2023). Leadership now more than ever is needed to make ethical decisions to reduce pollution, and waste and address ongoing inequities and access to health and social care services. Collaboration, partnerships and working

together to achieve outcomes is essential. The writing of this text is evidence of collaboration to achieve a common goal. From a drawing on an office white-board to the bringing together of academics and health leaders from across Australia, with a common vision to publish an open educational resource text book, as Editors we are grateful to the team of writers, Library and Editing professionals (who have never been in the same room together) to deliver the concept.

The structure of the chapters are similar and outline the importance of the topic, embed activities and reflections and provide insights, the latest evidence and key learnings on leadership, people in health and systems and governance. Please use the text in ways that best support you and your teams of health and social care professionals. For those studying health leadership and management, we believe that all chapters will be of interest, others may read those that are of interest and relevance to them. We welcome feedback on the text and please email sheree.lloyd@utas.edu.au with suggestions and comments.

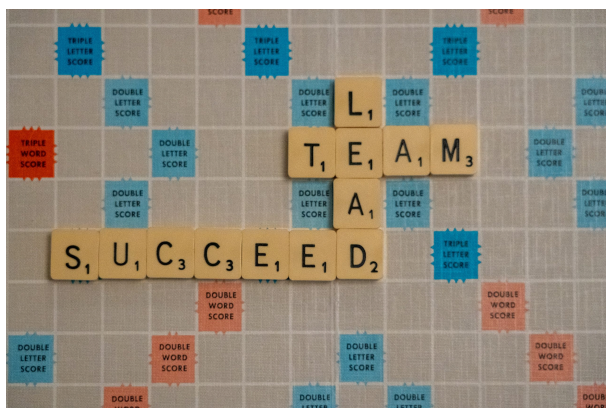
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PART I

LEADERSHIP



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This part covers the topics of ethics, leadership, cultural safety and safety and quality.

You will learn why ethics is important, the importance of culturally safe practices when delivering health and social care and the role of leadership and leader behaviours. Approaches to safety and quality are also included in this part of the text.

Politics, power, partnerships and governance

RICHARD OLLEY; ELEANOR MILLIGAN; AND SHEREE LLOYD

Introduction

The leadership of health and social care organisations is influenced by factors such as the prominence of health to societal well-being and the partnerships, priorities, politics and governance requirements that enable and constrain the delivery of services. Strong health and social care systems are critical to achieving good health, well-being and a prosperous society. Our world faces many challenges and climate change poses an existential crisis for humanity. Leading health and social care services through the current and future challenges will be complex and influenced by the responses from governments, corporations and industry. Priorities, politics, partnerships and governance requirements impact and constrain leaders. Leaders in the health and social care industry must be adept at working with and recognising the influence of power, politics, priorities and governance.

This text written by health service leaders, managers and academics from Australia provides insights, the latest evidence and key learnings on leadership, people in health and systems and governance. To understand the unique context, the text begins with this chapter, an overview of the priorities, political nuances

and governance that health and social care leaders negotiate to deliver services to communities across the world.

The political context of health and social care

Healthcare is inherently political, and often politicised. For example, recent experiences with the management of COVID-19 around the world highlighted stark differences in national government and public health approaches, demonstrating how deeply politics and healthcare are intertwined. Elections around the globe frequently see healthcare, its funding, its people, and its successes and failures co-opted for political ends. Ineffective but politically palatable or ideologically driven health goals are often pursued at the expense of evidence informed best practice.

In 2020-2021, spending on healthcare goods and services in Australia exceeded \$220 billion, representing 10.7 % of the GDP (Australian Institute of Health and Welfare, 2023). The USA and UK are currently estimated to spend \$4.3 trillion (19% GDP) (World Bank. 2023), and £283 billion (12.4% GDP), respectively (Office for National Statistics, 2022). Globally, over the past 20 years, GDP spending on health has escalated across the world from high to low-income countries, and now sits at around 11% worldwide (World Health Organization, 2023b). Ironically, high GDP spending does not automatically translate into better health outcomes, as demonstrated by the USA, where GDP health spending is almost 19% (World Bank, 2022), but where performance compared to spending is the lowest among high-income countries (Commonwealth Fund, 2021). In Australia, around 15% of our total workforce are employed in health-related jobs (Australian Bureau of Statistics, 2022). Universally,

these figures denote a significant investment by governments and the population through taxation and personal spending. They also reflect the high individual and collective value placed on ensuring good health as a foundation for a functional and flourishing society.

An obvious point is that while these social and financial capital amounts are large, healthcare inevitably operates in a resource constrained environment. There is always more money that could be spent, and more interventions that could be funded. Government budgets are finite, and health must (reasonably) compete with other government priorities, such as education, infrastructure, housing, and the environment. Every dollar spent on health is a dollar not spent on another collective priority or communal good, which is the basis of the economic term 'opportunity cost'. Within the healthcare budget itself, there is always competition for funding for services, which communities receive higher standards of care and access, and which innovation or drug will be subsidised. Compromise, advocacy, and negotiation are therefore an inherent part of leading, managing and funding a sustainable health service.

The inability to translate and implement key research findings into practice is a stubborn feature of healthcare, noting this as a "key failure", and concluding that "research transfer has become one of the highest priority areas for health services research" (Browman, Snider, and Ellis, 2003, p.10). This persistent failure to translate research into practical change highlights that knowledge alone is often not the key determinant of how practice evolves and improves. Collecting more data and analysing it to make a case for change is not sufficient alone. A political case for change must also be made, and the political will to implement it must be present. As a leader, the ability to identify the interests of all stakeholders, bring the relevant knowledge to the table, and find a mutually valuable path that benefits all stakeholders is a critical skill. Ideas, evi-

dence, and personal or organisational commitment are important, but alone are not sufficient.

As a healthcare leader in this competitive and resource constrained environment, understanding the politics and power dynamics behind how funding allocations, workforce allocations, and service choice decisions are made is critically important. Later in this chapter, you will learn about forming partnerships, engagement with key stakeholders, and developing shared priorities. Recognising and navigating the power and politics, learning how to best use your influence on impact, and how to harness the influence of others will be integral to the impact and success you can collectively achieve.

Power and Politics in Healthcare

Later in this book, in the Chapter Ethics in Healthcare Leadership – Knowing, Doing, Being and Becoming the text talks in more detail about understanding power in its multiple forms, used to build or to undermine. As an introductory concept, power can be simply thought of as the ability to cause or prevent change (Collins Online Dictionary, 2023). This chapter also provides more in-depth exploration of the use of power to nurture, compete, manipulate, exploit, and support.

A helpful working definition of politics in our context, is “the ways that power is shared in an organisation”, including how personal relationships are negotiated between people who work together (Bourne and Walker, 2005). Politics, and the gaining, sharing, and use of power determine the types of activities we engage in, and how we engage. Politics shapes the decisions we make, the way that resources are distributed, and how status is built and maintained across our organisations and networks.

At its core, health is a collective endeavour; hence, as a leader, you will need to identify the key stakeholders in any given situation. Bourne and Walker (2005, p.650) described stakeholders those “affected by a project and having moral (and perhaps non-negotiable) right to influence its outcome”. In health, stakeholders may include funders, politicians, clients, carers, clinicians, organisational leaders, community groups, interest groups, policy makers, educators, researchers, and others. Each of these groups will have varying degrees of interest, influence, and impact. They will also have differing power statuses within the context of the issue. There will also be differences in where the ultimate control or delegation over parts of the decision making, such as approval of funding or access to resources are held among stakeholders. As a leader, your role is to identify the interested parties, clarify their interest, ascertain their expectations, search for values alignment or common goals, identifying where the decision points are, where the authority to make key decisions lies – and ensuring you align these critical considerations. Exploring these basic questions up front will provide a clear platform from which to work, identifying synergies and lowering barriers at the outset.

Partnerships and Priorities in Health and Social Care

Providing effective and efficient health and social care relies on partnerships. These partnerships may be related to care provision, logistics, back-of-house and front-of-house functions, information technology and management, safety and security, planning, funding, and so forth. Thus, partnering in healthcare is essential for providing services to consumers and the health and social care workforce. Partners may be others who work within the health or social care sectors, non-government and government organisations, private sector organisations, or individuals. Effective partnering in health and social care is an important skill, and health leaders understand that many organisations do not have the economies of scale or size to

effectively and efficiently deliver all the services required to provide health and social care to consumers. Those who successfully lead in health and social care must have a deep understanding of the importance of partnerships and the priorities of health and social care that change over time, and that these may be related to advances in science and technology, government policies, political pressures, funding and quality and safety pursuits, and safety or quality failures.

The Australian Commission on Safety and Quality in Healthcare (2023 a) defined person-centred care as a system that “treats each person respectfully as an individual human being, and not just as a condition to be treated. It involves seeking out and understanding what is important to the patient, their families, carers, and support people, fostering trust, and establishing mutual respect. It also means sharing decisions and planning care together”. Much has been written about making equitable, safe, and quality healthcare available through the principles of person-centric care, often referred to as patient-centred care. While healthcare practitioners, healthcare organisations, and those who regulate healthcare systems aspire to implement a person-centred approach, the competing priorities inextricably tied to priorities, partnerships, and power relationships within healthcare can impede the attainment of such a worthy goal.

The evidence is as sound as it is prolific that person-centred care facilitates improvements in safety and quality of care (Rossiter, Levett-Jones, and Pich, 2020). In a systematic literature review, Sobolewska and colleagues (2020) found that person-centred care is well articulated approach in health policies. However, the lack of definitive measures or approaches is a barrier to embedding it into operational services, largely due to the competing priorities of governments and health organisations (Rossiter, Levett-Jones, and Pich., 2020) confounding its implementation (Sobolewska et al., 2020). Consumer and staff

satisfaction improvements also attest to the value of person-centred approaches (Huang et al., 2020; Kullberg et al., 2019; Larson et al., 2019; Vassbø et al., 2019a; Vassbø et al., 2019b). Moreover, the complex financial structures and ever present drive towards greater efficiencies and cost-effectiveness measures of health care make implementing patient-centred approaches difficult, other than paying lip service to a worthy concept (Pirhonen et al., 2020).

The systems and processes for the implementation and the sustainability of person-centred care currently in operation in the health and social care structures, coupled with the often competing priorities of governments and the health organisations, mean that healthcare organisations often lose the essence of person-centred care. Sobolewski and colleagues (2020) found three themes that emerged in the publications added to their systematic literature review:

1. the patient versus the government;
2. the health care delivery versus the political agenda; and
3. healthcare organisational processes versus the patient.

These themes assist in discussing priorities, partnerships and health and social care politics. However, before discussing priorities, some analysis of what partnering means in health and social care is necessary.

Partnering in Health and Social Care

A partnership is made between two or more people or organisations who agree to administer operations, share profits and liabilities and steward outcomes. These arrangements are usually formal in a business sense. However, informal relationships are also established to support and benefit consumers and

providers. Therefore, understanding the meaning and objectives of any partnering arrangements is important. This arrangement is often referred to as partnering. Partnering, in its simplest terms, refers to any agreement to have a relationship between people or organisations and may be entirely a verbal arrangement to work towards a shared goal.

In Australia, a 2019 report of a rapid review with an advisory group of various stakeholders from several state-based jurisdictions by Safer Care Victoria, launched the Partnering in Health Care Framework (Nelson et al. 2019). This framework strengthens approaches to person-centred care to empower healthcare consumers, carers, and family members to participate in healthcare. Nelson and colleagues (2019) led the writing of the rapid review, which is titled *Partnering in Strengthening Healthcare: opportunities for patients, carers, and family members to escalate care in Victorian health services* and contains important material relating to the evidence of patient, carer and family member participation in escalating concerns, barriers and enablers for effective escalation processes and evaluation, evidence, and learnings from the process. There are also compelling recommendations on the escalation procedures enabled by the partnering model. The framework is found [here](#).

A strategic contributor to establishing healthcare partnerships is ensuring that people feel as though they are heard when they raise concerns about the care delivered. It is important to understand the context in which this initiative was implemented. Implementation was driven by the National Safety and Quality Health Service Standards (2023 a) and calls for strengthening consumer partnerships with health services, specifically Standard 8 – Recognising and Responding to Acute Deterioration. This Standard is now a requirement for Australian health service accreditation. However, it is important to understand that these partnering arrangements may apply

to all standards. In Australia, the Aged Care Quality Standards (2021) also direct aged care providers toward partnering agreements with consumers in concert with the government's consumer-directed care policy. Globally, there is a push toward recognising the importance of person-centred care in the provision of care. Partnering is demonstrated to improve quality and practices with health and social care organisations (Clavel, Pomey, and Ghadiri 2019), identify and help solve ethical issues that emerge (Martineau, Minyaoui, and Boivin, 2020), and assist consumers and their families in understanding the elements of partnering and developing strategies and policies (Lasker, Weiss, and Miller, 2001).

Partnering may refer to consumers or their relatives or significant others in their life, or it may refer to arrangements between healthcare providers and other service providers. Partnering arrangements with consumers and their families may be implied or expressly stated in how the health and social care organisations engage with their consumers. Informal partnerships are not meant to infer that there is no legitimate relationship between the consumer and providers of care. The arrangements may well be covered in the scope of practice of the various health professions that provide care. They may be contained in other documents, such as the consent documents used by the healthcare organisation.

Partnering arrangements with other organisations usually require formal documents such as a contract or memorandum of understanding (MOU). Health and social care leaders must understand the differences between a contract and an MOU. A formal document may cover these arrangements, such as a MOU, which is not a written contract but is the expression of a document detailing a 'handshake agreement'. It documents the agreement in written form, outlining a framework or key terms that may be included in a written contract later. The agreement may be used to guide discussions and actions from

two parties who have agreed to work together and is a useful tool in helping all the parties to the MOU know the purpose of the relationship and generally what will be achieved by the association. In other words, it keeps all parties to the MOU on the same page and is a useful point of reference if any dissent arises.

It should be remembered that the document is generally not legally binding because it is labelled an MOU. However, if its content resembles a contract, it may be legally binding and enforceable. Before any partnering arrangement is implemented, the priorities of what the parties will achieve must be set out. Thus, an MOU is an agreement between the parties. However, it is not a contract, because it does not contain legally enforceable promises. For a contract to be valid, the parties to the contract must voluntarily respond to and accept an offer in a situation where they intend to create a legally binding agreement.

Priorities

Greater explanation, discussion, and analyses of the priorities are provided within the relevant chapters of this book. Therefore, they are not explored in any depth here, other than to provide evidence of their importance, and they are listed here as the origins of the priorities.

Priorities are very contextual for all health and social care enterprises; however, in thinking globally about this, when consulting the peer-reviewed and grey literature, four themes emerge for priority setting for health and social care service provision. There is no intention to suggest that the priorities listed under each theme are exhaustive. They are considered the most significant, have an evidence base, and represent the most challenging problems. It should also be noted that this section

focuses on the global priorities and issues that are, or have emerged. These priorities would be similar for all developed and developing countries.

The definition contained in an article classified as a Clinical Brief by the American Journal of Managed Care Services is a useful definition of value-based partnering (AMGEN, 2018). The publication asserts that “value-based partnering is the term that refers to two or more organisations sharing a mutually beneficial endeavour to deliver the highest value to the health system and society by focusing on improving consumer outcomes in the context of the system and the total cost to society” (AMGEN, 2018).

The four **priorities** are principally driven by the unrelenting increases in demand for healthcare and social care, as discussed below.

Priority 1: The health workforce

Workforce challenges in health and social care occur daily in most services, with the need for qualified and experienced clinicians and other highly qualified technical and leadership professionals as a global phenomenon. On their Health Topics/Health Workforce website, the World Health Organization (WHO) (2023c) describe the impact of the global shortage of healthcare workforce, they estimate a shortage of 10 million health professionals by 2025 and the governments of developed countries are committing significant funding to new horizons in healthcare such as digital transformation in the healthcare sector and this will largely go to salaries and wages. For example, in March 2022 the Federal Government of Australia announced an additional commitment of AUD 537 million over the next four years (Minister for Health and Aged Care

2022). Most clinical settings in health and social care face workforce challenges (Klimek et al., 2020). See also the part on People in Health and Social Care.

Priority 2: The mismatch between rising demand for health and social care and funding

The population of the world is ageing (Herwartz and Theilen, 2014, Littlejohns et al., 2019, Mitton and Dionne, 2020). This is a direct result of increasing life expectancy and declining fertility rates (Kendig, Lucas, and Anstey, 2013, Stewart Williams et al., 2020). This is particularly evident in developed countries because there is greater access to pharmaceuticals, technology, and clinical expertise. The ageing of the population coupled with an emerging consumerism in health and social care is increasing the demand and the complexity of health and social care which in turn increases the costs of delivery (Fifer, 2019; Fifer, 2020; Williams, 2020a; Williams, 2020b). Most developed countries (perhaps with the exclusion of the United States of America) are striving for equity and equality of health and social care access to improve population health outcomes (Robards et al., 2019).

Priority 3: Safety and quality of care and improving consumer outcomes

Safety and quality initiatives in health and social care reduce adverse outcomes of care, prevent unnecessary hospitalisations, provide for the development of safer health products and technologies, provide financial savings, improve efficiency and effectiveness of care, and improve the quality of life for health

and social care consumers. This is discussed in quite some detail in the Safety and Quality chapter of this book.

Measuring the safety of care and addressing the issues that emerge are well established in most developed countries. This includes evidence such as studies with positive outcomes for those with dementia (Grealish et al., 2019; Ho et al., 2021), indigenous consumer access to primary care (Brickley et al., 2023), cerebrovascular accident (Stevens et al., 2022), other chronic diseases that require ongoing management (Sobolewska et al., 2020), and psychoses (Richter et al., 2015). What many of the studies recommend is echoed by having the appropriate organisational culture to effect the necessary changes toward implementing person-centered care (Carlstrom and Ekman, 2012; Sobolewska et al., 2020). Most researchers have concluded that measuring the appropriateness of care and addressing the issues that emerge in a timely and effective way.

Priority 4: Urgent reforms for health and social care

The following issues are included in this priority:

- Governance of our health and social care systems: Governance is inextricably linked to leadership and is concerned with ensuring that strategic policies exist and are embedded within the system aimed at effective oversight of the systems, coalition or partnership building, regulatory compliance, and attention to system design and accountability (World Health Organization, 2023a). There is a well-recognised need for better systems of governance. This is particularly so in the social care sector, which also requires an emphasis on care governance that looks at social indicators such as social isolation, mood and happiness mea-

tures, and those clinical indicators that are care related.

- The inadequacies of health and social care funding: There is also an urgent need to address the inadequacies of health and social care funding systems. This is addressed in some detail in the Governance and financial management in health and social care chapter of this book, and it is explained further there. The purpose of mentioning it in this chapter is to highlight the urgency with which this is needed. A weight of evidence calls for significant and transformative strategies needed in all areas of healthcare, particularly in the areas of aged care, mental health care, palliative care, emergency care, digital healthcare, to name several.
- Funding of clinical and health and social care research: There are two significant areas to cover when discussing research in health and social care; clinical research and health policy and systems research. Both areas require a significant investment of funding to prepare our health and social care systems for the future.
- Clinical and health disciplines research: Clinical research refers to research in which people, or data or tissue samples, are studied to understand health and disease (National Cancer Institute, 2023); thus, helping to find new and better ways to detect, diagnose, treat, and prevent disease.
- Health policy, systems, and services research: This is a neglected area in global health financing and there has been little growth in investment in this type of research for an extended time, with approximately 2% of all global health funding outcomes including an identifiable health policy, systems and services research component globally (Kentikelenis et al., 2023). This type of research has high value to society, providing important information about disease trends, risk factors for ill health and disease, treatment outcomes, patterns of care, outcomes of treatment

interventions and, of course, health care costs. Health and social care leaders must firstly recognise the importance of this type of research and allocate secure funding to grow it.

Digital health and the application of artificial intelligence (AI)

Digital health offers significant benefits to health and social care, and it is transformational in the ways that consumers and health and social care professionals interact. These benefits include the obvious ones of health information storage and sharing that information among those who work with consumers and, of course, consumers themselves. Digital technologies are modifying almost every aspect of contemporary life, and health and social care is a significant part of that transformative change, including:

- providing connectivity between health and social care professionals and the consumer;
- versatile working for health and social care professionals;
- the creation of learning opportunities;
- diagnostic tools and decision support;
- workflow automation; and
- information storage.

The barriers to implementation of digital health strategies in health and social care are areas that health and social care leaders must deal with, including:

- Access to technology: While health and social care are undergoing major digital transformations, a major barrier to the uptake of the benefits is consumers' access to plat-

forms and technologies (Lazarus et al., 2019). Dahlhausen et al. (2022) researched this phenomenon by exploring healthcare stakeholders' roles and potential to foster consumer access in qualitative research that found, among other things, that healthcare professionals had the greatest potential to promote access and consumer adherence to digital therapeutics and that health insurers, pharmaceutical companies, and consumers need to take action to improve patient access and adherence to digital therapeutics assisted by several macro-level changes to support access, such as including broader information dissemination, improved financial incentives, simplified prescription and activation processes, and a wider adoption of blended care and pay-for-performance payment models.

- Digital literacy of health and social care professionals and consumers: This is one of the most significant barriers to a successful digital transformation and one that was investigated in a Spanish study of 1624 health professionals by Navarro-Martínez, Igual-García, and Traver-Salcedo (2023), who found that while medical practitioners had significantly more training than other health disciplines, there was insufficient training in digital literacy for health professionals and that only 20% of nurses surveyed had received some training from their healthcare employers that related to healthcare technology. Another study Busse and colleagues (2022) examined approaches to improving digital health literacy that support a focus on digital health literacy for all health professionals to improve competency in the digital health space.
- Change management proficiency: For the inevitable systematic changes that must occur in the health and social care workspace, change management proficiency is of vital importance for a successful digital transformation (Scott, Sullivan, and Staib, 2019). The health and social care sectors are undergoing a major transformation toward

digital health technologies that assist with easing the challenges for healthcare professionals and provider organisations. Specialist leadership for successful implementation must include change management skills and the ability to navigate an increasingly complex health and social care ecosystem (Nilsen et al., 2019).

- Privacy and information security: The integration of advanced digital health and associated technologies is transformative for the health and social care sectors. There is considerable evidence that these transformative changes have resulted in considerable improvements in the efficiency and effectiveness of healthcare and related services (Eastwood, 2019). However, this integration has fostered the emergence of a new set of challenges for consumers, healthcare professionals and providers, and suppliers of the adopted technologies. This makes for a difficult time for the health and social care sectors, because as we have seen in many data breaches such as the Singapore Health breach, Medibank Private data breach, and most recently, a breach in the implementation of digital systems in the Northern Territory of Australia, health and social care organisations are a significant target for hackers and cybercriminals, potentially compromising private and confidential healthcare data and placing the safety and health of patients at risk.
- The rapid emergence of digital health, including the application of artificial intelligence: Health and social care are experiencing rapid change largely driven by technology, along with the growth in digital health solutions and fast technological solutions that will redefine the nature of work and the nature of research in the field of artificial intelligence. These advances are related to wearables and mobile health that will increasingly be used to collect real time and real-world data for potential use as evidence supporting clinical decisions.

We are currently observing new artificial intelligence (AI) and digital health solutions that require sensitive regulation, which is certainly on the horizon in most developed countries (Chen and Decary, 2020). Decision-support systems will be revolutionised to use AI as a solution to support health professionals' decision-making and robotics will continue to evolve (Amann et al., 2022). Digital diagnostics and digital therapeutic medical devices have also emerged as an exciting opportunity to innovate in the provision of healthcare, but require careful planning related to equity of access, funding, and costs (Grosserueschkamp et al., 2021; Sorace, 2020; Noorbakhsh-Sabet et al., 2019). The enhanced use of AI raises new questions about tort liability and risk mitigation (Chamberlain, 2022). See Innovation and performance in health and social care organisations and Leading innovation in healthcare through digital health technologies chapters.

Governance

Health funding is a valuable and often scarce resource and strong stewardship and governance implicit to maximising benefits from health spend and investment. Governance and governance frameworks provide the systems, policies, and procedures by which an organisation is controlled and operates, and the mechanisms for holding the organisation and its people to account (Governance Institute of Australia, 2023). Governance is identified as an area of reform for the health and social care systems nationally and internationally. Governance systems, provide the frameworks describing who has the authority to act on the behalf of the organisation, and to identify who can make decisions and who is accountable for organisational performance and the delivery of services (Chartered Governance Institute). Governance frameworks enable lead-

ers and managers to run the organisation and meet the needs of the broader community and stakeholders (Chartered Governance Institute).

In health and social care, a strong governance framework should cover finance, human resources, information technology, and management and clinical operations. Governance has four key components, as explained in the table below.

Table 1: Created with reference to the key components of governance (Governance Institute of Australia, 2023)

Transparency	Open and clear details about the organisation's structure, operations, and performance, both externally and internally, including establishing a genuine dialogue with stakeholders and the community.
Accountability	Clarity of decision-making within the organisation. Mechanisms that ensure that the right people have the authority for the organisation and to support efficient and effective decision making. Appropriate consequences must be put in place for failures to follow the stated processes.
Stewardship	Maintaining and developing an enterprise-wide recognition that the organisation is managed for the benefit of its stakeholders, the community, and to take account of the interests of funders, staff, and consumers.
Integrity	Developing and providing a culture committed to ethical behaviour and compliance with legislation, policy and law.

Governance structures and systems

Most health and social care organisations take a structured approach to governance, with the Board or senior leaders responsible and accountable for governance. Governance structures include regular meetings with agendas, minutes, and reporting to discuss compliance, finance, risk, opportu-

nities, accountability, and emerging issues. Governance structures, for example, Boards, should ensure diverse representation and involvement of individuals with the right skills and knowledge. Importantly, to be effective, structures and systems should be responsive to emerging needs.

Governance frameworks and systems will be unique to each organisation and are informed by legislative, credentialling, service agreements, and other needs and constraints. These frameworks guide organisations to do the right things and take responsibility for the decisions and actions taken. Governance frameworks assist organisations to comply with financial reporting and other requirements – see Governance and financial management in health and social care chapter. Ethical approaches are an integral component of governance and are addressed more fully in the Ethics in Healthcare Leadership – Knowing, Doing, Being and Becoming chapter.

Risk management is an important element of governance systems. It involves a proactive and ongoing approach to the identification, remediation, and minimisation of risks to all aspects of a health and social care organisation. All individuals and organisations confront risks and their impacts. Risk awareness involves recognising the potential for incidents, hazards, and damages that occur within the health and social care environment that can result in harm to the workforce, the public, visitors, patients, and health and social care consumers. Risk awareness and management apply to financial management, decision making, and information assets (Woodward, 2010). Understanding risks and being aware of their impacts can assist individuals and organisations to prevent errors, reduce waste, and avoid harm to the workforce, patients, and all who interact with health and social care organisations (Woodward, 2010).

Activity

Watch this short video that explains risk awareness and reflect on risks to your organisation. How can risks be minimised and managed in your organisation?



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://oer-collective.caul.edu.au/leading-in-health-and-social-care/?p=948#oembed-1>

What is Risk Management ? (Governance Institute)
video sourced from Youtube <https://youtu.be/TcK-oUe8vRE0>

What does a governance structure look like?

Governance frameworks and systems will be unique to each organisation and informed by legislative, credentialling, service agreements, and other constraints. In health and social care, a wide range of services (clinical and non-clinical) are provided. A

robust governance structure will include the elements of corporate, environmental, social, and clinical governance.

Environmental, corporate and social governance

Corporate governance defines the processes through which a company or health and social care organisation sets goals and objectives and pursues these within the regulatory and funding constraints to achieve agreed organisational goals and objectives. While the focus between profit driven companies and not-for-profit and government run organisations might differ, the central tenants of accountability, transparency and responsibility remain the same. Corporate governance provides stewardship, transparency and accountability over people, finances, physical and information assets. Environmental and social governance refers to how health and social care organisations operate with respect to the planet and its people. In countries, such as Australia, the United Kingdom, Europe, and the United States this broader perspective of governance is included in governance frameworks. It would be remiss to speak about governance and the optimisation of health system performance without reference to the Quadruple Aims of enhancing patient experience, improving population health, reducing costs, and improving the work life of those who deliver care (Arnetz et al., 2020; Bodenheimer and Sinsky, 2014; Sikka, Morath, and Leape, 2015). Similarly, the Sustainable Development Goals 2023 Report (United Nations, 2023, p. 38) describes a need for “increased finance, political commitment, coordinated policies, international cooperation, ecosystem stewardship and inclusive governance are all urgently needed for effective and equitable climate action”. Climate change, equality issues, discrimination, and other major social and envi-

ronmental concerns are major challenges for the world. There is now growing recognition that these challenges are the responsibility of companies and governments. Sustainable practices, waste reduction, human rights, the environment, and climate change should be included as part of governance and the responsibility of leaders and Boards of Directors.

Clinical governance

Clinical governance is an area of interest to all health and social care organisations. Clinical governance has a long history, with Scully and Donaldson (1998 p. 1) noting that “clinical governance is a system through which National Health Service (NHS) organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish”. In Australia, clinical governance is defined as the set of relationships and responsibilities established by a health service organisation between its state or territory department of health, governing body, executive, workforce, patients, consumers, and other stakeholders to ensure good clinical outcomes (Australian Commission on Safety and Quality in Healthcare, 2023a).

Many developed countries globally have similar publications to Australia, which has a National Clinical Governance Framework that is underpinned by the National Safety and Quality Health Service (NSQHS) Standards (NSQHS, 2023), in particular the clinical governance standard. The National Australian Clinical Governance Framework includes the following components:

1. governance, leadership, and culture;
2. patient safety and quality improvement systems;

3. clinical performance and effectiveness;
4. safe environment for the delivery of care; and
5. partnering with consumers (Australian Commission on Safety and Quality, 2023b).

These components recognise that governance requires leadership and a 'no blame' culture, where mistakes can be openly discussed, and harm minimised. Clinical governance involves safety and quality improvement systems that proactively manage risks and identify opportunities for enhancement on a continuous basis (Scully and Donaldson, 1998). Effective clinical and other practices based on evidence, resources to deliver care (people, finances, and physical buildings) are the foundations of a well performing health and social care system – see the part of the Text on People and chapter on Governance and financial management. Safe environments protect consumers and the workforce from injury and recognise that a range of approaches are required to prevent exposure to harmful chemicals, pathogens, abuse, or other physical risks.

First Nations people suffer disadvantage and delays to care due to unconscious bias, intergenerational trauma, colonisation and cultural differences – see the Cultural Safety and Awareness Frameworks in Health and Social Care: Whose Cultural Safety?. Leaders play a role in creating safe environments for First Nations people through adopting cultural safety considerations and working with First Nations community leaders and communities to deliver culturally appropriate care and the Cultural Safety and Awareness Frameworks in Health and Social Care: Whose Cultural Safety? chapter describes this in depth. Finally, working with the consumers of health and social care services and identifying how to deliver care that is safe, appropriate, effective, and sustainable is key to clinical governance. See Safety and Quality in Healthcare, Cultural Safety and Awareness Frameworks in Health and Social Care: Whose Cultural Safety? and Leading a Healthy Workforce chapters.

Research governance

This refers to the processes used by health and social care organisations to conduct research according to ethical principles. Research governance processes include approval for research, and ensuring that any research conducted complies with regulations, legislation, and codes of practice, establishes intellectual property ownership, risk and financial management and reporting requirements (National Health and Medical Research Council, 2011)

Key Takeaways

Strong health and social care sectors are important for the well-being and economic growth in our societies. In this chapter, we introduced the tensions of power and politics, the partnerships and future priorities facing health and social care leaders, and the role of governance. Leaders must develop skills to understand these tensions, recognise the need for partnerships to successfully deliver health and social care services, and work within governance frameworks to deliver safe, high-quality care that meets the needs of the community at a sustainable and realistic cost.

This introduction sets the scene for the text written by health service leaders, managers and academics from Australia providing insights, the latest evidence, key

learnings, guidance, and inspiration for all leaders in health and social care systems.

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Ethics in Healthcare Leadership - Knowing, Doing, Being and Becoming

ELEANOR MILLIGAN

Introduction

Why do Ethics Matter in Healthcare Leadership?

Ethics matter because, in health and social care, we strive for the most human of endeavours, which is to care for other human beings. Mostly, those 'others' we care for are strangers, many of whom may be experiencing highly fraught, bewildering, distressing, and vulnerable times in their lives when injury, illness, or disease become an inescapable reality. Healthcare is an 'ethically laden practice' (Gastmans, 2001). It requires professionals to care for others and their significant others, in the physical and human sense, at times of personal fragility and disempowerment. Healthcare therefore happens within a moral relationship between the carer and the cared for. In providing care, we act to minimise harm, to bring good, to respect, to advocate, to preserve dignity, and to reassure. Care is the very heart of health and social care, and ethics can help us understand how best to care, to understand why we value the

things we do, why we can sometimes disagree on fundamental questions such as whose interests will prevail when there is conflict, or what values we will prioritise if there is disagreement. We need to turn our minds to these questions if we are to achieve shared respect and understanding when decisions are to be made. While technical clinical, operational, and managerial skills are essential, leading in health and social care is an ethically laden practice – one that requires you as a leader to bring a practical and ingrained ethical way of knowing, doing, being, and becoming to every aspect of yourself. So, what does that mean in practice?

What is Ethics?

Ethics is a term that means different things to different people; yet, as a word, we often use it as though there was a clear and agreed understanding of what we collectively mean. According to Beauchamp and Childress (2001, p.1), ethics is best understood as a “generic term for various ways of understanding and examining moral life”. Within these ‘various ways’ there are many conflicting and competing accounts of ‘ethics’ based on different starting presumptions, offering differing explanations of what ethics is, how it ought to be practised, and what its purpose and potential is. Clearly, our starting presumptions, expectations, and understandings of ethics shape how we attempt to ‘do’ ethics; yet, as Isaacs notes, (Isaacs, 2003, p.3) we rarely stop to settle on a shared understanding of what ethics means – to acknowledge it is not simply categorised as one way of thinking, but rather requires us to incorporate multiple (sometimes competing) perspectives and foundational assumptions.

Activity

Write a short paragraph (100 words or less) to describe what ethics means to you.

Within the multiple definitions of what ethics is, the understanding that most dominates the health literature is that of a theory centred, knowledge based, abstract, and generalisable application of moral principles. Such principles, or theories, are held as points of reflection and guidance when considering 'cases' that present an ethical dilemma or quandary (Beauchamp and Childress, 2001). Such principles and theories can be applied to reveal a consistent, considered, and rational response to the ethical question 'What should I do'? Drawing on analysis of multiple ethical theories, Beauchamp and Childress (2001) famously developed and promoted the Four Principles approach (principlist ethics), supporting ethical decision making through consideration of four equal principles or lenses: 1) autonomy, 2) justice, 3) beneficence, and 4) non-maleficence. While this approach to ethical deliberation and decision making has gained traction in healthcare, there are significant deficits in this approach, and many critiques have been made of this model:

First, this approach implies that moral knowledge and abstract truth can be known absolutely. Critiques of principlism often centre on the need to reduce the multifaceted and complex realities of ethical situations and engagement to the sterile prescriptions of what Caplan (1982, p.8) described as "moral engineering", further claiming that the resolution of complex moral issues "demands more than the ability to marry moral theory with the facts" (Caplan, 1982, p.2). Hence, the pitting of

one principle against another or overlaying moral theories and principles onto indisputable 'facts' to reveal a generalisable moral truth may lead to superficial or detached analysis and prevent us from reaching the human core of our ethical decision making.

Second, the positioning of ethics as detached intellectual and scholarly inquiry may further segregate ethics as yet another expert specialty, beyond the grasp of executives, clinicians, or patients who may lack the analytical skills or philosophical language deemed necessary to contribute to such specialised discussions (Komesaroff, 1995; Pellegrino, 2003). In an era where the worth of collaborative decision making between practitioner and patient is accepted best practice and promoting 'patient-centred' practices permeate policy and funding models, perpetuating the separation of ethics as another 'expert outsider' activity is ultimately unhelpful for all stakeholders negotiating real, embedded, and emotion charged ethical decisions in health care.

Finally, this familiar approach to ethics has distracted from the 'micro-ethical' concerns of the everyday (Komesaroff, 1995). While big 'headliner ethical quandaries', complex moral dilemmas, and principled debates can hit the headlines, it is arguably the day-to-day, almost unnoticed, 'micro-ethical' moments and interactions that most create and reveal the true moral climate and culture of our organisations, where every action, every day, builds or undermines ethical culture (Winch, Milligan, and Rolley, 2015).

Pellegrino (2003, p10) noted that, "Medicine, being simultaneously the scientific and humanistic study of man, cannot escape being based in an explicit or implicit philosophy of human nature". Ultimately, the health condition is embedded

in the human condition; hence, the human condition must be understood first, with the medical condition and the organisation and delivery of care also framing the fuller picture. Ethical conversations and deliberations must therefore begin and end, embedded in context, negotiated in relationships, and approached in a way that enables the moral perspectives of all those impacted to be an integral part of our shared considerations (Beauchamp and Childress, 1999; Pullman, Bethune, and Duke, 2005; Walker, 1993).

With these opening points in mind, this chapter takes an ontologically (being) centred approach to ethics that defines the ethical as situated within relationships and society, acknowledging the subjective and engaged nature of our lived experiences, and accepting that, while we seek shared meanings, the moral meaning and interpretation of each situation must accommodate each stakeholder's subjectivity. Adopting this orientation to ethics will equip us to see multiple perspectives, to see the people receiving our 'care' through their lived experience and create strong ethical organisations and cultures that grow and lift our staff, while respecting and caring for our clients. This chapter will help leaders to develop a comprehensive, practical, and compassionate approach to leading ethically through focusing on three fundamental building blocks of practical ethics and leadership:

- care (Illness, vulnerability, and dependency),
- trust (and trustworthiness),
- power (and relationships).

Care – Illness, Vulnerability, Dependency

The term 'care' is ubiquitous in health, and, like the term ethics, has multiple layers of meaning. Care can describe a 'something', a noun – as in the activities of care; for example, clinical interventions, medications, surgeries, assistance with activities of daily living and so on. But care is also a verb – to care – to have a disposition, which Edwards (2009) explained as, "an orientation from which one is prompted to develop adequate responses to moral problems and to the moral dimension of experience". The precursor to 'caring' is that we must first value, and then take responsibility for, the outcome such care seeks to promote. Within the health and social care domains, our training, resources, and organisations are all directed towards the wellbeing of those in our care. We can care for, care about, give care, receive care, and be caring or careless. When there is no cure, we can still care, and it is this disposition to care, and the small and large actions that demonstrate it, that leave the deepest impressions on those for whom we care.

Our system of organised healthcare, and the vast array of people, resources, and skills required to deliver it, is set up to attend to the needs of people at times of illness/injury/disease and vulnerability in their lives. As a foundational understanding, health and social care leaders must appreciate the lived experience of illness, injury and disease, of needing care, and how this significantly disrupts and shape one's sense of self on multiple levels. Attention to these fundamental human realities shapes the context of the care required, and how best to deliver it.

Ill health impacts:

- Our physicality and environment. The physical impact of illness can impact our agency and autonomy. Tasks that

once came easily may now require additional time and effort, or in some cases, may no longer be achievable at all, with or without assistance. Walking distances that once felt close may now feel far. For those receiving care in organisations, the loss of autonomy over simple daily tasks such as eating, showering, or having visitors can feel diminishing.

- Our notions of time. Once busy lives can become a series of 'waitings'; waiting for results, waiting for clinicians, waiting for a bed, waiting to be discharged, waiting for the next appointment. In addition, confronting one's own mortality, the emotional reality of time viewed through the lens of 'life years ahead' versus 'life years past' can be sobering, with deep psychological impacts.
- Our social and cultural connections. A person's social world contracts during illness – often usurped by appointments based on others' timetables. Once valued social activities and connections can dwindle, and the additional effort required to keep connecting can feel overwhelming, leading to social withdrawal, as Toombs (1999) noted, "When ceaseless and ongoing effort is required to perform the simplest of tasks (getting out of bed, dressing etc) there is a powerful impulse to withdraw, to cease doing what is required. The person with a disability is tempted to severely curtail involvements in the world".
- Our language. Illness brings a whole new language to learn. The language used can be excluding through the use of jargon or it can be disrespectful (e.g., the personality disorder in bed 10). Importantly – language is not neutral – it can overtly and subtly convey what 'really' matters. However, language has the power to connect and mediate shared understandings; hence, must be chosen carefully.
- Our spirituality. A person's illness experience can deeply impact their particular sense of spirituality, and space must be made for consideration of this important aspect

of wellbeing, alongside clinical or scientific priorities.

The multiple disruptions of illness create an inevitable vulnerability; hence, an inescapable dependency on others (Dodds, 2014). Hoffmaster (2006, p43) further summed this point up, saying, “Human beingsbecause they have bodies, are vulnerable.....it is our very vulnerability that creates the need for morality”. Our embodied human existence inescapably creates the need for care by others, in the moral context of healthcare, the ‘ethically laden practice’. To be an effective leader, you will need a deep appreciation of the moral disruption of illness to attend to “the global sense of disorder that permeates the patient’s everyday life” (Toombs 2001). This is our leadership challenge. As discussed earlier, “human being and becoming is always at risk and our ability to deal with such misfortunes, cope with them and recover from them usually depends on the support and care provided by others” (Isaacs, 2003).

Our further challenge in health is to see beyond the disease, to consider Arthur Kleinman’s (1989, p.4-5) view, “When I use the terms illness....., I shall mean something fundamentally different from what I mean when I write disease. By invoking the term illness, I mean to conjure up the innately human experience of symptoms and suffering. Illness refers to how the sick person and the members of the family or wider social network perceive, live with and respond to symptoms and disability.....Disease is what the practitioner creates in the recasting of illness in terms of theories of disorder. Disease is what practitioners have been trained to see, through the theoretical lenses of their particular form of practice”. Our moral obligation in leading ethically is to always see the person, to be alert to the lived human experience, and to care.

Activity

In the context of healthcare, write 100 words on what 'care' means to you personally.

As a leader, list the behaviours that you model to colleagues and clients to demonstrate that you 'care'.

As a leader, identify what features of your organisation demonstrate that you have created a 'culture of care'.

Trust and Trustworthiness

"Whatever matters to human beings, trust is the atmosphere in which it thrives."

(Bok, 1978, cited by Baier 1986).

In the previous section, we considered the impact of illness, injury, and disease, the inescapable vulnerability and dependency this creates, and the need to rely on others to respond with care. Dependency and vulnerability inevitably then raise the issue of trust. Baier (1986, p1) explained, "to trust is to accept vulnerability to another's will. In trusting someone you put yourself in their power to some extent, and in doing so, risk being harmed if they do not take seriously the ethical demands of having that power." O'Neill (2018) further explained that when we trust, we become susceptible to being let down, betrayed, or dismissed. In the context of healthcare, the stakes could not be higher, as we must rely on others to access spe-

cialist knowledge and resources when our wellbeing, and ultimately, our lives, depend on others taking the gravity of this ethical obligation seriously. As O'Neill (2018) pointed out, trust is only valuable "when placed in trustworthy agents and activities, but damaging or costly when (mis)placed in untrustworthy agents and activitiesto place and refuse trust intelligently we must link trust to trustworthiness, and must focus on evidence of honesty, competence and reliability."

By entrusting healthcare providers to care for our health and wellbeing, patients and clients must trust the providers of such care to use their expertise and discretion to make judgments that ensure the best outcomes for each individual. This dynamic, situated in the unequal relationship between those needing care and those providing it, lies at the heart of health and social care (Mackenzie, 2020).

So, what do trust and trustworthiness look like in healthcare? While there are disagreements about the exact nature or definition of trust (Khodyakov, 2016), trustworthiness generally encapsulates multiple components, including acting with honesty, competence, and reliability (O'Neill 2018). An attitude of goodwill towards the other engendering loyalty, faith, and confidence are additional elements discussed in the literature (Baghramian, 2020).

Trust is built on an individual and institutional level within relationships (Ward, 2017). As health and social care occurs in teams, interprofessional trust is critical to highly functioning teams. The positive impact on patient/client outcomes in contexts of high trust in clinicians, service providers and healthcare institutions is well documented (Birkhauer et al 2017; Ward, 2017, Sifaki-Pistolla et al., 2020). Ultimately, when distrust arises, people are less likely to engage in their healthcare or to follow advice, and therefore have worse health outcomes (Ward 2017). As a leader, your attention to nurturing the ongoing and

dynamic process of building trust at individual and institutional levels, to being individually and organisationally trust-worthy, is one that delivers great dividends to all, as “without trust, relationships and the organisations that depend on them will fail. Thus, when the elements of leadership and care provision are distilled, building trust is the critical precursor to effective relationships and the benefits” this brings to care recipients” (Olley et al, 2021).

Reflection

In your leadership, how do you convey trustworthiness (Honesty, Competence and Reliability).

- To your clients and patients?
- To your TEAM?

How do you promote trust building between interprofessional teams in your organisation?

Power and Relationships

Vulnerability creates dependency, which creates the need to trust in others. Our need to trust demands those caring for us to be trustworthy, as noted. Dependency and vulnerability then inevitably create a power imbalance between carers and those being cared for. As care occurs in relationships with individuals and institutions, the final important ethical lens considered in

this chapter is that of power, and the ethical use of power to promote care and trustworthiness within such relationships.

It is relevant here to briefly think about sources of power, particularly in the health care context. Much has been written about legitimate and illegitimate sources of power, including reward, and coercive, legitimate, expert, and referent powers. In health, perhaps the most important framing of sources of power are best described as 'expert power', where there is a knowledge gap between the client and the health provider, and the less knowledgeable person is in a highly dependent position; and 'legitimate power', where a person's position of authority allows them control and privileged access that can support or hinder the less powerful person (Camm 2013).

In his seminal text, *Power and Innocence*, Rollo May (1976, p100) talked about the use of this power and defined power as "the ability to cause or prevent change" to people or situations. May defined five ways that power is exercised that can be beneficial or harmful:

- **Competitive power** – power against. In health, this could manifest as competing for limited resources (personnel, equipment, funding, etc) in a win-lose scenario. The more powerful actor gains the benefit, the less powerful misses out. However, May (1976) also flagged the positive use of competitive power as a way of spurring each other on to continuous improvement, where practice improvements are shared and celebrated.
- **Manipulative power** – power over another person. In health, this could manifest as the delaying of access to treatment by the powerful actor, until behavioural change of the patient is achieved (e.g. no operation until smoking ceases). While the reason for such a delay to ensure the best clinical outcome is based in care, the manipulative power exerted can breed resentment and disengage-

ment.

- **Exploitative power** – power with force and coercion. An example of exploitative power in health could be the misuse of a position of authority/privilege to recommend interventions with limited evidence of success for the financial benefit of a service/clinician rather than the interest of the client/patient. Within healthcare teams, exploitative power could manifest as blocking a colleague's career or withholding of development opportunities.
- **Nutrient power** – power for another, arising from concern and care. In health, nutrient power could include partnering with clients to support them in achieving health goals, for example, diabetes education and support programs. The client does the work, with the encouragement and sharing of expert knowledge to foster success. Organisationally, nutrient power could manifest as intentional mentoring and development of staff to reach their own career potential while contributing to the organisation's needs.
- **Integrative power** – power with another. Examples in health could include multi-disciplinary teams, each bringing the best of their expertise to solve a shared problem or reach a shared goal. Multiple forms of power may be present in any given interaction, with harmful and beneficial forms of each type of power present. Your role as leader is to create positive change and prevent harmful change. Power and power imbalances are present in all aspects of life, but particularly so in healthcare. In the context of illness and vulnerability, such imbalances create strong moral obligations on those holding the power to exercise it thoughtfully, to cause or prevent change for the collective and individual good.

Poorly managed or understood power imbalances have been

shown to have significant detrimental effects on patient outcomes, including discomfort in 'speaking up' when things seem wrong, unwillingness to ask questions, and the acceptance of a passive role even when concerns are held (Joseph-Williams et al., 2014a and b). Some research notes that when doctors become patients, they also succumb to passive compliance in face of the power imbalance they now experience as a patient, concluding that knowledge alone is not sufficient to overcome the impact of the power imbalance that exists in the clinical encounter (Tomlinson, 2014). Hence, the misuse of power in organisational settings can have a pernicious effect on culture, which ultimately erodes patient and client care, undermines staff, and destroys community trust in health and social care services we are collectively invested in and reliant upon.

Key Takeaways

In this chapter, we have brought together three key ethical dimensions of leading in health and social with attention to:

- Care: Healthcare occurs in a context of vulnerability and dependency of others experiencing illness. This creates the call to care.
- Trust: With attention to trust and trustworthiness.
- Power: The ethical use of power to strengthen relationships and seek good in delivering health care.

The people-centred and fast-moving work of health

and social care leaders requires a people-centred, relationship-based understanding of ethics, rather than a theory or principles-based approach. Healthcare is delivered in a complex environment demanding an understanding of the vulnerability inherent in experiences of illness/injury/disease, of the power imbalances such vulnerability creates, of the need to understand the various types of power, and how to positively harness this power. The centrality of trust and trustworthiness and the appreciation that ethics informs every interaction, small and big, every day, the micro-ethical that shape and strengthen our organisations culture (Komesaroff, 1995), all form the basis of ethical leadership.

Ultimately, all of these aspects of ethical leadership will require you to engage in deep self-reflection, to know your own values and motivations, and to reflect on the values alignment with your organisation, staff, clients, patients, and other stakeholders/colleagues that you interact with in the course of your work. What kind of leader will you be and become? In finishing this chapter, you are invited to complete this final reflection to answer this final question.

Reflection

When you think about the three elements of **care, trust, and power** together:

- What insights resonate with you?
- What behaviours will you continue or change to reflect these insights?
- How will you check-in on yourself, your colleagues, and your clients to ensure you are living and modelling authentic and ethical leadership?

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The Theories of Leadership

RICHARD OLLEY

Introduction

Leadership theories have abounded since the first leadership theory was published by a historian, Thomas Carlyle, in 1840. Carlyle believed that “the history of the world is the biography of great men”; hence, the central position of this theory suggests that some people (e.g., men) are born to lead. Great leaders are therefore not made, as leadership qualities are innate. Of-course, there is very little evidence to underpin this theory, and it has little support in in our contemporary world. Since Carlyle’s first documented leadership theory, our understanding of the practice and purpose of leadership has evolved, and a range of other approaches have emerged. As leadership theory has evolved, we have come to understand that the development of the specific skills, knowledge, attributes, and abilities required for successful leadership can be learned and enhanced through training and personal growth for existing and emerging leaders.

The leadership literature contains many leadership attributes and behaviours, ranging from gender to generational perspectives. Undoubtedly, many leaders struggle with the notion that traditional leadership is about control, rules, regulations, and boundaries. In contrast, more contemporary leadership models emphasise freedom of thought, making room for creativity, valuing outcomes, welcoming new ideas, and focussing on the

behaviours leaders exhibit toward their followership to create positive organisational outcomes.

Contemporary leadership thinking showcases leader behaviours, considering how leaders use personal influence to develop and inspire others in the organisation to develop and inspire people to achieve organisational goals, while also making a difference in the community being served. There is now a significant body of evidence in modern literature to support this contemporary leadership approach (Avolio, Bass, and Jung, 1999; George, 2004; George and Sims, 2007; George and Sims, 2007)

Before we discuss the literature on theories of leadership, what do you perceive as leadership?

Activity

Before progressing to the next section, take some time to document what you believe best describes leadership in the text box provided below (maximum of 100 words).

Your description does not need to be evidence-based, but should express what you consider to be the essential components of effective leadership.

Reflection

For me, effective leadership is described as:

Leadership Theories

Leadership is an individual's ability to influence, motivate, and enable others to contribute to the organisation's effectiveness and success (House et al., 1999). Table 3.1, below, outlines the major leadership theories. Before examining the theory groups listed in Table 3.1, it must be made clear that the grouping framework developed to achieve this deliberately omits the Great Man Leadership Theory, as it does not drive the course of events in more contemporary knowledge (Mouton, 2017).

Grouping Framework for Leadership Theories

Table 3.1 shows the grouping framework developed by (Olley, 2021), summarises the more common theories, identifies notable researchers who have developed and explained the main theory concepts, and provides a broad development timeline.

Table 3.1. Grouping Framework for Leadership Theories (Adapted from Table 1 in Olley, 2021, licensed under CC BY-NC 4.0)

Theory Group	Explanation
Trait theories	<p>Effective leaders share common personality characteristics known as traits (Stogdill, 1959). For those who subscribe to the Trait theory, effective leadership occurs when the traits of integrity, ethical decision-making, assertiveness, and compassion are evident (Bass and Stogdill, 1990). These traits are behaviours manifested because of the individual's internal beliefs and processes necessary for effective leadership.</p> <p>These theories extend an early theory known as the Great Man Theory, asserting that individuals are born with or without the necessary leadership traits.</p>
Behavioural/ Motivational theories	<p>Behavioural theories as the name suggests focus on how leaders behave and hope these behaviours can be copied by other leaders and thus created as leaders based on learned behaviours. Greenwood (1996) provides an excellent historical perspective on the development of behavioural theories of leadership.</p> <p>These theories posit four types of leaders: autocratic, democratic, and passive-avoidant identified initially by Lewin and McGregor (McGregor, 1960) and more recently transformational.</p> <p>Other theories in this group include psychoanalytical theory of leadership, behaviourism, cognitivism, ecological, humanism and evolutionary.</p>

Theory Group	Explanation
Contingency theories	<p>Contingency theory emerged from growing evidence that there is no one correct leader type (Fiedler, 1967, Fiedler, 1971). These theories posit that leadership style is contingent upon the situation, the people, the task, the organisation, and other environmental variables.</p> <p>The Blake and Moutin Management Grid plots a manager's or leader's degree of task-centeredness versus their person-centeredness, and identifies five different combinations of the two and the leadership styles they produce (Molloy, 1998).</p>
Power and influence theories	<p>This theory group applies French & Raven's Five Forms of Power (French and Raven, 1959). Theories that belong to this theory group highlight three forms of power; namely, legitimate, reward, and coercive power; and add two additional sources of power: expert power and referent power. Transformational and transactional leadership theories fit this group, and includes the laissez-faire style.</p> <p>Ethical leadership uses ethical concepts of situational ethics, cultural relativism, professional ethics, value-based ethics, rule-based ethics, and fairness-based ethics to manage subordinates (Brown et al., 2005). Ethical leadership is concerned with influencing people through the application of ethical principles (Brown and Treviño, 2006). The idea of authentic leadership is that leaders are seen as genuine and "real". created this theory in his book <i>Authentic Leadership</i>, promoting leader behaviours that are transparent and ethical. Authentic leaders accept follower input and encourage the open sharing of information needed to make decisions.</p>

Activity

Think about a leader you have personally worked with, whom you consider to be a successful leader. Write down what made them a successful leader in your eyes. Which of these attributes do you seek to incorporate into your leadership practice? In the square brackets following each behaviour listed below, rank each of the following leader attributes in their order of importance to you. The most important attribute is ranked 1, though the least important is ranked 7.

Willingness to listen []

Perseverance []

Honesty []

Selflessness []

Decisiveness []

Trust []

Integrity []

Power and Influence Theories

A leader's effectiveness comes from their ability to influence others at all levels of an organisation; hence, the ability to positively influence is an essential leadership skill. It is fundamental to success, providing the impetus for accomplishing team goals and fulfilling team responsibilities. Power and influence theories are therefore central to understanding contemporary leadership and have generated a broad body of knowledge discussed throughout this chapter.

Power and influence are deeply ingrained in human conscious-

ness and fundamental social phenomena. Toffler (1992) argued that the human psyche is the product of power, and that fascination with power is the basis of politics (Warren, 1969). Organisational actors seek power to control and determine the future of organisations, the outcomes of interpersonal conflicts, and personal security perception in organisations (Kahn and Boulding, 1964). Hence, effective leadership requires a sound appreciation and understanding of power, and the ability to navigate and negotiate power in all circumstances.

Theories of power and influence take an entirely different approach to explaining leadership from those previously discussed. Rather than personality traits or environmental factors, these theories consider how leaders use power and influence to achieve the desired organisational outcomes.

These theories mostly examine the personal style of the leader. They include the full range leadership model of transactional and transformational approaches to leadership (Bass and Avolio, 1994). This theory group consists of the later-developed theories of authentic leadership (B. George, 2004) and ethical leadership (Brown Treviño, and Harrison, 2005). Bass and Avolio's (1994) full-range leadership model includes three leadership styles transactional, transformational, and laissez-faire leadership.

Transactional Leadership

The transactional leadership style emphasises the importance of the relationship between the leader and followers. This theory focuses on mutual benefits derived from the 'contract' through which the leader delivers rewards or recognition in return for the followers' service, commitment, and loyalty Bass and Avolio (1994), Weber (1947), (McCleskey, 2014)

According to transactional leadership theory, motivating and directing followers is primarily achieved by appealing to their self-interests (Avolio et al., 1999). Transactional leaders' power comes from their position of authority and responsibility within the organisation. Transactional leadership achieves results by making the followers obey or comply with leaders instructions through a series of transactions and motivation is achieved by a system of leader-initiated reward and punishment (McCleskey, 2014). If a follower complies, a reward will follow. If the follower does not comply, punishment follows. Each transaction may involve observable dimensions between leader and follower, including:

- Contingent Rewards, in which transactional leaders link the goal to rewards, clarify expectations, provide necessary resources, set mutually agreed-upon goals, and offer various rewards for the successful performance of the task (Beauchamp, Welch, and Hulley, 2007).
- Active Management by Exception, in which the leader monitors team members' work closely, looks for deviations from policy and procedure in work undertaken, and takes corrective action to prevent mistakes (Judge and Piccolo, 2004).
- Passive Management by Exception occurs when transactional leaders only intervene when unmet standards or performance are not expected (Doucet, Poitras, and Chênevert, 2009).

A leader who deploys a transactional leadership style subscribes to a strategy of granting rewards based on employee performance and functions in a heavily structured environment that encourages employees to achieve their best by applying workplace or team rules (Avolio, Bass, and Jung, 1999).

Transformational Leadership

Transformational leadership theories, first described by Bass in 1985, assert that, unlike transactional leaders, transformational leaders inspire followers to abandon self-interest for the sake of the organisation. This approach has been found to have a profound impact on followers, with Bass (1985) noting a reduction in staff turnover, increased productivity, and higher staff satisfaction levels.

Transformational theories view the leader as a catalyst for a visionary approach while maintaining a strategic view of what needs doing. Transformational leaders value networking and collaboration (Bass and Avolio, 1994). These leaders are vigilant in their search for others who can demonstrate transformational leadership skills (Bass and Riggio, 2006). In terms of health and social care, the transformational leadership approach seems to have captured contemporary views on leadership. It appears to be the basis of the current industry-preferred leadership capability frameworks relating to health and aged care leadership (Australasian College of Health Services Management, 2017, Aged and Community Services Australia, 2014).

Transformational leadership theories posit that people are motivated by the task that they must perform. Those who practise transformational leadership emphasise cooperation and collective action, and individuals exist within the organisation or community context rather than in competition with each other (Bass, 2008).

Laissez-Faire Leadership

Laissez-faire leadership is a leadership style where leaders allow group members to make decisions with disengagement from

the team, the organisation's goals, and team members, expecting that they will solve problems themselves (Anbazhagan and R. Kotur, 2014). Laissez-faire leaders abrogate their responsibilities and avoid making decisions. As a result, the group can often lack direction.

Authentic and Ethical Leadership

Authentic leadership (B. George, 2004) and ethical leadership (Brown, Treviño, and Harrison, 2005) fit within the group power and influence theories and is complementary to the transactional and transformational leadership styles of the full-range leadership model (Avolio, Bass, and Jung, 1999), as they do not appear to be a subset of the full-range leadership model.

Authentic Leadership

Authentic leadership finds its conceptual roots in positive psychology, especially growth and self-fulfilment (Braun and Peus, 2016). Authentic leadership theory is a prominent and contemporary theory for which B. George (2004) is considered the primary theorist. This theory postulates that leadership is composed of four distinct components:

- Self-awareness (knowing oneself): A prerequisite is knowing one's strengths, limitations, and values. Knowing what one stands for and what values are critical. Moreover, self-awareness is needed to develop other components of authentic leadership (George and Sims, 2007).
- Relational Transparency (being genuine): This involves being honest and straightforward in dealing with others (George and Sims (2007).

- **Balanced Processing (being fair-minded):** Authentic leaders consider views that are divergent from what is commonly held and consider all options on their merit before choosing a course of action. There are no impulsive actions or “hidden agendas”, and plans are well thought through and openly discussed (George, 2004).
- **Internalised Moral Perspective (doing the ‘right thing’):** An authentic leader has an ethical core. They know the right thing to do, driven by a concern for ethics and fairness (Walumbwa et al., 2011).

Self-reflection is common to authentic leaders who dare to do the right thing, even when a degree of selflessness or personal and organisational risk is required. Self-reflection is core to observing the roots of authentic leadership, which comes from ancient Greek philosophy that focuses on developing core or cardinal virtues (Gardner et al., 2011).

Prudence	Temperance	Justice	Fortitude
<ul style="list-style-type: none"> • Being fairminded • Demonstrates wisdom • Perceiving many courses of action from which to choose 	<ul style="list-style-type: none"> • Being emotionally balanced and in control of self. 	<ul style="list-style-type: none"> • Being fair in dealings with others. 	<ul style="list-style-type: none"> • The courage to do the right thing.

The Cardinal Qualities of Authentic Leaders

Authentic Leadership Theory has become popular as people search for leaders with previously defined qualities. George, (2004) asserted that authentic leaders demonstrate qualities of:

- understanding their purpose,
- practising solid values,

- establishing connected relationships, and
- demonstrating self-discipline.

George's (2004) model focuses on the authentic leader's different qualities and asserts that demonstrating these qualities or characteristics promotes the follower group to recognise they are an authentic leader. In response, their followers will display positivity and the organisation will benefit. Each of the qualities espoused by (W. George and Sims, 2007) is associated with an observable characteristic:

- **Purpose and Passion:** Authentic leaders display a sense of purpose to their follower group, knowing what is critical and the direction the follower group should take. The manifestation of purpose is passion (Iszatt-White and Kempster, 2018). Passionate people are interested in what they are doing, are inspired and intrinsically motivated, and care about their work (Northouse, 2019). Authentic leadership occurs when individuals enact their true selves in their role as a leader (Leroy et al., 2012).
- **Values and Behaviour:** Those who practise authentic leadership have organisationally known values, know what they are, and do not compromise those values (B. George, 2004). This quality manifests itself through the leader's behaviour, and authentic leaders act only according to their values.
- **Relationships and Connectedness (Relational Transparency):** The ability to build relationships with others and connect with their followers is also an attribute of authentic leaders who are willing to share their experiences, listen to others' experiences, and communicate with their followers (Northouse, 2019).
- **Self-discipline and Consistency:** Self-discipline and consistency comprise the fourth dimension of authentic leadership. Self-discipline and consistency provide for leader

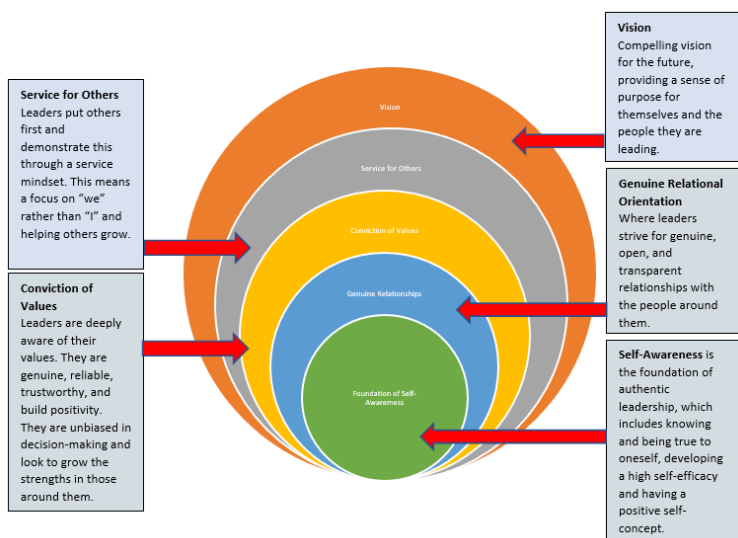
focus and determination. Authentic leaders have a well-developed ability to focus on a goal and move forward towards that goal, even in the face of setbacks. Self-disciplined leaders remain cool, calm, and consistent during stressful situations (Northouse, 2019).

- Heart and Compassion: Importantly, leaders have “heart” and demonstrate this by showing their compassion. They are sensitive to others’ needs and are willing to help them (B. George, 2004; Northouse, 2019).

Acquiring these five dimensions of an authentic leader is not a sequential process; leaders develop continuously throughout their lives.

Dimensions of Authentic Leaders

Growing demand for increased transparency, integrity, and ethical behaviour within organisations has led to authentic leadership development (Gardner et al., 2011). Authentic leadership principles improve follower job satisfaction (Braun and Peus, 2016; Spence Laschinger and Fida, 2015). The figure below demonstrates the foundational relationship of self-awareness to the other attributes of authentic leaders.



The Dimensions of Leadership

The strengths of authentic leadership are that it fills a need for trustworthy leadership (Wang and Hsieh, 2013, Gill and Caza, 2015, Henley, 2018), and it provides broad guidelines for leaders with an explicit moral dimension (Sidani and Rowe, 2018). In turn, authentic leaders interact with their follower group in ways that build the team's authentic leadership capacities, such as transparency, morality, ethical dealings, and future orientation (Avolio and Luthans, 2006, Luthans, 2003, Luthans, Norman, and Hughes 2006, May et al., 2003).

Luthans and Youssef (2016) described the emerging authentic leadership development literature succinctly:

“Authentic leaders are developed through the concerted contributions of life experiences and stable personality traits, positive psychological states, and a supportive, developmental organisational climate.”

Authentic Leadership Theory is grounded in positive psychology and has generated some criticisms; notably, that the focus on confidence, hope, optimism, and resilience, whilst important, cannot be considered in isolation from facing practical problems that require practical solutions. While there is ongoing research, it is not yet clear how authentic leadership leads to positive organisational outcomes (Breevaart et al., 2014), the moral elements of leadership, and their impact.

Ethical Leadership

Leadership often requires decisions and deliberations that requires consideration from a moral or ethical perspective. These include allocating scarce resources, colleague and workforce issues, meeting performance targets, improving organisational culture, disclosure responsibilities, and transparency to identify errors or misadventures. At their core, decisions we describe as ‘ethical’ have a dimension of power use or abuse, values alignment or dissonance, and the creation of prevention of harm. In other words, most decisions in health care have an ethical dimension. While this list of ethical decisions is not exhaustive, the decisions made for these crucial areas in any organisation mean that ethical leadership has increasingly

become an important theory of leadership. This is a complex area of leadership theory, as ethics is a pluralistic discipline, with Beauchamp and Childress (2001, p1) describing it as “a generic term for various ways of understanding and examining moral life”. Ethical leadership therefore draws on multiple ethical theories to equip leaders in navigating the moral dimensions of their leadership through various lenses to arrive at a well-considered decision. Importantly, ethical leadership requires that leaders consistently act and ethically lead, whether it is apparent to the follower group or not, and that the leader’s actions are consistent and within an ethical framework integrated into everyday leadership practice.

Ethical leadership draws upon concepts of:

- Situational ethics, where the ‘right’ action is dependent on the context of the situation (Fletcher, 1966).
- Cultural relativism determines what is ‘right’, noting the potential for harm in judging other cultures based on one’s own culture (Herskovits and Herskovits, 1972).
- Professional ethics considers that what is right is determined by a code of ethics of a specific profession that people in the profession should follow (Dinovitzer, Gunz, and Gunz, 2015).
- Value-based ethics is where a person’s values should guide their behaviour (Fusco, 2018).
- Rule-based ethics is where the rules of a specific group or organisation determine what is right, including society’s rules, religious rules, and an organisation’s rules (Fusco, 2018),
- Fairness-based ethics is a core issue of stakeholder theory in which fairness determines the ‘right’ actions and behaviours requiring fair and equal treatment of everyone (Hayibor, 2015).

While each of these elements are present in ethical decision

making, ethical leadership practice requires an approach of seeing, valuing, and incorporating competing ethical interests. Ethical leaders foster trust and they value the maintenance of good relationships, provide a balance between the well-being of the followers, the wider community. Modern ethical leadership theory emphasises service in that the leader is a 'servant' of their followers. This understanding of leadership emerged from Greenleaf's (1991) concept of servant leadership, which postulated that service to others is a leader's primary concern. Recent literature has made similar claims (Wright and Quick, 2011, Sharma, Agrawal, and Khandelwal, 2019).

Ethical leadership is associated with authentic leadership, with May et al. (2003) linking authentic leadership, ethical decision-making, and positive organisational behaviour to develop a decision-making model to understand how authentic leaders make morally appropriate decisions. In organisations, ethical leadership centres around respect for others' ethics, values, rights, and dignity **and** the leader's honesty, integrity, trust, and fairness in leadership practice. Leaders demonstrate respect for ethical beliefs and values and maintain others' dignity and rights, leading by values, vision, voice, and virtue (Brown and Treviño, 2006).

One model that may help structure ethical thinking for leaders is the 4-V Model (Center for Ethical Leadership, 2014). This model invites leaders to think about four aspects of leadership (virtues, values, vision, and voice) and align internal beliefs and values with external behaviours to pursue the common good as they apply in a particular context. The 4-V Model has four elements, with virtue being the centrepiece achieved by values, vision, and voice, and is related to trust, honesty, consideration, and charisma, as shown in this figure.

Considerable discussion continues about high profile ethical failures in leadership across a range of settings, resulting in

increased interest in promoting ethical leadership (Den Hartog, 2015, Keselman, 2012, Brown and Treviño, 2006) organisational ethics, organisational behaviour, and organisational psychology to better understand how to promote ethical leadership (Den Hartog, 2015).

Unethical leadership may lead to follower disappointment and distrust, leading to a lack of interest and commitment, negatively impacting patient outcomes and organisational effectiveness (Keselman, 2012). Schaubroeck et al. (2012) examined how leadership and culture relate to followers' ethical thinking and behaviours, and found that ethical leaders embed shared understanding through influencing ethical culture in follower teams and they positively influence followers' ethical cognition, behaviour, and performance. Mayer et al. (2012) described similar findings, and demonstrated that employees are less likely to engage in unethical behaviour when the leader models desired ethical behaviours. Ethical leaders have less relationship conflict with co-workers, with Mayer et al. (2012) concluding that reinforcing leaders' moral identities may promote ethical behaviours at several organisational levels. Ethical leadership is based on trust, respect, integrity, honesty, fairness, and justice, and promotes positive relationships. Research into the intersection of ethics and leadership remains mostly unexplored, and there are opportunities for further research and leadership practice development (Brown, Treviño, and Harrison, 2005).

Leadership theories such as transformational leadership and authentic leadership overlap with ethical leadership (Brown and Treviño, 2006). They are all ethically principled, share a social motivation, and require an engaging leadership style. Each of these approaches is associated with positive results in organisational commitment from nurses (Lotfi et al., 2018), increasing the retention of the healthcare workforce (Ibrahim, Mayende, and Topa, 2018), engagement of employees (Lahey,

Pepe, and Nelson, 2017, Engelbrecht, Heine, and Mahembe, 2014), and the development of trust in the workplace (Engelbrecht, Heine, and Mahembe, 2014).

Activity

We now ask you to revisit what you thought about the person you considered the most successful leader from whom you would like to model their leadership practice earlier in the chapter.

Make any changes in the ranking based on what you have learned in this chapter.

Remember, the most important attribute is ranked 1; the least important is ranked 7.

Willingness to Listen []

Perseverance []

Honesty []

Selflessness []

Decisiveness []

Trust []

Integrity []

Activity

Take some time to document what you believe best describes leadership (maximum of 100 words).

Your description does not need to be evidence-based, but should express what you consider to be the essential components of effective leadership.

Reflection

Revisit your description of what leadership is to you and record any differences to that description based on what you have learned in this chapter.

Key Takeaways

1. There is no clear consensus on a definition of leadership.
2. There is general agreement that leaders set direction and help themselves and others to do the right thing to move forward.
3. Leaders achieve this by creating a vision and motivating and inspiring others to reach that

vision. They also manage the delivery of the vision, either directly or indirectly, and build and coach their teams to make them stronger.

4. Effective leadership is about all of this – and it's exciting to be part of this journey!

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Cultural Safety and Awareness Frameworks in Health and Social Care: Whose Cultural Safety?

JENNIFER EVANS

Introduction

This chapter is about cultural safety and awareness frameworks and approaches for First Peoples in health and social care contexts. Various theories and models will be discussed, along with their implications for practice. The key messages from this chapter are that competency in cultural safety and awareness requires a continuous process of education, leadership, and accountability, at both organisational and inter-personal levels. All people have unconscious bias positioning (settler and other), and behaviours that flow from these in the context of healthcare, and the power imbalance that exists. Therefore, it is particularly important that health practitioners, workers, and administrators are open to and recognise their own settler and other positioning, unconscious bias, and racist behaviours in order to demonstrate sustainable and meaningful cultural safety for their First Peoples patients, health service consumers and colleagues. This also extends to First Peoples practitioners, who likewise require cultural safety and can be

negatively impacted by unconscious bias and racist behaviours. I write this chapter from my own Indigenous standpoint as a Dharug person belonging to the First Peoples in Australia.

This chapter refers to First Peoples¹ in settler state² I use the term 'settler states' to refer to First People's sovereign states which are colonised by invading settlers, whose occupation affords them political control over First Peoples.[/footnote] contexts in the Global North (e.g., Australia, New Zealand, Canada, and the United States of America). In settler states there are differing degrees of recognition and respect for First Peoples (Langton and Palmer, 2004; McDonald, 2023). Social justice and civil rights movements have given rise to the acknowledgment that settler mentalities are variable regarding how First Peoples are treated as human beings in all aspects of their lives (Fredericks et al., 2013; Collins and Watson, 2023). Workplaces, corporations, institutions, and communities have embarked on broad policies to improve the treatment of First Peoples under the banner of cultural respect, safety, awareness, and competency (Fleming, Creedy and West, 2018; Tremblay et al., 2023). Since the 1990s, some efforts have been made by the health and social care sectors to deliver appropriate cultural safety, awareness, respect, and competency education (Curtis et al., 2019). However, as of 2023, the impacts are variable; for example, in acute care settings racism, unconscious bias, and lack of cultural safety and respect towards First Peoples is resulting in improper and inequitable medical treatment and care (Abraham, Tauranga and Moore, 2018; Rahman et al., 2023). In Aus-

1. I use the term 'First Peoples' to refer to First Peoples and Indigenous Peoples globally.
2. I use the term 'settler states' to refer to First People's sovereign states which are colonised by invading settlers, whose occupation affords them political control over First Peoples.

tralia, there is “decades of evidence showing that institutional and interpersonal racism serve as significant barriers to accessible healthcare for Aboriginal and Torres Strait Islander Peoples” (Gatwiri, Rotumah and Rix, 2021, p. 1). Thus, there is still much work to be done by health practitioners, workers, administrators, and their organisations to deliver equitable and safe care for First Peoples.

Background

Why is cultural safety important?

There is an expectation that health practitioners, administrators, managers, leaders and general associated health workforce workers demonstrate cultural safety, respect, and competency at all points of First Peoples patient and consumer interaction in order to provide equitable access to health and social care (Greenwood et al., 2017; Mitchell et al., 2022). Hence, it is vital that appropriate policy settings and mechanisms are in place for cultural safety training underpinned by evaluation of performance, which need to be embedded and role modelled at all levels of health and social care services. In the absence of such integrated cultural safety approaches, First Peoples can be negatively impacted in varying ways (Browne et al., 2011; Chapman, Smith and Martin, 2014). For example, poor health outcomes (Milligan et al., 2021), lack of access to services (McLachlan et al., 2022), and perpetuation of racism and ongoing colonisation (Owens, Holroyd and McLane, 2020). All of these can contribute to continuing failures of state-based policies for equity of care of First Peoples, such as Closing the

Gap ³(Altman, 2018), and may contravene international conventions such as the United Nations Declaration on the Rights of Indigenous Peoples (Browne et al., 2020).

It is important to note that tension exists between settler state responsibility and the individual health worker's ⁴ responsibility to deliver culturally safe health and social care services (Downing, Kowal and Paradies, 2011). That is, both collective and individual responsibilities require leadership. Both spheres of responsibilities are vital for enduring change to deliver culturally safe, appropriate, and respectful health and social care services (Downing and Kowal, 2011; Gladman, Ryder and Walters, 2015). It is difficult to deliver this if both spheres of agency are not working together, as ongoing cooperation and commitment is required (Downing and Kowal, 2011; Mitchell et al., 2022). This chapter calls for leadership at all levels to improve outcomes for First People's health.

What will you learn about cultural safety and why does it matter?

There are over 476 million Indigenous Peoples globally (United Nations, 2023), living on, caring for, and defending their rights, homelands, and ways of being across Earth (United Nations Department of Economic and Social Affairs [UN DESA], 2021). First Peoples are diverse and have specific ways of being and

3. Closing the Gap is an initiative of the Australian Government aimed at overcoming inequity experienced by Aboriginal and Torres Strait Islander Peoples and reduce inequality.
4. I define 'health worker' as any employee that works in health and social care services who interfaces with First Peoples patients.

knowing. They are impacted by colonisation in varying ways (Pardadies, 2016; UN DESA, 2021). In some instances, First Peoples migrate or are displaced to places that are not their ancestral homelands, making their requirements for cultural safety distinct from the First Peoples homelands they are resettled in. Further, First Peoples are discrete within traditional estates and Nation areas and have well-defined tribal boundaries within nations, languages, and customs. Often, First Peoples are being serviced by settler health networks that do not reflect First Peoples geographies, but rather the geographies of colonisers⁵. Thus, the health and social care service and worker must understand that providing services that are culturally respectful requires recognition that “one size does not fit all”. Rather, that the practice of delivery of culturally safe and appropriate care requires specific knowledge, training, political action, and acknowledgement of diversity.

In this chapter, you will learn why cultural safety was established as a concept, and the different models, practices, and terminologies that developed over time. You will also learn about models and approaches to reaching cultural safety, the criticisms and debates surrounding them, and their limits for effective implementation. This chapter discusses how cultural safety models can be improved by applying Indigenous and decolonising methodologies and theories. A reflection on who ultimately benefits from cultural safety models and approaches is included. The chapter finishes with information about how to be a leader in the landscape of cultural safety frameworks.

5. I use the term ‘coloniser’ interchangeably with the term ‘settler’ to refer to people who have colonised, invaded, and now occupy First People’s sovereign states, including their descendants.

Theory and models

Development of cultural safety concepts

The concept of cultural safety was initially championed by the work of Māori nurses in response to Western based nursing practices that ignored issues of power imbalances between health service providers and health care consumers (Ramsden, 2002). As a Māori nurse and scholar, Ramsden (2002) argued that “the nurse is exotic to the patient, and that only the person experiencing the service can say whether it is fully effective” and that cultural safety “gives power to the patient or families to define the quality of the service on subjective as well as clinical levels” (Ramsden, 2002, p. 110).

Williams (1999, p. 213) defined cultural safety as a means to evaluate and “determine pathways to genuine empowerment” for Indigenous clients and stakeholders using the following accepted definition developed by Eckerman et al. (1992, np.):

An environment which is safe for people; where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning together with dignity, and truly listening.

In their paper, Williams (1999, p. 213) opened up the debate to encourage people to “examine their organisation, programs and their work practices” beyond ‘quick fixes’, economic imperatives and ‘conservative hegemonic practices’ around cultural safety. Emphasis for meaningful cultural safety was placed on *no assault on a person’s identity* (Williams, 1999).

Similarly, Fulcher (1998, p. 333) defined cultural safety within

the context of Indigenous culture in the education and training of social workers working with children in New Zealand:

...state of being in which the [individual] knows emotionally that [their] personal wellbeing, as well as social and cultural frames of reference, are acknowledged – even if not fully understood. Furthermore, [they are] given active reason to feel hopeful that [their] needs and those of [their] family members and kin will be accorded dignity and respect.

Fulcher (1998, p. 335) concluded that “Indigenous peoples possess knowledge that we won’t allow ourselves to know because it doesn’t fit into our scientific paradigm”. Fulcher (1998) called for the acknowledgement of Indigenous culture in a day-to-day sense, coupled with the fundamental requirement for health practitioners to be open to learning more and thinking outside Western cultural frames of reference.

As the implementation of cultural safety programs and education began to develop, attention turned to the impact on cultural educators. Wepa (2003) studied the experiences of cultural safety educators in nursing education in Aotearoa, New Zealand to elucidate improvements required in cultural safety education. It was concluded that Māori educators were in a “state of perpetual stress”, lacked support and faced many issues out of their control (Wepa, 2003, p. 346). This led to further refinement of cultural safety as “unsafe cultural practice is any action that diminishes, demeans, or disempowers the cultural identity and well-being of an individual ” (Wepa, 2003, p. 340).

In 2010, the First Nations, Inuit and Métis Advisory Committee, Mental Health Commission of Canada sought advice about cultural safety in application to Indigenous health. The authors advised that “cultural safety is not about ethnocultural practices, rather it highlights the need for the development of critical consciousness toward the power differentials inherent in

the health care system as well as the broader socio-historical and political factors that shape health care and Indigenous health" (Smye, Josewski and Kendall, 2010, p. ii). The narrative around cultural safety had shifted focus toward "social, structural and power inequities... prompting moral and political discourse and dialogue" (Smye, Josewski and Kendall, 2010, p. ii).

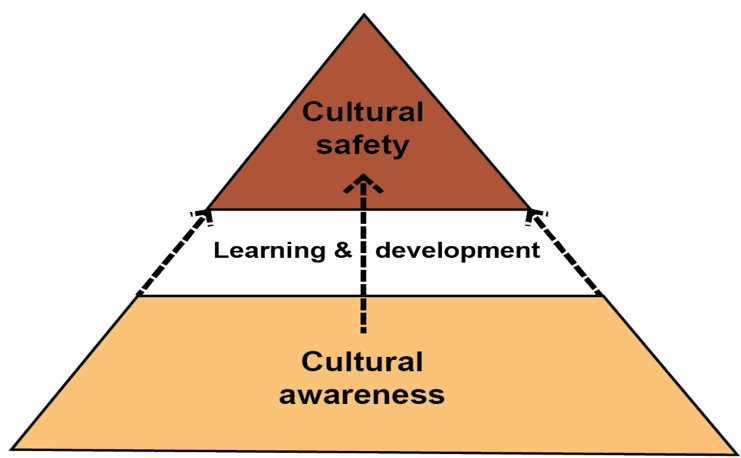
Models and stages of reaching cultural safety

Since then, a body of work has focused on the models and stages that aim to achieve cultural safety, ranging from cultural awareness to cultural competence, cultural sensitivity, cultural respect, cultural capability, cultural responsiveness, cultural security, and cultural safety (Coffin, 2007; Phiri, Dietsch and Bonner, 2010; Heckenberg, 2020; Gollan and Stacey, 2021). However, cultural safety has been adopted as the preferred term as it was developed in an explicit First Peoples context, as opposed to cultural competence developed in a cross-cultural context (applicable to people from diverse cultural backgrounds) (Gollan and Stacey, 2021). Further, some argue that the term cultural competence is an unrealistic goal for non-Indigenous people due to the diversity among First Nations groups (Gollan and Stacey, 2021) and the Anglo-privilege, homogeneity, and lack of diverse lived experiences of some non-Indigenous peoples (Dunn et al., 2010; Durey and Thompson, 2012). Cultural diversity is mutually embedded in place and people (Kassam 2008). Thus, First Peoples *in situ*⁶ are

6. I use the term 'in situ' to refer to the diverse country, homelands, traditional or tribal estates, and ancestral lands that First Peoples know as their places of belonging.

best placed to determine the “presence or absence of cultural safety” (Gollan and Stacey, 2021, p. 8) according to their culture.

Models and stages of reaching cultural safety are illustrated in the figure below. It summarises the components and stages for reaching cultural safety according to the models developed by Heckenberg (2010), Phiri, Dietsch, and Bonner (2020), and Coffin (2007). These models agree that attainment of cultural safety practices must involve sequential learning and development starting at the foundation of cultural awareness. The applicability of cultural competence and cultural security differ in the models, as does cultural sensitivity. This reflects current debates about how cultural safety practices might be achieved.



Model and stages of reaching cultural safety

Heckenberg (2020) proposed that cultural safety regarding Indigenous Peoples is the culmination of processes of individual and or institutional personal growth and education, such that the coloniser reaches an understanding and practice of cultural safety after developing cultural awareness, sensitivity,

and competence. Whereas Phiri, Dietsch and Bonner (2010) excluded cultural competence, moving from the stage of cultural sensitivity to applied cultural safety. However, it is noted that Phiri, Dietsch and Bonner (2010) applied their model to culturally diverse groups (cross-cultural), not exclusively to First Peoples. This highlights the nuances present in the application of cultural safety models, whereby the unaware reader may miss the importance of understanding and applying cultural safety models from an Indigenous Standpoint (Nakata, 2007), including the specificities required for caring for First Peoples as a separate group (Gollan and Stacey, 2021).

Coffin (2007) moved beyond cultural safety to cultural security in their focus on Aboriginal People in Australia. “Cultural security directly links understandings and actions. Policies and procedures create processes that are automatically applied from the time when Aboriginal people first seek health care” (Coffin, 2007, p. 23). Coffin (2007) focussed on cultural security as the ultimate goal, requiring processes of cultural praxis and critical reflection, protocols and brokerage to move beyond measures of ‘competence’ to address power differentials.

Regarding cultural safety, Cox and Best (2022, p. 78) argued that “cultural safety clarifies the connection between interpersonal racism and institutionalised systems of privilege/discrimination”. This view is supported by Downing and Kowal, (2011, p. 12), who proposed that cultural safety frameworks are more beneficial as they “move beyond cultural training in action” to requiring the health worker to understand their own culture and identity, unequal power balances, and “processes that may be sites of colonial practice”. Therefore, cultural safety must be embedded in health profession course accreditation, standards governing clinical professionalism and quality, and measures must be taken to reduce resistance (Laverty, McDermott and Calma, 2017).

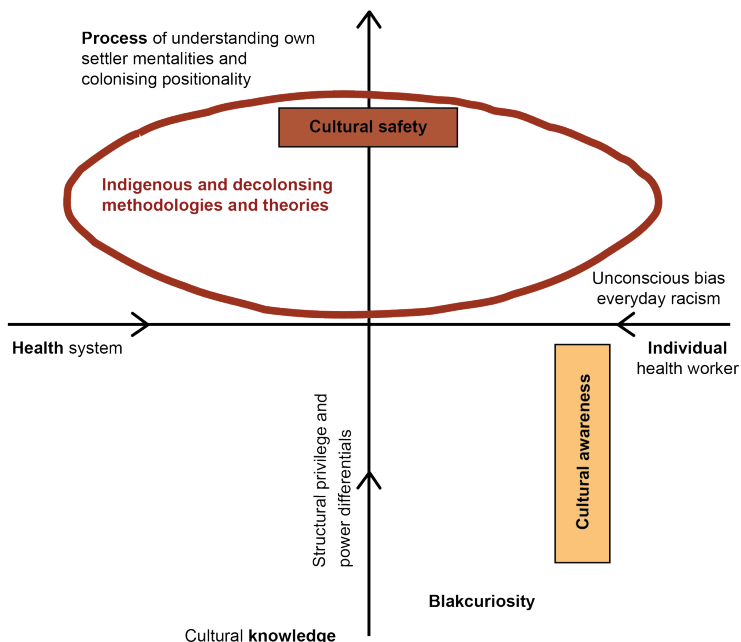
Some argue that there is no one model (cultural safety versus cultural competence) adequate enough to address health disparities and the diverse local histories and politics that shape them (Kirmayer, 2012). For Australia, New Zealand, Canada, and the USA “there is a lack of evidence from rigorous evaluations on the effectiveness of interventions for improving cultural competency in health care for Indigenous Peoples” (Clifford et al., 2015, p. 89). Jongen et al. (2018) argued that the fault of the failure of cultural competency lies in the fact that the health sector (where the power is held) has not fully acted on the philosophy and practice of cultural competency. Merlo (2021) went further to define structural competence, which relates to the requirements of physicians to address systematic problems and unconscious or implicit bias that cause healthcare inequities. Similarly, others have found that organisational and service-level strategies and policies are required to address structural barriers to achieving cultural respect for health care practitioners (Freeman et al., 2014). There is also criticism that cultural awareness frameworks (the foundation of the models in the above figure) have questionable efficacy, essentialise and *other* Indigenous culture and Peoples, and re-inscribe power differences between health services and First Peoples (Downing, Kowal and Paradies, 2011).

Criticisms of cultural safety models

In their review of approaches to Indigenous cultural training for health workers in Australia, Downing, Kowal and Paradies (2011) found that evidence of their effectiveness was poor. They identified six major models by which cultural training can be conceived: “cultural awareness, cultural competence, transcultural care, cultural safety, cultural security, and cultural respect” (Downing, Kowal and Paradies, 2011, p. 248). The figure below (adapted from Downing, Kowal and Paradies, 2011) shows two

of these models (cultural safety and cultural awareness) plotted on an x axis (individual versus systemic behavioural change) and y axis (individual understanding of their own culture and processes of identity versus understanding the culture of others). Downing, Kowal and Paradies (2011) were critical of cultural training programs, in particular, the cultural awareness model, arguing that it focuses on limited conceptualisations of culture and identity, while failing to examine the culture of health workers or the health system; thus, implicitly positioning them as the norm. This view is supported by Downing and Kowal (2011 p. 8) who argued that the cultural awareness framework (when analysed using postcolonial theory) creates “essentialism, ‘othering’, and allows ‘the negligence of systemic responsibility’ creating a ‘limited conceptualising of culture and identity may explain its failure to contribute to the development of culturally appropriate health services’”.

Whilst Downing, Kowal and Paradies (2011, p. 247) concluded that the cultural safety model “may offer the most potential to improve the effectiveness of health services for Indigenous Australians”, they warned that the current models continue to produce power imbalances, social inequality and ‘othering’. They further suggested that Indigenous cultural training can create a “false sense of cultural knowledge” and that emphasis should be placed toward understanding processes of formation and one’s own identity/positioning (Downing, Kowal and Paradies, 2011, p. 254).



Decolonising the theoretical models used in Indigenous cultural safety training. Adapted with copyright permission from Downing, Kowal and Paradies (2011), p. 249. Copyright permission kindly granted for publication in this book only.

Key implications for practice

Using Indigenous theories to improve cultural safety models

Given the limitations of cultural awareness frameworks and its implied complicity regarding health worker and systems negligence (Downing, Kowal and Paradies, 2011; Downing and Kowal, 2011), I question the cultural safety models previously mentioned (Coffin, 2007; Phiri, Dietsch and Bonner, 2010; Heck-

enberg, 2020), as these models are founded on cultural awareness as the first step in achieving cultural safety and appear to lack explicit Indigenous theoretical frameworks. Perhaps the conception of their models may benefit from a critical review using Indigenous and decolonising methodologies and theories?

One way that this could be achieved is to review the theoretical models for cultural safety presented by Downing, Kowal and Paradies (2011). In the Decolonising the theoretical models used in Indigenous cultural safety training figure above, I have inserted a red shield as the site for potential application of Indigenous and decolonising methodologies and theories in their comparison of theoretical models. My site is a location of resistance against settler possession of cultural awareness frameworks, a place to protect First Peoples from ongoing colonisation; thus, a shield is appropriate. My shield site aims to focus on the entire x axis to include both the health system and health worker, whilst seeking improvements for both toward the positive y axis to address power differentials between First Peoples and the health system and health worker. At my site, Whiteness theory (Moreton-Robinson, 2004, 2008, 2015) and Indigenous Standpoint theory (Nakata, 2007) are coupled with an Indigenous Research Agenda (Smith, 1999) as decolonising methodologies to seek insights for improvement of cultural safety models.

Whiteness theory is powerful when challenging the superiority of the settler in colonised states and expanding understandings of the complexities of Indigeneity (Moreton-Robinson 2004, 2009). Moreton-Robinson (2008, p. 85) stated that “it [Whiteness] is a location of structural privilege, a subject position and cultural praxis. Whiteness constitutes the norm operating within various institutions influencing decision making and defining itself by what it is and is not”. Whiteness theory can assist in understanding how power relations are informed

by racialised knowledge, and how such knowledge can regulate subjugation (Moreton-Robinson, 2006). Whiteness theory is useful in addressing racialised practices that are deeply embedded in health systems and reproduce unsafe practices (Gatwiri, Rotumah and Rix, 2021).

At my shield site, Whiteness theory could assist the health worker by encouraging them to engage with notion that the acquiring of cultural knowledge (bottom of y axis) without recognition of their own settler mentalities may bring implicit bias, explicit racism, perpetuate colonisation, and entrench cultural *unsafety*, personally and within the health systems they operate. The strength of Whiteness theory is that it has the potential to shine light on power differentials and talk back and up to dominant white structures and systems (Moreton-Robinson, 2015). This would be beneficial for health workers to move from the position of potentially learning to “hug a blackie” (Hunter, 2001, as cited in Fredericks, 2006, p. 88), becoming faux-woke⁷ or Blakcurious⁸ (by limiting their training to cultural awareness) towards recognising their colonising

7. I use the term ‘faux-woke’ to refer to an individual attitude and behaviour regarding First Peoples rights and affairs, that are seemingly supportive, but fall short of recognising their settler White possessiveness by denying complete First Peoples sovereignty and land rights (Evans 2023).
8. I use the term ‘Blakcurious’ to define interest in Aboriginal culture in Australia by non-Aboriginal People whilst respectfully acknowledging that the term ‘Black curiosity’ is used to define a ‘complex arrangement of interests and alignments around blackness and black collectivity’ (Crawford in Brown et al., 2014, p. 96) regarding African Americans and the African diaspora (Evans 2023).

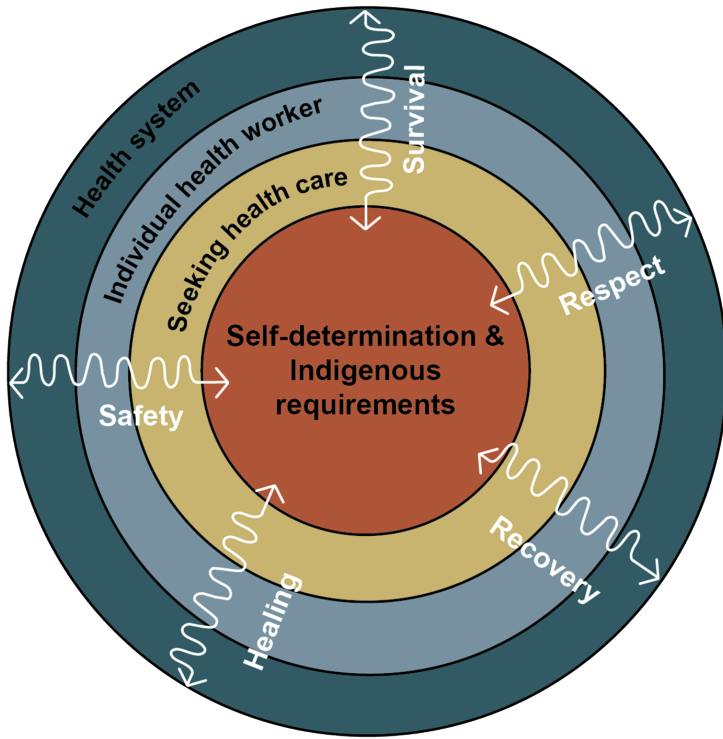
positionality and impact on First Peoples (fully embracing cultural safety).

At the cultural interface where Indigenous and Western systems collide, Indigenous Standpoint theory helps us make sense of our everyday lives as First Peoples (Nakata 1997, 2007). Nakata (2007, p. 12) described their Indigenous Standpoint theory as a “method of enquiry, a process for making more intelligible ‘the corpus of objectified knowledge about us’”. The great strengths of Nakata’s Indigenous Standpoint are that it can “generate accounts of communities of Indigenous People in contested knowledge spaces” and aims to “acknowledge the everyday tensions as the very conditions to what is possible between Indigenous and non-Indigenous positions” (Nakata, 2007, p. 13). At my site, Indigenous Standpoint theory works in a similar way to Whiteness theory, in that it brings into sharp focus the objectification of First Peoples and their cultural knowledges as a consequence of the health worker focusing on developing cultural knowledge (cultural awareness) at the low end of the y axis. At this location, an Indigenous Standpoint speaks to the everyday tensions of being First Peoples and reflects the innate reality of everyday racism possible through abdication of the health worker and the health system in addressing their settler privilege and power status. Indigenous Standpoint theory works in a parallel way to Whiteness theory, as it helps shift the focus of improving cultural safety models upward on the y axis toward my site.

In Linda Tuwhai Smith’s seminal and enduring work, the reader is invited to consider an Indigenous Research Agenda (see ‘Figure 6.1’, 1999, p. 117). In Smith’s decolonising methodology and Indigenous Research Agenda, four major tides of survival, recovery, development and self-determination fluidly shift back and forth as conditions and states of being in which Indigenous communities are moving. Smith’s Indigenous Research Agenda recognises that Indigenous Peoples are not in control,

are subject to a continuing set of external conditions, and are not experiencing sequential development. Smith invites their Indigenous Research Agenda to be applied as processes in practices and methodologies rather than goals or end points. In the figure below, I have adapted Smith's (1999) model of tides of survival, recovery, healing, safety and respect and applied them to fluid interactions that First People's encounter when seeking health care. This model illustrates decolonising approaches to cultural safety to privilege Indigenous requirements, whereby the individual health worker and health system must place Indigenous self-determination at the centre of care giving.

When I bring Smith's (1999) Indigenous Research Agenda to my site, it works in a comparable way to Whiteness and Indigenous Standpoint theories, but a deeper level situating Indigenous requirements as a core value. Its application gives voice to ongoing colonisation, the vast gulf between white possession (Moreton-Robinson, 2015) in health systems, injustice, First Peoples' self-determination, requirements for survival, recovery, and development through being kept safe and respected during health care. Smith's (1999) Indigenous Research Agenda is a powerful tool for expressing an Indigenous Standpoint to health workers and health systems, whilst calling out white possession. Again, an Indigenous Research Agenda has the potential to bring focus upward on the y axis to enhance cultural safety models. Although it would be difficult to visualise, the figure below could be completely overlaid on this figure. In this situation, Smith's (1999) notions of tides could counter the very Western x-y axis of Downing, Kowal and Paradies' (2011) model and reclaim the agenda of cultural safety through acts of decolonisation.



Model for decolonising approaches to cultural safety to situate Indigenous requirements.

Whose cultural safety?

Reflecting on my site of resistance (the shield) in this figure, I ask a fundamental question: If current models of cultural safety are yet to be proven to keep First Peoples safe in health and social care, then who is benefiting from these models? When I applied Indigenous and decolonising theories and methods to current cultural safety models and frameworks, inequities were highlighted. It appears to me that the settler and their health

system is benefiting from current cultural safety approaches, as they remain anchored toward the bottom of the y axis in Downing, Kowal and Paradies' (2011) model and unchallenged in facing their own identity and positioning as colonisers. This allows them to remain in a place of power, comfort, and affords them cultural safety as settlers.

Key Takeaways – how to be a leader in cultural safety

Leading in cultural safety requires a continuous process of education, training, reflection, improvement, and accountability both at organisational, interpersonal, and personal levels. Health practitioners, workers, administrators, leaders and managers must recognise their own settler positionality, unconscious bias, power relations, racism (institutional and interpersonal), and their roles in perpetuating colonisation and/or resisting positive changes towards attaining cultural safety. As a leader, you will have learnt and now understand about the conceptualisation of identity and culture (most importantly your own), and how power imbalances through interactions or relationships can make people feel unsafe and be detrimental for their health and wellbeing. You will have learnt about the diversity of First People's identities and what is important for them to feel safe within a health service. Being able to recognise and protect a person's cultural identity will be an important goal for you. All of these learnings will be underpinned by your commitment to ongoing cultural

training, whilst always being cognisant of your own identity and positioning within that training and its application.

Within your role and organisation, you will have committed to continuous processes of education of yourself and others, and will hold institutional and interpersonal accountability and performance measuring for cultural safety. You will have learnt that First Peoples and their communities are dynamic and changing, as are their requirements for health and social care services, and you will champion changes that make them feel safe within changing environments. Likewise, you will have built relationships through engagement with local First Peoples who you serve, and you will be maintaining these relationships, allowing an open dialogue. These relationships will give you feedback (formal/informal) on your service delivery and health outcomes for First Peoples, not only confined to cultural safety, but overall, if the service is fit for purpose. From here you will continue to lead in your role and influence others in your professional/work networks, encouraging them and referring cultural safety training and support services, allowing them to improve their own practices and outcomes for First Peoples.

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Safety and Quality in Healthcare

Safety and Quality in Healthcare

MELANIE MURRAY AND AMANDA BARNES

Introduction

The terms ‘quality’ and ‘safety’ are frequently used in health and social care. But what does quality mean? In healthcare, quality is defined as “how well healthcare services for individuals and populations achieve desired health outcomes that are consistent with current professional knowledge and standards” (Kelly Vana, Vottero, and Altmiller, 2023, p. 5). Safety, then, is to provide care without harm. Like all things, health, quality and safety are dynamic and should never be considered separate from everyday business but should be ‘business as usual’. In a health and social care system that is ever-evolving, attention to quality and safety is of utmost importance.

Clinical standards and governance systems are central to safety and quality. They are the backbone of effective healthcare and must be in place to ensure quality care, without which expected patient outcomes are threatened. The six domains of a healthcare quality framework were developed by the Institute of Medicine (2001), and assert that care provision should be safe, timely, efficient, equitable, effective, and patient-centred. These were further expanded by the Agency for Healthcare Research and Quality, (2015), and adopted by agencies world-wide, to include “doing the right thing, at the right time, in the

right way, to achieve the best possible results" (Kelly Vana, Vottero, and Altmiller, 2023, p. 5). These are reflected in the Australian context through the National Model Clinical Governance Framework (Australian Commission on Safety and Quality in Healthcare [ACSQHC], 2017), and in the United Kingdom (UK) through the National Institute for Health and Care Excellence (2023) standards and guidelines.

Throughout this chapter, we will discuss the following topics in the hope that it will provide you with a better understanding of these processes and the confidence to manage them in your workplace:

- The concepts of safety and quality in healthcare
- Challenges to quality and safety improvement in healthcare
- Human factors and systems thinking
- Clinical governance
- Standards and accreditation
- Practices within healthcare organisations that support quality and safety in healthcare

Background

The landmark report from the Institute of Medicine, now the National Academy of Medicine, in 2000, *To err is human*, highlighted the significance of medical errors and adverse events in the United States of America (USA) up until that time. In the 23 years since, healthcare providers globally have been striving to improve patient outcomes by introducing clinical governance and quality improvement strategies. The gaps in quality identified by the Institute of Medicine (2001) include the growing complexity of science and technology, the increase in chronic conditions, and constraints on exploiting the revolution in

information technology. This issue does not solely affect the USA. There have been reports of patient safety failures globally. Of note is the Bristol Royal Infirmary Inquiry (Kennedy, 2001), the Queensland Public Hospitals Commission of Inquiry (Davies, 2005), the Special Commission of Inquiry into Acute Care Services in New South Wales Public Hospitals (Garling, 2008), the Mid-Staffordshire National Health Service (NHS) Foundation Trust Public Inquiry (Francis, 2013), the investigation into perinatal outcomes at Djerriwarrh Health Services (Wallace, 2016), and the Royal Commission into Aged Care Quality and Safety (Commonwealth of Australia, 2021). These are a few examples of investigations and reports into poor quality care across the UK and Australia. Whilst considerable improvements have been made worldwide, there is still significant room for improvement.

In response to these global reports of poor patient care and adverse events, the World Health Organization (WHO, 2018) initiated their series of global patient safety challenges. The first challenge of 'Clean Care is Safer Care' put handwashing in the spotlight, and is where the Australian National Hand Hygiene initiative (ACSQHC, 2023) began. The WHO's (2018) second challenge, 'Safe Surgery Saves Lives', saw the surgical safety checklist introduced into operating rooms as the 'time out' procedure; and the third and current challenge is 'Medication Without Harm' aiming to decrease medication errors globally by 50% over five years. These challenges can be viewed as large-scale quality improvement activities aiming to decrease preventable adverse events globally (WHO, 2018).

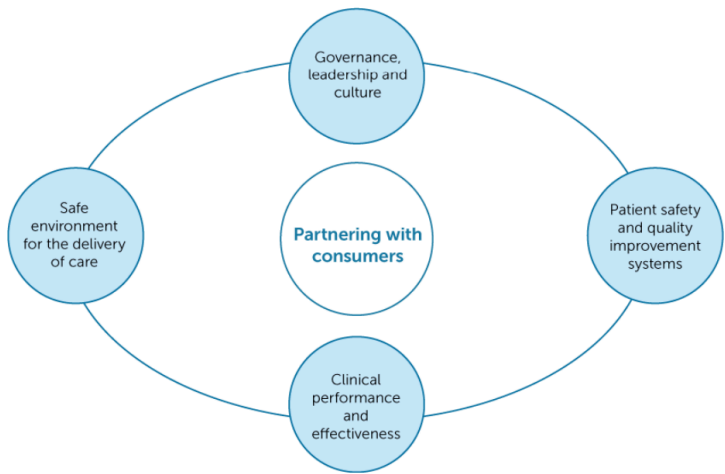
In 2006, the Council of Australian Governments made a commitment to improve quality of health services, resulting in the establishment in 2011 of the Australian Commission on Quality and Safety in Healthcare (ACSQHC, 2023) (the Commission). The Commission is the primary organisation charged with national improvements for healthcare in Australia. Many

changes have been instigated since the Commission was established, including the implementation of the National Safety and Quality Health Service Standards (NSQHSS) (ACSQHC, 2017), the National Inpatient Medication Chart (ACSQHC, 2023), and the Early Warning System observation charts (ACSQHC, 2012), to name a few (ACSQHC, 2023). These changes have proved effective through the demonstration of improved patient outcomes nationally. Evidence of this can be seen in the decrease in potentially preventable healthcare-acquired complications, or adverse events, following the guidance offered in NSQHSS' Preventing and Controlling Infections standard. We have seen a decrease in Australia, from 10% in 2014/15 to approximately 2% of all hospital separations in Australia in 2021 (Australian Institute of Health and Welfare, 2022). However, the health system is reliant on human beings and errors and adverse events are going to occur. Clinical governance and quality improvement (QI) systems therefore must be robust enough to manage the challenge.

What is clinical governance?

According to the ACSQHC (2017, p. iii), clinical governance “...ensures that everyone – from frontline clinicians to managers and members of governing bodies, such as boards – is accountable to patients and the community for assuring the delivery of health services that are safe, effective, integrated, high quality and continuously improving”. Clinical governance has been introduced into healthcare worldwide to address the extensive variations in standards and quality of care. Many frameworks are available, and the Commission published the National Model Clinical Governance Framework (the Framework) in 2017, supporting the NSQHS Clinical Governance Standard (ACSQHC, 2017). While being an individual standard, clinical

governance is also embedded throughout all eight NSQHS standards as action item one. This specifically addresses the minimum quality standards expected in all Australian health-care organisations concerning governance, leadership and culture, patient safety and quality systems, clinical performance and effectiveness, and a safe environment for the delivery of care (ACSQHC, 2021, Standard 1). The figure below illustrates Australia’s clinical governance framework.



Australia's Clinical Governance Framework (Source: ACSQHC, 2017, p.7). Used under a CC-BY-NC-ND 4.0 license.

The many incidents of poor care around the world can be linked to a lack of clinical governance. All organisations require some form of corporate governance encompassing all aspects, specifically risk, finance, and other areas such as human resources (HR), and information technology (IT). Frameworks may vary; however, the consumer is central to most.

As with any framework, there are often supports and chal-

lenges. Examples of supporting principles underpinning effective clinical governance are:

- vision and values;
- clear organisation and committee structures;
- cultural and professional safety;
- recruitment and retention strategy;
- induction and orientation programs, performance reviews, goal setting, and performance management; and
- mandatory training and clinical competency framework.

Challenges of implementing a clinical governance system include the following:

- knowledge and understanding of the concept,
- unclear organisation expectations and outcomes,
- lack of infrastructure to support the organisation's vision,
- not having the right people to deliver on the vision,
- budget,
- tools,
- time,
- accountability, and
- gradients of hierarchy that are often the cause of conflict.

Clinical Governance Vignette

The landscape of health is complex, and often described as being a beast! It is in a perpetual state of change and requires an effective governance framework to prevent the whipping up of a 'perfect storm'

that is likely to result in the delivery of sub-optimal care, harm to a patient or staff member, or increased reputational risk for the business. A plethora of literature evidences how a structured clinical governance program can prevent this from happening.

Reflection

Ask yourself...what does this mean? What is clinical governance, and how do we take it from the 'too hard basket' and make it 'business as usual'?

If you are unsure and find yourself doing a sneaky Google search, you can be sure you are not the only one! Ask anyone in your organisation what is clinical governance, how to 'do it', and what the expectation or intended outcomes are, and you will either get the tumble weeds of silence or an abundance of differing perceptions and descriptions of the concept. Either way, this is not going to help you embed the principles and optimise the delivery of safe and effective patient-centred care.

Ask the question... it will provide you with insight into the general understanding of your team.

Now that you have oversight of your team's understanding, you have a starting point and can begin to build your governance framework. Find a definition

that you understand and can relate to, after all, you are the one that will need to explain it and make it real.

Beware...there are a LOT of definitions, so take the time to do your research. Like all areas of health, clinical governance has its own suite of jargon that you would be wise to investigate and understand; clinical governance is indeed one of those terms! 'Pillars' is another one, and it means nothing to those not indoctrinated into the world of quality management. Early literature describes frameworks with four pillars of governance(ACSQHC, 2017); however, as health systems have grown and services become more complex, the number of pillars of clinical governance has expanded to six or seven. Pillars are essentially 'buckets' in which actions, activities, systems, and processes can be grouped so they create an outline for your clinical governance framework and include (but are not limited to):

- Policy – A platform where your policies and procedures are stored. This should include visibility of version control and review dates and should be easily accessible by all staff.
- Risk management – An incident reporting system that includes an incident investigation model (Root Cause Analysis [RCA], Failure Modes and Effects [FMEA])
- Consumer engagement – Clear processes for allowing consumers to provide feedback, compliments, and complaints.
- Education and training – A mandatory training program outlining what programs must be com-

pleted, the frequency, and mode of delivery, including scope of practice and clinical competency requirements.

- Monitoring systems – An audit framework outlining what should be measured/monitored, the frequency, and outcomes. This should include both clinical and non-clinical areas.
- Clinical effectiveness – This incorporates recruitment practices, retention strategies, induction, orientation, professional development, performance review, and performance management.

Activity

Action...Take a look at your organisation and consider the list above.

So, what comes next? Now you know the key processes that create a clinical governance framework, it is essential that you learn and share how each process is dependent and inextricably linked to each other.

PRIORITY ACTION

Failure to do this effectively will result in the systems being siloed, your team will become disengaged from

the vision, and there will be minimal safety and quality improvement in your organisation.

Clinical governance is only as effective as the effort and commitment put in to achieve it. Spend the time to find the right interested people who have passion and are keen to learn, as these are your champions and will fight for your vision. Make the time to hold workshops, let everyone share their ideas, and decide how all the pieces fit together. Shared learning creates team-ship, builds trust, and develops a common goal, getting everyone on the same page.

Key Takeaways

Key learning...Be sure to include the multidisciplinary team in the development and implementation of your program. Taking them on the journey will promote organisational accountability and will be key to your success.

Design your committee structure to mirror your clinical governance framework, review your meeting attendees to ensure you have appropriate representation, and make your meetings matter by using structured agendas, minutes and clear actions, owners, and time-frames.

And finally, communicate, communicate, communicate!!!

Quality Improvement

Quality improvement (QI) is central to the success of any clinical governance program, and a well-executed program offers structure, accountability, and oversight of progress. In recent years, the emphasis on QI in healthcare has become a major focus, with the Commission publishing the National Clinical Governance Framework at the same time as detailing what an effective quality improvement system looks like under Action 1.8 of the NSQHSS Version 2 (ACSQHC, 2017, updated 2021).

However, QI is one of the most challenging principles to implement consistently, because it has its fingers in the pies of all the other pillars of safety and quality systems. Additionally, despite QI being recognised as the key to advancing quality processes, we quite often find that QI barely gets a mention in textbooks, with a measly offering of a couple of pages outlining only the high-level concept. Not at all helpful! So, what is the potential of QI?

Well, we already know the systems that can help us identify opportunities for making improvements, audit, staff suggestions, complaints, and incidents, but QI is so much bigger and can be so much better. Quality improvement practices give us an opening to collaborate with our people, we can use it to encourage professional development, promote trust through the sharing or delegation of responsibility, and when your people are recognised for their input, no matter how big or small, their commitment will grow. QI is the perfect opportunity for you to invest in your people, show your respect for them, celebrate the successes together, and watch your organisation embrace change.

A method used to monitor the quality of Australian health services is regular accreditation surveys. Accreditation to the

NSQHSS is a national approach to set a minimum expected quality, safety, and care standard throughout all healthcare facilities (ACSQHC, 2017). Developing a strong safety culture and achieving successful accreditation outcomes requires commitment from all levels within the organisation, from the executive to the bedside. This principle underpins the success of any clinical governance framework, assuring best and consistent practice across the continuum, including risk management and quality improvement.

Although QI is essential to improving patient safety and outcomes, as with any change or QI activity, there will be barriers and facilitators. Some barriers highlighted in the literature include lack of protected time to undertake QI, healthcare workers (primarily nursing staff) prioritising other duties, lack of leadership support, lack of QI champions, and ineffective or poor communication (Zoutman and Ford, 2017).

To support ongoing quality care, the New South Wales Health Clinical Excellence Commission put together the following resource that explains the practical application of the six domains of healthcare quality for improving practice.



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://oercollective.caul.edu.au/leading-in-health-and-social-care/?p=416#oembed-1>

The Six Dimensions of Healthcare Quality was created by Clinical Excellence Commission and is available from <https://www.youtube.com/watch?v=l8Y962VTiBY>

Quality Improvement Vignette

Tips to make QI successful

In health organisations, there is generally a person or department dedicated to safety and quality, and they will have access to these systems. The risk here is that the scope and potential of improvement ideas and activities are narrowed because the wider organisation does not have visibility or access and are unlikely to be aware of the issues, and are therefore unintentionally excluded from the opportunity to innovate.

You can change this by being transparent with the information, finding a way to share it, and making it accessible.

Suggestion: Have a 'Challenges' page on your Intranet, grouping issues together and inviting people to share their ideas and solutions. Use your strongest resource (the people) and make them the drivers.

Once the improvement idea has been identified and you have a group of super enthusiastic champions, you need to ensure you do not lose track and momentum of the project. Like we said, QI activities are happening constantly, with differing levels of priority and urgency, and often involving more than one area of the business or the clinical governance framework.

Each QI activity should have an action plan (see the example below). The plan should clearly identify who is responsible for each action, when the action is due to be completed, and how and when the success of the action will be measured.

You then need a register collating this information for all your active QI activities, which becomes your platform for oversight, ensuring you have visibility of accountable persons, deliverables, and timeframes. Each action plan owner must be responsible for updating the register (usually monthly) and this is then included in your Safety and Quality Committee for review and tracking. Do not underestimate the power of QI. An example register is provided below.

Reflection

Ask yourself, what is the point of having, using, and monitoring quality systems if you are not going to

invest in the process of remedying the suboptimal findings?

Theories and Models

There is no one way to approach quality and safety. Here, we will briefly discuss some different theories and models that may underpin your organisations approach to safety, risk, and QI.

Safety-I to Safety-II

Smith and Plunkett (2019) proposed that the approach to safety, and subsequently, incident and accident investigation, has moved into a third ‘age’. The first two ages being the “age of technology” and the “age of human factors”, with the third being “age of safety management” (Smith and Plunkett, 2019, p. 508). In 2015, Hollnagel et al. (2015) published a white paper describing the perspectives of safety and the shift from ‘safety-I’ to ‘safety-II’. The safety-II approach to investigation is that the focus should be on “how things usually go right” (p. 4), rather than the safety-I philosophy of safety being “...a state whereas few things as possible go wrong” (Hollnagel et al., 2015, p. 3). While we are advancing from the ‘age of human factors’, consideration of human factors during development and optimisation of systems supports the safety-II approach. Humans are fallible but flexible and can adjust where necessary to avoid

an incident, whereas fixed systems are often not flexible, and errors will inevitably occur.

Incident investigation – Root Cause Analysis

Many organisations undertake incident investigations by way of a root cause analysis (RCA), a somewhat linear approach seeking a cause amongst the many layers of an organisation. Despite its linearity, this model can be very effective if used appropriately. The following video developed by ThinkReliability© (Galley, 2018) provides a simple overview that demonstrates how the cause-and-effect tools, the 5 why's, and Ishikawa (fishbone) diagram can be used at various depths to seek the underlying systems issues that lead to incident occurrences.



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://oercollective.caul.edu.au/leading-in-health-and-social-care/?p=416#oembed-2>

What is Root Cause Analysis was created by CauseMapping and is available from <https://www.youtube.com/watch?v=sFQFfrYjtPU>

Reflection

Have you been involved in an incident investigation in your workplace? If so, what method does your organisation use? If not, speak to your supervisor or whoever is responsible for incident investigation in your organisation to find out more.

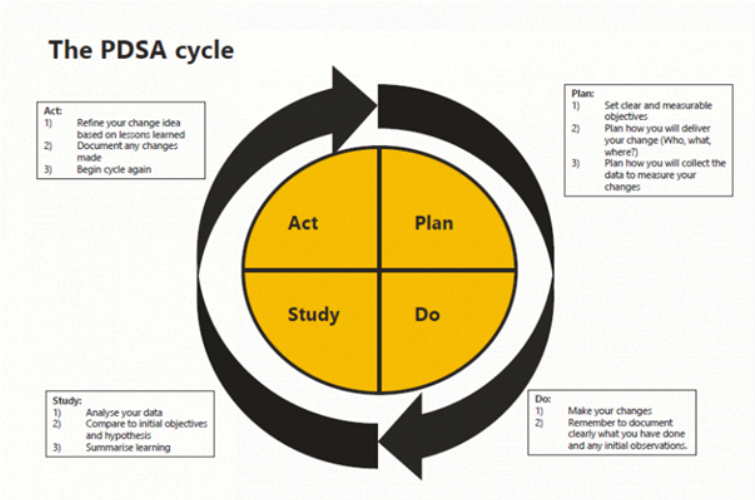
Systems Thinking

Industries outside of health, such as the safety-critical aviation industry, continually search for new ways of assessing incidents to ensure maximum levels of safety. However, healthcare often lags. Systems thinking and the systems approach to safety and investigations are more holistic approaches that acknowledge the complexities of a system such as health (McNab et al., 2020). However, the systems approach needs to be supported by the whole organisation to ensure a culture of safety and effective leadership is essential. Engagement of all healthcare team members is necessary for successful outcomes and, more importantly, overall safety culture. With the significant advancement and integration of technology into healthcare, quality and safety issues have also been associated with this (McNab et al., 2020). As such, a multidisciplinary approach, including Information Technology (IT), is required (Bates and Singh, 2018). As you saw in the RCA video, getting to the 'root/s' of the problem requires us to look at the systems as a whole and not stop at the individual/s who made the error.

Plan, Do, Study, Act (PDSA)

A QI activity needs a structured approach. The Plan, Do, Study

Act (PDSA) cycle is the common model used in healthcare, initially developed by Shewhart around 1936, and further refined by Deming throughout the 1990's, with the model we know today described in 1996. The figure below illustrates the cycle and provides a brief outline of what occurs in each stage. You may see some similar features from this model in the nursing process of assess, diagnose, plan, implement, evaluate (ADPIE) (Mason and Attree, 1997), or the Clinical Reasoning Cycle (consider the situation and collect cues, process the information, plan, implement, evaluate, and reflect) (Levett-Jones, 2017). It would be rare that you follow the cycle just once. QI cycles, as with the nursing and clinical reasoning cycles and continue iteratively as situations evolve.



The PDSA cycle. This figure is licensed under CC-BY-NC-ND 4.0 licence (Source: 'The PDSA cycle', created by The Strategy Unit, 2002).

Reflection

Have you been involved in a QI project in your workplace? Was it successful? Were you aware of the method being used? If there was no particular method, how could you integrate the PDSA into your next QI project?

Human Factors

Human factors are about understanding human behaviour and performance to recognise the capabilities and limitations of working with people. This is important in healthcare, as when we understand these behaviours, capabilities, and limitations, we can better design systems to consider these, and thus reduce the likelihood of errors (Lock, 2018). In 1993, Gordon Dupont, an aircraft maintenance engineer and accident investigator, sought to better understand the commonalities among the accidents he was investigating (Dupont-Adam, 2021). A retrospective review of thousands of maintenance error records found 12 'preconditions' associated with these reports. These became known as the 'dirty dozen', and have been adopted worldwide to help develop systems to mitigate these issues. The dirty dozen are:

- lack of communication,
- complacency,
- distraction,
- stress,
- lack of teamwork,
- lack of resources,
- pressure,
- lack of assertiveness,

- lack of knowledge,
- norms,
- fatigue,
- lack of awareness.

These 12 factors have been shared by the Clinical Excellence Commission (2021) in an effort to provide strategies to address some of the issues that have arisen in health systems during the COVID-19 pandemic.

Reflection

Think about an incident or near miss you may have been involved with.... Can you relate to any of the 'dirty dozen' factors? Did they/could they have contributed in any way?

Risk Management Vignette

Managing risk is about identifying and reducing harmful or adverse events in a health service's clinical and non-clinical environments, investigating incidents that have occurred, and progressing remedial and improvement activities to prevent repetition of the event. Risk management is one 'pillar' of the overall governance framework, and as an individual component, is a much less complicated concept to understand, and therefore in theory, should be easier to apply. Additionally, the processes and workflows applied across the continuum of risk management are linear and often prescriptive in direction and application.

Reflection

Why is there an abundance of literature evidencing significant variance in the levels of compliance and success in managing clinical risk?

How do established healthcare organisations become the focus of public inquiries, such as Bacchus Marsh/Djerriwarrh Health Service in Victoria (2015), or the Perth Children's Hospital inquiry in 2021 following the death of Aishwarya Aswath in 2021?

You can read more about these inquiries here:

ACSQHC – Review of the Department of Health and Human Services' management of a critical issue at Djerriwarrh Health Services

Independent Inquiry into Perth Children's Hospital

Note that these incidents are at the extreme end of the incident spectrum, but the system failings identified as contributing to these catastrophic outcomes did not develop overnight and have been proven to be largely preventable. As leaders, we are responsible for understanding why our current incident management sys-

tem may be at risk of failing and how we can prevent this from occurring.

Let us explore some of the barriers to a successful system. Identifying if any of them apply to your organisation, as remedying them may well be the key to your future success.

First, risk management relies upon a robust risk register – without this, there is no order to, oversight of, or accountability for the safety of your business.

What is a Risk Register?

Simple...it is a register that collates the risks in your organisation, allowing clear identification of them, and strategies to be put in place to prevent eventuation of these risks. Identified risks tend to fall into standard categories, such as financial, reputation, environmental, business continuity and clinical, and the register should be monitored regularly by the committee in your organisation with the highest level of governance. Risks are identified through many sources, the most predominant being the Incident Management System (IMS), and in many organisations, this is where management and prevention of risk begin to fail.

Failure to report

Be honest... following an incident have you ever found yourself thinking “why on earth did they do that”? We all have, haven't we?

The incident may not have been a high level, severe, or significant event, but I imagine everyone one of you reading this text has at least one example of an incident that invoked feelings of disbelief or embarrassment, fear, or mistrust, and some that make us want to protect ourselves because of the fear of blame. Previous experience or perceived outcomes, your own or anecdotal, may result in the non-reporting of incidents.

How do we make sure there is integrity in a ‘no-blame’ approach?

We look at the system, not the person. This is much easier said than done, and of course there will be times when behaviour and performance come into the equation. However, starting your investigation by looking at the process, working through it step by step, and identifying the gaps will demonstrate commitment to a blameless process.

Ineffective investigation

Root cause analysis (RCA) is the process most often used in the healthcare industry; however, several methods of investigation come under this umbrella, and you must determine which one fits your needs and the incident being investigated.

Be consistent with the approach you use (5 Whys, Ishikawa [Fishbone], Failure Modes and Effectiveness Analysis [FMEA]), allocate a

lead for the process and make sure your leadership team is trained in the principles of RCA.

Once you have found the style that fits – stick with it – you will get better outcomes as confidence and competence develops.

Get the right people in the room. This can be uncomfortable. The fear associated with RCA is historical and deeply rooted. Medical or administrative hierarchy can be challenging, but you must do this to ensure integrity in the process and improvement in clinical safety.

If this process is ineffective, your outcomes will be suboptimal, recommendations will likely acquiesce to the loudest voice or most senior representative present, there will be limited change, and therefore no improvement.

Do not be ineffective. Trust the process and challenge the status quo!

No oversight of outcomes

Your staff will lose trust and faith in you and your IMS if they do not receive feedback on the incidents they report. Make time, either at your team meeting or individually depending on the incident type, recognise the time taken to complete the report, and include them in the journey of investigation and development of improvement recommendations. This may seem like additional work for you, but it will pay off.

Even high acuity incidents should be discussed. Of course, you should apply censorship to maintain confidentiality, but use incidents and investigations as opportunities to learn. Providing real examples with tangible outcomes will support change in your organisation, including providing the reasons and rationale for the change.

We have identified fear as a common theme throughout this piece.

Reflection

Ask yourself, is the fear associated with incident management yours or your team members?

What is this fear driven by? And how can we turn that fear into a driver for change?

Lead with bravery

When investigating incidents, it is important to take into consideration any influencing human factors such as those in the list. It is extremely rare that anyone purposely acts to cause harm. However, there are often a series of issues in the lead up to a particular event where human factors plays a role. Poor communication, or the lack of, is often a significant factor that can result patient death. Many coroner's reports outline communication failures at critical points throughout a patient's journey that significantly contributed to a patient's death. While lack of communication is just one of the 'dirty dozen', many of the other 11 can each effect how someone communicates. Many can also influence the safety culture of the environment, particularly where complacency is accepted. These factors also need to be considered in the overall risk management of an organisation.

Action Plan Example

Audit & Outcome	Failed Elements	Remedial Actions	By whom	Date Due	Comments	Status
Document the audit completed and the area requiring improvement. Include the date identified	List/outline what the failed items were plus any additional information that might support success of the action plan	Detail immediate actions taken (if any) and longer-term actions to prevent recurrence	Identify the most appropriate person/s to complete each action	Set realistic dates for completion Consider aligning with relevant committees	Add additional comments to support the tracking of progress	Use this column to show progress
WHS Safety Inspection March 2021	2 Fire doors propped open with chairs	IMMEDIATE ACTION: The chairs were removed from both exit doors and advice given to staff present regarding fire safety immediately.	WHS Rep	NA		Complete
		LONGER TERM ACTIONS: Review of signage on all fire exit doors Review of mandatory training compliance with Fire Safety modules Discuss at Team/Site Meetings	Unit Manager	Before next scheduled team/site meeting	Signage in place and clear on all doors (30.3.21) Next team meeting – 5.4.21	Commenced & on track
		Conduct random audits over the coming 2 months	WHS Rep	Weekly for 2/12		Ongoing
		Investigate the option to add alarms to all Fire Exit doors Consider adding alarms to the doors if non-compliance persists	Unit Manager			Not yet Commenced

Date:	Dec 2020					
Version:	V1.0					

Not Yet Commenced	Commenced – On track	Commenced – Ongoing	Overdue	Complete

QI Register Example

Ward or Unit	QI Reference	Start Date	Background	Improvement Idea	Improvement Impact	Review Method	Progress	Approving Committee	Status
All	Add your reference number here	Nov-20	Site audits identified inappropriate items in the trolleys that do not align with the level of life support offered on the sites or the competency of the staff.	Standardise the content and layout of all resus trolleys and develop a visual display card to ensure consistency is maintained.	A standardised trolley will ensure all staff are familiar with content and layout, making it easier to find items required in the event of a medical emergency.	Monthly emergency trolley audit Post-incident debrief sessions	Nov 2020: Risk assessment and questionnaire developed. Dec 2020: Trolley items identified based on risk assessment. Jan 2021: Contents of all trolleys updated and photographed, and copies laminated and placed on all trolleys. Policies and procedures updated. Audit requirements updated on the schedule.	Safety & Quality	Jan 2021 Complete



Failure to understand, commit to, teach, and embed the principles of clinical governance will result in catastrophic outcomes for patients. Just as we have seen from the inquiries referred to earlier in the chapter, this cannot be disputed. But the negative impacts do not stop there. What about our employees, our colleagues, ourselves? We are sure you have all heard the saying “people don’t leave bad jobs; they leave bad leaders”. Bad leadership goes hand in hand with poor governance. If we recognise and accept this, then we can use this to our advantage and use the clinical governance systems to empower our people to be the best version of themselves.

Through inclusive practice and communication, we can provide variety in the roles undertaken, and can expand the scope of work and provide professional development, in turn creating interest and motivation. Recognition of interest and involvement demonstrates investment and respect, inspires confidence, and supports role and organisational succession planning. Retention stops being an issue and reputation recognises you as the healthcare provider of choice.

Version 2 of the NSQHSS has significantly increased its focus on culture, because the power of kindness, having integrity, and truly believing in and adhering to your organisation’s values is how to build your organisation’s framework of safety (ACSQHC, 2017).

Genuinely caring for your people, hearing them, and leading them with respect is the way to deliver great governance and patient care, and achieve amazing staff satisfaction.

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PART II

PEOPLE IN HEALTH AND SOCIAL CARE



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People are critical to the delivery of health and social care services. In this part we learn about talent identification, recruitment and development. Professional development and ongoing training in the highly skilled and professionalised health and social care sector is critical. The health and well-being of the most critical resource, our people, the health and social care workforce is also addressed in this part.

Leading a Healthy Workforce

Leading a healthy workforce

ANA RITA SEQUEIRA AND KATY AISH

“But it is precisely because we are dedicated that we walk into a burn-out trap. We work too much, too long and too intensely. We feel a pressure from within to work and help and we feel a pressure from the outside to give.”

Herbert Freudenberger (1974, p. 161)

Introduction

The global healthcare industry is dealing with an ageing population and workforce, with increasing worker shortages and occupational burn-out in times of increased healthcare demand. The COVID-19 pandemic exposed the systemic gaps in supporting the mental health and well-being of the healthcare workforce, leading to a further public health crisis (Leo et al.. 2021; Rotenstein, Melnick, and Sinsky 2022).

There is growing evidence of the association between work well-being, organisational performance and staff satisfaction, which creates further urgency for systemic changes to improve the mental health and well-being within the health and social care workforce both for frontline workers, corporate services, and leadership teams.

The well-being of leaders has been overlooked in the literature, yet leaders have significant influence on frontline workers' health and well-being outcomes. The role of leadership and the promotion of work health and well-being has been largely absent from health and social care leadership textbooks. Academic and professional literature on staff well-being among the aged care and disability sectors is also scarce (Sheerin et al., 2022). This professional knowledge and practice gap needs to be addressed, and this chapter aims to meet this need by exploring innovative models and providing examples to inspire healthcare leaders and encourage systemic improvements to mental health and well-being within organisations. It is critical that governments and organisations make systemic changes to ensure they can attract and retain talent and promote a sustainable workforce (see also the Talent Management, Recruitment and Selection chapter)

This chapter builds on leading evidence, professional practice, and policy lessons learnt from Australia and elsewhere. The first part provides facts about staff burn-out among the health-care and care sector, and its impact for individuals, patients and organisations. After mapping some of the missed opportunities, it also examines emerging good practices in professional practice, policy, and organisational culture. The second part focuses on two innovative models designed to support the health and well-being of workers – the Trauma-Informed Systems Model (San Francisco Department of Public Health, 2014) and the Framework for Improving Joy in Work (herein, Joy in Work Framework) (Perlo et al., 2017). The main features and dissimilarities are examined, as well as the measures of success. The chapter concludes with reflective questions for the reader.

Symptoms of occupational burnout

Emotional Exhaustion

Depersonalisation

Decreased sense of personal accomplishment

Source: Rotenstein, Melnick, and Sinsky (2022)

Background

Facts about staff burn-out

Driving high-quality and safety care in healthcare, disability, and aged care sectors requires the examination of a 'blind spot' in the delivery of care: the well-being of those caring for the elderly, ill, and people living with a disability. Evidence on burn-out among workers is far and wide, having a global reach (Feleke et al. 2022), impacting throughout the career journey (from nursing and medical students to senior clinicians and nurses) and across specialties (Shanafelt et al., 2022). The COVID-19 pandemic exacerbated this long-dated issue. For example, Ghahramani and colleagues (2021) reviewed 30 articles for a systematic review and meta-analysis on burn-out among healthcare workers (2020–2021) and concluded nurses and/or physicians had the highest reported burn-out at 66%.

Staff burnout was cited for the first time in 1974 by Herbert Freudenberger. In his pivotal work, Freudenberger discusses some of the signs and preventive measures to address burnout among paid and volunteered staff in a clinical setting.

In 2019, the World Health Organisation included burn-out in the 11th Revision of the International Classification of Diseases (ICD-11) as a work-related stress syndrome, and not a medical condition. This is a reflection of the increasing evidence about the significant prevalence of burn-out and depression across the workforce globally. Further, in 2014, the change from the 'triple aim' of health care (improving patient experience, patient outcomes and efficiency) to the 'quadruple aim', which includes improving healthcare staff experience, was developed to acknowledge the impact staff well-being has on patient outcomes (Bodenheimer and Sinsky, 2014).

There is increasing evidence of an association between health-care worker well-being, organisational culture, and patient safety that emphasises the inclusion of staff well-being in the aims of healthcare (Bodenheimer and Sinsky, 2014; Fitzpatrick, Bloore, and Blake, 2019; Mannion and Davies, 2018). On the other side, burn-out among clinicians has been associated with poorer health outcomes and an increase in the cost of health-care (Bodenheimer and Sinsky, 2014; Brand et al., 2017). The table below provides an overview of the negative impact of staff burn-out on the individual, patients, and organisations, and reinforces the system-wide strategies to improve the mental health and well-being of healthcare staff, and the need to be a priority for leaders and policymakers alike (Brand et al., 2017).

Table Impact of Clinical Staff Burnout

For Staff	For Patients	For Organisations
Mental illnesses (Bahar et al., 2020; Pappa et al., 2021)	Poorer health outcomes (Bodenheimer and Sinsky, 2014)	Staff turnover (Leo et al., 2021)
Physical, cognitive and emotional exhaustion (Bahar et al., 2020)	Lower productivity (Leo et al., 2021)	
Chronic insomnia, fatigue, injuries, chronic diseases and domestic issues (Bahar et al., 2020)	Absenteeism (Leo et al., 2021)	
Reduced situational awareness (Bahar et al., 2020)	Increased costs of healthcare (Brand et al., 2017).	
Poor health behaviours (e.g., poor diet and low activity)(Brand et al., 2017)	Stock market performance (Goetzel et al., 2016)	

Missed opportunities?

In the social and healthcare sector, the COVID-19 global pandemic propelled health and social care staff burnout to widespread visibility, and health systems have increased stressors associated with the complexity of a global pandemic (Fitzpatrick, Bloore, and Blake, 2019; Javakhishvili et al., 2020). On the other hand, these pressures accelerated the implementation of initiatives and research into the mental health and well-being of frontline healthcare providers (Daniels et al., 2021; Jackson Preston, 2022; Javakhishvili et al. 2020; Lewis et al., 2020; Rangachari and Woods, 2020; Sheerin et al., 2022).

Despite the limited initiatives to address frontline staff well-

being, other frontline worker cohorts within healthcare (including allied health professionals and leaders) have been largely overlooked in the academic and professional practice literature (Pollock et al., 2020).

In Australia, the examination of national policy and guidelines such as the National Standards and Quality Health Service (NSQHS) Standards (Australian Commission on Safety and Quality in Health Care, 2021), the Aged Care Standards (Aged Care Quality and Safety Commission, 2018), and the National Health Reform Agreement (Australian Health Ministers, 2021) are largely silent on the impact of clinician health and well-being on the safety of patients.

Despite the slow-moving integration of staff health and well-being as part of every day and everybody's business, there are emerging and positive examples alluding to a shift in professional practice, policy, and organisational culture.

Examples

Professional Practice

In Australia, the Australasian College of Health Service Management (2022) published the *Master Health Service Management Competency Framework*, which includes staff well-being as part of Business Literacy and Talent Management. Sector managers and executives are expected to promote the creation of "... an environment that monitors and supports staff health, well-being and satisfaction, and responds appropriately to stress in the workplace".

Policy

Comprehensive policies on health, safety, and well-being are emerging, and can be found across various sectors. In Australia, the Queensland Department of Health (2020) created a health, safety, and well-being policy aimed at prioritising employee well-being as a requisite of delivering quality health services. Ambulance Victoria (2022) is implementing a Mental Health Wellbeing plan 2022–2025 that focuses on early interventions and person centred delivery of mental health and well-being support for their employees, first responders, and their families.

Internationally, Canada in 2013 implemented a voluntary National Standard on Psychological Health and Safety in the Workplace, which provides employers with a tools and resources to protect the psychological health of employees.

Organisational Culture

In the United Kingdom, the National Health Service (NHS) is considered UK's largest employer (Nuffield Trust, 2022). Boorman's (2009) review of the NHS Health and Well-being Workforce collected evidence on health and well-being across the NHS and recommended measures for improving organisational behaviours and performance, achieving an exemplar service, and embedding staff health and well-being in NHS systems and infrastructure. This review ignited fundamental changes in the NHS, with staff health and well-being being integrated into governance and regulatory instruments, and initiatives being implemented from the boardroom to the ward. In 2018, the NHS launched the Health and Wellbeing Framework, which was implemented across over 70 organisations, and the positive results evaluated widely (NHS England and NHS Improvement, 2021).

“Organisational culture represents the shared ways of thinking, feeling, and behaving in healthcare organisations.”

Mannion and Davies (2018, p. 1)

Models designed to support the mental health and well-being of workers

“For me the lever is a simple one – recognising that protecting and improving staff health is not a fluffy, cuddly thing to do, but rather a key enabler to support improvements in high quality care, patient satisfaction and improved efficiency” (Boorman, 2009, p. 6)

The Trauma-Informed System (San Francisco Department of Public Health, 2014) and Joy in Work framework (Perlo et al., 2017) are presented in this section. These two models were selected from a range of models available in the literature (see Additional Resources) due to their relevance, validation, impact, applicability to healthcare and care sector, and complementary features. The examination of the two models is followed by a compare and contrast analysis and practical considerations for leaders and organisations interested in improving health and well-being among the workforce.

Trauma-Informed System Model

The trauma-informed approach to care has been widely researched, with formative research beginning in the 1970's (Substance Abuse and Mental Health Services Administration, 2014). Until recently, the focus of most research and delivery has been on ensuring all those who have contact with clients/patients practice trauma-informed care to reduce secondary traumatic stress for those accessing services and support. However, research has shown that staff who support trauma survivors are at high risk of developing vicarious stress and trauma, burn-out, and compassion fatigue (Handran, 2015; Wolf et al., 2014).

Trauma Definition:

"Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being"

Substance Abuse and Mental Health Services Administration (2014, p. 7)

In 2014, a panel of experts in the San Francisco Public Health System identified a gap in the trauma-informed approach research on how trauma impacts staff, providers, and organisations. They explored how a trauma-informed approach was being used across different organisations and identified the need for an initiative to reduce the impact of vicarious trauma experienced by staff and workers providing care to improve the organisational culture (San Francisco Department of Public Health, 2014).

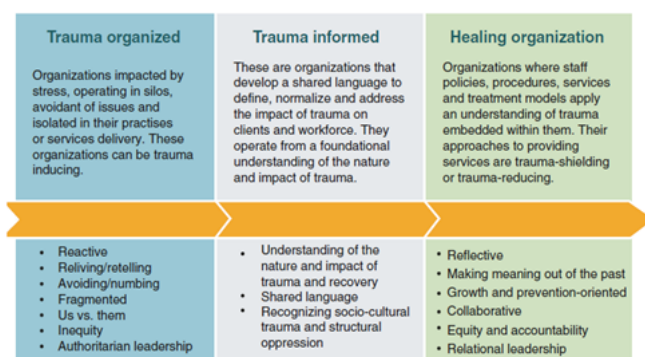
Trauma Informed Approach Definition:

"A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization."

(Substance Abuse and Mental Health Services Administration, 2014, p. 9)

In collaboration with a group of mental health and psychology experts, leaders, individuals with lived experience, primary care providers, and behavioural health representatives, and drawing on research on organisational culture and implementation science, the San Francisco Public Health System developed the Trauma-informed Systems (TIS) model as an initiative to move organisations from 'trauma organised' to 'healing organisations' (San Francisco Department of Public Health, 2016, p. 2).

This emergent model leveraged existing trauma-informed approach models and was designed to address trauma at a system level to create a healing organisation and build resilience, and improve the overall health and functioning within an organisation. The TIS model acknowledges that organisations can inadvertently organise themselves around patterns of behaviour that create and reinforce vicarious trauma within the workforce and provides a structured approach to transforming organisations into healing organisations (McGoldrick and Hardy, 2019). The model is seen as a continuum (see figure below), with organisations growing foundational skills to promote and support sustainable well-being for providers, staff, and administrators (Loomis et al. 2019, p. 257).



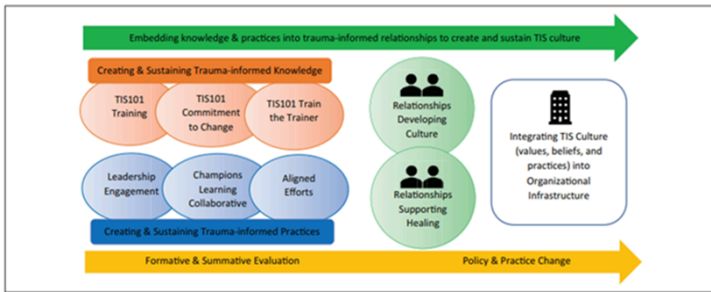
From trauma-inducing to trauma-reducing

*The continuum of transformation from a trauma organised to a healing organisation with sustainable healing practices. **Source:** Copyright permission kindly granted for publication in this book only (San Francisco Department of Public Health, 2016, p. 2)*

The TIS model recognises that to build lasting change within an organisation a fundamental shift is required in how we respond to trauma in organisations that support individuals, families, and communities, and aim to build an environment that provides the support and resources for organisations to become healing organisations (Gerber et al., 2019). The TIS initiative training framework builds knowledge in trauma informed care, provides tools to create and sustain trauma informed practices that support building a relationship building culture, and ultimately, aims to integrate a TIS culture within the organisation (see figure below). To underpin this training, the TIS model includes six core principles that can be put into action at individual and organisational levels. These principles guide all associated resources developed by the SFDPH and include :

1. Understanding Trauma and Stress
2. Compassion and Dependability

3. Safety and Stability
4. Compassion and Dependability
5. Collaboration and Empowerment
6. Resilience and Recovery (Loomis et al., 2019, p. 253)



Features and organisational behaviours of the San Francisco Department of Public Health's Trauma-Informed Systems Initiative.
Source: Copyright permission kindly granted for publication in this book only (Loomis et al., 2019, p. 254)

Loomis et al. (2019) acknowledged that the benefits and impacts of implementing a TIS model need to be measured and evaluated. Evaluation of the TIS model has mostly been limited to the self-reported success of participants achieving goals, maintaining a commitment to goals set within training sessions, and continuing to iterate and improve training resources and program delivery (Loomis et al., 2019). However, potential future measurements of success could include employee retention and satisfaction, client satisfaction and outcomes, and the organisation's progress towards embedding the six core principles of the model, and there would be benefit from further evaluation to understand the impact of the TIS model on the broader organisational culture within early-adopter organisations (Loomis et al., 2019).

Framework for Improving Joy in Work

In 2017, the Institute of Healthcare Improvement (IHI) published a White Paper entitled *Framework for Improving Joy in Work* (Perlo et al., 2017). This model is the culmination of a literature review, co-design process, expert and consumer interviews, and a process of co-design, implementation and evaluation by IHI and selected healthcare services. Although this framework is recent, some studies have validated this approach (Galuska et al., 2018; Reid, 2018) and it has been widely referenced and influential (Gandhi et al., 2018; Kruk et al., 2018; Smith and Plunkett, 2019). NHS has also published several case studies following the principles of the Joy in Work Framework (NHS England and NHS Improvement, 2021).

As an approach to get leaders and healthcare organisations to begin strategising about well-being at work, IHI proposes four steps (Perlo et al., 2017).

Step 1. Listen and Learn: “What is the most meaningful part of your work? What makes you proud to work here? When we are at our best, what does that look like?”

This form of appreciative inquiry builds on the employees’ voice and its significance for each and every team member. It also sheds light on the existing strengths that will be a catalyst for change.

Step 2. Identify unique barriers to joy in work in your workplace: “What frustrates you at work? What gets in the way of what matters?”

This step identifies the challenges and hurdles experienced by employees, and can lead to the generation of ideas on how to overcome them, and in which order of priority.

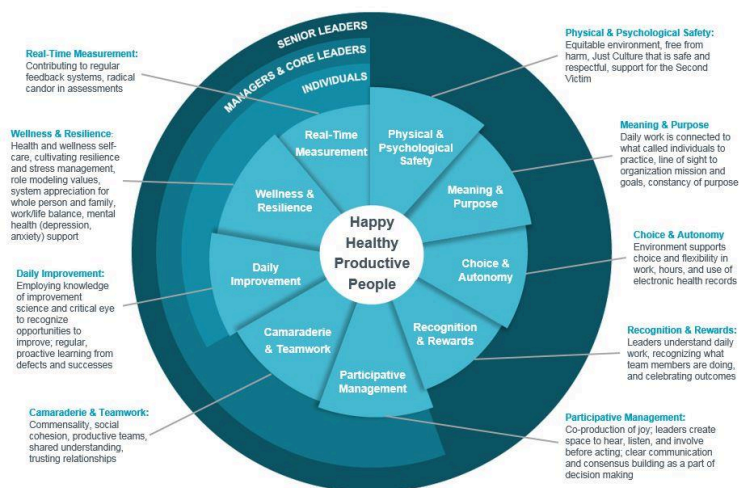
Step 3. Driving a system approach supported by shared responsibility: “What should we tackle first? What activities should be co-designed?”

The framework presents staff well-being as ‘everyone’s businesses’ from senior leadership to individuals. It includes nine critical components per level of responsibility (see figure below). By acknowledging workplace discrimination towards racially and ethnically minoritised healthcare staff (Nunez-Smith et al., 2009; Rhead et al., 2021), the framework considers fairness, respect, and equity towards patients, colleagues, and managers as foundational dimensions to the success of the nine critical components.

Nine critical components are assigned to different levels of responsibility and roles of individuals, managers, and senior leaders.

Individuals are responsible for maintaining respectful and constructive relationships, upholding the organisation’s values, and contributing to three critical components: daily improvement, wellness and resilience, and real-time measurement.

Managers and leaders at clinical, department, or program levels have a pivotal role in improving the morale and job satisfaction of frontline staff, ensuring high-quality and safe patient care, and contributing to a strong sense of belonging and engagement. Therefore, in addition to the ‘individual’ critical components, they are also responsible for fostering *camaraderie and teamwork* and *participative management*.



IHI Framework for Improving Joy in Work (nine critical components). Source: Copyright permission kindly granted for publication in this book only (Perlo et al., 2017, p. 16).

“Senior leaders are accountable for developing a culture that encourages and fosters trust, improvement, and joy in work” (Perlo et al., 2017, p. 20). It is expected they will clearly communicate their vision for the organisation and ensure the required resources and systems to execute it. Although senior leaders are ultimately responsible for all nine critical components, the framework considers a focus on *physical and psychological safety, recognition and awards, choice and autonomy, and meaning and purpose*.

Step 4. Plan, implement, monitor, evaluate, and plan again... together: “What results were achieved? What did we learn? What’s next?”

Although the activities to build a healthy and joyful workforce emerged from ‘grandiose’ principles such as collaboration, engagement, systems approach, and continuous improve-

ment, the actions themselves tend to start small and be relevant to the local context (e.g., team, department or unit). Measures of process and outcomes need to be designed, as well as the systems to monitor them over time. Improvement effort also needs to factor in staff workloads and levels of stress. Examples of system-wide metrics might include retention of health workers, turnover of health workers, employee reported burn-out, and employee reported well-being .

Some criticisms worthy of consideration include the absence of financial well-being and employee job security, which we see as a vital element for staff engagement and joy in work. Linzer and colleagues (2019) also referred to the absence of trust in the model.

Key implications for practice

Leadership has a significant role in guiding organisational culture within the volatile, uncertain, complex, and ambiguous (VUCA) health and social care industry. Still, the wider organisational culture also influences well-being within the organisation (Pandit, 2020). Both models identify that leaders have a significant role in guiding cultural change within an organisation; however, both also note that the change needs to be 'everyone's business' and must outlast individuals and become embedded within the governance, functions, and operations across an organisation (Loomis et al., 2019; Perlo et al., 2017)

Both models share the need for a 'whole-of-organisation' commitment and change towards integrating health and well-being in the operations. The main similarities between the two models and the structure and measurement of success as the main dimensions that differentiate the two models as shown in the figures below.

Features	TIS Model	Joy at Work Framework
Commitment at all levels of leadership within the organisation	✓	✓
Champions embedded within the organisation	✓	✓
Listen and understand local needs	✓	✓
Build collaboration and trust within the organisation	✓	✓
Empowerment of staff to make choices that promote well-being	✓	✓
Shared decision-making in strategy, implementation, and evaluation	✓	✓

Key Similarities Between the Trauma-Informed System (TIS) and Joy at Work Framework

Features	TIS Model	Joy at Work Framework
Structure	Prescribed training and very structured implementation plan	Based on local context
	Guidance on developing and embedding policy and practice change	Challenges and meaning guides implementation and structure
Measurement of success	Individual commitment at all levels is measured three months post-training	Determined at the local level.
		Measures of success should include processes and outcomes.

Key Differences between the Trauma-Informed System (TIS) and Joy at Work Framework.

Healthcare organisations are unique ecosystems serving a vulnerable clientele, at the same time ensuring their professionals are not only protected from trauma and compassion fatigue, but find strategies to strive and achieve health and well-being. These two models provide key principles and resources for supporting organisations’ exploration of health and well-being initiatives to foster an organisational culture that integrates staff health and well-being into primary operations and strategies.

Key Takeaways

For leaders ...

Improving health and well-being among the health-care workforce is not an easy fix, and it should be a priority for organisations amidst the pressures faced by health systems and poor health outcomes reported by healthcare staff.

The two models reviewed in this chapter highlighted the importance of a 'whole-of-organisation' commitment in order to succeed, a 'bottom-up' approach anchored in effective engagement in all stages, and a continuous improvement culture.



Listen and Learn

- Each local environment is unique
- Identify gaps, needs and priorities
- Identify evidence-based solutions



Engage all levels within organisation in planning

- Strategy
- Implementation
- Evaluation



Support active local champions at

- Board level
- Leadership levels
- Frontline staff levels















Strive for continuous improvement and make sure you measure success

- Identify which indicators to measure
- Identify how frequently to measure indicators
- Identify short, medium and long-term goals

Essential organisational behaviours to drive continuous improvement of staff health and well-being

Many organisational culture assessment tools can guide system wide assessment and strategy development; however, one of the most frequently used is the Safety Attitudes Questionnaire (Sexton et al., 2006). This example has been widely used in the US and the NHS to assess how safety culture changes over time (Mannion and Davies, 2018). Other indicators can also assist in measuring the process within the organisation (output measures) and impact of health and well-being interventions (outcome measures), as shown in the figure below.

Output Measures	Outcome Measures
 Number of assessments / baselines conducted	 Staff satisfaction and engagement e.g. <ul style="list-style-type: none">• 'Pulse' survey to measure physical, social and psychological health• Employee Net Promoter Score
 Financial and non-financial resources allocated	 Absenteeism and Presenteeism e.g. <ul style="list-style-type: none">• Absenteeism – time away from work• Presenteeism – low quality work or decreased productivity
 Uptake of trainee attendees by department or level (frontline, middle managers, senior managers)	 Performance review outcomes / Promotions e.g. <ul style="list-style-type: none">• Staff engagement with professional growth• Staff upskilling and education• Mandatory education compliance
 Awareness of initiatives among staff	 Frontline led innovations and initiatives e.g. <ul style="list-style-type: none">• Continuous improvement ideas• Innovative solutions to complex problems
 Number of interventions fully implemented	 Staff retention / turnover e.g. <ul style="list-style-type: none">• Recruitment pattern changes• Turnover reason (e.g. promotion, resignation)
 Policy, strategic documents, KPIs aligned with health and wellbeing goals	 Reportable incidents e.g. <ul style="list-style-type: none">• Staff injuries or near misses• Client reported complaints/complements• Client related incidents

Examples of metrics available to measure improvement in organisational culture

Reflection:

As a leader, consider how you would gather evidence and create a strong business case to influence key stakeholders in adopting health and well-being priorities in your organisation?

As a board member and being strategic about other members' key responsibilities, what intelligence about staff health and well-being and other impact areas would you need to gather to influence them?

As a frontline worker, what can you do to advance health and well-being initiatives in your organisation? Consider short and mid-term actions.

As a decision-makers, where should you start first – developing the strategies and governance around health or well-being, or starting ad-hoc interventions that promote health and well-being among staff, or both? Discuss advantages and disadvantages.

Key Takeaways

An overview of the status of the healthcare workforce well-being was reviewed in this chapter, stressing the

urgency of organisations integrating staff health and well-being as part of their business operations and strategic direction. Emerging examples in professional practice, policy, and organisational culture were also featured. The second part of the chapter provided an in-depth exploration of the Trauma-Informed System and the Joy in Work Framework, followed by a comparative analysis.

Additional Resources

A Journey to Construct an All-Encompassing Conceptual Model of Factors Affecting Clinician Well-Being and Resilience (Brigham et al., 2018) <https://nam.edu/journey-construct-encompassing-conceptual-model-factors-affecting-clinician-well-resilience/>

Model of Wellbeing and Psychological Care for Frontline Doctors found in (Daniels et al., 2021) <https://www.mdpi.com/1660-4601/18/18/9675>

Mental Health and Well-being: A Socio-Ecological Model (Michaels et al., 2022)

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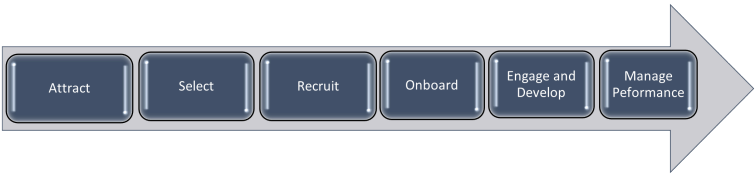
Talent Management, Recruitment and Selection

RICHARD OLLEY

Introduction

Despite the pressures of the current economy, three things remain high priorities for workforce management in the health sector. First, organisations must maintain a diverse workforce reflective of the increasingly diverse society in which we live. This requirement is essential to building the capability to meet future challenges, because we require innovation in thinking and service delivery that such diversity brings. Failure to address this could lead to the loss of valuable talent. Equity and equality are also essential within the health and social care workforce. Not only because to do otherwise would counter the laws of most developed and democratic countries, but also for the diversity reasons already discussed. Finally, talent management assists with understanding the organisation's skills, experience, and capabilities requirements to enable delivery on the mission and strategic objectives set. Leading talent management strategies in the workforce is a critical function of health and social care leaders, including the vital functions of recruiting, selecting, and retaining the workforce, performance management of staff through implementing equitable and legal disciplinary procedures, and the importance of the training and development of the workforce.

Overall, talent management may be considered a series of six connected and interdependent processes that are, in some cases, systems. The figure below details these processes that make up that system.



The Interdependent Talent Management Systems

This chapter examines attracting, recruiting, and retaining talent in the health and social care workforce and the important function of tracking the performance of an organisation's talent management system using talent management metrics.

Attracting, Recruiting and Retaining Talent

Attracting the right person to the right job at the right time is the goal of any organisation embarking on recruitment processes. Retaining the right person for the job is enormously important. This task is made even more complex due to the competition between healthcare and social care providers experienced globally, particularly in recent times (van den Broek et al., 2018). The costs of recruitment and selection procedures and onboarding and orientation of new staff are climbing (Castro Lopes et al., 2017), so they must be carefully

managed, particularly in the fiscally tight environment of the health and social care sectors.

The benefits of talent management are well-documented in the literature (Naulleau, 2019, Papa et al., 2018). Leaders who concentrate their efforts on implementing a talent management strategy that empowers staff to perform at their best will drive success in the recruitment of talent that is in demand ahead of their competitors for staff. They will minimise service disruption by establishing a talent pipeline, and therefore maintain service operations by filling any vacancies quickly (Mitosis, Lamnisos, and Talias, 2021). Additionally, they will improve the productivity of their workforce, reduce costs, and encourage innovation by and within their workforce (Wadhwa and Tripathi, 2018).

Attracting Candidates

Attracting talent is the first and the most important function of talent management, because if an organisation cannot attract candidates, there is no one to move into the selection process. Talent attraction refers to the organisation's ability to persuade potential staff to apply to join the organisation. There are several opportunities to consider when deciding what strategies to use for a successful outcome. There is a critical shortage of workers in the health and social care sector (Klimek et al., 2020, Dussault and Zurn, 2020, Van den Heede et al., 2020), and this has a great impact on the sustainability of services because health and social care is a labour-intensive enterprise.

The critical skills shortage experienced globally has made health and social care an increasingly competitive market (Ybema, van Vuuren, and van Dam, K, 2020). Related to the de-funding of Health Workforce Australia in 2015, limited Aus-

tralian data is available, other than scanning the job vacancies in organisational job boards and other media advertising for staff. One survey conducted in the United States by Glassdoor (2023) , an employer branding and staff sourcing company, found that health and social care organisations had the longest average time to employ in any industry, with 23% of positions needing about 112 days to fill, lengthy by any standard. There is no data to confirm whether this is the case in Australia, but anecdotally, it appears to take a long time to employ.

Attracting high-performing candidates is achieved by harnessing the outputs from channels such as:

- Organisational job boards that prospective candidates use to search for positions that interest them.
- Online healthcare job sites, similar to organisational job boards.
- Social media channels such as LinkedIn.
- Referrals from existing and former staff.
- Professional association web sites, because they foster networking by some of the best talents for the various disciplines and professional groups in health and social care and often conduct conferences and continual professional development opportunities and events aimed at career advancement for their members.
- The organisation employing internal talent management specialists to scan various other channels and put a personal touch on recruiting staff.
- External health and social care recruiters, who can be freelance recruiters or those who work within a large recruitment specialist firm.

This list is by no means exhaustive or specific for either health-care or social care because there is wide choice. The important point is to find channels and organisations that are successful for the particular discipline or professional group organisations

are searching. The literature suggests that the use of publicly available channels relates to the organisation's brand and is the intersection of marketing and talent management (Yohn, 2020). Helping to attract the best talent is especially important in labour markets like health and social care, which have intense competition for the scarce health and social care workforce. Health and social care organisations that are prominent and unique in some way must offer potential candidates persuasive reasons to apply for workforce vacancies (Yohn, 2020).

The health and social care organisation's reputation and brand, and the marketing of that brand are important. A German study by Hoppe (2018) sampled 366 hospital healthcare professionals and found increased organisational attractiveness, organisational identification, and favourable employee behaviours to corporate branding lead to increased retention.

The Recruiting and Selection Processes

Sourcing Candidates

Selection of the right candidate who best matches the organisational culture sets the baseline for employee behaviour, employee interaction with healthcare consumers and families, and employee-to-employee relationships. Without a culture match, organisations set themselves up for long-term retention issues (Nangoli et al., 2020), with workforce metrics demonstrating climbing attrition and turnover rates. Without retention of employees who match the organisational culture, results will not improve, and may worsen in terms of quality, safety, and costs. The organisation's brand will suffer as a con-

sequence. Recruitment and selection are the centrepieces of any talent management system. Its success or failure will be felt throughout the organisation to change or maintain the organisational culture, consumer experience, staff experience, and viability.

Tracking Applicants

Tracking applicants and their applications, including their resumes, is the next step in recruitment and selection. Applicant tracking can be a manual process, and for some organisations, applicant tracking systems (ATS) are rapidly becoming extremely helpful to those seeking to attract new talent. This technology aids in the management of authorised recruitment when a vacancy is identified and applications are received for every open position. Employment specialists use an applicant tracking system to review applications.

Abilities, Aptitude, and Skills Tests

These tests can be either pencil and paper tests or job sample tests. They assess the abilities, aptitudes, or skills required for the job. Both types of tests are scored, with minimum scores established to screen applicants. The “cut-off” score can be raised or lowered depending on the number of applicants and the quality of applications received. When selection ratios are low, the cut-off score can be raised, increasing the odds of employing better qualified employees.

Only after thorough and careful job analysis should tests be selected. For example, an examination of a job description for a central sterile supply technician would show that manipulation of parts and pieces relative to one another and the ability

to perceive geometric relationships between physical objects are required. These abilities are a part of a construct called mechanical aptitude. For care-related positions, the focus would be more related to soft skills of communication, respect for all people, caring aptitudes, some ability to multi-task, and technical skills related to the type of care the person is expected to deliver. Some organisations develop their job sample tests rather than relying on commercially available aptitude tests. Job simulation exercises are closely related to job sample tests as part of the selection process, placing applicants in simulated job situations to observe what they do.

Personality Tests

Certain jobs require unique personalities or temperaments. We sometimes occupy specific jobs due to personal work preferences. However, there is little evidence that people must have a specific personality type to succeed at a particular job. In describing the use of personality tests for determining suitability for a rural nursing appointment, Terry and colleagues attempted to consider whether personality trait assessment assists in understanding professional career choices (Terry et al., 2019). They found that the two general personality tests are self-report and projective personality tests, sometimes deployed to decide which applicant best fits the job demands. These tests are also frequently used as part of assessment centres, a popular method of identifying potential talent.

Personality measures may adversely impact the process (Risavy and Hausdorf, 2011). Other critics contend that it is difficult to demonstrate that personality characteristics are job relevant (Santos et al., 2018). Job specifications should emphasise the skills and abilities needed for a job rather than personality traits. Personality measures assess specific personality con-

structs rather than behavioural patterns associated with the job. Scepura (2020) asserted that health and social care leaders involved in approving recruitment and selection processes should consider eliminating the use of instruments that screen for personality traits. According to Scepura (2020), this relates to the risks associated with candidate profiling, favouring processes that identify candidates with diverse credentials. These diverse credentials in candidates signal to consumers and other staff that the organisation honours diversity and inclusion, and will therefore better serve the increasing number of culturally diverse consumers and staff by eliminating trait profiling in the selection process.

The Selection Panel

What needs to be clearly understood when forming an interview panel is that interviewing is not an innate skill. Training is required for the merit process to operate as intended relating to panel members and panel chairs. Without appropriate training, there is an increased risk of inequities in the selection process, and therefore increased risk of reputational damage and lawsuits.

In the interests of credibility, the chairperson, or delegated officer, should have a defensible rationale for committee members' inclusion (or exclusion). It is important to have a gender balance, selection panel diversity, appropriate professional credentials, and a process for disclosing any conflicts of interest when assembling the selection panel. As a rule, those appointed to the panel should be experts in the field and have the confidence of all panel members.

Selection Panel Responsibilities

The chairperson of the selection panel ensures the fairness of

the selection process and has the responsibility of reminding all members of their duties, which include:

- ensuring the confidentiality of the proceedings,
- the requirement to declare a conflict of interest,
- anti-discrimination and privacy legislation requirements, and
- organisational policies on recruitment and selection and equal opportunity.

Merit Processes

The author defines a merit system as employing and promoting employees that emphasise their ability, education, experience, and job performance, rather than their connections or other factors. The merit process is governed by uniform and impersonal policies and procedures. Merit processes should be followed throughout the selection process, from advertisement to the selection panel's recommendations. It is important to understand that merit applies throughout the employment process, not just in the selection interview.

Observing merit principles is most obvious during the interview process, and the selection panel uses these in their deliberations for the important task of selecting successful candidates based on their ability, knowledge, and skills to perform the role for which they have applied.

Shortlisting of Applicants for Interview

Interview short listing may include a preliminary phone interview before the applicant is invited to a panel interview. An initial review of an applicant's submitted documents will reveal

those applicants who do not meet the minimum requirements for the job. While a talent specialist may probe further into an applicant's experience and people skills, this interview aims to narrow the applicant field for consideration. Conducting a preliminary phone interview will obtain information about an applicant's background, work history, and experience. The objective is to determine whether or not the applicant has the requisite skills and qualifications for the job. From this point, the applicant field is narrowed to a "shortlist" of candidates considered of equal merit before the formal interview or other selection processes.

Selection Interviews

Well prior to inviting any applicant to a more formal interview/selection process, organisational policy will dictate what method or methods will be used in the selection process. Several selection methods available for the selection processes used in the recruitment. Because interviews are the most common form of selection process, it is discussed here in some detail.

Selection interviews are tools that allow the exchange of information between applicants and interviewers relating to an applicant's suitability for the job. Interviewers can then probe more intensely in the interview to elicit additional relevant information.

Watch this video "How to Interview Candidates for a Job"



One or more interactive elements has been excluded from this version of the text. You can

view them online here: <https://bercollective.caul.edu.au/leading-in-health-and-social-care/?p=229#oembed-1>

Video Source: Videojug. 2011. How to Interview Candidates for a Job. Available at <https://youtu.be/d6uzZqkcsa8>

Common interview panel mistakes include:

- Lack of preparation, either in job requirements or applicant history and interests.
- Being nervous about the responsibilities of panel members or the panel's work.
- Being overly blasé or indifferent and failing to connect with the applicant.
- Being overly enthusiastic and not allowing the applicant to complete responses to the questions asked.
- Intimidating the candidate through the interview style portrayed.
- Not being able to fully answer legitimate questions the interviewee asks about the position or the organisation.
- Apparent bias or a conflict of interest exhibited by panel member.
- Being overly friendly or oversharing with the applicant.
- Being unfair in questioning or not properly listening to the applicant's answers.
- Being overly kind, to the point of making the applicant uncomfortable.

Reflection

Read the list of selection panel mistakes listed above.

Think about interview panels you have experienced as an applicant or as part of a selection panel.

Identify which (if any) of the list you have experienced, as either an interviewee or interviewer.

List others not mentioned above.

Reflect on how you felt about the identified mistakes and what you would do next time to prevent them from happening again.

Approval following Selection Committee Report

The selection report is effectively the minutes of the implemented selection process. The report's main purpose is to convey the panel's recommendation and provide enough information for the delegate with authority to authorise the candidate's employment to make an informed and fair recruitment decision. In most organisations, there is a requirement for the "one-up" rule to apply. This means that the person who can approve a candidate's employment is at least one level in the hierarchy above the person's immediate supervisor or manager. This is a check and balance so that merit processes are evident and the talent management processes are followed.

Of-course, there are methods in addition to those already discussed. Group assessment centres set various tasks and hurdles for the applicants to complete under observation and

group activities to demonstrate applicants' soft and technical skills. The deployment of these methods is a matter of policy and practice for the organisation seeking to recruit.

Reference Checks

It is always better practice to ask for referees from applicants. Generally, reference checks would be undertaken after the applicant is offered the position to protect the applicant's privacy. Reference checks allow representatives from the organisation to gain independent insights about candidates that relate to their work capabilities. It is most unlikely that a referee supplied by the applicant will not support the application. However, at the same time, asking the right probing questions usually elicits a truthful response from referees. It is worth remembering that the person you are requesting to provide the reference is often busy with their work, so it is important to keep your questions concise and focused on the following:

- the essential skills for the job requirements,
- some of the applicant's personal attributes, and
- role-specific questions.

The following table contains examples of some questions that address these three important areas.

Possible questions for referees

Essential Job Skills	Applicant Personal Attributes	Role Specific Questions
Please detail the nature of your working relationship with the applicant.	Please describe the applicant's ability to use initiative when problem-solving.	Please rate and comment on their overall performance.
Please confirm the general duties and responsibilities of the role.	Please rate and comment on their verbal communication skills.	How would you rate their customer service skills? (Please explain your answer and provide an example)
What do you consider the applicant's strengths relating to technical skills and personal attributes?	Please rate and comment on their general conduct and behaviour.	Can you comment on the level of supervision they require? How well did they work autonomously?
Are you happy for us to contact you for further information, and if so, is there a preferred time or day that would be best for you?	What level of drive and motivation did they display during the time that you worked with them?	Please rate and comment on how they worked with and related to their team and management.
Would you re-employ them if given the opportunity and had an appropriate role?	Please rate and comment on their honesty and integrity.	Please rate and comment on their ability to find innovative ways to solve problems

Activity

Looking for opportunities

Scenario:

Your email inbox contains a request for a written reference for one of your better performing staff members. You had no idea that the staff member applied for a new position and you believed they were happy in their job.

Activity Instructions:

Considering the value of this staff member to you personally and to the organisation, list some lawful and ethical actions that you would take in an attempt to retain them. Think about things such as understanding the reason for why they explored employment options, remuneration level, other benefits, training and development, or professional education options that could be offered. Remember, you can only negotiate within your delegation limits.

Extending an Employment Offer

The employment offer is the final process in the recruitment and selection process. Once the most suitable candidate for the job is determined, it is time to inform the candidate of the pre-employment requirements. These requirements may include background inquiries, drug tests and, if applicable, licensing information, and any other pre-employment requirements such as background and criminal history checks, medical fitness, and so on.

When recruiting for positions where employment terms need to be negotiated, such as compensation and benefits and

other issues, a draft employment offer may change based on information from the candidate to the employer until the parties reach an agreement. An employment offer should always be in writing to document the terms of your agreement with your prospective employee. Most importantly, the documents should be executed before the person takes up the position.

Labour Metrics – Measuring Recruitment and Retention Outcomes

There are options to consider that relate to metrics that assist in determining the success of recruitment and retention strategies and processes used to recruit and retain the health and social care workforce. While what is included here is not exhaustive, it contains relevant and achievable evidence-based metrics currently considered within the health and social care sector and the wider workforce management communities. These metrics require scrutiny as to the data sources available to implement them and the usefulness of each metric relevant to individual health and social care organisations.

It is vital that when considering the recruiting metrics, that they have relevance and useability within health and social care organisations. This may mean collecting a smaller data set and resultant metrics than using a large quantity with less impact on the workforce (Fishbein et al., 2019).

The recruitment and retention metrics should also be tied to specific business goals because they will have greater relevance and use within the organisation as one of the strategies used to achieve desired outcomes in line with those business goals. Labour metrics not aligned with strategic and operational business goals will not be as relevant and useful to

organisational leaders and talent management specialists who use them.

The process of obtaining a result from workforce data must move beyond just collecting it. When improvements are required, there must be an appropriate analysis of the results compared to action strategies. Health and social care leaders must use these metrics as part of an actionable improvement process to gain the most value. It is recommended that a regular review of recruiting metrics is undertaken. These reviews should:

- occur annually as a minimum,
- be accompanied by a review of the frequency of measure and the quality of data collected, and
- examine the success or otherwise of improvement strategies to ensure that these labour metrics are gathered and used successfully to support improvement.

The focus of these reviews will in provide valuable information related to the following:

- employee recognition and reward strategies, and employee engagement;
- the organisation's strategic goals; and
- fostering a culture of continuous improvement within the organisation.

It is also vital to choose recruiting and retention metrics that focus on early warning about any issues of concern in the recruitment or retention of the health and social care workforce addressed by strategies that help to improve the results.

The Importance of Sound Recruitment

and Retention Results

While finding and employing the right people is critical, retaining them is just as important. There is considerable cost involved in finding the right person for vacant jobs within any health and social care organisation. Losing members of the workforce often incurs prohibitive costs, including losses in revenue, because services cannot be safely offered with an available and appropriately qualified and experienced workforce, causing a decline in productivity. This can even harm staff morale.

Employee retention metrics provide valuable information about why employees stay with the organisation. These can be used to monitor employee retention, identify at-risk employees, and look at trends for what may be expected in the future. Such analyses can help strengthen employee retention strategies and minimise attrition costs. When employee retention is monitored this way, the organisation can assess the level of satisfied employees and use the information to reduce attrition. Providing competitive salaries and wages, training opportunities, and work-life balance are a few ways to improve employee retention rates. Helping employees feel engaged, challenged, and supported so they feel a sense of accomplishment and fulfilment can also boost employee morale and retention. Work is not just transactional for many employees. Engaged workers are more likely to continue their employment, and even become high performers. Helping employees understand their impact on the business can give them a sense of participation and help improve their fulfilment.

From a cost perspective, replacing an employee is expensive, and anecdotally some estimates demonstrate that it could be as much as 50–100% of an employee's annual salary (Guilding, Lamminmaki, and McManus, 2014). When an employee leaves

a position, the employer also loses the time, money, and effort associated with recruiting, hiring, and training them. Additionally, an employee's departure can damage staff morale, particularly when a highly regarded, long-term employee leaves. This can also affect brand perception. With social media at their fingertips, current and former employees can be valuable brand ambassadors if their experience is positive; however, if their experience is a negative one, the reverse may also be true.

Watch this video “Cost of Employee Turnover”



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://oercollective.caul.edu.au/leading-in-health-and-social-care/?p=229#oembed-2>

Video Source: Stream Dental HR. 2019. The True Cost of Employee Turnover. Available at <https://www.youtube.com/watch?v=c4tZX-p8DSM>

Employee retention is the percentage of employees who remain with the organisation for a fixed period. Retention is usually calculated on an annual basis. Retention may also be tracked for specific roles or teams if areas need extra attention. Overall, a good employee retention rate is typically about 90%, and it also needs to be stated that a 100% retention rate is not necessarily desirable. Some of those who leave are the lowest performers, and that can make room for more engaged, higher-performing employees. Good employee retention rates vary by industry. Retention refers to how many employees stay, and turnover refers to how many employees leave. These are two of the most important metrics for any business.

Ways to motivate teams to do their best work should also be examined. Tracking and monitoring retention metrics can explain why employees remain loyal and uncover areas for improvement. Table A describes fourteen (14) recruitment metrics, and Table B describes eight (8) retention, attrition, and turnover metrics for workforce recruitment and retention processes and procedures.

Recruitment and Retention Metrics

The following are all variations from several sources (Pozo-Martin et al., 2017, Green, 2012, Durai D, Rudhramoorthy, and Sarkar, 2019, Russell, Humphreys, and Wakerman, 2012). Tables A and B are a composite of evidence from each of the cited publications rather than any of them coming directly from any one of them.

Table A: Recruitment Metrics for Consideration

	Metric Name	Rationale/Explanation	Formulae
1	Time to Fill	<p>The number of calendar days between the fill approval and candidate's acceptance of the job offer.</p> <p>Several factors can influence time to fill, such as supply and demand ratios for specific jobs and the speed of the recruitment.</p> <p>Time to fill is a good metric for business planning. It offers a realistic view to assess the time it takes to attract and employ a replacement for a departing employee or to employ against a newly established position.</p>	<p>Calendar days elapsed from requisition to commencement expressed as an average.</p>

	Metric Name	Rationale/Explanation	Formulae
2	Average Time to Employ (TE)	<p>Time to hire is the days between the candidate's application and acceptance of the job offer. It is the time the applicant takes to move through the hiring process once they submit their application.</p> <p>Time to hire provides a solid indication of how the recruitment process is performing. In some literature, this metric is also known as 'Time to Accept.'</p> <p>A shorter time to hire prevents better candidates from being employed by an organisation with a shorter time to hire. It also impacts the candidate's experience by identifying a process that takes a long time (e.g., the data might show a long time between resume screening and the next stage of the recruiting process). The recruiting funnel heavily influences the metric. When hiring for jobs with a straight-forward recruitment process of one interview, the time to hire will be shorter than for a more arduous process, and for this reason, care should be taken when interpreting the data this metric provides.</p>	The number of days between the candidate's application and offer acceptance expressed as an average.

	Metric Name	Rationale/Explanation	Formulae
3	Source of Employee (SE)	<p>Tracking the sources that attract new employees is one of the most popular recruiting metrics and assists with monitoring recruitment channel effectiveness. Some examples are organisational job boards (internal or external), a career page, social media, and recruitment agencies.</p> <p>Having a clear understanding of which channels work and which do not helps to determine the channels creating the most return on investment (ROI). Less time can then be spent on more successful channels; for example, if the job board provides better recruitment than LinkedIn, then that is the channel to focus on.</p>	No formula required

	Metric Name	Rationale/Explanation	Formulae
4	Candidate First Year Retention Rate (CRR)	<p>First-year attrition or first-year turnover is a key recruiting metric and indicates recruitment success. Candidates leaving in their first year of work often fail to become productive.</p> <p>First-year attrition can be managed and unmanaged.</p> <p>Managed attrition means that the employer terminates the contract and is often an indicator of bad first-year performance or a bad fit with the team.</p> <p>Unmanaged attrition means that the employee leaves of their own accord and is also referred to as voluntary turnover. This is often an indicator of unrealistic expectations that cause the candidate to quit, which may be due to a mismatch between the job description and the job.</p>	No formula required
5	Manager Satisfaction (MS)	<p>Relating to the quality of hire, manager satisfaction with the quality of recruitment is indicative of a successful recruiting process. When the employing manager is satisfied with the new employees in their team, the candidate is likely to perform well and fit well in the team, and the candidate is therefore more likely to be successful.</p>	No formula required

	Metric Name	Rationale/Explanation	Formulae
6	Candidate Job Satisfaction (CJS)	This metric provides information about whether the recruit's expectations match their experience after commencing the role. If the candidate expresses low candidate job satisfaction, this indicates a mismatch between the candidate's expectations and experience.	No formula required
7	Applicants per Job Opening	Many applicants could indicate a high demand for jobs in that area or a job description that is too broad.	
8	Selection Ratio (SR)	<p>The selection ratio refers to the number of candidates employed compared to the total number of candidates.</p> <p>This metric is similar to the number of applicants per opening. When there is a high number of candidates, the ratio approaches zero. The reverse is true and provides a good indicator of the value of the various assessment and recruitment tools used.</p>	<p>Employed candidates</p> <p>Number of candidates</p>

	Metric Name	Rationale/Explanation	Formulae
9	Cost per Recruitment (CR)	<p>Cost per hire considers the significant costs involved with recruitment. These costs are often divided into internal and external costs.</p> <p>Internal costs include: compliance costs, administrative costs, training and development, and talent acquisition costs.</p> <p>External costs include: criminal and other background checks, sourcing expenses, travel expenses, and marketing costs.</p>	<p>Internal costs such as: Advertising, any employment agency costs, candidate expenses, etc.</p> <p>External costs such as: recruiter costs (average labour costs x hours spent), manager costs (average labour costs x hours spent), recruit onboarding time, lost productivity, and other internal costs.</p>
10	Candidate experience (CNPV)	<p>Candidate experience is how job seekers perceive an employer's recruitment and onboarding process and is often measured using a candidate experience survey.</p> <p>This survey uses a net promoter score and helps identify key components of the experience that can be improved.</p>	No formula required

	Metric Name	Rationale/Explanation	Formulae
11	Offer Acceptance Rate (OAR)	This metric compares the number of candidates who accepted a job offer with the number of candidates who received an offer. A low acceptance rate means that issues such as pay and conditions or the role as explained in the job description or by the recruiter do not meet the candidates' expectations.	<p>Number of offers accepted</p> <p>Number of offers made</p>
12	Percentage of Open Positions	<p>This is the percentage of open positions compared to the total number of positions that can be applied to specific departments or the entire organisation.</p> <p>Where a higher percentage of open positions exists in a specific department, this can mean those positions are in high demand (for example, due to fast growth). However, it can also mean that there is currently a low supply of workers for those positions.</p> <p>This metric can offer insights into the current trends and changes occurring in the labour market, which can be valuable when building your talent acquisition strategy.</p>	<p>Number of open positions</p> <p>Total number of available positions</p>

	Metric Name	Rationale/Explanation	Formulae
13	Application completion rate (ACR)	<p>This talent acquisition metric shows how many candidates who started a job application finished it. It can also measure the reverse as “applicant drop-out rate”; that is, the share of candidates who did not complete the application.</p> <p>Application completion rate is especially interesting for organisations with elaborate online recruiting systems. Many large corporate firms require candidates to manually input their entire curriculum vitae or resume in their systems before they can apply for a job.</p> <p>The drop-off in this process indicates problems, for example, web browser incompatibility with the application system or a non-user-friendly interface. This recruiting metric fits well with the following metric (yield ratio).</p>	<p>No of commenced applications</p> <p>No of completed applications.</p>
14	Yield Ratio (YR)	<p>The recruitment process can be seen as a funnel that begins with sourcing and ends with a signed contract. The yield ratio per step is measured by the effectiveness of all the steps in the funnel.</p> <p>The yield ratio represents the percentage of candidate movements from one part of the hiring process to the next. This metric demonstrates movements between each stage (e.g., from application to screening calls) and from start to finish.</p>	<p>At each recruitment stage: completed applications</p> <p>Applicants who entered this stage</p>

Table B. Retention Metrics for Consideration

	Metric Name	Rationale/Explanation	Formula (where applicable)
1	Employee Satisfaction (ES)	<p>Organisations are more likely to retain satisfied staff than those who are not.</p> <p>An employee survey often achieves this, which can help measure employee satisfaction.</p> <p>A common metric used is the net promoter score (NPS) used to gauge satisfaction which is based on a Likert scale response to a question such as: "How likely are you to recommend this organisation to a friend or colleague as a good place to work?"</p> <p>Likert Scale: 1 2 3 4 5 6 7 8 9 10</p> <p>Not Likely – Extremely Likely</p>	% of promoters – % of detractors
2	Overall Retention Rate (ORR)	<p>This refers to the organisation's ability to retain employees over a period of time. A good overall retention rate might hover around 90%.</p> <p>Remember, there is always room for some turnover. Turnover can allow for refreshing the workforce with employees who possess desirable and useful skill sets. The turnover rate is a good companion to this metric.</p>	For a specific time period: employees retained x 100 total employees

	Metric Name	Rationale/Explanation	Formula (where applicable)
3	Overall Turnover Rate (OTR)	<p>The percentage of separations, or employees who leave, either voluntarily or involuntarily.</p> <p>A high turnover rate directly affects productivity and makes it difficult to attract top talent, which can indicate leadership or organisational culture problems.</p>	<p>For a given time period:</p> <p>Number of separations Average number of x 100</p>
4	Voluntary Turnover Rate (VTR)	<p>Voluntary turnover rate is the percentage of employees deciding to leave a job, but what causes high employee turnover?</p> <p>It is typically a variety of reasons, such as switching to another job or retiring. Because these employees are more skilled than those who leave involuntarily, and they tend to cost more to replace.</p>	<p>For a given time period:</p> <p>Voluntary separations Average no. of employees x 100</p>
5	Involuntary Turnover Rate (IVR)	<p>The involuntary turnover rate is the percentage of people fired or laid off in a given period. The higher the involuntary turnover rate, the more urgent it is to evaluate the employment processes to avoid future mis-hires.</p>	<p>For a given time period:</p> <p>Involuntarily separations Average no. employees x 100</p>

	Metric Name	Rationale/Explanation	Formula (where applicable)
6	Employee Absence Rate (EAR)	This indicates unplanned employee absences for sickness, personal emergencies, or other unanticipated reasons.	For a given time period: Unexpected absences Total workdays x 100
7	Retention Rate per Manager (RRM)	This metric demonstrates the percentage of employees who remain in their jobs under an individual manager or team.	Staff terminated/ manager total staff per manager x 100
8	Turnover Costs (TC)	These costs include termination of employment costs, salary sacrifice or other benefit costs and productivity costs. This is not a good benchmark indicator, because costs will vary in different organisations due to their different recruiting cost structures.	Sum of variables associated with turnover x total number of employees who leave

The real value of these metrics lies in analysing these data to inform process control and identify improvement areas. These metrics reduce an overly complex phenomenon to numerical data that has practical use. However, the development of trend data and upper and lower control limits to measure variation further enhances this to the extent that quantitative data can. A deeper understanding of the reasons why the metrics return the results they do will require qualitative analysis. There is also a need to consider what qualitative data may be gathered to gain a more in-depth understanding of the employee perspective that can be thematically analysed using proven methods

to achieve this, which is the subject of further enquiry not discussed here.

Activity

From the suite of recruitment and retention metrics provided in this chapter, select three recruitment and retention methods that you assess as being the most valuable for the organisation in which you work (if you are not working, then think about an organisation in which you have previously worked, or one for which you would like to work).

Select three recruitment and two retention methods, and record them in a column labelled 'metric'. In a column labelled 'rationale', state why you believe the metric is included in the 'top five'.

When selected, each metric consideration must be given to the availability of the data to calculate the metric, how the results could be applied to solving the weighty issue of workforce availability and sustainability, and the benefits of having trend over time data for the metric would provide.

Key Takeaways

Talent management is a series of processes, including the important functions of attracting, recruiting, and retaining talent.

There are many sources or 'channels' to attract candidates for jobs. Success lies in knowing which channels deserve additional effort and attention.

Organisational brand is an important variable in attracting, recruiting, and retaining a workforce. Treat all applicants well, even those who were unsuccessful, and provide advice as to the outcome of their application and feedback on their performance if requested.

Reviews on the various types of psychometric testing are mixed.

Selection panel chairs and members require ongoing training and development to ensure that organisational policies are upheld and that merit is applied in all processes.

There are many formulae for recruitment and retention metrics. The metrics are most successful when they are based on reliable data, sound analyses, and they are used to inform actions that trend over time data suggests.

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Performance Management and Training and Development of the Health Workforce

RICHARD OLLEY

Introduction

Performance management is an ongoing communication process between a leader and team members to establish a shared awareness of the organisation's expectations about what is to be achieved at individual employee or team levels (Galeazzo et al., 2021). It aligns the organisational goals with employees' agreed measures, skills, competency requirements, development plans, and results delivery. Contemporary emphasis is moving from performance assessment in terms of efficiency, resulting in improvement toward what Noto and Noto (2018) asserted is the achievement of broader goals and outcomes, and an increased focus on performance management governance. The focus has shifted towards identifying learning, training and development needs, and other strategies to facilitate achieving an individual's personal goals and couple these with the overall business strategy, thus creating a high-performance workforce.

Performance management is about what team members have

not achieved and what they can achieve linked to organisational goals and strategies (Mukarramah et al., 2017). To this end, performance management should not be a term for managing poor performance. It is contended here that performance management is more about the self-regulation of behaviour by team members, and that individuals may actively participate in planning their performance goals by monitoring their progress toward their achievements (Presbitero and Teng-Calleja, 2019). Presbitero and Teng-Calleja (2019) demonstrated that proactive feedback-seeking behaviour, or team members actively seeking feedback on performance when empowered to be proactive and self-regulate, mediates the relationship between the team member's personality and their ability to plan their performance.

In concert with performance management is the necessity of training and development of team members, so that they have the skills, knowledge, and abilities to fulfil the role for which they are employed (Rodriguez and Waters, 2017). Training is critical for the growth and development of employees in any organisation. It is vital in the healthcare and social care industries due to the need for highly reliable workforce practices and procedures due to safety. Undoubtedly, having robust and relevant staff training and development programs for the health and social care systems is a critical strategy for retaining talent. This chapter also examines training and development needs and evaluates training needs analysis.

Performance Management in Health and Social Care Workforces

A Brief History of Performance

Management

Modern performance management became the topic of discussion and a human resource management practice approximately 60 years ago.

Watch the following video, *The History of Performance Management*, made by the Bersin Academy (2020), which shows the progression of performance management over time and sets the scene for this chapter section.

This video shows older and contemporary approaches to performance management, and what occurs today has come from quite ancient beginnings. We have moved from setting output targets to being more focussed on outcomes, objective assessment, and self-regulation from team members. Increasingly, the performance review focuses on what learning, training, and development is required and how individual employees and teams could further improve their performance and outcomes for their efforts.



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://bercollective.caul.edu.au/leading-in-health-and-social-care/?p=239#oembed-1>

The history of performance management, from the Josh Bersin Academy. Source: Bersin Academy, (2020) https://www.youtube.com/watch?v=YqdR_ejViMI

Initially, performance management was a source of income

justification and was used to determine an employee's future remuneration based on performance . In those early years, organisations implemented various performance management techniques for specific efficiency and productivity outcomes (Justin and Joy, 2022). In practice, this worked well for certain employees solely driven by financial rewards. However, where employees are driven by the learning and development of their skills, it fails miserably (Justin and Joy, 2022).

In the late 1980s, the gap between the justification of pay and the development of skills and knowledge became a huge problem in performance management. It came with the realisation that a more comprehensive approach to managing and rewarding performance is required. It was further developed in the United Kingdom and the United States much earlier than in Australia. More recently, managing people, and therefore their performance has become more formalised and specialised. In contemporary organisations, replacing older performance appraisal methods with aims for a more extensive and comprehensive management process is complete with those that concentrate more on developmental strategies designed to improve the technical and also the soft skills of employees (Anna, 2016). The main drivers of the change in approach were the introduction of human resource management as a strategic driver (Popescu et al, 2022) and an integrated approach to employee management and development (Albrecht et al., 2015). Performance management and should not be a once-off annual event coordinated by the Human Resources Management Department which unfortunately is often the case.

Purpose of Performance Management

Performance management is about aligning the organisation's

employees to the requirements of the organisation, and aligning organisational culture with performance (Tan, 2019). Establishing a performance management system can be difficult, and any or all of the following may prevent a smooth implementation and ongoing system maintenance:

- organisational culture (Kuo and Tsai, 2017),
- leader commitment and expertise (Oygarden et al., 2020),
- employee engagement (Sandhya and Sulphrey, 2020),
- legal obstacles – this may include contractual, civil, and employment law considerations,
- industrial obstacles.

To implement a performance management system and maintain it once it is operational, the organisation must clearly articulate and manage workforce expectations and executive management. It is essential to establish role and goal clarity for the system, but most importantly, for the workforce using the performance management system (Justin and Joy, 2022). Team members must understand their roles and be clear about their expectations. To do otherwise would be unfair to them and damaging to the organisation. The performance management system provides an opportunity to identify and act upon support that employees require to give them the best possible opportunity to attain the mutually agreed goals.

Empirical data shows that future career aspirations are important to employee engagement (Cattermole, 2018, Barhate et al, 2021). When these are achievable, retention of valuable employees is more likely. However, the performance management system also identifies those employees that warrant further development for future leadership positions. Thus, identifying developmental needs in employees identified for advancement or promotion becomes an integral part of the system (Justin and Joy, 2022).

The other purposes of performance management are monitoring and reviewing employees' performance and determining their performance level in terms of their work standards, work output and outcomes, and other measures agreed upon with the employee. These performance levels are used to assess the degree to which agreed targets are achieved. Effective performance management recognises good performance, demonstrates areas that could be improved, and identifies areas of employee performance that the organisation must address (Karolina, 2012).

The purposes and the objectives of performance management relate to:

- aligning employees to organisational requirements,
- clearly articulating and managing expectations,
- establishing role and goal clarity for all in the organisation,
- providing an opportunity to discuss and plan for future career aspirations,
- monitoring and reviewing employee performance, and
- monitoring and maintaining standards of performance against expectations.

Recognition of good performance

It is unlikely that well-led organisations would not have some sort of employee performance management system in place. This could be as simple as an annual discussion, a file note in a personnel file, or a quick chat over some workplace issue that has emerged. These are all important parts of the system; however, they are only a small part of a performance management system. Some organisations have an 'employee appraisal system' that is more commonly undertaken annually after a qualifying or probationary period. The most often asked question

when discussing workforce performance is, “How does performance management differ from performance appraisals or staff reviews?”. The simple answer is that the deployment of performance management promotes employee activities and outcomes congruent with the organisation's strategic goals and objectives and may entail specifying the activities and outcomes that will result in the organisation successfully implementing the strategy.

An effective performance management process:

- Creates a planning hierarchy that links individual employee objectives with its mission and strategic plans. However, the important part is that the employee clearly understands how they contribute to achieving the overall business objective.
- Sets clear performance objectives with the employee, thereby managing the expectations of the employee and the organisation.
- Documents individual or team development plans in partnership with the individual or team members, which will underpin the achievement of the performance objectives.
- Formally provides feedback, encouragement, and guidance of the employee by conducting regular discussions throughout the performance cycle, including coaching, mentoring, feedback, and assessment.

The Differences Between Performance Management and Performance Appraisal

There is a difference between performance management and performance appraisal. The definition of performance management was discussed earlier in this chapter. The issue relates to the lived experiences of many health workforce members

because they associate performance management with an annual performance review. In comparison, performance management is about what might assist an employee to continue developing to improve their performance. For the employing organisation, this refers to the methods used to evaluate the progress toward goals mutually set between the individual or team. There is regular discussion on these goals between the parties during the year rather than at the end (Justin and Joy, 2022). In earlier times, performance appraisal referred to judging an employee's past performance based on criteria not necessarily individualised to the employee (Justin and Joy, 2022). This is the reason why early forms of performance appraisal placed no obligations on the organisation. It probably did not have reliability and validity in terms of what it measured and now performance management has shifted the focus from an annual event to an ongoing process. What needs to be understood here is that performance appraisal is about the past whereas performance management is about the future and uses previous experiences with the staff member to focus on the future. This means the appraisal process reviews the employee's performance in the immediate past, while performance management focuses on the present and the future.

The table below highlights the differences between performance management and performance appraisal.

Differences between Performance Management and Performance Appraisal

Performance Appraisal	Performance Management
Considered more operational than strategic.	Can be considered more strategic than operational.
Top-down assessment.	Involves a dialogue between the leadership and team member or members.
Undertaken retrospectively to correct mistakes or tardiness.	Undertaken prospectively to develop team members and is future-oriented.
Often uses rankings or ratings to assess progress, mostly annually.	Ongoing and continuous reviews interspersed with more formal measures.
Rigid structures and systems.	Flexible process tailored to the developmental needs of the team member(s).
Often it is not linked to the employing organisation's strategic goals and objectives, including business needs.	Linked inextricably to the strategic goals of the organisation, including business needs.
Usually takes a quantitative assessment approach using rating scales and rankings.	Usually is a mixed methods approach (quantitative and qualitative) in combination.
This is an individual activity relating to a specific team member.	It may be an individual activity but also a collective one because it can accommodate a whole team approach.
Often linked to remuneration, such as an increment payment after a defined service period.	Not usually linked to remuneration.

Activity

Watch the embedded video, identify the problems or issues with how this performance appraisal is performed, and write them down.

While there are only a few minutes of the performance appraisal shown in the video, several significant issues must be addressed. For each problem or issue identified, please describe what is required to correct them.

Reflect on your experiences with performance appraisal, and if there were similar issues or concerns, how did that make you feel?

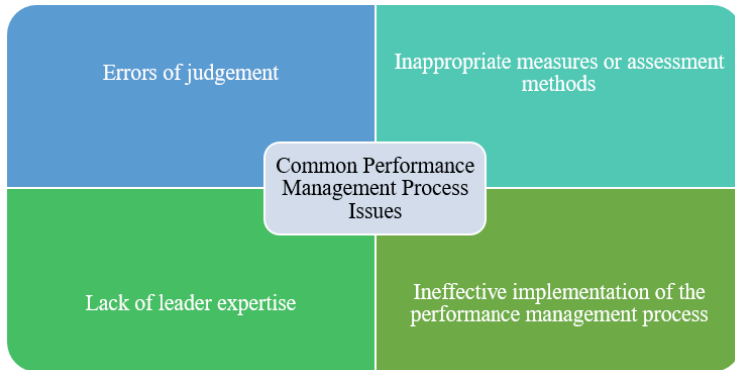


One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://oercollective.caul.edu.au/leading-in-health-and-social-care/?p=239#oembed-2>

Source: Brown, M. (2010) The performance appraisal from hell. <https://www.youtube.com/watch?v=JIn-liAnN8Y>

Common Performance Management Problems

Common problems associated with performance management are summarised into four themes, as demonstrated in the figure below.



Thematic Analysis of Common Performance Management Process Issues

Activity

Using the four themes detailed in the thematic analysis shown in the figure above, sort each of the common problems discussed below into one or more of the four themes. A problem or issue may be relevant to more than one theme.

Managing Expectations

This occurs particularly when the performance management system requirements and outputs are poorly communicated to employees, causing the team member and the leader to enter these discussions with low confidence levels. Poorly managed

expectations are often due to a lack of operating rules, observance of those rules, and even knowledge about how to go about the performance review process when coupled with a lack of understanding of the expected outcomes. There is little chance of fruitful discussions benefiting the team member or the organisation.

Moreover, because these discussions are often infrequent, the employee may view them as an opportunity to discuss remuneration, promotion prospects, and other issues. Domination of the discussion related to employee content rather than understanding the achievements and what is now required to satisfy organisational requirements or team member's interests and abilities may occur. This can lead to a vague definition of performance goals and perpetuate poorly defined and executed performance reviews. Given that the performance review process is often an annual process, leaders and team members may find it difficult to remember what happened during the year, let alone forge a partnership of benefits to both the employee and the organisation. Typically, it is true that both come to the meeting ill-prepared, and there is little meaningful discussion. The situation makes the performance review more difficult and frustrates both team members and leaders.

Timing Issues

In many organisations, appraisals are undertaken annually and related to the team member's work anniversary. Thus, it is only possible to align, at best, 50% of the staff with future objectives, assuming there is an even distribution of start dates across the workforce. Given that most appraisal systems are not automated, there is poor reporting and low visibility of who achieved their objectives.

Advancement/Promotion Not Inherently Tied to the Performance Review

Since many organisations conduct performance reviews annually, most line managers only seriously think about and plan for these once a year, which is a primary cause for employees leaving the organisation. There is a lack of competency assessment in most performance management systems. They also often lack an active development plan to which the employee and manager mutually agree. Staff are often disillusioned and leave the organisation if they can see no personal development prospects or if personal development has not occurred in practice for the last several years, despite many promises.

Performance management implementation requires specific objectives tied to the strategic and operational plans. When this occurs, organisational performance outcomes will increase quickly.

Imagine your CEO sets an objective for the financial year requiring a 3% decrease in the health service labour costs. This objective would be cascaded down to every department, team, and individual who can influence the target.

Those who are successful at achieving this objective will receive a favourable review, and any benefits or rewards flow to them as a result.

The reverse is true of those who do not achieve this. Thus, the performance management process drives organisational performance outcomes by cascading responsibility to those who influence it.

Example

In the example provided above, the team members and leader enter the process with better confidence levels, as the objective that provides the rule stipulates what assessment will entail and how it will be implemented. Team member evaluations related to the achievement of objectives occur as planned once they are clear to the team member and the leader. It is important that what constitutes the three per cent decrease in labour costs is agreed upon between the leader and the team member or members. The outcome is that the leader and the team members have an informed discussion and focus on achieving personal and business objectives, not irrelevant issues. The performance review is a part of an ongoing process, not just an annual procedure. The performance process requires that discussion and performance measurement occurs more often than annually. The agenda for that discussion is about performance against target and what the team members need to achieve the objectives and strategies. In a good performance review process, what team members need to achieve the requirements is part of the overall planning process. Moreover, emotional discussions can be displaced by business-focused discussions on achieving objective outcomes.

Subjective Assessment, Invalid and or Unreliable Tools, and Unreliable Measures

These three significant issues make the process of annual per-

formance appraisal meaningless. If this is examined purely from the team member's perspective, it is easy to recognise that team members feel that their future depends on their leader. This is not conducive to the support and development of the employee necessary in contemporary organisations.

Rules and Requirements Not Known by All Employees

In many organisations, all parties lack an understanding of the governance of the performance management process. When team members and leaders enter the process knowing the 'rules of engagement', they have more confidence because 'rules' stipulate what is being assessed and how. The assessment of team members is based on their achievements of clearly identified and agreed objectives. Leaders then have a better framework to determine an employee's performance as they are familiar with the assessment criteria. The outcome is that both parties have an informed discussion and focus on achieving both personal and business objectives, not on irrelevant issues. The performance review process is then just a part of the process, not simply an annual procedure, and requires discussion more frequently than annually. The agenda for that discussion is about performance against target rather than employee needs. This is necessary because, as already discussed, the team member's needs are already factored into the strategies designed to meet the target.

A properly implemented performance management system requires managers and employees to commit to three things:

- A competency review of the team member's work towards meeting the set objectives.
- A team member's development plan.

- Regular monitoring meetings between the team member, or team, and the leader.

Implementing the performance management system in these ways means that the employee experiences personal development and becomes more engaged with the organisation. Team members feel they have a voice in the organisation and therefore feel part of it, with a growing understanding of the relationship between themselves and the organisation. Managers feel more confident in the team member's expectations, and the team member's wishes are also central to the discussion.

Performance Management and Employee Engagement

Employee engagement refers to unlocking employee potential to strengthen organisational and employee performance, resulting in discretionary effort and increasing the team member's self-efficacy, which is important to achieving objectives and targets. Self-efficacy relates to the individual's belief in their capacity to produce specific performance attainments. It combines employee potential and organisational performance to create a highly engaged workforce. Carter et al. (2016) found that human resource management practitioners (HRM) should address self-efficacy and employee engagement, as doing so boosts job performance.

Performance reviews also concern the treatment of team members and how leaders relate to others within the organisation. Leaders and team members share responsibility for creating the organisation's future by being clear and aligned on mission, purpose, and goals through continuous communication, individual development, and creating opportunities for

those employees who are top performers. Understanding that employee engagement is not a program, but part of organisational culture is essential.

Performance management is therefore about keeping the dialogue open with team members, working in partnership with them to achieve the organisational goals set, and allowing some locus of control to rest with them so that they are part of the solution. Lappalainen et al. (2019) investigated the relationship between performance management and employee engagement. Their study, founded on stakeholder analysis, contained a significant finding that employee engagement is driven more by the inherent attitudes of employees than environmental factors present in the organisation. The Lappalainen et al. (2019) study found that employee engagement was more related to the ability of team members' skills in analytical thinking, their level of extroversion, systems thinking assertiveness, and leadership. The recommendations that emerged from this study suggest performance management should concentrate on developing these soft skills in the workforce to increase stakeholder (in this case, team members) engagement.

Legal and Industrial Implications Relating to Performance Management

Labour and employment laws do not mandate performance management but prohibit discriminatory employment actions based on non-job-related factors. Training leaders and team members on job evaluation fundamentals is vital if an organisation develops a performance management system. Consistent application, unbiased evaluation, and timeliness are the three core elements of effective performance management. When these three core elements are not evident, it leaves the organisation open to complaints from team members that

could end up in a legal or quasi-legal proceeding initiated by either the employee or their union.

When fully implemented, a performance management system may identify how team member and organisation targets are aligned, determine whether an employee is promoted or even kept on staff, and justify salary increases. On this basis, they are useful for many employment decisions, and fair implementation of the review manages the legal and industrial aspects of performance management. Conducting them properly and fairly means that all employees are subject to having their job performance evaluated and using the appraisal rating for the same reason. Another application related to legal risk management of the performance management process is that organisations sometimes use performance management to have a legally defensible means of making employment and job decisions that will discourage frivolous lawsuits, or ensure the organisation is likely to win a court or tribunal decision.

Performance management can also be viewed as a risk management strategy that, if implemented and supported properly, can provide some protection provided it is done properly, particularly concerning discrimination allegations or equal employment opportunity complaints. Keep in mind that it is always the courts that decide on the merits of a particular case. It is reasonable to ask what legally defensible performance management systems' characteristics are. The meaning of defensible is that:

- Employees participate in establishing performance standards for their position.
- The standards used are relevant to the essential elements of the job, are documented, and available to all employees.
- Employees are informed of, understand, and sign off on critical job requirements and expectations before the appraisal.

- The system should not be a comparison between employees.
- Employees are allowed and encouraged to be a partner in the process.
- Employees are informed of any performance problems and issues and allowed to rectify the problems.

As a result of early union bargaining, workers today enjoy a variety of benefits, such as a legal minimum wage, workplace safety standards, paid overtime, health care, and a defined working week in terms of hours at ordinary pay. As a result of unions, union members often receive higher pay and better benefits than equivalent non-unionised workers. Unions have worked in partnership with organisations to improve the sector regarding occupational health and safety, remuneration and reward, time and attendance issues, and employee rights.

The best strategy for dealing with union involvement in performance management is to consult early and invite the relevant unions to be part of the overall process. That way, unions can be part of the solution.

Training and Development of Team Members in the Health and Social Care Workforces

One of the critical factors in employee motivation and retention is the opportunity for employees to continue growing and developing job and career-enhancing skills. Developing personally through training is one of the most important factors in team member motivation and, by necessity, engagement.

Before we examine various workforce training and development methods, it is essential to understand that a manager

can significantly impact training and development through the responsibilities ascribed to an employee in their current job. The goals of training and development are to:

- embed lifelong learning,
- provide for employee engagement and voice, and
- promote a performance culture in the organisation.

The following strategies are considered excellent opportunities for employee development and engagement. They will assist in improving organisational systems and processes and provide opportunities for team members to be confident in what they are doing and why they are doing what they do.

Seven Strategies for Employee Engagement and Development

1. Expand the job to include new, higher-level responsibilities and stretched but attainable goals, and allow them to experience success in their work and additional assigned responsibilities.
2. Reassign responsibilities that the team member does not like or are routine, where possible, practical and safe.
3. Invite the team member to contribute to the more important department or organisation-wide decisions and planning.
4. Provide more authority for the team members to self-manage and make decisions.
5. Assign the team member to lead projects or teams.
6. Provide more information by including the team member on specific mailing lists in organisation-wide briefings.
7. Provide more access to essential and desirable meetings.

The Importance of Training and Development in the Workplace

The opportunity for team members to engage in training and development opportunities cannot be underestimated. It is important to emphasise here that workplace training and development requires budget allocation if leaders are to maximise the benefits. The costs associated with training and development include time off to participate and whether there is a need to backfill team members. The costs associated with other required resources may appear excessive on first examination. However, the benefits, including cost benefits, are well documented in the literature (Coulson-Thomas, 2010; Zgrzywa-Ziemak and Walecka-Jankowska, 2020).

The benefits listed below demonstrate the importance of training and development in the health and social care workforce and illustrate the importance of training and development in the health and social care workforce. Training and development provide teams with:

- **A clear conception of their role and responsibilities.** Onboarding and orientation are clear examples of this. Team members better understand their organisational role when they have access to up-to-date training and resources.
- **Improved team member morale and engagement.** Job satisfaction and commitment are vital in the workplace. When organisations actively invest in their workforce, it demonstrates to the workers that they are valued. This promotes a good organisational culture and a positive relationship between leaders and team members. This positive relationship emanates from team members feeling that they are actively learning and developing in their roles and the organisation. This increases their work satis-

faction and avoids the feelings of stagnation experienced when team members continue to do the same things over and over in a working week. When offered the opportunity to gain experience, team members will feel the organisation is investing in their future, strengthening loyalty and engagement with the work and the organisation.

- **The means to attract and retain valuable team members.**

The costs involved with recruiting new staff are considered alongside the costs associated with training and development. As such, it is beneficial to invest time and resources into training and developing existing team members. As with the previous point, demonstrated investment in the workforce strengthens organisational culture and loyalty, and research consistently asserts that investing in team members nurtures loyalty, as they are less likely to seek a new challenge with another organisation. This avoids further recruitment and selection costs, including advertising and interviewing. Team members will increase net promoter scores; thus, marketing that the organisation provides regular training, which is a great incentive to attract other candidates.

- **Leadership training opportunities for emerging leaders.**

If a leadership position unexpectedly becomes available, this results in increased use of resources and decreased productivity during the search for a replacement. This can leave the organisation exposed until the vacancy is filled. However, when an organisation prepares for such a risk and implements a leadership development program crafted specifically for organisational needs, the risk is decreased by ensuring that underqualified team members are not left with the responsibilities. Leadership training is a risk strategy that will provide leadership training for relevantly qualified and interested team members and can save considerable financial and other resources and provides a means for leadership continuity. Any organisa-

tion that keeps evolving limits disruption.

Approaches to Learning That Underpin Training and Development

The evidence-based approaches to organisational learning to consider when organisations must consider planning training and development opportunities include, but are not limited to, those outlined below.

Behavioural Approaches

Behavioural learning theory, or behaviourism, is a common concept that educators and business leaders may use to encourage positive behaviours (Kuhl et al., 2019), and in the case of training and development, this means in the workplace. The behavioural approach is based on stimulus/response conditioning. The instructor must show factual knowledge and observe, measure, and modify behavioural changes in a specified direction. Behavioural approaches target conditioned responses or the commitment to the memory of facts, assertions, rules, laws, and terminology. The correct response is achieved through the stimulation of the senses.

Cognitive Approaches

Cognitive approaches assert that humans generate knowledge and meaning through the sequential development of an individual's cognitive abilities (Kuhl et al., 2019), such as the mental processes of recognition, recollection, analysis, reflection, application, creation, understanding, and evaluation. The cognitivist learning process refers to learning techniques, procedures,

organisation, and structure and developing an internal cognitive system that strengthens synapses in the brain. The learner requires assistance in developing prior knowledge and integrating new knowledge.

Humanistic

Humanist learning theory describes learning as a function of the entire person, coupled with the belief that learning is impossible unless both the cognitive and affective domains are involved (Schneider et al., 2015). For humanist approaches, the learner's ability for self-determination is paramount. For example, humanists promote a sense of individual control over their learning and work. Team members grow exponentially with success and improve when achievements are recognised and reinforced. Respecting the whole person in a supportive environment can encourage learning. Learning is also fostered through structuring information appropriately and presenting it in meaningful segments with feedback.

Constructivist Approaches (also known as transformative approaches)

The constructivist approach considers learning as the ability to think autonomously (Schneider et al., 2015). It is usually (but not exclusively) applied in pedagogical approaches designed for adult learning (Demick and Andreoletti, 2003). It allows learners to be individual in their thinking, develop a sense of meaning, engage in “autonomous thinking”, and learn by using contexts of their formal learning experiences to construct and reconstruct personal meaning. This phenomenon is a uniquely adult form of metacognitive reasoning. Metacognitive reasoning involves actively and assiduously assessing reasons, providing

arguments that support beliefs, and resulting in decisions to act. Thus, beliefs are justified when based on sound evidence-based grounds. The reasoning process may involve such tacit knowledge as aptitudes, skills, and competencies.

Determining Training Needs

A training needs analysis (TNA) reviews an organisation's learning and development needs by considering individual needs, the operational needs of units and departments, and the organisation's needs. The TNA examines the knowledge, skills, and behaviours those working in the organisation require and how these can be developed effectively. A TNA is essential to deliver appropriate and effective training that meets the needs of individuals and the organisation and represents value for money. There are three phases to a TNA that are interlinked.

1. Individual (Person) Analysis
2. Operations (Task) Analysis, and
3. Organisation Analysis.

Determining the health workforce's training needs is a significant task, complicated by the many types of occupations and situations of team members. Coupled with an ageing and diverse workforce, ensuring that robust and appropriate systems meet training needs and processes is key to the success of training offerings.

The key issues to address in designing a training needs analysis are:

- know the present situation,
- identify the required competencies,
- consult with employees,

- make the results of surveys or consultations known throughout the organisation,
- prepare specific employee developments,
- implement the plans, and
- evaluate the success of the plans.

Watch the below embedded video about the essentials of conducting a training needs analysis that demonstrates the application of these principles.



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://oercollective.caul.edu.au/leading-in-health-and-social-care/?p=239#oembed-3>

Source: Tobing, H, (2013) Training Needs Analysis (TNA). <https://www.youtube.com/watch?v=X3cSAjHDeag>

Effective training is an important element of a successful organisation. Training needs require systematic examination whilst considering the competencies for the various jobs in any health care organisation. There is little point in offering and implementing a training program based on the latest fad or because some other organisation is using it. This systematic process consists of undertaking analyses of the following:

- The competency required of an individual who must perform a specific job.
- What area or group in the organisation needs the training.
- What the employee must learn to satisfy the competencies.

- Who needs the training, and what specific training is needed.

Kirkpatrick's (2007) Four Levels of Evaluation contain these processes. The model is a globally recognised method for evaluating training and learning outcomes for both formal and informal training and allows for rating against the four levels established in the model. The model is useful for designing evaluations of training and development deployed by the organisation and provides a useful tool to determine the effectiveness and reach of the training activities. Such analyses must be undertaken by people trained and skilled in using the model.

Key Takeaways

Appropriate training and development for team members are aligned with system and process improvements, making it easier for employees to know what they are doing and why they are doing it. Team members who do not have a clear idea of their expectations of them can severely impact their job performance.

Training and development provide great opportunities to expand the knowledge base of all team members and team leaders. However, many organisations such as health and social care find development opportunities expensive in tight fiscal climates. They are often unsure about or unwilling to commit the necessary resources to implement employee training and development opportunities successfully, and this is problem-

atic, particularly when this should ideally be linked to with performance management goals. Team members who attend training also miss work time, and there is recognition that this may impact service delivery while the team member is absent from the work area. However, it must always be clear that training and development provide both individuals and organisations with benefits that make the cost and time a worthwhile investment.

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PART III

ORGANISATION AND GOVERNANCE



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This part of the text covers systems thinking, evaluating health and social care systems, finance, digital health, innovation and implementing complex interventions.

Systems Thinking in Health and Social Care Delivery: An Overview

Systems thinking in health and social care delivery: An overview

ALI LAKHANI AND HANAN KHALIL

Introduction

Health is fundamental to a thriving and successful population, community, and economy, and delivering this is contingent upon a strong health and social care system. A health and social care system is made up of a number of components, including, but not limited to: primary, secondary, and emergency care; the health workforce; health information systems; pharmaceutical dispensing systems; and financing and leadership/governance. Inevitably, complexity arises with diverse systems, services, and processes. The complexity of health and social care can be due to several issues, including difficult conditions and circumstances experienced by consumers and patients presenting for care, clinician experience, and knowledge and the structural arrangement of the healthcare organisation (Trbovich, 2014). This has also been complicated by the advancement of medical technologies that require clinicians to be familiar with technology, as well as interacting with the components of a healthcare system and associated workforces. Several methodologies have been used to test, implement, and evaluate interventions in the health system with varying

degrees of success, partly due to this complexity and the evolving nature of the current health care system (Wiig et al., 2014).

A system is a connection of variables that result in a behavioural pattern (Meadows, 2008). Systems are not unique to any discipline or field of inquiry. They are generally characterised as involving elements (factors or variables), connections between elements, and a boundary that establishes what resides within the system and what is outside (Williams and Hummelbrunner, 2010). The elements within the system interact and/or are influenced by outside factors that result in outcomes. Thus, systems thinking is a holistic approach to examining the factors and interactions that contribute to outcomes. Systems thinking focuses on the dynamic interaction, harmonisation, and integration of individuals, processes, and technology by addressing the interconnecting factors between the different layers of the health system (Linnéusson et al., 2022). The advantages of applying systems thinking to solve complex problems in healthcare include its ability to apply a holistic approach to problem-solving. The benefits of a systems thinking approach are its advantages of nurturing great leaders committed to positive changes, its proactive approach to identify leverage points and creating a culture, integrating higher thinking, and creativity in the problem-solving of complex issues in health and social care. This chapter covers many aspects of how system thinking can be used to solve complex problems in healthcare.

Background

Healthcare delivery is consistently faced with 'wicked' or complex problems. The concept of wicked or complex problems (hereafter described as complex problems) was initiated by Rit-

tel and Webber (1973). Such problems are socially complex, unable to be addressed by a single group or stakeholder, and fit a set of criteria (Australian Public Service Commission, 2007), including being multicausal, being difficult to define, and having multiple interdependencies. They are constantly evolving, and interventions that aim to address the problem usually result in unforeseen consequences (Australian Public Service Commission, 2007, Williams and Hummelbrunner, 2010). Thus, simple solutions are non-existent, and instead, strategies to address rather than solve remain the best option. Examples of society level complex problems include obesity (Frood et al., 2013), climate change (Head, 2014), and homelessness (Norman-Major, 2018). Since the identification of complex problems, such problems have been considered across diverse disciplines, including health administration (Rusoja et al., 2018).

Increasingly, health administration and management problems are recognised as complex. For example, Rozario (2019) described the severity of physician burnout, and particularly highlighted how a combination of interrelated factors, including competition for employment, poor resourcing, increasing caseloads and administrative workloads, alongside a backdrop of a continual threat of litigation contribute to prevalent physician burnout. Rozario (2019) confirmed that effective strategies to manage complex problems must be developed from diverse stakeholders who are impacted by and contribute to the problem. Whilst, in relation to the delivery of health care, Periyakoil (2007) clarified a diversity of palliative health care problems as complex, including end-of-life decision making, aggressive treatments, and communication problems. Additionally, while stigma around mental health issues persist as a complex problem (Henderson and Gronholm, 2018), the provision of high-quality physical care (for example, wound care) amongst those experiencing mental health issues is also characterised as complex (Samuriwo and Hannigan, 2020).

Systems Thinking Approaches: Addressing Wicked Problems in Health Care Delivery

Systems level approaches – informed by systems thinking – have been identified as ideal methods to address complex problems, and particularly, complex problems surrounding the delivery of health care (Samuriwo and Hannigan, 2020). Systems thinking can be characterised as a way of seeing the world. In relation to addressing problems, using a systems thinking perspective involves moving beyond traditional mechanistic, linear methods of understanding and addressing problems reliant on the expectation that problems fall neatly into a cause and effect relationship (Chapman, 2004). Instead, strategies to address problems need to consider diverse perspectives (for example, perspectives from different disciplines and stakeholders with different experiences relating to an issue), and be aware of interrelationships (the notion that diverse factors contributing to a problem impact one another) and boundaries (that distinct elements fit within a problem) (Williams and Hummelbrunner, 2010). Systems thinking methods are approaches that aim to develop understanding around and strategies to address problems, while considering these domains (perspectives, relationships, and boundaries) (Williams and Hummelbrunner, 2010). The application of systems thinking methods as an approach to treat complex problems in health care delivery is increasing (Rusoja et al., 2018), and these methods are expected to continue to have an important role to play, given an ageing demographic living longer with chronic conditions and disability.

Systems thinking is characterised as big picture thinking, and methods aligned with systems thinking attempt to consider the macro-level picture, while also being cognisant of micro

elements that are interrelated and contribute to a problem. Systems thinking methods are extensive, with specific methods better suited to particular problems (Williams and Hummelbrunner, 2010). Williams and Hummelbrunner (2010) described several systems thinking methods in their text, including systems dynamics modelling (an approach to understand how resources flow through a system), social network analysis (an approach used to understand relationships and the impact of these relationships), and systemic questioning (an approach used to broaden perspectives and/or identify and mobilise untapped resources). A detailed review of the extent of systems thinking approaches and their application to health administration problems is beyond the scope of this chapter. It is worthwhile to consider the application of widely used approaches in health administration and management, as increasing understanding in these areas can inform how health professionals address complex problems. The following section details some of the approaches used in systems thinking to solve complex problems.

Causal Loop Diagrams

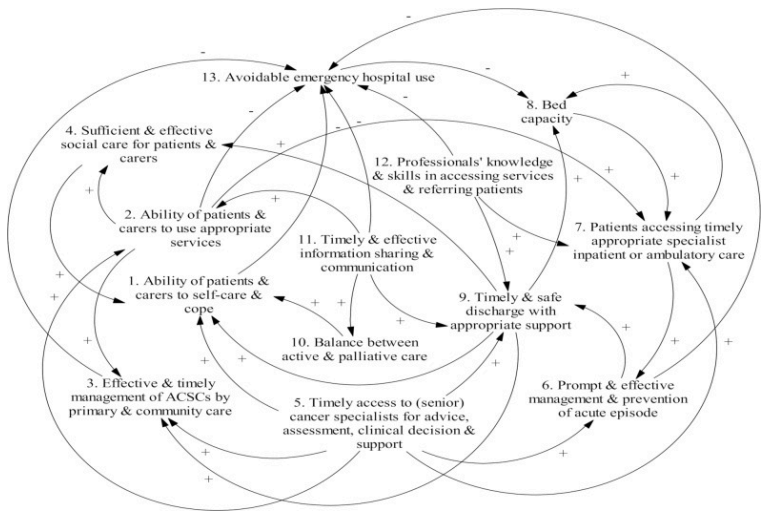
A causal loop diagram (CLD) is a systems thinking method where relationships between diverse factors contributing to a problem are mapped (Williams and Hummelbrunner, 2010). It is a visual methodology, and key aspects of a causal loop diagram include factors (elements contributing to an issue), and the connections between these factors and the overarching problem (these illustrate the direction of a relationship). Connections between factors are denoted with a '+' or 'S', which means that factors move in the same direction (an increase in one factor results in an increase in the connected factor); while connections denoted with a '-' or 'O' mean that factors move in the opposite direction (an increase in one factor results in a

decrease in the connected factor) (Kim, 2011). Feedback loops are central to CLDs (Kim, 2011), and these can either be reinforcing or balancing. Feedback loops emerge as multiple factors impact upon one another in a circular fashion. Simply put, a change within a single factor has an impact on interrelated factors in such a way that the initial factor is also impacted. Reinforcing feedback loops emerge when the change in a single factor causes changes in interrelated factors, which eventually amplifies the same change in the initial factor (for example, a reinforcing loop would mean that an initial positive change is amplified). Whilst balancing loops are feedback loops where an initial positive change in a factor impacts interrelated factors in a way that produces a reduction in the initial factor (thus, producing a diminishing effect in the initial factor). Feedback and balancing loops are important because they can become leverage points for interventions to produce change.

Causal Loop Diagram Application

Increases in emergency department presentations for people with mental health conditions, cancer, or other chronic disease are complex problems. Increased emergency department presentations are due to a variety of factors, including a growing population, a rise in complex health issues among an ageing population, and health and social service pathways that prioritise referrals to emergency departments (Chen et al., 2019). Chen et al. (2019) suggested a poor understanding around contributing factors and the interrelationship between these factors; thus, employing a systems thinking approach could assist in generating knowledge. They interviewed senior clinicians with the aim of developing a CLD to map factors contributing to emergency department presentations. The CLD they developed was used to explain the drivers of emergency cancer care. The figure below, (taken from Chen et al.'s article), illus-

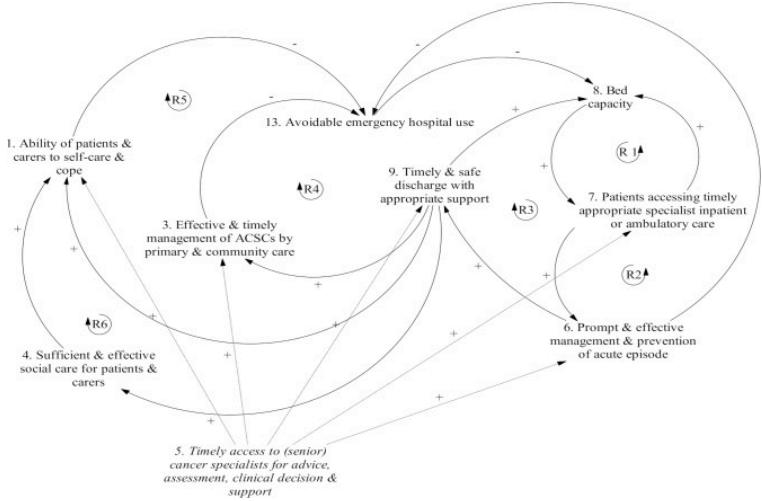
trates these drivers and their interrelationships. Twelve direct and indirect drivers of avoidable emergency hospital presentations included the ability for patients and carers to self-care, timely and safe discharge with appropriate support, and professionals' knowledge and skills in accessing services and referring patients (Chen et al., 2019).



Drivers of emergency department presentations (This figure is licensed under CC-BY 4.0, 'Fig. 3' in Chen et al., (2019))

Relationships between drivers were explored and reinforcing loops articulated within the figure shown below (Chen et al., 2019). A review of reinforcing loops assisted in identifying a leverage point for intervention. They concluded that prioritising interventions that affect the eight factors contributing to the five reinforcing loops they identified could best address the issue of increased emergency department presentations. In this respect, they suggested that interventions and/or programs that promote timely access to specialist care could address factors embedded in reinforcing loops and assist in reducing avoidable emergency department presentations. As

illustrated below, programs that improve timely access to specialist care can favourably impact: (i) patients and carers' ability to self-care and cope, (ii) timely management by primary and community care, (iii) timely and safe discharge, (iv) accessing timely appropriate specialist inpatient or ambulatory care, and (v) prompt and effective management and prevention of acute episodes. The impact of such an intervention on the first of these two drivers was suggested to have a direct effect on avoidable emergency hospital use and produce a reduction in avoidable emergency hospital use. The later three were identified to have an indirect effect and also contribute to a reduction in avoidable emergency hospital use (Chen et al., 2019).



Reinforcing loops impacting emergency department presentations (This figure is licensed under CC-BY 4.0, 'Fig. 4' in Chen et al., (2019))

Soft Systems Methodology

The soft systems methodology is a qualitative systems thinking approach that aims to identify the impetus for change by

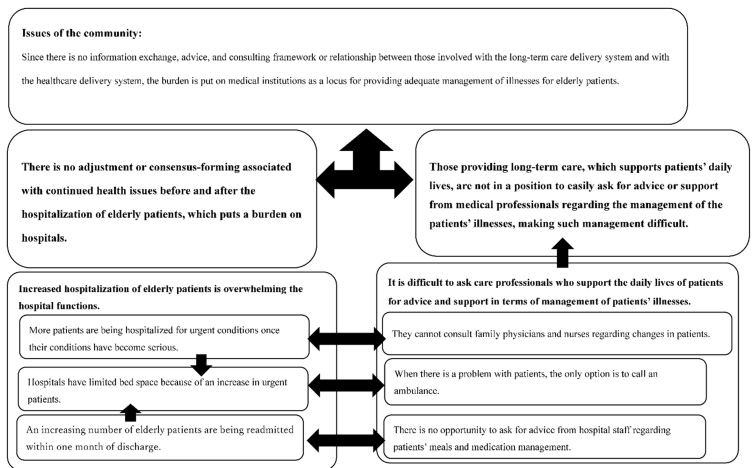
exploring tensions between individual lived experiences, and systems perspectives (generated by collating the perspectives of diverse stakeholders). The approach was initiated in response to the inadequacy of problem solving approaches, which assumed that interrelationships are uniformly understood (Checkland and Scholes, 1999). It is a seven-step process where stakeholders: (i) identify the problem requiring response, (ii) develop a description of the problem scenario using rich pictures (or rich picture), (iii) develop root definitions of the problem situation based on diverse perspectives, (iv) develop models of the problem scenario and system informed by definitions, (v) compare rich picture descriptions to modelled descriptions, (vi) establish interventions for change in response to the tension derived from comparing rich picture and modelled descriptions, and (vii) take action to address the problem scenario. Steps 1 and 2 align with the real-world perspectives (individually based), while steps 3 and 4 align with the systems thinking world, which considers and integrates diverse perspectives relating to the issue and/or problem scenario. The soft systems methodology is increasingly being used to address problems in the delivery of healthcare, and in this capacity, is largely used to understand the dynamic perspectives and interpretations of a problem, and potential interventions to address the problem (Augustsson, Churrua, and Braithwaite, 2020).

Soft System Methodology Application

Ageing adults and people with complex disability often find themselves moving between residential and/or supported accommodation and hospital and health service and/or inpatient services (Australia Institute of Health and Welfare, 2020). Such movement can be challenging for end users and providers of care, with challenges around ensuring continuity

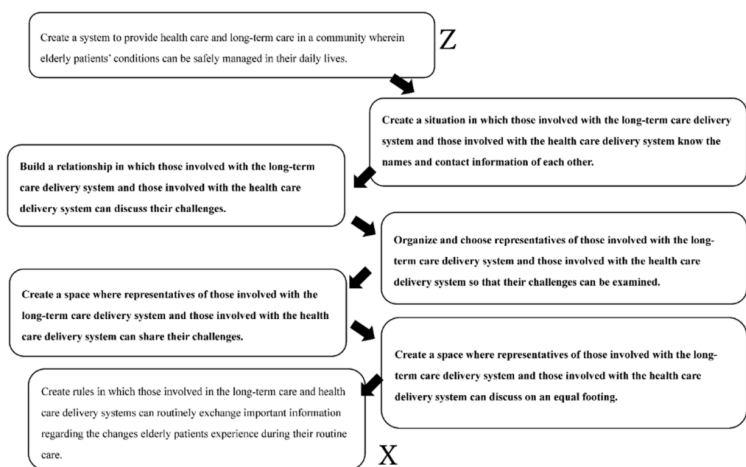
of care to promote the best health outcomes. Distinct factors make offering responsive, high-quality coordinated residential aged and hospital care challenging, including (i) a general increase in demand for community and clinical services resulting from an ageing demographic, (ii) an increase in repeated hospitalisations due chronic conditions, (iii) a mix of fee-for-service, private health insurance, and public health insurance (for example, Medicare in Australia) payment options, (iv) the support required to ensure that ageing adults are able to make difficult decisions, and (v) differing understandings of the challenges experienced by end users (Goto and Miura, 2022). As a response to challenges in offering high-quality coordinated care, Goto and Miura (2022) utilised the soft systems methodology to ascertain issues and challenges resulting from linking healthcare and residential care delivery, and clarify solutions that could result in high-quality integrated delivery. Over a three-year period, community care coordinators (n=20) – coordinators responsible for ensuring service coordination across residential and hospital services – participated in workshops where group discussions were held to establish coordination challenges and solutions. Drawing on input from three coordinators within a single municipality, Goto and Miura (2022) followed a revised soft systems methodology. Issues identified surrounding the challenges of linking healthcare and residential care delivery contributed to a rich picture, where the dynamic interplay between coordination issues were synthesised, as illustrated in the figure below. As included within the rich picture below, healthcare issues identified include: (i) an increase of admissions based on urgent conditions, (ii) a lack of bed space due to increased urgent admissions, and (iii) and increasing number of inpatients readmitted within one month of discharge. Long-term residential care issues identified include: (i) inability (perhaps due to communication gap) to consult with doctors regarding resident health issues and/or symptoms, (ii) the need for advice around care required for

patients post discharge, and (iii) given the expertise of care staff, the best option to support patients in need is to call an ambulance.



Visualisation of information on community issues. (This figure is licensed under CC-BY 4.0, 'Figure 1' in Goto and Miura (2002)).

Given the rich picture, and further analysis of stakeholder perspectives resulting in the development of root definitions of the overarching issue, a conceptual model where characteristics of coordinated care responsive to the accumulative issues was developed. This model is shown below.



Conceptual model (This figure is licensed under CC-BY 4.0, 'Figure 2' in Goto and Miura (2002)).

In summary, the model of care proposed involves ensuring that open lines of communication exist between individuals working within long-term care and hospital health services. This would allow for relationships between groups to be established, whereby challenges and opportunities could be discussed, and nominated representatives from both groups could explore challenges as they emerge. An equitable opportunity and space where representatives from both groups can present and discuss challenges is theorised by Goto and Miura (2022) as facilitating high-quality care responsive to the needs of end-users.

Implications for Practice

The case applications provided highlight the value of systems thinking approaches as a method to tackle complex problems

in healthcare delivery. The diversity of methods aligning with systems thinking have value in distinct circumstances, and certainly, developing competencies around the implementation of methods. In particular, an understanding around methods best suited to address particular problems is an important and worthwhile endeavour. Initially, it is necessary to shift ways of thinking in healthcare organisations. In this respect, health and social care managers and leaders have a role to play, as they can foster an environment where those in the space are able to become systems thinkers, and value diverse perspectives, interrelationships between factors contributing to an issue, and understand boundaries. Healthcare leaders have a role in developing an environment where professionals can collectively learn and develop strategies to address complex problems (Senge, Hamilton, and Kania, 2015). Senge, Hamilton, and Kania (2015) suggested that systems leaders need to have three core capabilities to foster an environment where professionals can utilise systems thinking and collectively learn. These capabilities can be developed and consist of the ability to: (i) see the larger system, (ii) foster conversations and reflection, and (iii) change focus from reaction to co-creation. Senge, Hamilton, and Kania (2015) clarified a diversity of tools that leaders can engage with to promote their ability to build the three competencies, including the development of systems maps to see the larger system, and peer shadowing to foster conversations and reflection.

Key Takeaways

For Leaders – You Will Know You Are Successful If.....

System thinking approaches can support leaders to develop deeper insights, consider unexpected consequences, develop contingencies, and coordinate actions to manage complex problems in the health system (Hobbs and Midgley, 2020). As leaders, you will know if you are successful if you challenge assumptions, develop critical thinking, and explore wider contexts to solve complex problems. Strategic choices for decision making should include sharing multi-dimensional problems with others, and developing several options for solutions, then comparing them and choosing what it is best for the problem at hand. You will also know that you are successful if you manage to engage others and allow them to share their perspectives of the complex problem at hand, identify possible solutions, reflect on them, and find an appropriate middle ground that can address the problem.

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Governance and financial management in health and social care

JOHN ADAMM FERRIER AND HANAN KHALIL

Introduction

This chapter explores the relationship of finance in the delivery of healthcare and social care by examining how funds are governed, raised, pooled, and distributed. The chapter examines the funding sources for health and social welfare in Australia; where and how funds are sourced, pooled, and managed; methods of payments from an individual's perspective; as well as how funds are distributed to hospitals and health services. We review the five common funding methods used in health delivery, and then examine how governance ensures quality outcomes through financial reporting.

Over the last century, healthcare and social care have evolved from a charitable and benevolent focus towards becoming highly commercial in nature (Collyer & White, 2001). Healthcare, that is, the provision of services that permit an individual to return to a state of well-being, has become more complex (Braithwaite et al., 2005), involving collaboration to achieve both direct or indirect care (West, 1992) and demanding resources in terms of human inputs, equipment, and consumables. Medicare is the main funding body for the provision of

health services in Australia. To provide access to medications, the Australian government subsidises the cost of medicine for most medical conditions under the Pharmaceutical Benefits Scheme. Australians also have the option to purchase additional insurance from private health insurance companies for health services not covered by Medicare, such as dental and ancillary services, or for accommodation in a private hospital.

Social care, or welfare, is a broad topic. The Australian Institute of Health and Welfare (2021) describes welfare as supporting individuals, families, and even communities who require assistance to achieve positive well-being. The International Labour Organization (2023) lists the minimum standards for social security that include “medical care, sickness, unemployment, old age, employment injury, family, maternity, invalidity and survivors’ benefits”.

In Australia, funding for these services is predominantly public via Commonwealth Government departments. Other funding is provided for health related services by the Department of Health and Aged Care Services (statutory authorities are Medicare and the Pharmaceutical Benefits Scheme). The Department of Social Services provides welfare related funding through the statutory authorities of Centrelink (pensions, etc) and the National Disability Insurance Agency (which oversees the National Disability Insurance Scheme [NDIS]). There are additional funding sources in Australia, such as those provided by the Department of Veteran’s Affairs and state government authorities that insure for specific purposes, such as workplace injuries and road trauma.

Regardless of whether a health service is privately or publicly owned; or how it is funded, understanding financial management is now crucial for all managers. (Braithwaite et al., 2005; Courtney & Briggs, 2004; Duckett & Willcox, 2015; Edwards, 2015). Clinical managers must understand financial informa-

tion and develop the skills to effectively communicate with financial staff.

Healthcare needs and costs vary over the span of an individual's life. Assuming an uncomplicated birth, the average lifetime healthcare costs are higher for females than for males; healthcare costs are lowest in childhood, and rise relatively slowly until after the age of fifty, where they start to increase (Alemayehu & Warner, 2004; Meering et al., 1998). For the poor, serious ill health may swiftly become catastrophic, not only in terms of treatment costs, but also with respect to the potential loss of income (Kutzin et al., 2017; Li et al., 2014). The highest costs occur in the final years of life, and in the absence of some form of cost sharing of the financial burden, can contribute to intergenerational poverty (Li et al., 2014; Shan et al., 2016).

The World Health Organization (2021) determined that all citizens should have access to universal health coverage as a basic human right, meaning that a person should receive timely and responsive provision of essential healthcare without becoming impoverished. The evolution of health service provision in any nation depends on the population's historical developments and cultural expectations and is often shaped by political debate. This contributes to international diversity regarding the way health systems are structured, governed, regulated, and financed. Governments face a range of choices and priorities with respect of achieving improvements in population health (Duckett & Willcox, 2015, p. 7). Most countries who are members of the Organisation for Economic Cooperation and Development (2016) implement forms of universal healthcare coverage so that the costs and risks associated with healthcare provision do not fall to the individual.

At its heart, universal healthcare coverage requires the pooling of resources and sharing of risks of potential future health needs across a population. A wide diversity of health systems

and the way they are financed exist across the globe. In designing a health system that features universal healthcare coverage, decisions are based on a given population's needs and, perhaps most importantly, who will contribute funds and who will benefit.

- United universalism, where citizens have access to the same opportunity for healthcare regardless of their ability to pay, through government operated schemes as seen in the United Kingdom's National Health Service, Medicare in Australia and Canada, New Zealand Health, and the Unified Health System in Brazil.
- Stratified universalism, where access to care is available to all, but limited by their ability to pay, the insurance is provided through private or commercial health insurance, with additional provisions made for those who cannot afford healthcare.
- Differential access, where portions of the population cannot access any form of insurance and must rely on out-of-pocket expenditure.

In Australia, Medicare is an example of national health insurance, where the citizens and eligible residents have access to healthcare, regardless of their personal ability to pay. While it is funded by a levy on all personal income tax, most Medicare funding comes from general government revenue. The Australian private health insurance industry operates under a requirement called community rating, where (apart from some qualifying periods) the insured pays the same contribution for the insurance product regardless of their past health history or risk of developing an illness and those classified as low risk effectively subsidise those with a high-risk profile (Lo Sasso & Lurie, 2009). Without such a policy, private health insurers would follow the American model of experiential rating and vary premiums or even deny care based on risk by charging

higher premiums for groups considered to be at higher risk, such as older people, current or former smokers, or those with chronic diseases.

Strategies to pool funds and spread the risks associated with future ill health are not mutually exclusive. Although every taxpayer in Australia contributes to Medicare through a surcharge, Australians may also choose to take up discretionary options in addition to Medicare. A list of potential pooling strategies is listed in the table below.

Table Pooling options

Level	Description	Capacity	Example(s)	Risk	Potential benefits	Potential disadvantages
Individual	<p>Where a person funds their care from their personal resources.</p> <p>Favoured by the affluent as an expression of "self-determination" and/or "freedom from government interference".</p>	<p>Low – constrained by access to economic resources throughout a lifetime: relatively high for the affluent, inaccessible to the poor.</p> <p>Requires discipline to achieve.</p>	Individual health fund (e.g. health account.	<p>Inability to afford care that may be required for serious or unexpected illnesses or accidents/mishaps.</p> <p>Funds are only used for personal health needs, negligible contributions to public health (social goods).</p>	<p>If economic resources are limited, funds may be redirected to meet more pressing immediate needs such as accommodation and food.</p> <p>Control of the accumulated funds, preserved for the sole use of the individual.</p>	<p>Healthcare is progressively becoming too expensive for an individual to fund.</p> <p>Unmet healthcare needs.</p> <p>Health provision becomes a societal "luxury" item rather than a universal service.</p> <p>Poverty and chronic disease are more likely in old age.</p> <p>Reliance on charity.</p>

Level	Description	Capacity	Example(s)	Risk	Potential benefits	Potential disadvantages
Family	<p>Funds are pooled by family members and used to assist those who fall ill.</p> <p>Requires careful pooling and prudent management of family wealth across generations.</p>	<p>Relatively low – constrained by access to economic resources, pooling of family wealth over generations.</p>	<p>Family trusts, extended family collectives.</p>	<p>As above, in addition to intergenerational poverty.</p>	<p>Cohesion of the traditional and extended family unit; clan membership.</p> <p>Benefits high status and wealthy members of a hierarchical society.</p>	<p>Unmet health needs, inequality among family members may lead to favouritism.</p> <p>Hegemonic patriarchal structures potentially disadvantage females in favour of males.</p> <p>Contributes to the establishment of a hierarchical society and privileged behaviours and expectations.</p>

Level	Description	Capacity	Example(s)	Risk	Potential benefits	Potential disadvantages
Social	Where groups of people contribute towards a common fund with a common contribution and expressed outcomes.	Moderate – presumes that not all members will require resources at the one time. Capacity increases over time, but is susceptible to being wiped out in an epidemic or other calamity affecting the community.	Friendly societies, guilds, alms <i>(historical forerunners of private health insurance organisations)</i>	Inability to cope with large scale disasters that affect all contributing members at the one time, such as epidemics. Potential for contributions to public health (social goods).	Social cohesion of the local population's environment. Reduction in sedition arising from social unrest. Strengthens the role (and purpose) of religious and other benevolent communities.	Healthcare access and security rely on social status within the contributory group. Regional and community health inequities. Restriction on geographical mobility. Can be used to enforce social conformity. Inequality for nonconformists and/or minorities. May be subject to religious dogma

Level	Description	Capacity	Example(s)	Risk	Potential benefits	Potential disadvantages
						or social prejudices.
Work-related	Where health insurance forms part of the employee's remuneration package that extends to their spouse and dependents.	Dependent upon the size and stability of the work environment. Low to moderate – if the fund is managed internally. Moderate to high if premiums are purchased from private health (re)insurance.	Company sponsored health insurance schemes.	Inability to cope with medium to large scale disasters that affect all contributing members at the one time, such as epidemics. Potential for contributions to public health (social goods) but constrained by perceived economic benefit to the company.	Employer benefit: creates incentives for workers to remain with the company. If internally managed, creates a fund that may be invested to benefit the parent company. Can reduce personal income tax obligations.	A disincentive for employees' workplace mobility. Benefits end with employment. Invested funds belong to the company rather than the workers. Personal income tax is replaced with fringe benefits tax, which is factored into the remuneration package.

Level	Description	Capacity	Example(s)	Risk	Potential benefits	Potential disadvantages
<p>Indirect taxation/levy</p> <p>Premiums are indexed according to actuarial risk associated with the type of industry and the employer's history of claims.</p>	<p>High – if guaranteed by government.</p>	<p>Indirect taxation/levy for Workcover insurance as a salary on cost.</p>	<p>Premiums may not cover the lifetime costs associated with permanent injuries or disabilities.</p>	<p>Raises funds for the treatment of injuries incurred in the workplace.</p> <p>Encourages workplaces to institute work safety practices to avoid increased premiums.</p>	<p>Indirect charge (staffing overhead) not visible to workers, therefore little personal financial incentive to ensure a safe workplace.</p> <p>People must disclose previous Workcover claims if seeking a new role – may impact employment opportunities.</p>	

Level	Description	Capacity	Example(s)	Risk	Potential benefits	Potential disadvantages
Private health insurance	Commercial companies that offer insurance products for a regular premium payment from individuals.	Moderate to high – dependent upon the volume of members or purchasers and presence of an industry wide opportunity to reinsure through a common pool.	<p>“Not-for-profit” companies where surpluses are invested back into the fund.</p> <p>“For profit” private companies contribute shareholder dividends.</p>	<p>Subject to economic downturns.</p> <p>Without a reinsurance pool, companies’ risk insolvency in periods of high demand.</p> <p>Higher potential for contributions to public health (social goods), but this is constrained by perceived economic benefits to the company through a reduction in health burden via preventive health.</p>	<p>Risk is spread across all members, the more members the better.</p> <p>In the absence of universal (nationwide) schemes, this is a good option if appropriately regulated and reinsurance mechanisms are provided.</p> <p>Provides subscribers with a sense of security and potential of choice regarding their health providers.</p>	<p>Without government regulation, (i.e., community rating) can impose higher premiums on those who are deemed to have pre-existing conditions or who may be at risk or needing benefits.</p> <p>May have complex exclusion rules, benefits are determined by actuarial study and commercial viability rather than matching health needs.</p> <p>Often out of reach</p>
	Companies may be publicly listed private companies that pay dividends to shareholders, or not for profit organisations that reinvest surpluses back into the fund.					

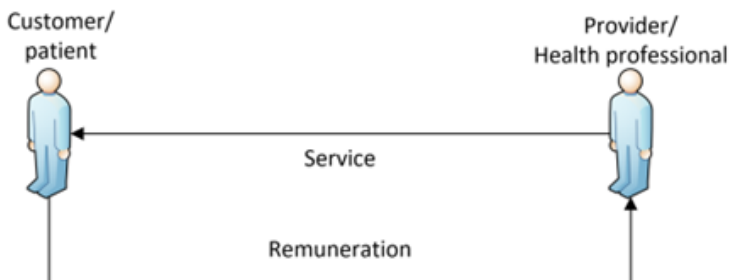
Level	Description	Capacity	Example(s)	Risk	Potential benefits	Potential disadvantages
						of those who are socioeconomically disadvantaged (i.e. those who need it.

Level	Description	Capacity	Example(s)	Risk	Potential benefits	Potential disadvantages
State-sponsored insurance	Systems of funding healthcare that can either be managed as part of a government department, instrumentality or, in some cases, outsourced to existing insurance companies.	Highest capacity to cope with collective health needs across a national or regional area. Strong capacity for collection of reliable data.	Medicare Australia (national universal payer).	Financial risk spread across the population.	<p>Widest capacity for revenue collection.</p> <p>Mechanisms that can achieve equality across regions and nations.</p> <p>Strong capacity for funding preventative health programs.</p> <p>Transparent redistribution of economic resources to benefit the socially disadvantaged.</p>	<p>Challenging to meet demand.</p> <p>Perception of “rationed” care.</p> <p>Can be mired in bureaucracy and slow to adapt.</p> <p>May not provide comprehensive coverage (e.g. Medicare Australia does not cover dental care).</p>

Funding Flows and Access to Health Services

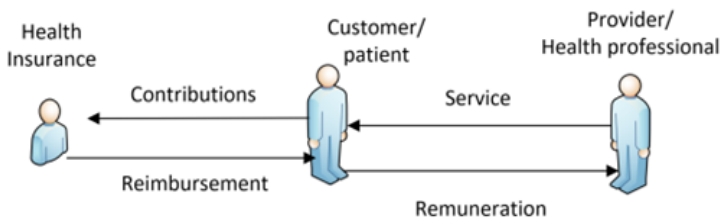
One of the challenges in determining how to address funding a health system is that the “health market” is vastly different from what may otherwise be considered a “perfect market”, where the behaviours of customers and sellers cause equalisation. The health market operates with information asymmetry (sellers have more information than buyers). The transactions are not independent, health provision includes both private and public goods, health provision is not inherently selfish, and although there are many buyers (patients), the sellers (practitioners) are restricted and subject to regulation, and the products are heterogenous, which means the product has different characteristics compared to other products. (Legge, 2015) emphasised these differences.

The simplest funding relationship is between the customer and the provider, in that services are provided in exchange for something of value. This is a direct payment model, where the customer (the patient) is responsible for meeting all of their costs, and the provider is free to determine the charges they will make, as shown in the figure below.



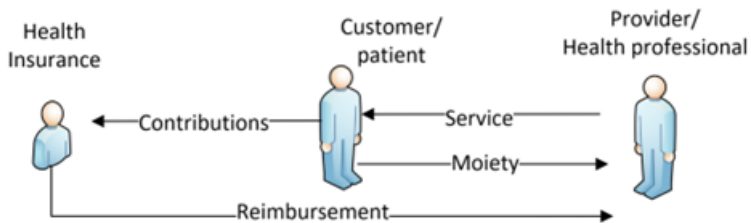
Direct payment (created with reference to lecture notes created by Legge, 2015)

Where a patient voluntarily enters into a health insurance arrangement, the patient may then seek reimbursement of the costs associated with the care provided **after** paying the provider, as shown in the figure below. The patient is often left with “out of pocket expenses”: that is, the reimbursement often does not match the total expenditure. In this situation, the patient is aware of the total costs and must bear the full economic impact of the health services provided until reimbursement is received from the third-party insurer.



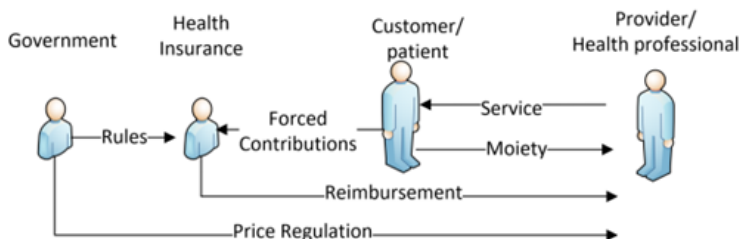
Direct payment with reimbursement (created with reference to lecture notes created by Legge, 2015)

A variation on this arrangement is co-payment, where the health provider can charge the patient's health fund directly, with the patient only having to pay any shortfall or co-payment. If there is no shortfall or co-payment, then the customer/patient may consider this “bulk billing”. Disability services in Australia, are quoted and accepted by the NDIS, and when services are provided, the bills are forwarded to the NDIA (National Disability Insurance Agency) and payment is made up to the agreed budget.



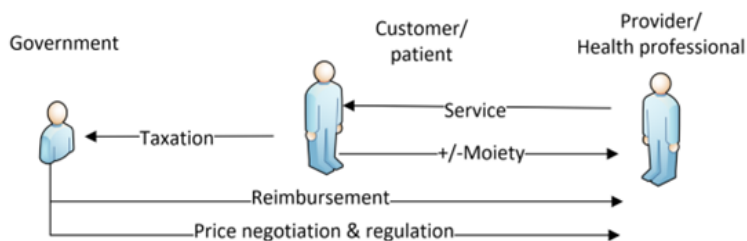
*Co-payment/Bulk Bill Model (no moiety)
(created with reference to lecture notes created by Legge, 2015)*

Direct payments to the provider establishes the possibility for negotiation between the health insurance organisation and the provider regarding agreed levels of remuneration through a divested health remuneration model, as shown in the below figure. In this arrangement, the provider remains free to determine the charges sought for the service; however, there is now a weak mechanism through which costs may be negotiated, and the customer or patient is no longer a cost “acceptor”. A government may choose to adapt this model to achieve divested universal health coverage. The attractiveness is that this preserves existing funding institutions (private health insurance) and mechanisms. The government may also ensure the economic viability of such a system by requiring the participating health insurance funds to contribute towards a centralised pool as a form of reinsurance.



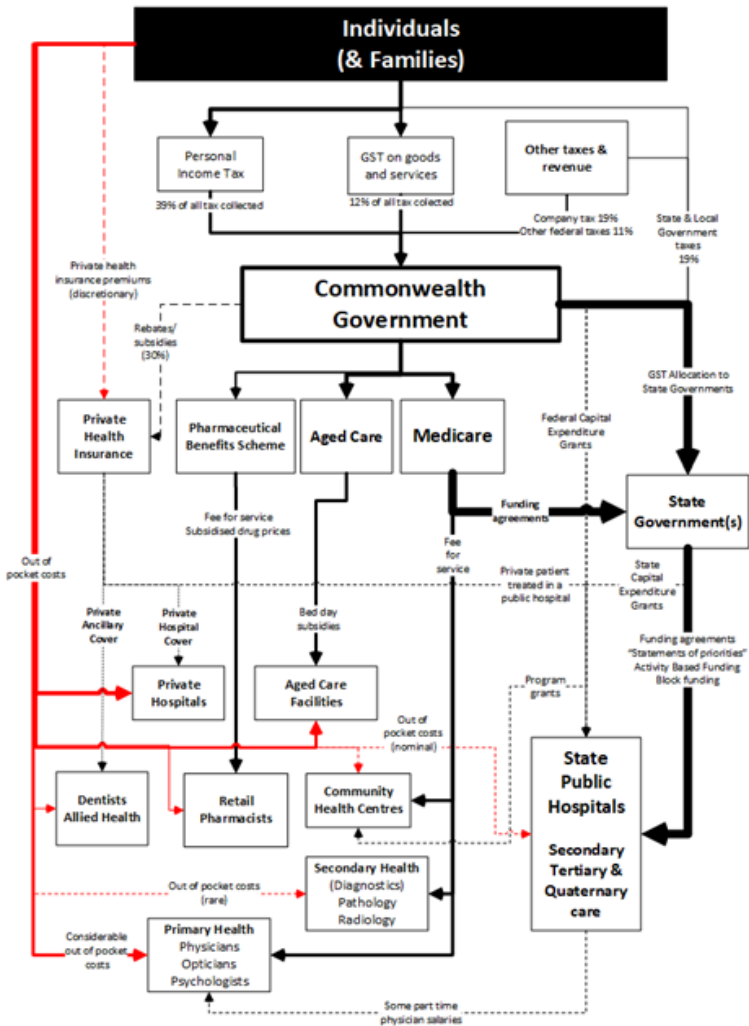
*Divested health payer model
(created with reference to lecture notes created by Legge, 2015)*

A further development is where a government takes over the responsibility of funding of health services directly through a centralised health payer model, as shown in the figure below. In this case, the government can influence the payments made for health services on behalf of the patient. Universal health-care occurs where most of a population's health needs are funded from a centralised revenue pool. The provision of health in the “public system” may appear to be “free” from the consumer's perspective, especially if few fees or user co-payments (moieties) are avoided. In the case of bulk billing, there may not be a patient payment or co-payment.



*Centralised (government) health payer model
(created with reference to lecture notes created by Legge, 2015)*

A further complication if a health system is vast is that additional funding pathways will be required as services and stakeholders are added. For example, the current funding pathways in Australia are complex, as shown in the figure below.



Payment flows for common health services in Australia (Based on an original concept devised by Duckett & Willcox, 2015, p. 380 [Appendix 1])

Since Federation, taxation in Australia become progressively centralised, enabling the Federal Government to influence

areas outside its constitutional boundaries using funding as a lever in place of statutory legislation. Notably, the provision of public health services remains a state responsibility; however, because the Federal Government controls taxation in general and the grants for operating the health systems via Medicare, it can influence policy decisions with respect to the provision of “free” public health services. To date, this influence has been focused on the population’s access to health services, regardless of the ability to pay or location. The mechanism for this has been the Healthcare Agreements with activity based funding (ABF) included as a funding reform. The current arrangements of a comprehensive public hospital system supplemented by private hospitals with access managed by general practitioners have arisen due to fierce political debate. The focus of health provision differs across the levels of government in Australia.

Responsibility for the delivery of hospitals remains a state responsibility; however, the Federal Government has increasingly acted to consolidate and harmonise the delivery of health via funding mechanisms.

The table below provides examples of a fragmented health care system and lists the principal roles of each level of government.

Principal responsibilities

Level of Government	Principal Role in Health	Examples
Commonwealth Government	Policy harmonisation	Australian Health Practitioner Regulation Agency
Funding	Medicare Pharmaceutical Benefits Scheme Aged Care National Disability Insurance Scheme	
State Government	Regulation and funding agreements	Public Hospitals Funding Agreements Community Health Services
Services	Public Hospitals Aged Care centres Water and sewerage	
Local Government	Regulation	Bylaws
Services	Sanitation (garbage collection)	

How are funds for health services distributed?

Health service funding should encourage the allocation of resources based on population and clinical needs so that care and treatment occurs at the appropriate time. Ideally, remuneration methods *should* ensure that services are patient focussed and that there is equity of access. Equity of access means that patients' health needs are treated similarly (hori-

zontal equity), and those with the greatest/immediate need are treated first (vertical equity).

Various methods are commonly used for funding health services, and are often used in combination to meet differing needs.

Fee-for-service

Fee-for-service is when a health provider is paid an agreed or negotiated amount for a discrete service provided. The provision of primary and secondary health services for non-admitted patients is commonly remunerated using a fee-for-service model. The *Commonwealth Medical Benefits Schedule* contains a list of fee-for-service care that Medicare will fund provided by medical practitioners and other primary health providers, such as optometrists, nurse practitioners, and many practitioners connected to chronic healthcare. Outpatient pathology and radiology are also funded on a fee for service basis. Practitioners are free to charge patients more than the scheduled rebate, and co-payments are common. Dental services are fee-for-service and not subsidised by Medicare. A fee-for-service model via a single payer scheme such as Medicare can create a wealth of reliable health information for planning and monitoring purposes. Other advantages include transparency, funding levels can be closely related to costs, and that they are simple to operate and discourage underservicing. The disadvantages of this funding model are that financial risks lie with the funding source, and patient overservicing is possible, although patient co-payments restrict this to some extent (Biggs, 2014).

A major feature of the National Disability Insurance Scheme is that funds are made available to people living with a disability

for services that they deem give their lives meaning. The disadvantage of this system is the relatively weak capacity for price negotiation and or competition by providers.

Per diem payments

Per diem “per day” funding is a mechanism for the remuneration of hospital inpatient care where a hospital is remunerated for each 24-hour period an inpatient occupies a bed. In some respects, it is similar to a fee-for-service model, where a period of time replaces the service; the key measurement is length of stay. The major advantage of this mechanism is its simplicity; the daily fee remains fixed regardless of the actual costs incurred. Per diem payments create a perverse incentive to keep patients admitted longer than necessary to maximise income. To address this, a tiered fee arrangement can be used, where the daily fee reduces after a number of days. The major disadvantage is that this may not recognise complexity, it rewards inefficiency, and does not encourage quality of care. Per diem payments have progressively been replaced by activity-based funding models, but may still be used to remunerate smaller private hospitals, or where there is a clinical reason to supplement activity-based funding models for a complex admission. (Duckett & Willcox, 2015, pp. 248-250; Willcox, 2005). Until 2023, per diem payments were the mainstay of remuneration to the aged care sector; however, a form of graduated activity based remuneration is currently being introduced (Department of Health and Aged Care, 2022).

Block funding

Block funding is where a provider is paid a given amount of

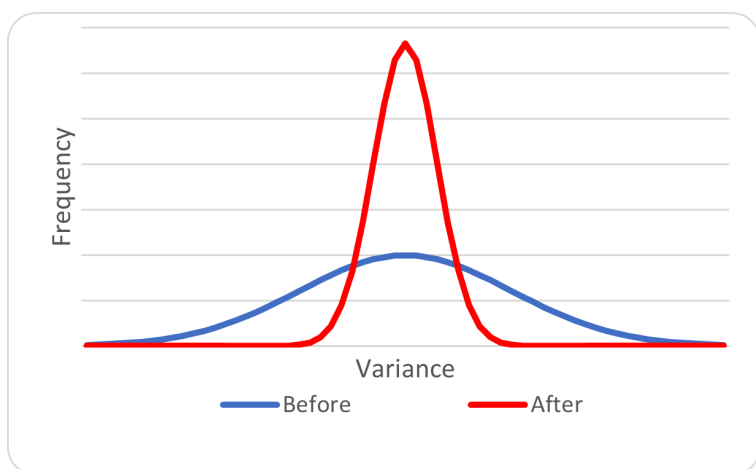
money in return for predetermined defined services over a given period. The funding agreement between the funder and provider includes prospective and specific activity targets and requirements expressed in a service agreement between the funder and the provider. Block funding remains a standard mechanism for providers that tend to be smaller and who may lack the volume or throughput to benefit from models such as activity-based funding or those that provide care that is not easily defined into discrete episodes. The major disadvantage of block funding is that it is a prospective funding arrangement; providers are given a budget for availability, that is, the *intention* to treat patients, rather than for the work achieved. It is therefore challenging for the funder to hold the provider accountable or to increase their technical efficiency.

Block funding has historically been used to fund categories of health-related activities that previously fell outside of an ABF model, such as provision of resources for teaching, training and research in public hospitals, as well as funding outpatient (non-admitted) health services such as mental health (including child and adolescent mental health), home ventilation, home dialysis and other chronic disease management (National Health Funding Body, 2021). Classification systems have been refined to describe outpatient and emergency department services and are now included in ABF models. For people living with a disability, block funding has often been used by fund providers who determined levels of care. With the introduction of the National Disability Insurance Scheme (NDIS), individuals are provided with individual funding for the services they require, which consumers pay via a fee for service arrangement. The impact of this development on community health services has been profound. Funding, provided annually is now diverted to the consumer, and care plans need to be individually negotiated (Buckmaster & Clark, 2019).

Activity-based funding

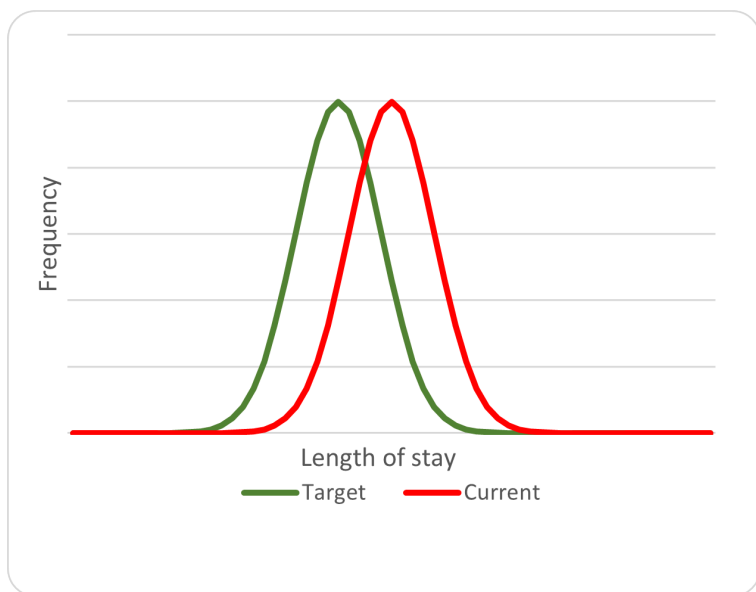
Activity-based funding (ABF), also known as case-mix funding, is the primary funding model used in Australia to fund hospital services (Solomon, 2014). This was initially in public hospitals, and is increasingly *mirrored* by private health insurance companies (Willcox, 2005). ABF was first used in Australia to fund inpatient care including emergency department and outpatient presentations and has progressively been extended to encompass funding for subacute (rehabilitation, palliative and geriatric services) and non-acute care (chronic conditions) using Australian National Subacute and Non-Acute Patient Classifications (Independent Health and Aged Care Pricing Authority, 2023b).

The theoretical principles of activity-based funding are that health services are recognised for the provision of services based on the type of service provided according to the diagnosed needs, where a specified amount is paid on the completion of the treatment, which is adjusted according to the relative complexity and resources required. The aim is to “improve patient access to services and public hospital efficiency through the use of activity based funding based on a national efficient price” (Council Of Australian Governments, 2011, p. 5 (Section 3a)). ABF is intended to provide transparency and equity of funds allocated to providers and incentivises providers to use the funds more efficiently as a form of technical efficiency. It also encourages allocative efficiency through the provision of timely quality of care (Independent Health and Aged Care Pricing Authority, 2023a; Solomon, 2014). ABF is used to encourage hospital providers to reduce variation; with the payment being based on the average costs associated with a particular diagnosis related group, as shown in the figure below.



Theoretical impact of Activity Based Funding

The second imperative is for providers to reduce the costs of care provision. ABF models recognise length of stay as a proxy for cost. If the overall average costs associated with care are lower than the national average, then the hospital will generate a theoretical surplus for that Diagnostic Related Groups (DRG), as shown in the figure below, and the opposite also applies; if the overall costs are higher than the national average, then the “business” associated with that DRG will operate at a loss. Service agreements at Commonwealth and state levels and state and provider levels are negotiated based on forecasted activity and usually capped. This contrasts with ABF models used in other countries, such as the United States.

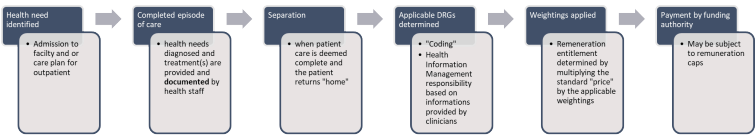


Management impact of Activity Based Funding

The principle of activity-based funding is that healthcare recipients should receive comparable care using similar resources. Ideally, providers would be paid according to *outcome* (the impact of the care); however, this is complex to quantify. ABF allocates payment based on *output* (the completion of the care or “separation” of the patient from the provider), with penalties if a patient is readmitted for the same issues within a certain period after separation.

Episodes of care are grouped according to similar diagnosis, procedures and other resource requirements, according to the Australian Refined Diagnostic Related Groups (AR-DRGs). AR-DRG software analyses the diagnoses and treatments and assigns the DRG. Each DRG has a weighting so that all treatments can be compared to one another. A standard remuneration

neration amount is modified according to the weightings associated with the AR-DRG, as shown in the below figure.



ABF funding process

The foundation of any ABF system is reliable data. This includes not only aggregated clinical data, but also the costs associated with the provision of care and factors that may influence the delivery of care, for example, the use of intensive care or other high cost services (Edwards, 2015). This may also include clinical issues such as historical demand and comorbidities, environmental issues such as proximity to state capital cities (which influences the capacity to attract specialist clinical staff), and delivery response times associated with medical and other supplies.

DRG systems use data routinely collected by clinicians, with clinical coders analysing this at the hospital level and assigning codes to episodes of care. For example, in Australia, these data then flow through to state health departments and then to the Australian Institute of Health and Welfare. In Australia, the management of the AR-DRG and standardised pricing is the responsibility of Independent Health and Aged Care Pricing Authority. As each DRG has a weighting, appropriate episodes of care can be funded using a single price multiplied by the weighting. Using a national price ensures fairness across providers.

Hospital management has autonomy to design and deliver

care within a transparent funding and accountability framework, and the funder can determine the overall quantity and quality expectations within the available funds. ABF is dependent upon reliable data, and systems must be in place to understand what services are provided to whom and at what cost across many different types of hospitals and services (National Health and Hospitals Reform Commission. 2009).

Activity

Type

Watch this video on Activity Based Funding and reflect on the different ways that healthcare can be funded and how it works in Australia (IHACPA, 2021).

<https://www.youtube.com/watch?v=4MvZcrggK7U>

AND

Watch this video on the link between medical records and ABF (IHACPA, 2017).

<https://www.youtube.com/watch?v=07azCxfdNPA&t=2s>

Capitation

Capitation is a method whereby a health provider is paid a regular fee based on a population and its expected health care needs. In theory, this encourages the provider to engage in preventative healthcare, identify effective treatment pathways, and limit unnecessary care and overservicing. The risks of

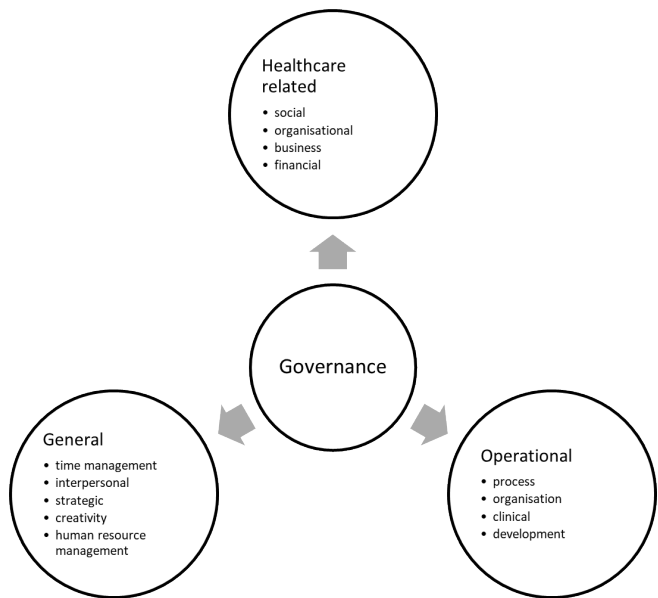
demand management lie with the provider. For example, if an entire health budget was equally distributed according to geography, wide variances would soon become apparent between different regions (i.e. the outback and the inner city. Capitation is uncommon in Australia; however, there are two programs of note. The first is the Indigenous Australians' Health Programme primary health care funding model, which uses a combination of capitation and activity-based funding. The second is a program for primary health provision by general practitioners, the Voluntary Patient Enrolment Program (AIHW, 2020, p. 175).

Governance in healthcare

Health and social care organisations require leadership. Specific competencies can be categorised as health related, operational, and general (Pihlainen et al., 2016, pp. 101-103), as shown in the figure below. Organisational leadership can be described as having three main functions; shaping future direction by identifying goals and avoiding risks, fostering external relationships, and monitoring the performance of the organisation (Margolin et al., 2006, p. 5). The principal benchmark for hospitals is the extent to which resources are efficiently deployed so that patients' needs are achieved in a responsive and timely manner to resolve the health issue and, in the case of infectious agents, to prevent the spread of disease (Srimayarti et al., 2021, p. 87).

Healthcare organisational structures can be hierarchical in nature, with the medical and other professions demanding autonomy and resisting external oversight (Braithwaite et al., 2005, p. 4). Understanding the culture and power dynamics in the health and social care relating to professionalism is impor-

tant, as it can influence the organisation of governance structures.



Relationship of governance to management and leadership competencies (visualisation of Pihlainen et al., 2016, pp. 101-103)

The role of governments

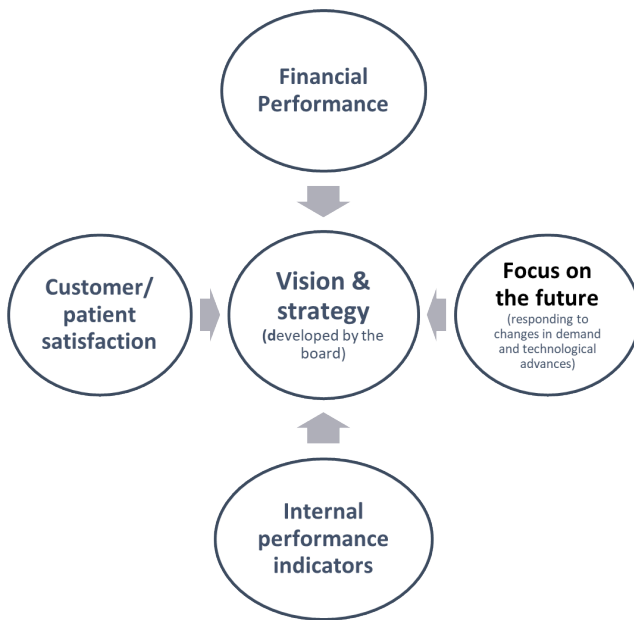
In Australia, the government is accountable for much of the expenditure on healthcare, funding Medicare, pharmaceuticals, and hospitals. Managers and leaders in publicly funded health and social care organisations are accountable for expenditure. Governments demand accountability to ensure that public resources are achieving quality outcomes.

A board is responsible for the overall governance, management, and strategic direction of the organisation and for delivering performance in accordance with the organisation's goals and objectives (Australian Institute of Company Directors) . In

Australia, Boards have now been established by health services, primary health networks and non-government organisations to provide oversight, direction, accountability for clinical and financial performance, and to meet community needs in the delivery of services.

Bismark et al. (2013, p. 686) found that boards historically focus on the performance of the Chief Executive and the financial status of hospitals. Issues of healthcare quality and safety are often subject to internal regulatory systems, which Braithwaite et al. (2005) argued are insufficient, and that a coordinated national and even international approach is required to achieve a responsive regulatory framework.

Kaplan and Norton (1992) first identified the need to expand the focus on financial outcomes as a sole organisational performance indicator and include other contributory measures such as consumer satisfaction, the internal processes within the organisation, and the capacity for change and growth. They stressed that there was no single measurement and proposed a reporting format called the balanced scorecard, of which the financial outcomes are a *contributory* part, as shown in the figure below.



The Balanced Scorecard

Amer et al. (2022) found that implementation of a balanced scorecard by health care organisations had a positive effect on patient satisfaction and financial performance, but only a limited impact for the satisfaction of healthcare workers. Volatile changes can occur in the financial status of any organisation for any number of reasons, and activities (e.g. increased surgery, pandemic response) in an organisation can have financial impacts, and changes in the factors that affect the non-financial measures are often heralded by changes in the finances.

Budgets

Financial planning, budget development, and implementation are essential for all organisations and should be linked to strategic and operational planning processes. A financial plan enables management to keep abreast of income and expenditure. It is a legal requirement that organisations must remain solvent to continue trading, that is, their total assets must remain greater than their overall liabilities. In general terms *income* (the addition to the overall asset pool) should exceed expenses (the total liabilities). Should liabilities exceed the available assets, an organisation is insolvent and must cease operating. A technical insolvency is where cashflow *into* an organisation is *temporarily* restricted, limiting the organisation's ability to meet its liabilities.

Budgets are tools that enable health and social care managers to operationalise strategic objectives into realities through resource management, engaging the appropriate number of staff, securing drugs, supplies, etc via procurement strategies, assigning work to match the availability of resources, determining timelines, communicating desired financial targets, and helping motivate staff. From a broader perspective, budgets are critical to assist the organisation to achieve organisational strategy, measure financial performance, plan and facilitate capital expenditure, anticipate operational expenses, plan for provisions, control expenditure, and monitor actual income and expenditure against that which has been anticipated.

Simons (2000, p. 81) conceptualised budget planning as having three interlinked cycles where the initial cycle is concerned with how the organisation generates revenue. This gives rise to how the surpluses or “profit” is managed (whether by paying down debt, increasing reserves and or capital investment), which finally leads to the overall outcome through which the performance of the organisation is measured, and where appropriate, dividends are paid.

The operational management indicators in revenue generation include factors such as the amount of operating cash on hand, the value of both human and non-human resources required to provide the required services, and the resultant revenue after operating expenses are settled. Ideally, the operational activities should generate an overall surplus, and it is an Executive Management responsibility to advise the board regarding the appropriate use of these funds; such as to what extent the surplus should be used to repay debt, or alternatively, invested in new equipment or procedures that could increase return on the value already invested in the organisation. An organisation's performance can be measured in terms of the organisation's value using ratios such as owner's equity, return on equity, and asset utilisation. The best performing organisations in the private sector generate sufficient surpluses to pay down debt, invest in new assets, and also pay a dividend acceptable to the shareholders.

For example, in the publicly funded hospital sector, management is concerned with service delivery, and managing human and non-human resources within a defined budget. Executive Management is responsible for variations in budget and making recommendations to the Board to address surpluses or shortfalls. The Board of Directors and or governing body reviews overall performance. Monthly management financial reports against budget expectations are generated to assist the operations and to encourage optimal performance, culminating in annual financial reports.

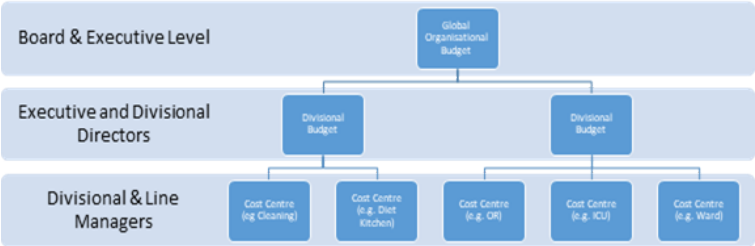
Types of Budgets

Finance departments may develop different budgets with varying degrees of input from stakeholders (Birt, 2020; Edwards, 2015).

Most managers will be familiar with **operating budgets**, as these hold accountability for their management. A budget is

prepared for each work unit (ward, units, or department) and each of these is assigned a “cost centre”. In practice, cost centre managers are provided with an **expense** budget that is granular in detail, with staffing as the primary cost. In units where there is a high consumable use in the provision of care, such as the operating suite, intensive care unit and emergency departments, a greater proportion of their budgets will be allocated to consumables.

Divisional budgets can be created by aggregating the individual budgets that contribute to or are a part of the division. For example, surgical wards and the operating theatre will be aggregated to a Division of Surgery budget. The organisational wide or **master budget** is where the information from all departmental budgets is aggregated and the impact of the organisation’s finances for the reporting period may be reviewed, as shown in the figure below. The global budget is reported to the Board regularly, usually monthly. All anticipated costs and revenues associated with the business are included, such as “services and facilities”, contracts, education/ staff development, with the Finance Department, and Executive Management included. The global budget has all the granularity of the individual unit budgets, but is often presented in a summary form. The organisational wide budget forms the basis of the annual profit and loss statement, although the budget amounts are not reported in the formal statement. The figure below shows budget relationships.



Budget relationships

Capital budgets describe the organisation's plans for making investment decisions where a surplus is invested back into the organisation. In publicly owned organisations, major capital expenditure is usually predicated on the availability of capital grants from the government, loans approved by the government, or fundraising appeals to the public, donations, and or bequests from trusts. Major capital improvements are initiatives that will have a useful working life beyond 12 months and are classified as a non-current asset in the balance sheet. Smaller capital expenditure (often under a certain value) will need to be funded from operational revenue and surpluses. In private organisations, capital expenditure is funded from the organisation's profits, secured loans, raising capital from the owners (shareholders increase their equity or more shares are created to increase working capital) and, less often, through public fundraising.

A **cashflow budget** is generally managed within the Finance Department, and the information is shared with Senior Management. The purpose of the cashflow budget is to identify and, where possible, predict periods of expected cash shortages. (Birt, 2020, p. 397). Understanding cashflow is necessary because there is often a significant delay in a service being provided and the remuneration associated with that service being received. If payments for services rendered are delayed, there may be insufficient cash available to meet current expenses. Cash flow is the difference between the receipts or amount of cash flowing into an organisation (the revenue) and the disbursements or actual cash flowing out of the organisation (bills, staff payroll etc.). Delays in receipts and the need to meet regular obligations such as payroll can lead to a situation where even the largest of organisations may experience insufficient ready cash to make payments, with short term borrowings or overdrafts becoming necessary. It is a key responsibility of the Chief Financial Officer and their staff to develop and monitor

cashflow projections. The performance of actual cash levels against projections serves as a warning device to alert the Finance Department if cash reserves are falling too low. Cash inflows can be increased where payment collection processes can be improved, increasing market share and economic activity, reduction of stock levels, short term borrowings, injection of capital from the owners, or selling underperforming assets. Similarly, cash outflows can be minimised by identifying and cutting expenses associated with waste, duplication of services or inefficiencies, utilising creditor terms (purchasing on credit), moving to “just in time” inventory management and, if necessary, deferring capital expenditure.

An **opportunity budget** is contained within a **business case**, which lists the purpose and rationale for the proposed service in detail, as well as the benefits, risks, stakeholders, gap analysis, and a range of alternatives with the reasons why they should be rejected in favour of the desired or proposed project/program. Opportunity budgets are **speculative** and exist for a particular purpose **in anticipation** of funds becoming available for use.

Project budgets are the financial plans associated with supporting a project. A project is a unique, time limited activity with a specific purpose to meet a need that is not part of usual operations. In organisations, projects are often used as change management tools to assist an organisation to achieve strategic goals. The major difference between a project budget and an opportunity budget is that funds have been approved and set aside to finance the project.

Budget Approaches

The critical issue for any organisation planning a budget is to

understand the market in which it operates. Fortunately, the health sector is relatively more stable and conservative than more volatile markets; however, in principle, the development of an organisational budget relies on three factors:

1. understanding the market in which it operates in terms of size and potential for growth,
2. the market share (or in the case of health, the likely local demand), and
3. the opportunities for strategic development.

In addition, the organisation's funding sources and revenue (in terms of forecasting demand) dictate the capacity to introduce new revenue generating activities and any changes to the remuneration levels must also be considered. Finally, costs associated with providing consumer services, changes to supplier prices, and staffing costs (such as a new enterprise bargain agreement that increases staffing remuneration levels) and other contingencies must be identified and quantified.

Edwards (2015, p. 232) identified five main approaches in developing budgets in hospitals and health services, as outlined below.

The **global budgeting approach** or “base budget allocation”, is common when health organisations are funded in block grants; management then divides or allocates funds to the various departments or cost centres. This method of budgeting is still commonly used in community health services, although activity-based funding is prominent in the acute sector. Government departments will often increase their allocations by a percentage rate each year, and the provision of funds will be tied to performance expectations. The advantage of this method is simplicity, opportunity for cost containment, and elimination of unnecessary services (Dredge, 2004, p. 3); however, the disadvantage is that the levers to encourage quality of

care are lacking. Internal power relationships within organisations can influence internal funding decisions; thus, allocations may not necessarily be directed to meet customer needs.

Historical budgeting (also known as static, fixed, or forecast) is used when the expected income and expenses will remain relatively constant and are relatively simple to achieve. A disadvantage is that historical budgeting stifles change and development; there is no incentive for organisations to improve quality or to avoid large deficits. “Historical budgeting is designed to maintain the status quo” (Edwards, 2015, p. 232), and as such, has fallen out of favour in the funding of health services.

Flexible budgeting is used when there may be seasonal variations in demand or other fluctuations. This type of budget approach is far more common in private hospitals, where bed occupancy and operating theatre demands can change. For example, surgery demand often decreases significantly over holiday periods if large numbers of medical staff decide to take time off for family purposes (Edwards, 2015).

Zero based budgeting is used to construct a budget completely from the start. This is an extremely involved process for organisations, but may be used to periodically “reset” their historical budgets. Conversely, zero based budgets are used for the development of opportunity and project budgets for purposes that are speculative and without previous activity within the organisation (Edwards, 2015).

Activity based budgeting is used to determine the costs associated with the provision of a particular range of services associated with their respective diagnosis groups and was described earlier in this chapter in more detail (Edwards, 2015).

Health services use a variety of these techniques as appropriate.

Financial Reports

Budget outcomes need to be reported for organisational management. There are two main categories of financial reports: formal reports and management reports.

Formal Financial Reports

Formal reports document an organisation's economic outcome and describe performance in terms of the change from one reporting period to another. Formal reports do not include budget information or performance against anticipated economic activity. Formal reports are subject to strict auditing requirements, and often take up months to prepare, review, approve, audit, and publish.

The International Financial Reporting Standards (IFRS) determine the structures and formats of formal financial reports. The benefit of this is that financial statements for any health service, hospital or community health centre can be compared to any other country or industry that has adopted IFRS. The Australian Accounting Standards Board gives *equivalence* with the IFRS the force of law in accordance with S334 of the *Corporations Act 2001* (Australian Government 2001). The Act requires that every organisation subject to the provisions of the Act must provide a formal set of reports at least twice a year. There are three fundamental standard reports, each of which follow a strictly prescribed structure as defined by the IFRS (as adopted by each nation).

The **balance sheet** (also known as a *statement of financial position*) explains the **value** of a company or organisation at a given point in time and always states a particular **date**, *never* a period. It lists an organisation's assets (what they own and control), liabilities (what they owe) and equity (the actual worth of the organisation). The balance sheet is prepared on an **accrual basis** — it reports on the organisation's value at a specific time,

regardless of whether the organisation has paid the bills or received the remuneration owed to it. A balance sheet describes three main components: assets, liabilities, and equity. Current assets are listed in the order in which they may be redeemed as cash.

The key terms found in a balance sheet are listed in the below table.

Terms listed in a balance sheet

Source: (Birt et al., 2012, pp. 21-22; Edwards, 2015, p. 231)

Term	Formal definition	Examples
Asset	Possessions (and skills) that are owned and have value that can be used to generate income in the future	Earnings and savings (money) Things that you own that can be sold if needed House or dwelling that you own
Current assets	Assets that are either cash or items that can be easily and quickly converted to cash (sold)	Cash Short-term (+/- long-term) investments Accounts receivable (monies you are owed) Inventory Prepaid expenses
Non-current assets	Non-current assets are items of value but are <i>either</i> not able to be <i>or</i> expected to be converted to cash in the short term	Long-term investments (full value) Plant and equipment Real estate Patent rights Trademarks
Liability	Most commonly, items of value owed to other people or organisations for which a payment or trade is required	Bills waiting to be paid Rent Mortgage payments
Current liabilities	Obligations that need to be paid in the short term within the current reporting cycle	Accounts payable Loan repayments Dividends to shareholders Income tax payable Rent (i.e. year 1 of a three-year lease) Sinking funds Contributions to capital reserves
Non-current liabilities	Payments that the organisation is obligated to pay in the future but not in the next immediate reporting phase, these are sometimes known as fixed liabilities	Loan repayments after the next year Lease payments beyond the next reporting period (i.e. if a lease is taken out for three years, the lease payments required for years 2 and 3)

Equity	The monetary value of an organisation after all liabilities are paid. Owner's equity is the amount of money the business owes the owners.	A house is valued at \$810K (asset) but has a mortgage (liability) of \$450K, so the equity (residual economic value) to the owner is \$360K: in other words, the owner has 44% equity (ownership) in the property, the bank has 55% equity
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The **profit and loss statement** (also known as *income statement* or *statement of financial performance* or *revenue statement*) is perhaps the most intuitive report to read, and always refers to a period of time; for example, an annual report will explicitly state a period of time ending at a particular date, such as *For the Financial Year ended 30 June 20XX*. The report has two main sections: income (revenue flowing in) and expenses (staffing costs, supplies and expenses, and depreciation of plant and equipment) incurred in providing the services, and these will indicate whether a surplus or a loss has been generated from the operating activities (core business) as the *net operating balance*. Any losses or gains from investing or financing activities are then listed (derived from the cash flow statement) to provide a *net result for the year*. Any other comprehensive changes are then listed, which then provides a *comprehensive result for the year*. The profit and loss statement may include a line for depreciation expenses that refers to the manner in which the cost of valuable assets are “charged” to the organisation over their useful working life.

The **cash flow statement** (also known as a *statement of cash flows*) reports on the **money** that the organisation has received and spent over a given period in accordance with how it has been generated or expended. Health and social care organisations may generate cash from operating activities, such as the provision of health services. However, when an organisation uses surplus funds to buy new assets or sells assets to cover a loss these are termed investing activities. Monies generated

from borrowing or paying back loans are referred to as financing activities.

Management reports

In contrast to formal reports, **management reports** are not defined by IFRS, and vary according to the needs of the managers within an organisation. They often resemble profit and loss statements, with economic activity compared to the anticipated budget amount for that period and variances, as well as a progress amount against planned activity in terms of year to date and variances. It is also helpful to include the previous year's year to date information.

Rationale for standardised reports

The benefit of having standardised reports is that the information can be read in terms of horizontal analysis (the change from one reporting period to another) as well as vertical analysis (the proportion each element against the sum). In addition, several standardised ratio analyses can be applied to compare an organisation's performance against any organisation that uses IFRS reporting.

Managers are expected to control costs listed within their budgets, act if unexpected adverse variances (overspending) may occur, or be prepared to justify (defend) their reasons using evidence-based decision making. To a new or inexperienced manager, an overspend on a management report may appear confronting; however, there are often very good reasons for this to occur; for example, overspending maybe due to increased activity or purchasing. Overspending is viewed with concern if there is no corresponding increase in activity, income, or explanation.

Key Takeaways

The relationship between finance, financial management, and healthcare provision is complex and dependent upon political choices that shape policy decisions made according to the human, economic, and geographical resources historically available to the government considering the cultural values of the population.

Regardless of the choices made, the reduction of activity to financial terms alone is both relatively easy given the art and science of accounting, but perilous if the quality and impact of the health service outcomes are not considered. Managers in health and social care in the 21st century are expected to be able to read cost centre reports. Leaders must have a strong grasp and understanding of financial reporting and governance practices. Professional financial staff are key partners in effective healthcare delivery.

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Innovation and performance in health and social care organisations

SHEREE LLOYD AND KARRIE LONG

Introduction

In Australia, the sustainability of our health system is of increasing concern as the population ages and the burden of chronic disease increases. The global COVID-19 pandemic disrupted health services and the way we work and deliver healthcare. The pandemic demonstrated that when there is a pressing real-world problem to solve, we can innovate at speed (Palanica and Fossat, 2020) and collaborate to develop new products, adapt to technologies, and integrate them into our daily practices. Changing patient needs, technological advances, budgetary cuts, sustainability issues, the growth in chronic diseases, and an unstable operational landscape have been identified as drivers for innovation in the health sector (Akenroye, 2012). The health and social care industry is highly educated and professionalised, and clinicians and professionals have many ideas about how to improve practices and models of care to deliver safer, more efficient, and effective services. Akenroye (2012) cited Don Berwick's observation that it is not the scarcity of innovation in health, but the adoption and dissemination of innovative concepts that are the problem.

The pursuit of innovation is on the agenda of countries worldwide and is identified as a key driver of growth, well-being and productivity (OECD, 2015). Innovation can also contribute to solving core public policy challenges in health, education and issues with food security, the environment and public sector efficiency (OECD, 2015). Key challenges relating to the ageing population and climate change could be solved through innovation-led approaches (OECD, 2015). Innovative digital technologies can provide new options for the delivery of care (see digital health chapter). The World Health Organization (WHO) (2021) recognises the value of digital health innovation to support the achievement of the Sustainable Development Goal (Good Health and Well-being). In Australia, the opportunities to utilise the power of technology and promote innovation to support high-quality, sustainable health, and care for all have been clearly outlined in digital health and other strategic documents (Australian Digital Health Agency, 2018). Phasing out obsolete practices and adopting innovation are fundamental drivers of high-quality and sustainable healthcare (Balas and Chapman, 2018).

This chapter will also examine the concept of health system performance. A health system can be regarded as performing well at the population level if the population is leading long and healthy lives, there is low infant mortality and disease-specific morbidity, and mortality is improved over time through targeted interventions and public health campaigns. Access and equity are also used as measures of performance (Australian Institute of Health and Welfare 2022c). Indicators of health system performance that reflect access to healthcare in geographic locations, services provided, and hospital beds by population ratios are examples of possible measures. Examining the safety and quality of care delivered to patients is also an indication of performance. Measures such as waiting times, access to care and consumer satisfaction are used to under-

stand the safety and quality of a healthcare setting. Health services will not be effective without a workforce that is available at the right place, at the right time, with the necessary skills. As the sustainability of our healthcare system is important, we can also evaluate performance based on financial indicators such as cost per patient, average length of stay, and budget variances. Finally, the availability of equipment, treatment centres, supplies, and medicines can also determine effectiveness and performance.

Innovation and innovation theory

The topic of innovation is vast, and innovation has been of interest since the 1770s, with new ways of business emerging (Salter and Alexy, 2013). Innovations that are sustained usually make an improvement to the way that ‘things are done’. This is true in the health sector, where innovations will be sustained if new methods make work easier or reduce workloads. Innovation has been studied at the industry, firm, and individual levels, and many factors impact the uptake and sustainability of innovation and innovation behaviours (Damanpour, 1996; Greenhalgh et al., 2005). We often think of innovations as new technologies or breakthroughs; however, the literature reveals that there are many different types of innovation. Innovations may be new products, processes or services, technologies, organisational structures or administrative systems, or new policies, plans or programs (Damanpour, 1996). Importantly, new ideas should be directed at improving health outcomes, cost-effectiveness, administrative efficiency, and user experiences, and implemented through coordinated and deliberate actions (Greenhalgh et al., 2004).

In Australia, the health industry provides millions of services

each year in general practices, hospitals, pathology and imaging centres, pharmacies, aged care, primary health, and other settings (Australian Institute of Health and Welfare, 2022a). Service innovation has wide appeal and application in health, and the potential to have a huge impact. Service innovations may involve improvement in the way healthcare services are delivered and organised; for example, the use of novel technology, new medical procedures, the introduction of new services, new care pathways or models of care, or the crafting of new professional roles (e.g. medical or allied health assistants) (Scarborough and Kyratsis, 2022). Johannessen (2013) noted that service innovation has two categories – tangible and intangible service products. In the health industry, this may be new treatments or models of care, and intangible products, such as change of attitude, change in service experiences for patients and consumers, or change in communication styles or methods. Examples of innovation in health are the adoption of checklists to reduce infections (Pronovost, 2008), hospital and rehabilitation in the home, day of stay surgery, e-government, and of course, technological innovation such as artificial intelligence, the metaverse, and robotics (see Digital Health chapter). These innovations have reduced complications, allowed hospitals and healthcare settings to manage increased demand for services, reduced length of stay, and provided greater accessibility through enabling technology such as teleconsultations.

Schumpeter, who is identified as the father of the study of innovation, suggested that most innovations are combinations of elements that already exist (Salter and Alexy, 2013). This may involve the development of new technologies and processes or ways of organising. Innovation may be transformative or incremental, and the literature outlines the strengths and weaknesses of each approach (Dobni, Klassen, and Nelson., 2015; Witell et al., 2016). Incremental innovations can have significant effects (Johannessen, 2013; Salter and Alexy, 2013). Over the

last decade, in the Netherlands, innovations to primary care funding and the introduction of primary care physician cooperatives have been successful in satisfying patients' needs for after-hours care, with 90% of patients visited in their homes within an hour of calling and a reduction in incidents of suboptimal treatment (Snowden and Cohen, 2012).

Damanpour (1996), a seminal writer on innovation, noted that empirically developed theories of organisational innovation are not adequately descriptive “despite continued scholarly effort in the past three decades to understand both the innovation process and the conditions under which innovation is facilitated”. Rogers' model of innovation adoption has been widely used over the past 30 years, and is still applied today, despite the theory being first described in 1962 (Kaur Kapoor et al., 2014; Pashaeypour et al., 2016; van Oorschot, Hofman, and Halman, 2018). Rogers' innovation adoption curve with early adopters and laggards is widely known (Rizan et al., 2017), and still taught in health and business schools. Studies have described how the health industry disseminates innovation, the processes for adoption, the determinants and antecedents for innovation (Chaudoir, Dugan, and Barr 2013; Crossan and Apaydin, 2010; Fleuren, Wiefferink, and Paulussen, 2004), and the factors that support innovation uptake and spread (Greenhalgh et al., 2004, 2005). Early work by Greenhalgh (2005) on innovation dissemination in health continues to be extensively referenced (Kaur Kapoor et al., 2014; National Health System, 2018; Rapport et al., 2018; van Oorschot, Hofman, and Halman et al., 2018) and is recognised as a significant and seminal work. Some aspects have been updated in her more recent work (Greenhalgh et al., 2010, 2017; Greenhalgh and Abimbola, 2019; Greenhalgh and Papoutsis, 2019).

Exercises

Watch this short video on innovation in health care. Consider your own work area and think about ideas where innovation could lead to solutions.



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://oercollective.caul.edu.au/leading-in-health-and-social-care/?p=593#oembed-1>

Innovation in Health Care created Canada Health Infoway.
Source : <https://www.youtube.com/watch?v=5yRKcZzaLA4>

Determinants and antecedents of innovation

Successful innovation involves several factors. Different models and frameworks for innovation in the literature explain how innovation occurs. Rao and Weintraub (2013) described six building blocks of an innovative culture; resources, processes, values, behaviours, success, and climate. Others have found

that the propensity for innovation is a more complex multidimensional construct grounded in service, process, cultural, and infrastructure aspects (Chaudoir, Dugan, and Barr 2013; Dobni, 2008). To foster innovation resources, processes and the measurement of success should be given attention, but we should also understand the harder-to-measure and people-oriented determinants of innovative cultures such as values, behaviour, and organisational climate (Rao and Weintraub, 2009, 2013).

Whilst some resourcing to support time for thinking, planning, and implementing innovation is required, the effectiveness of innovation depends on the organisational context – culture, leadership, and team dynamics (Phillips, 2013; Harrison et al., 2014; Körner et al., 2015). These factors can be more important underpinnings for innovation than resourcing (Rao and Weintraub, 2013).

A seminal literature review that synthesised more than 1,000 papers found that in health service delivery organisations certain structural determinants have a positive and significant association with organisational innovativeness (Greenhalgh et al., 2004, 2005). The conceptual model derived for the diffusion, dissemination, and implementation of innovation describes the system antecedents for innovation, innovation specific implementation process, readiness for innovation, and other factors. The devised model was then tested on four case studies (Greenhalgh et al., 2004) and has been elaborated upon in later work (Greenhalgh et al., 2017). The conceptual model suggests that an organisation will adopt innovations more readily if it is large (in size), is functionally differentiated into small autonomous departments, is mature, has high-quality data systems and strong leadership with a clear vision, and has resources to channel into innovation and decentralised decision-making processes. Greenhalgh et al. (2004, 2005) explained that large size and organisational complexity promote the adoption of innovation, as these determinants enable

specialised expertise to develop and that there are critical masses of problems that demand solutions. Similarly, environments that are changing or heterogeneous facilitate innovations, as these organisations and their cultures are exposed to new ideas imposed from outside, in contrast to stable environments (Greenhalgh et al., 2005).

A study by Leedham-Green, Knight, and Reedy (2021) found that service level innovations in healthcare contexts required a number of critical success factors, including:

- Supporting innovators with the right skills and experience, including implementation and leadership skills and evaluation expertise.
- Recognising and reinforcing the importance of collaborative and participatory approaches to align to organisational, societal, practitioner, community, and consumer goals.
- Providing opportunities to demonstrate the success of innovation projects amongst networks, colleagues and peers, building a community of support and expertise
- Supporting innovators with administrative and educational support.

Nested Hierarchy of Needs for Success in Health Service Innovation



Critical Success factors for service-level innovation in healthcare (This figure is licensed under CC-BY-NC 4.0, 'Figure 51' in Leedham-Green, Knight, and Reedy, 2021)

Many healthcare organisations have implemented innovative practices only to see abandonment or incomplete implementation (Greenhalgh et al., 2017; Scarbrough and Kyratsis, 2022). A Canadian study found that fewer than 40% of health care improvement initiatives successfully transitioned from adoption to sustained implementation and spread to more than one health care organisation (Scarbrough and Kyratsis, 2022).

Diffusion (passive spread), dissemination (active and planned efforts to persuade target groups to adopt an innovation), implementation (active and planned efforts to mainstream an innovation within an organisation), and sustainability (making an innovation routine until it reaches obsolescence) are terms used to describe innovation spread (Greenhalgh et al., 2004, 2005).

Activity

Read this paper.

From spreading to embedding innovation in health care: Implications for theory and practice (Scarborough and Kyratsis, 2022)

[Click here to access the paper](#)

Consider the policy and practice implications for embedding innovation. Jot down three key points.

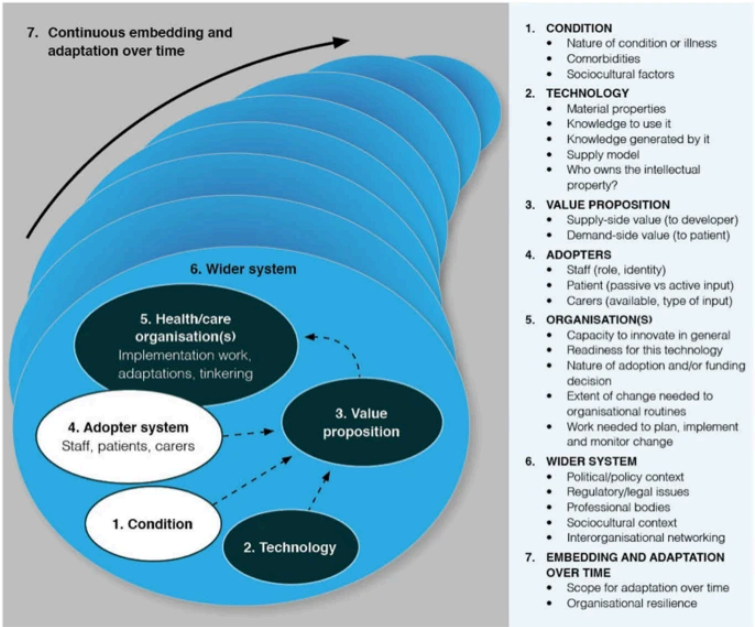
You can also listen to a podcast here where this paper is discussed by Cathy Balding and Cathy Jones and note three key points.

Context and the role of place in innovation

The literature reports that organisational context influences the adoption of innovative technologies (Greenhalgh et al., 2017). Context was demonstrated to shape the change outcomes of e-health implementations in rural settings in a study by Hage et al. (2013). Their study aimed to identify implementation factors that enable or restrain the adoption of e-Health and concluded that new technology innovations to support rural health sustainability can fail “due to underestimating the implementation factors involved and the interactions between

context, process and content elements of change” (Hage et al., 2013).

Greenhalgh and Abimbola, (2019) developed a tool for determining and understanding context and the complexities involved when implementing health interventions and technologies. Their Non-adoption, Abandonment, Scale-up, Spread, and Sustainability (NASSS) framework acknowledges that success is dependent upon the context, factors relating to the technology itself, and the wider context in which it is implemented (Greenhalgh and Abimbola, 2019), as depicted below.



The NASSS framework for studying non-adoption and abandonment of technologies by individuals and the challenges to scale-up, spread and sustainability of such technologies in health and care organisations (This figure is licensed under CC-BY 4.0, ‘Figure 1’ in Greenhalgh and Abimbola, 2019).

As noted, all organisations have unique cultures (Braithwaite et al., 2018) that will impact upon their performance and ability to innovate. Contextual factors have been shown to influence the implementation of patient safety interventions (Kringos et al., 2015; Ovretveit et al., 2011; West and Lyubovnikova, 2013).

Activity

Read the paper Nurturing innovative culture in a healthcare organisation – Lessons from a Swedish case study by Andersson et al., (2022)

[Click here to access the paper.](#)

Answer the following questions:

Why are relationships inside and outside of health an important enabler of innovation?

What is the role of leaders?

The link between performance and innovation

'It is essential that health care delivery systems innovate at scale to optimise performance. Achieving successful and sustainable improvements across complex health systems is, however, difficult.' (Wutzke, Benton, and Verma, 2016)

Health care is complex, and hospitals have distinctive characteristics compared to other industries (Lee, 2015; Wutzke, Ben-

ton, and Verma, 2016). Lee (2015) conveyed that hospitals aim to provide the best services to patients and employees, improve operational efficiency, reduce costs, and apply advanced technologies to internal and external functions.

Evidence linking innovation to performance is scant (Dias and Escoval, 2013). Surprisingly, “little is known about the nature of innovativeness in healthcare organisations and its relationship with performance” (Moreira, Gherman, and Sousa, 2017). Mafini (2015) conducted research in a public organisation and demonstrated a strong positive relationship between organisational performance and innovation, and inter-organisational systems and quality. Crossan and Apaydin, (2010) stated that “linking innovation outcomes with performance is critical in addressing whether and how innovation creates value”. They cited other management scholars and related that “innovation capability is the most important determinant of firm performance” (Crossan and Apaydin, 2010).

Dias and Escoval (2013) critically analysed the relationships between innovation and performance in the public health system in Portugal and explored the drivers of performance improvement through innovation. Their study used a range of techniques, including a survey, interviews, and nominal group technique to better understand the relationship between innovation and organisational performance. A conceptual framework was used in their study and included the variables of flexibility, innovation and performance (Dias and Escoval, 2013). The study suggested that the factors necessary to improve performance through innovation in the public health sector were organisational, financial, and cultural changes (Dias and Escoval, 2013). The authors concluded that it is possible to improve performance through different organisational structures and processes, but that certain organisational principles are also required, including an emphasis on the breakdown of hierarchical structures, fostering cooperation across departments,

and prominence given to the delegation of authority (Dias and Escoval, 2013).

Measurement of performance

Protecting patients from harm and ensuring that our hospitals, primary care, aged, and social care settings are delivering safe care at a cost that is acceptable to payers and sustainable in an environment of rising demand for health care services is on the agenda of many health and social care organisations (Australian Commission on Quality and Safety in Healthcare, 2021; Board and Watson, 2010; Chalmers, Ashton, and Tenbenschel, 2017). Hospitals can be assessed through measurement of performance against agreed standards and comparison with peers.

A shared understanding or common use of a definition of high performance with respect to a healthcare delivery system or the components of a delivery system, including hospitals, clinics, or nursing homes is yet to be determined (Ahluwalia et al., 2017). In a regular report, the Commonwealth Fund compares the performance of healthcare systems for high-income countries using measures that reflect access to care, care process, administrative efficiency, equity, and healthcare outcomes (Schneider et al., 2021).

Activity

Visit this web-page and read the report Mirror, Mirror

2021: Reflecting Poorly Health Care in the U.S. Compared to Other High-Income Countries

Note the high performing and lower performing countries across a range of performance indicators

Public reporting of health information for transparency, accountability, and for clinicians to action to improve care is well recognised (Board and Watson, 2010). In Australia, health information is routinely reported by the Australian and state governments (Australian Institute of Health and Welfare, 2022c; Bureau of Health Information, 2022). Internationally, performance reporting has been shown to exert a powerful effect on accelerating improvements in health services (Canaway, Bismark, Dunt, Prang, et al., 2018a; Leeb, 2018). Much has been written in the literature about the types of performance indicators used, barriers to indicator collection, disincentives to reporting, and how the information can be used (Canaway, Bismark, Dunt and Kelaher, 2018a, 2018b; Canaway et al., 2017a, 2017b)

There are a range of definitions for 'performance'; however, no single definition of what 'high performance' constitutes was able to be identified during the literature review. While there was no singular definition of what performance in health is, or agreed measures (Ahluwalia et al., 2017; Pronovost, 2017), three definitions were considered. Pronovost (2017) suggested that a high-performing health system is one that can achieve its purpose. Dias and Escoval (2013) conveyed that hospital performance may be defined according to the achievement of specified targets, either clinical or administrative; while Taylor et al. (2015, p. 1) used the definition that "High performing hospitals

consistently attain excellence across multiple measures of performance and multiple departments”.

In Australia, all public hospitals collect and contribute data to state and national data sets, and this performance data is routinely reported on sites such as the Australian Institute of Health and Welfare, NSW Bureau of Health Information and My Hospitals. Australia’s health system performs well when measured against other health systems (Philippon et al., 2018). Since 2009, in Australia, a National Health Performance Framework has been in place that routinely measures the performance of hospitals against measures of equity, quality, safety, appropriateness, and effectiveness (Australian Institute of Health Innovation University of NSW, 2013). While Australia has strong health data collection and data sets, there is no single data collection to determine whether our health system works in optimal ways (Srinivasan et al., 2018).

In summary, the measurement of performance in health using a range of indicators is now an accepted practice in Australian and other countries. Public performance measures are routinely reported through the Australian Institute of Health and Welfare website and organisations such as the Bureau of Health Information in NSW (Australian Institute of Health and Welfare, 2022b; Bureau of Health Information, 2022). This is the picture internationally, as well with Hibbert et al. (2015) who identified 34 organisations from 12 countries as having key roles in healthcare performance and public reporting.

Activity

To ensure that the Australian Healthcare system provides safe and high-quality care the National Safety and Quality Health Service Standards provide a consistent statement of the level of care that consumers should expect.

Visit the webpage and determine the available resources.

The Bureau of Health Information regularly reports on the performance of the NSW healthcare system. Visit the website and select a hospital and examine performance around consumer satisfaction, waiting times, and other indicators.

Poor performance has led to Royal Commissions and reports on failures. Visit the Victorian Department of Health, Targeting Zero site for further information and resources

Aboumatar et al. (2015) conducted a national study of high-performing hospitals with a focus on patient-centred hospital care. The study reported that leaders and clinicians actively worked together in the high-performing organisations studied. Further, organisational context and culture emerged as a common theme in their study, and were noted to be linked to success in high-performing hospitals. The study identified selected approaches to drive improvement, including the use of data, communication strategies such as rounding, hospital-wide education programs, recognition of high-performance teams, incentives for high performance, and development of new hiring policies (Aboumatar et al., 2015). Braithwaite et al. (2018) suggested that hospital performance is related to the pace of hospital life as measured by the length of stay, patient satis-

faction, and adverse events. Their article argues that to achieve the best performance, hospitals need to work under conditions of intermediate pace, what they referred to as the 'Goldilocks' zone, and they are undertaking further research to validate their theory (Braithwaite et al., 2018).

Integrating research evidence into practice and using data and experience to learn and improve are key to the performance and sustainability of healthcare systems and a learning health system (Agency for Healthcare Quality and Research, 2019). The goal of a learning health system is to create a cycle of continuous learning, improvement, and innovation that leads to better healthcare outcomes, lower costs, and a more efficient and effective healthcare system (Pronovost et al., 2017).

In Australia, accreditation is a widely adopted system for certifying the quality of healthcare organisations. This is a compliance against standards-based rather than an outcome-based approach or performance based approach. Bodies such as the Australian Council on Healthcare Standards survey healthcare organisations according to National Safety and Quality Health Service Standards (Australian Commission on Quality and Safety in Healthcare, 2018). The value of accreditation and linkage to performance was noted in the literature review (Accreditation Canada, 2015; Braithwaite et al., 2010; Greenfield & Braithwaite, 2008). A study by Braithwaite et al., (2010) observed that leadership behaviours and cultural characteristics show a positive trend between accreditation and clinical performance. The standards delineated by the Australian Commission on Quality and Safety in Healthcare focus on systems and processes that will reduce harm and drive high-quality health outcomes (Australian Commission on Quality and Safety in Healthcare, 2021).

Taylor et al. (2015) used the definition that "high performing hospitals consistently attain excellence across multiple mea-

asures of performance, and multiple departments”, and undertook a qualitative systematic review of the literature to identify high-performance hospitals and what ideas and factors are important for success. Their study utilised a “range of process, output and outcome and other indicators to identify high performing hospitals” (Taylor et al 2015, p. 1). The study identified seven themes that represent key factors associated with high performance; “positive organisational culture, senior management support, effective performance monitoring, building and maintaining a proficient workforce, effective leaders across the organisation, expertise-driven practice and interdisciplinary teamwork” (Taylor et al., 2015, p. 7).

In contrast, a study by Shwartz et al. (2011) demonstrated that there are challenges in identifying high-performing hospitals and warned that composite measures of performance that take into account multiple components may not recognise individual strengths and strategic priorities of individual organisations. Their study argued that when using multiple performance measures, only a small number of hospitals can clearly be classified as high performing. Their research concluded that “despite the lack of correlation among widely available hospital performance measures, it is still reasonable to calculate a composite measure of performance” (Shwartz et al., 2011).

Studies across industries also suggest that the systematic use of high-performance work practices could improve the quality of care in healthcare organisations (Garman et al., 2011; McAlearney et al., 2013). Garman et al. (2011) and McAlearney et al. (2013) described the concept of high-performance work practices as those practices that have been shown to improve the capacity to attract, develop, and retain high-performing personnel. These practices include performance-driven reward and recognition; information sharing; communicating mission, vision and values; mentoring; teams; and decentralised deci-

sion-making with training linked to organisational goals (Garman et al., 2011; McAlearney et al., 2013)

Challenges in performance measurement

Several authors have identified concerns with performance measures and measurement practices that can lead to dysfunctional and unintended consequences (Lynch, 2015; Mannion and Braithwaite, 2012). International studies have found that while performance measurement is important and can have benefits such as reducing waiting times, they can lead to unplanned outcomes in health care organisations such as bullying and gaming misplaced incentives, and they should be interpreted considering 'local contexts' (Aryankhesal et al., 2015).

Shahian et al., (2016) observed that some performance cards are flawed and that this fosters cynicism and distrust of performance measurement in general. Their article notes that patients and providers deserve transparent performance measures that are valid, and that doctors and hospitals should be held accountable for the care they provide. Flawed measures are meaningless and may harm health stakeholders, including patients (Shahian et al., 2016). The findings are supported by (Mannion and Braithwaite, (2012), who concluded that performance measurement can be strengthened by the inclusion of different types of measures (process, structure, clinical outcomes, appropriateness, resource use, patient-reported outcomes, and experience of care), data sources (registry, electronic health record), data quality, attribution of patients to specific providers, robust risk adjustment, presentation for-

mats, and the ability to monitor for unintended adverse consequences (Shahian et al., 2016).

While data quality and integrity may be challenges to performance measurement, considerable work on measurement and data quality has occurred and Board and Watson, (2010) and Hanson (2011) argued that we need to use the abundant information available to elucidate quality issues, which will result in better data to inform and improve the quality of health care in Australia (Hanson, 2011).

Public reporting of hospital performance data to increase healthcare provider accountability and transparency so that consumers can make decisions about their health is now routinely available. Public reporting is also intended for doctors, nurses, academics, health service managers, journalists, and the community (Australian Institute of Health and Welfare, 2022b). The unintended consequences of public reporting, such as gaming, the pursuit of short-term targets, deliberate manipulation of data, the need for clarity and different reports depending on the intended audience, and the need for timely data need to be considered and addressed (Freeman, 2002; Hibbert et al., 2015).

Accreditation and standards-based measures

Internationally, many examples of standards-based processes are used to assess healthcare systems; however, these are primarily focused on safety and quality performance and have been comprehensively documented and well-argued (Accreditation Canada, 2015; Greenfield et al., 2015, 2019). Some examples are shown in the table below.

Description	Country
National Safety and Quality Healthcare Standards developed by the Australian Commission on Safety and Quality in Healthcare (ACSQHC).	Australia/ International
Baldrige Performance Excellence (Foster et al., 2007; National Institute of Standards and Technology, 2016; Shields and Jennings, 2013)	United States/ International
Accreditation Canada Healthcare Standards (Accreditation Canada, 2022)	Canada
Accreditation standards Joint Commission on Accreditation in Healthcare (2023)	United States/ International
Health Assessment Europe (2023)	Europe

Accreditation and Standards-based measures for assessing healthcare system performance

Safe and high-quality healthcare delivery is extremely important; however, as we have described, performance is a multi-dimension concept. Performance measurement requires a comprehensive picture that considers health outcomes, safety and quality of care, financial performance, access and equity, workforce and availability of resources (medicines and equipment), and treatment settings.

The take home messages on high-performing health care systems are that they are characterised by:

- Consistent leadership that works towards common goals across the organisation.
- Development of leadership skills and enhancing system governance, accountability and performance measurement.
- Engaging clinicians and professional cultures.
- Quality and system improvement, embedded as a core strategy and investment made to support improvement.

- Organisational skills and capacity to support ongoing performance improvement.
- Being at the centre of the health delivery system are strong and robust primary health care teams.
- Patients, caregivers, and the public are engaged in and with the design of healthcare.
- Integration of care that promotes transitions from one sector to the other.
- Information as a platform for guiding improvement.
- Learning strategies and methods to test, pilot and scale up improvements that work.
- Support by leaders for an enabling environment and commitment to changes relating to improvement (Baker, 2011; Baker and Axler, 2015).

Summary and implications

The contextual and organisational factors for innovation have been described in this chapter. Performance measurement in health is topical, and there is continued appetite for using hospital performance data to drive improvements and increase transparency (Canaway, Bismark, Dunt, Prang, et al., 2018b; Canaway, Bismark, et al., 2017). This is enabled as we increase the use of digital solutions and implement new health information systems and technologies.

This chapter outlined why health system managers and funders are focussing on innovation and performance. The chapter identified the determinants of innovation and high performance within health organisations and an understanding of the role of context in the uptake and adoption of innovative practices. Context has been identified as an important influence on the dissemination of innovation and sustainability.

You will know you are successful if...

The research evidence suggests the following are critical success factors if organisations and policymakers in the health and social care industries want to support service-level innovation.

- The innovations selected for implementation provide value or benefits to the intended beneficiaries.
- The organisation supports safe innovation and empowers those with ideas to improve services to initiate ideas within resourcing constraints. Time and resources are provided to implement and evaluate innovation, and to avoid burn-out and turnover (Leedham-Green, Knight, and Reedy, 2021).
- Leaders are committed to the identified innovation and there are sufficient staff with the right skills and expertise to drive the implementation of the innovation.
- Resources, education, and time are made available to reflect on how improvement and innovation can ensure care is safer, less interventional, more cost-effective, involves consumers, and implements these innovative ideas using appropriate change and project management initiatives (Greenhalgh and Abimbola, 2019; Greenhalgh and Papoutsi, 2019; Leedham-Green,

Knight, and Reedy, 2021).

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Implementation of Complex Interventions in Health Services

HANAN KHALIL

Introduction

Complex interventions in health services are defined as interventions with multiple interacting components (Greenhalgh and Papoutsis, 2018). They usually include changes to health care professionals' diagnostics and treatments approaches, and operational systems such as electronic medical records, health technology, and systems in organisations (O'Cathain et al., 2019). Complexity arises from the dynamic nature of the health system and the funding models involved to operate certain activities (O'Cathain et al., 2019). Other sources of complexity may arise from the challenging behaviours of personnel involved, number of groups or organisations targeted, number and types of outcomes, and the degree of adaptability required for the implementation stage of any intervention (Craig et al., 2011).

Simple interventions usually involve drug trials where researchers and clinicians test the efficacy of a particular drug on a condition or a disease; whereas complex interventions usually involve a minimum of three main components, such as what should healthcare workers do, what qualifications should they have, and what should patients do? (Ma et al., 2020). Moreover, Ma et al. (2020) identified five main aspects of complex

interventions adopted in the implementation process: psychological support, cognitive support, behavioural support, social support, and environmental support (Wade and Halligan, 2017).

The importance of this topic lies in its applicability to health managers. Health managers face challenges in making decisions about budgeting, staff, resources allocation, and operational management of their units. Understanding the processes involved in implementing complex interventions creates the potential for their successful adoption in the workplace and ensuring that they are feasible and integrated in everyday practice. This chapter covers the components of complex of intervention, and their design, implementation, and evaluations in health services.

Background and context

In 2000, the United Kingdom Medical Research Council published guidelines for the development of complex interventions that highlighted assessing and evaluating the effectiveness of components of complex interventions (M. Campbell et al., 2000). The authors included interventions such as service delivery and organisations (i.e., cardiac units and hospital in the home), interventions directed at health clinicians (i.e., computer decision support systems and implementation of guidelines), community interventions (community programs to prevent stroke and primary care approaches to improve health), group interventions (behavioural change strategies and reduction of smoke in teenage pregnancy), and individual therapy (cognitive therapy for mental health conditions).

In 2008, the new Medical Research Council guidelines were revised in response to the limitations encountered with the

framework. (Craig et al., 2008) Examples of these limitations included lack of piloting of interventions at early stages, integration of processes and outcome measures in the evaluation, and understanding the context of where the interventions were being implemented. Since the first guidelines were published, various studies on complex interventions have been conducted, which resulted in some interventions being implemented with various success (Craig et al., 2008).

In 2021, a new framework was devised by the same group of authors. (Skivington et al., 2021) The new framework defines evaluation as going outside complex interventions efficacy and spanning its parameters to include whether the impact of other external factors on its implementation in the real world is significant, hypothesising how it works, taking account of how it interacts with the setting in which it is applied, and how the evidence generated can be used to facilitate decision making in realistic scenarios. Other aspects of interventions, such as cost effectiveness, scalability and transferability across various contexts are all equally important and should be considered when assessing any complex intervention (Skivington et al., 2021).

The shift towards other measures of complex interventions research arises from what decision makers require, as some research questions cannot be answered by addressing efficacy and effectiveness. Examples of various research questions proposed by funders or hospital managers could include the following:

- Is the intervention cost-effective?
- What other changes may happen as a consequence of this intervention?
- Will the intervention work across other settings?
- When there is no evidence generated from robust research methods, such as randomised controlled trials,

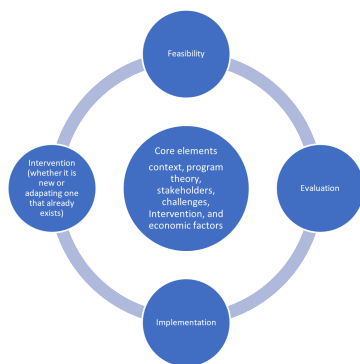
how feasible is the intervention to be implemented and what its degree of success?

The table below illustrates the four main research questions covered by this new framework, with examples and key considerations for health managers. Skivington et al., 2021) The main research questions include efficacy, effectiveness, theory-based, and systems. The new approach aims to encompass all the potential questions by decision makers in implementing complex interventions.

Research perspectives covered by the new framework (Skivington et al., 2021)

Research question	Example	Key considerations
Efficacy	The efficacy and safety of a particular drug or vaccine in a certain population.	Seeks to understand the extent of an intervention producing a particular outcome in experimental or ideal settings.
Effectiveness	The efficacy of a particular program in real life settings.	Seeks to understand the extent of an intervention, that is, immunisation program in a real-world situation in terms of what it is supposed to do (i.e., prevent the spread of a disease).
Theory-based	Why the effectiveness of certain interventions varies across contexts, and what might be explored behind effectiveness?	Seeks to understand how changes are brought about.
Systems	How is the intervention adapted to the current system?	Explores the dynamic of rolling out an intervention across a system and its impact on other programs, systems, departments, and so on.

The above framework divides complex intervention into four stages: development of the intervention, feasibility, evaluation and implementation. (Skivington et al., 2021) Each stage has a common set of core elements considering the context, developing program theory, stakeholder involvement, identifying any areas that might seem challenging, refining or adapting the intervention, and economic factors. The figure below shows the core elements of context, program theory, involvement of stakeholders, choice of intervention and economic factors.



Framework for developing and evaluating complex interventions (adapted from Fig 1, in Skivington et al. (2021), licensed underCC-BY 4.0.

Skivington et al., 2021 framework takes into account other factors of interventions success beyond its effectiveness in the complex health care system that we are currently facing. By also including theories of change and other contextual factors, the framework provides a broader picture about how and why certain interventions work and moving beyond one dimension of evaluation of interventions. The next section covers the vari-

ous theories/models currently used in implementation science for complex interventions.

Theory/models – Current evidence

Various theories, models, and frameworks noted in the literature of implementation science are used by clinicians to implement complex health interventions in any health care setting. Implementation science is about how interventions work in real life and how they are being used (Khalil, 2016). Identification of barriers and facilitators is crucial in this process to ensure the success of the intervention (Bauer and Kirchner, 2020). Before we describe these briefly in this section, it is important to define these terms and differentiate between them. First, a theory is defined as a set of principles or statements to structure observation, understanding, and explain a particular phenomenon. (Frankfort-Nachmias and Nachmias, 1996) A “good” theory provides a clear description of how and why specific relationships lead to certain events (Frankfort-Nachmias and Nachmias, 1996). A model usually involves an explanation of a particular phenomenon (Frankfort-Nachmias and Nachmias, 1996). Models do not have to be completely precise representations of reality to have value. Models and theories are very closely related to each other and are sometimes used interchangeably. Models can be described as theories with a more narrowly defined range of explanation; a model is descriptive, whereas a theory is explanatory, and may also be descriptive, as suggested by Frankfort-Nachmias and Nachmias (1996). On the other hand, a framework denotes a structure, overview and the relationship between each of its components, similar to the one mentioned above.(Khalil et al., 2019) Frameworks do not provide explanations, but describe various phenomena and try to fit them into a structure or cat-

egories. (Khalil et al., 2019) The three overarching aims for the use of theories, models and frameworks for complex interventions in health care are as follows:

- Describe and guide the process of evidence translation into practice
- Understanding what influences implementation outcomes
- Evaluation of implementation

Based on the stated aims and descriptions of these theories, models, and frameworks, these approaches are further classified into the following sections, as adapted from Nilsen, 2020.

- Determinants frameworks
- Classic theories
- Implementation theories

The following sections detail some of the models/theories and frameworks discussed in the literature.

Process models

The aim of these models is to facilitate translation of evidence into practice. Various process models are described in the literature, including the Canadian Institute of Health Research Model of Knowledge Translation (Canadian Institutes of Health Research, 2007), the Knowledge to Action model (Rycroft-Malone and Bucknall, 2010), the Iowa model (Collaborative et al., 2017), the Ottawa model (Gifford et al., 2017), and the Quality Implementation framework (Gifford et al., 2017). Most process models consist of steps to guide clinicians in evidence translation. For example, the Canadian Institute of Health Research Model of Knowledge Translation consists of six stages where

knowledge translation occurs, including defining research questions, conducting research, publishing research findings, placing research findings into context of various cultures, making decisions and taking actions informed by research findings, and finally, influencing subsequent rounds of research (Sud-sawad, 2007).

Determinants frameworks/classic theories/implementation theories

The aim of these models/theories and frameworks is to understand what influences the outcomes of implementation. Examples of these include Promoting Action on Research Implementation in Health Services (PARIHS) framework (Harvey and Kitson, 2015), the consolidated Framework for Implementation Research (CFIR) (Damschroder and Lowery, 2013) , Theoretical Domains framework (Rycroft-Malone, 2004) , and Theory of Diffusion and Normalisation Process theory (Murray et al., 2010), to name a few. The most commonly used model in this list is the PARIHS framework was initiated in 2011, as it has been cited widely in the literature and was updated in 2016 (Stetler et al., 2011, Harvey and Kitson, 2015). The model highlights that successful implementation is specified in terms of goal achievement and usually results from the facilitation of an innovation, with the recipients being an organisation or a health system (Hockley et al., 2019). The core components of this framework include facilitation, innovation, understanding recipients' needs, and context. Context has previously been defined by Titler (2018) as the physical setting of the implementation; however, in this approach, it includes the characteristics and dynamic nature of the environment likely to have an impact on the implementation of the intervention. Social fac-

tors are also included pertaining to the roles, relationship, and dynamics of the individuals with each other (Titler, 2018).

Evaluation frameworks

This is one of the most important frameworks to health managers and clinicians, as these are essential in specifying the various aspects of any intervention to determine its success. One of the most common frameworks is the RE-AIM framework by Glasgow et al., (2001). Other frameworks are also used, such as the PRECEDE-PROCEED by Porter et al. (2016). These are further explained in the evaluating health and social care chapter.

The remainder of this section focusses on a newer model titled the Triple C model (consultation, collaboration, and consolidation) (Khalil and Kynoch, 2021). This model is useful for translating evidence into practice and understanding what influences the outcome of any complex implementation. It also ensures the sustainability of implementing any interventions (Khalil, 2017, Khalil and Kynoch, 2021).

The Triple C model (consultation, collaboration and consolidation)

This model was developed using a two-stage process, including a literature review to map the existing models for implementing complex interventions and investigating their barriers and facilitators using a scoping review methodology, followed by devising the framework using a formal theory building used in sociology. (Sudsawad, 2007) This model has been successfully used by other authors to build theoretical concepts (M. Campbell et al., 2000, S. M. Campbell et al., 2001). It allows

researchers to evaluate the generalisability of the framework to other settings and support congruence and reliability in different situations (M. Campbell et al., 2000). The criteria upon which the theory was built are outlined below:

- It must have a precise description.
- It must have a logical explanation.
- It must establish information claims.
- It must be fit for purpose.

The model relies greatly on human resources (Khalil and Kynoch, 2021). Having a robust understanding of human performance, decision-making during significant situations, and recognising challenging issues are key considerations and have the potential to affect the success or failure of a project's implementation.

The Triple C model represents successful research implementation as a function of the relationships among consultation, collaboration, and consolidation. (Khalil and Kynoch, 2021). The proposal is that for implementation to be successful and sustainable, there needs to be a continuing consultation, collaboration, and consolidation among all stakeholders involved in the project. Consultation should be a continuous process that starts early in the implementation process where continuity is an integral part of the process. Continuity requires ongoing dialogue with the various stakeholders. Collaboration and teamwork are essential to the success of any implementation project. Collaboration involves five main steps: first, identifying any barriers that may impede the implementation process. One of the major barriers to effective collaboration is the conflicting needs, objectives, and priorities of the stakeholders involved in the implementation process. Second, recruiting the right team with the right skills required for the project. Third, identifying an agreed direction for the implementing team. A clear sense of directions helps to turn individuals into teams

sharing common goals and objectives. Fourth, clarifying responsibility in the implementation project is crucial for its success; this step relies on matching the right skills of the individuals with corresponding roles in the project. The last step in the collaboration process is the support of the team through relevant resources for the project. The consolidation stage is the most important part of the implementation process, as it ensures the sustainability and longevity of the project. Consolidation is defined as “an action or process of making something stronger or more solid” (Khalil 2017). The key role of consolidation is to incorporate an adaptable process to ensure the viability of the implementation. The success of the consolidation process relies on the development of procedures or processes that can become business as usual following the life of the project. This step also requires consultation and collaboration; hence, the continuing nature of the model is essential to its success.

Efficient teamwork requires cooperation, coordination, and communication between the various team members (Shediac-Rizkallah and Bone, 1998). Effective communication between and within teams enables cooperation and coordination. To support success every member of the team requires an understanding of the purpose, team roles, responsibilities, task requirements and the project plan. Trust in other team members and sharing information are also essential to enable cooperation between teams (Shediac-Rizkallah and Bone, 1998).

Key implications for practice (barriers and facilitators)

Several barriers and facilitators have been recognised in the literature regarding implementation and evaluation of complex

interventions. Kormelinck and colleagues (2021) identified five domains that should be considered when planning to implement and evaluate complex interventions. These included intervention characteristics, outer settings, inner setting, characteristics of individuals involved in the intervention, and the process used.

The complexity of the intervention is addressed in various studies as a barrier to successful implementation and evaluation, which is not a surprise, as the perceived easiness of the intervention will contribute to its success or failure in the system. This is especially relevant for interventions that encourage tasks to be undertaken as part of individuals' normal roles on the job (Kormelinck et al., 2021). The notion of adaptability of the intervention aligns well with the complexity issue as a facilitator, as the success of interventions will depend on their integration into normal day to day practice (Kormelinck et al., 2021).

The second domain highlighted in the literature is the outer setting, including patients' needs, external policy, and accreditation requirements as essential to be considered as main elements for the success of any implementation process, aligning the needs of the external stakeholders with the intervention ensures its uptake and likely success (McAiney et al., 2007, Boersma et al., 2015)

The third domain consists of inner settings, which are related to staff communications and collaborative relationships between the various stakeholders to ensure the success of the intervention. Other characteristics such as the organisational culture have been identified as both facilitators and barriers. (Boersma et al., 2015 and Bourbonnais et al., 2020) Other constructs, such as leadership and management, available resources for staff are essential for the success of this domain. (Boersma et al., 2015 and Bourbonnais et al., 2020)

Individuals' characteristics and their self-belief about their

capacity to undertake the tasks requested by them is also crucial, staff feelings and their validation have been documented in the literature as a factor of success of the process. (Mekki et al., 2017) Other personal attributes such as their knowledge, and willingness to adapt and learn are also key factors for the success of the implementation that should not be undermined (Mekki et al., 2017).

Finally, and most importantly, the process of implementation and engaging with the various stakeholders is a key contributor to enable organisational challenges, such as staff turnover and transfer of information between the various departments. (Bourbonnais et al., 2020).

Engaging champions has also been acknowledged as crucial to the success of any implementation process (Bourbonnais et al., 2020).

Case history vignettes demonstrating the practical application of the topic

This section provides examples of how models such as the Triple C have been used to implement complex interventions in healthcare.

Case Vignette 1

The Triple C model was used in the implementation of an electronic wound care program across several health services to follow wound healing and costs in rural Victoria in Australia (Khalil et al., 2016). Khalil et al 2014 used the triple C model to implement an electronic wound care system across 11 organisations

across a region to track the types of wounds managed by community nurses in terms of healing times and costs associated with the overall treatment. The program's implementation led to a substantial enhancement of wound healing times, and reducing dressing usage resulting in better healing and less costs incurred by the health service. (Khalil et al., 2015) The consultation stage was used to prioritise areas of research and plan for the project's delivery. Adequate resources were made possible by ensuring stakeholders participated early in the project through both in kind and financial resources. The collaboration stage was vital, as this project engaged multiple health services and training programs to support the successful delivery of the project across multiple sites. The consolidation stage included the development of standardising policies and procedures across all sites on management of wounds across the rural region and the initiation of a regional wound consultant role. These approaches ensured the long-term sustainability of the program. The project was supported by a research team to examine data quality across the sites to ensure the uniformity of the implementation plan across the various participating sites. This project led to a program of educational training to clinicians involved on the most frequent wounds they experienced in the region, which was then embedded in several organisations as part of continuous improvement.

Case Vignette 2

The second project where the Triple C model was used was in the implementation of a medication safety program in an Aboriginal health organisation in a large regional area in Australia. (Khalil and Gruis 2019) The aim of the project was to implement a culturally safe and relevant medication safety education program to Aboriginal Health Care workers and build an online resource to ensure its access to all staff at any time

(Khalil and Gruis, 2019, Khalil, 2019). The Triple C was used to implement and monitor the research involved with the program. The first stage was consultation, where initial interviews were conducted to understand and examine any medication safety issues in the Aboriginal community. (Khalil, 2019) This led to the formation of a process map about the intervention to inform the implementation of a medication safety program for the organisation. The collaboration stage consisted of identifying and engaging the staff necessary to deliver the medication safety intervention. In this case, the intervention consisted of a medication safety program and formation of policies addressing medication safety issues. The consolidation stage of the project involved data collection to monitor the efficiency of the programs and making the resources and policies available to all staff through an online platform.

Case Vignette 3

Another project where the Triple C model was utilised was the development of a skills matrix to identify areas of need to upskill palliative care nurses (Khalil, Byrne, and Ristevski, 2019, Khalil et al., 2019b). Previous research identified inadequate knowledge in this area of palliative care in rural areas (Khalil et al., 2019b). Several discussions with managers took place focussing on how to best capture the educational needs of staff. Once a plan was devised, a process map addressing the implementation of the project was devised that included the design of a skills matrix for managers to use to identify staff educational needs. The consolidation stage involved the use of this matrix as a standard form for staff assessments and discussion about occasions for future developments. This process led to the development of targeted educational interventions to address the gaps identified by the skills matrix.

Case Vignette 4

A final example of a project using the Triple C model in practice was the implementation of the validated Distress Thermometer to improve detection, evaluation and management of distress in the cancer care inpatient wards (Stephens, 2019). Initially, the project started with discussion with all identified stakeholders to encourage staff encouragement and to identify areas of improvement. This was followed by devising a procedure for patient distress management of patient in partnership with multidisciplinary teams across oncology. The design of strategies to enhance practice, including programmes such as teaching meetings on identifying and managing distress for patients and debrief sessions for staff, were implemented. The consolidation stage, which considered the sustainability, involved changes to current documentation, as well as the availability of a patient information booklet for patients and families to maintain the changes.

Key Takeaways

For leaders – You will know you are successful if...

Successful implementation of complex interventions in health services relies on several factors, including choosing the right model of implementation that clearly articulates the objective of the intervention and the reason for its implementation. This is followed by clear expectations and guidance from all those

involved to implement and evaluate the intervention, and engaging champions and leaders to role model and provide guidance as the process unfolds.

You will know you are successful when you succeed in managing the above factors and consider all aspects of a project's implementation and evaluation. Moreover, identifying any barriers and facilitators at the outset of project implementation will allow a clearer map of the whole process.

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Digital Health - Leading innovation in healthcare through digital health technologies

*Digital Health - Leading innovation in
healthcare through digital health
technologies*

SHEREE LLOYD AND JANELLE CRAIG

Introduction

This chapter is important to health service leaders because innovative technologies have a significant impact on health-care service delivery. While the impact of these technologies is disruptive, they create opportunities for a better experience when accessing healthcare, as well as achieving improved health outcomes for patients, consumers of health and social care services, their carers, and the community more broadly. In this chapter, you will learn how digital health technologies can improve health, the foundations that underpin and enable their use, and how the health service leader can be the catalyst for digital innovation through investment, supporting technology adoption, and realising the benefits of digitally enabled health care.

“Innovation is driven by the need to deliver new, more, better, and seamless health services and prepare for future crises with less funds, while addressing long-standing inequities” (World Bank, 2023).

Digital Health and the Role of Health Technologies

There are many published definitions of digital health. The breadth of definitions demonstrates that the impact of technology is broad, and the perspectives on what digital health means are diverse. The table below provides an overview of some of the definitions for digital health used around the world.

Global Definitions for Digital Health

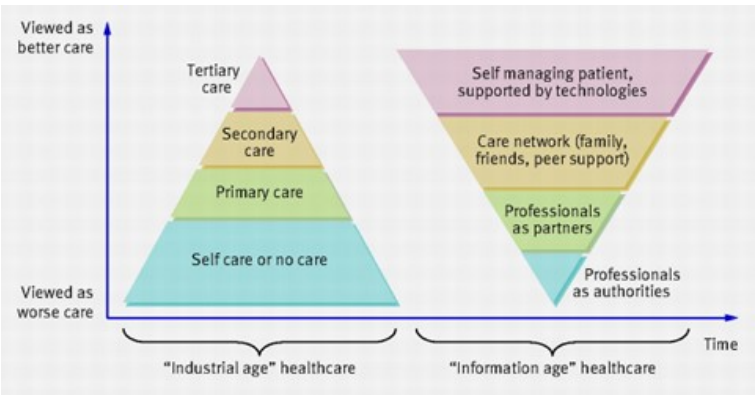
Definition of Digital Health	Organisation
<i>The application of technology to improve the health of populations.</i>	World Health Organization (2021)
<i>Using technology to improve the healthcare system for providers and patients alike</i>	Australian Government and Department of Health and Aged Care (2022)
<i>The use of digital technologies and accessible data, and the associated cultural change it induces, to help New Zealanders manage their health and wellbeing and transform the nature of health care delivery.</i>	New Zealand Ministry of Health (2022)
<p><i>Digital health includes diverse categories of products comprising telehealth and telemedicine, mobile health, wearable devices, health information technologies and personalised medicine.</i></p> <p><i>It refers to the usage of connected devices, wearables, software including mobile applications (apps) and artificial intelligence (AI) to address various health needs via information and communications technologies.</i></p>	Singapore Health Sciences Authority, Singapore Government (2022)
<i>The mobile apps and software that support the clinical decisions doctors make every day to artificial intelligence and machine learning, and how digital technology is driving a revolution in health</i>	United States and the Food and Drug Administration (2020)
<i>The tools and services that use information and communication technologies (ICTs) to improve prevention, diagnosis, treatment, monitoring and management of health-related issues and to monitor and manage lifestyle-habits that impact health.</i>	European Commission (2018)

Definition of Digital Health	Organisation
<i>The cultural transformation of how disruptive technologies that provide digital and objective data accessible to both caregivers and patients leads to an equal level doctor-patient relationship with shared decision making and the democratization of care</i> (Medical Futurist, 2021)	Medical Futurist (2021)
<i>Using technology to help health and care professionals communicate better and enable people to access care they need quickly and easily, when it suits them</i>	National Health System England (2019).

While the execution may be different, for health leaders to action the transformative potential of digitally enabled health-care, the following domains of action must be present, as these underpin the effective use of technology for enhanced decision-making and a thriving health and social care system. By integrating digital technologies, health leaders can offer services in different ways, engage individuals in managing their own health, and redesign health systems and services differently to the way in which consumers, carers, health leaders, and clinicians currently experience them.

It is now recognised that, for the future, a major shift is required from disease focused models of care to support informed, self-managing patients who actively direct their own health care (Greenhalgh et al., 2010). New models of care can be enabled through electronic health care records (longitudinal summaries) extracted from electronic medical records (organisational records) that link to personally held records that are shared with treating clinicians to maintain continuity of care (Greenhalgh et al., 2010). The diagram below from Greenhalgh et al. (2010) illustrates the impact of this shift, showing that it creates information parity between patients and health providers as it puts health information directly into the hands of individuals. With this ability to hold personal health infor-

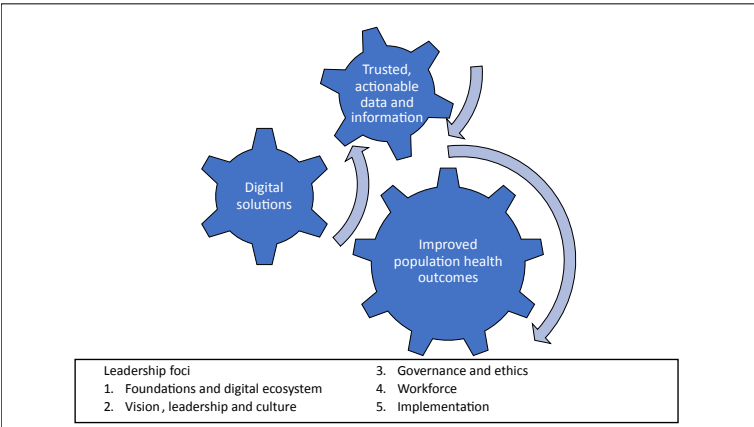
mation, individuals can now take a more active role in their health care. This also means a change in the role of health providers from authorities of care to partners and facilitators of care (Greenhalgh et al., 2010). An example of this might be when a chronic disease is diagnosed, the recipient of the diagnosis would be referred to a specialist team who would provide education, management tools for their condition, and monitoring devices. Regular monitoring and alerts would flag with consumers and healthcare professionals when intervention was required. Consumers and clinicians are empowered through information and digital health tools.



Industrial age health care and information age health care and role of professionals, individuals and care networks. This figure is licensed under CC-BY-NC 4.0, 'Fig. 1' in Greenhalgh et al. (2010)

This chapter concentrates on the focal points for health leaders wanting to progress a digital health agenda. The aim of digital transformation is to improve health outcomes for the population using digital health technologies, solutions, and trusted and reliable data and information. Consequently, the chapter is organised around the broad topics of foundations and the digital ecosystem, vision leadership and culture, governance and ethics, workforce, and implementation.

The below figure demonstrates the foci for health leaders to enable digital and social care service delivery.



Leadership foci for a digital healthcare system to support the attainment of improved population health outcomes

Foundations and Digital Ecosystem

A solid technical foundation is required to make significant progress in achieving digital transformation. This foundation is comprised of the infrastructure necessary to increase the capacity of health services to benefit from timely access to information, and for health consumers to feel more engaged in their care due to tools such as patient portals, personal health records, and health apps. Among the infrastructure requirements are:

- Appropriate information and communication systems (ICT) and access to high-performing, secure, responsive cloud services to host software and store quanta of data and information.
- Standards and terminologies to support technical interoper-

erability of systems across the health and social care sector to facilitate information sharing.

- Secure repositories for storage and sharing of information to leverage the value of information while safeguarding privacy to mitigate data breaches.
- Connected devices, often described as the internet of things (IoT), and software solutions that meet clinical requirements and support an expanded scope of health service delivery including self-care services.
- Software and hardware solutions that are consumer friendly, usable, affordable and accessible to the consumers of health and social care services.
- High-speed internet connections and bandwidth capacity to support mobile applications, telehealth, and IoT applications.

Collectively, these components work together to create the technical platform for a digital health ecosystem that supports an interoperable infrastructure that can be used by the health-care community across all care settings and care providers. When health information systems are interoperable data can be shared and the systems can seamlessly ‘talk’ to one another (World Health Organization [WHO], 2021). The components are described as the ‘digital ecosystem’ and should support the secure exchange of health data between providers, health system managers, health data services and consumers (WHO, 2021).

Seamless communication enabled by interoperability across Information Technology (IT) systems and sectors is essential for clinical data to be turned into meaningful information that can be used by health managers for effective decision-making. Data exchange architectures, application interfaces, and standards need to be in situ, as these are the foundation units that support interoperability (Healthcare Information and Management Systems Society, 2022). However, infrastructure alone is

insufficient to realise the benefits of digital health. This has been evidenced by many health IT projects in the past that heavily invested in technical equipment and left the change effort largely unsupported (Baghizadeh, Cecez-Kecmanovic and Schlagwein, 2020; Gauld, 2007; Kaplan and Harris-Salamone, 2009). Digital innovation is a step change in the way healthcare is delivered and how consumers interact with the healthcare system. Therefore, in addition to the enabling technical foundations, the below building blocks are required for change for which health leaders must take the lead:

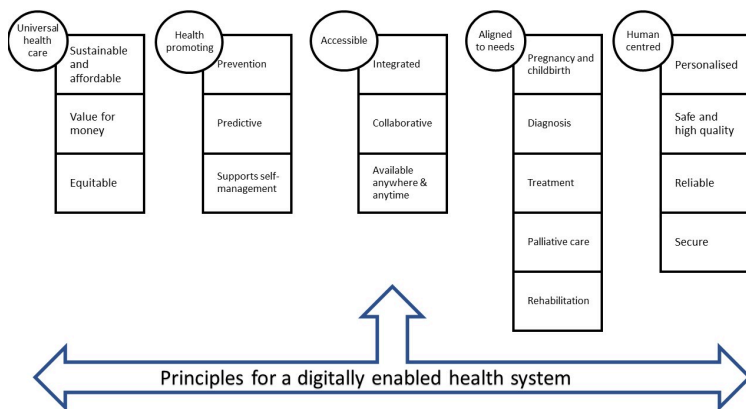
- vision, leadership, and culture;
- governance and ethics;
- workforce;
- implementation.

While over the past 25-30 years great progress has been made and we have witnessed massive technological progress and the availability of data, health policy decisions in many countries are still not based on reliable data (World Bank, 2023). They go on to say that in challenging fiscal environments, people-centered and evidence-based digital investments can help governments save up to 15 percent of health costs (World Bank, 2023). Further, a human-centered, health-data-driven ecosystem is required to tackle the disparate nature of health data (Stevens et al., 2022). Stevens et al. (2022) proposed a model that applies four data quadrants: “administrative and financial, logistics and facility, medical, and paramedical generating data based on four different questions: ‘Who am I?’, ‘Where am I?’, ‘Am I healthy?’, and ‘How do I recover?’”.

Vision, Leadership, and Culture

For health and social care services contemplating their digital future, the move to digital ways of working will encompass a range of options, with no universally agreed approach. Having a strong vision for why digital health is needed and how it will positively impact the health of the population, deliver safer care or improve work processes requires a compelling link between the change and the expected benefits. A successful vision for digital health needs to have strong alignment to overall strategy and priorities. The call to action for leaders is for investment in digital health to be aspirational and challenge the status quo and to have this clearly articulated in the vision statement for digital health.

Digital health will be valued and adopted if it aligns with accepted principles for strong healthcare systems that are accessible, universally available, of high quality, safe, sustainable, and that strengthen health promotion, disease prevention, support individuals with care when and where they need it, and from the 'cradle to grave' (WHO, 2021). Digital health can contribute to better health outcomes if there is adequate investment in governance, workforce, and organisational capacity to enable the change required for the implementation of digital solutions (WHO, 2021). Leadership, planning, staff development, and training are required because health systems and services are increasingly digitised and vital investments are made in people and processes. Leaders will lay out the vision for the digitisation of the health sector to improve health outcomes through new models for the delivery of services (WHO, 2021). The key principles for a digitally enabled health system are shown in the figure below.



Principles for a digitally enabled health system

The box below includes examples of vision statements from around the world and demonstrate the emphasis of digital health ambitions.

Australia

'Better health for all Australians enabled by seamless, safe, secure digital health services and technologies that provide a range of innovative, easy to use tools for both patients and providers' (Australian Digital Health Agency, 2018)

European Commission

Harnessing the potential of data to empower citizens and build a healthier society (Kolitsi et al., 2021)

World Health Organization

Digital health can help make health systems more efficient and sustainable, enabling them to deliver good quality, affordable and equitable care (WHO, 2021).

United States Food and Drug Administration

Empower stakeholders to advance health care by fostering responsible and high-quality digital health innovation. USA Digital Health Centre of Excellence (U.S. Food and Drug Administration, 2020).

New Zealand Ministry of Health

The Vision for Health Technology outlines how we see technology shaping the way New Zealanders 'live well, stay well and get well' in 2026 (New Zealand Ministry of Health, 2022).

The promise of digital health to deliver improved health outcomes, generate efficiencies, and maintain safety and quality requires vision and clear direction through the leaders of health and social care organisations.

Activity

As a leader or manager of a health service(s), what is your vision for health services and therefore, what is your definition of digital health?

Test your vision and definition against a society with many older people. Consider their challenges, their healthcare needs, and how they would prefer to live independently for as long as possible. What digital tools could be most effective to support their health-related quality of life?

Once the vision has been crafted for digital health innovation, health managers must demonstrate leadership through a commitment to their teams and organisation so that positive organisational culture is sustained throughout the change that will accompany the introduction of new technologies and health information systems. Acceptance and readiness to adopt innovation are more likely to be sustained if the digital application makes work easier, more accessible, safer, and delivers better quality. When people understand how technologies will support them, they can feel excited about their future working in health and social care. Not all innovation and technology implementation efforts are successful; thus, there must be a tolerance level for failure and for sharing important lessons without fear of blame and retribution. A culture of innovation has a healthy risk appetite and supports experimentation and learning from failure. Additional insights into the topic of innovation can be found in the Innovation and performance in health and social care organisations chapter. Involvement of all users of digital technologies and consumers in co-design will lead to more optimal and suitable solutions.

Health leaders that communicate clearly, and model and promote the vision for digital health will set the tone for the organisation and its culture. Cultures that support innovation have a strong connection to why change is necessary, and leaders who collaboratively take their people forward into the future.

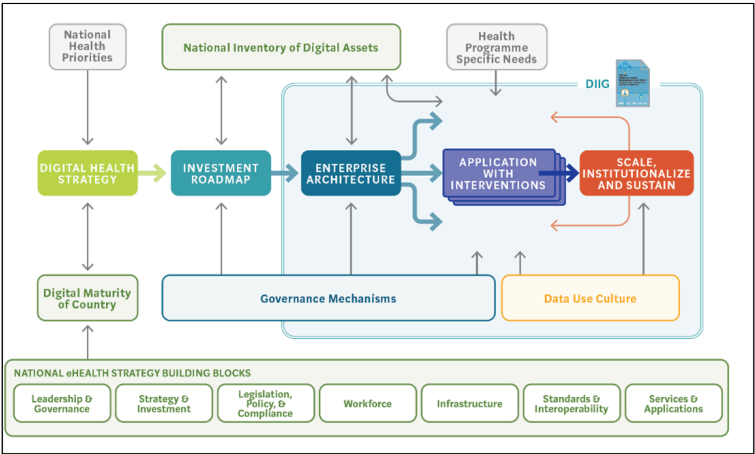
For insights into leadership approaches and styles best suited for significant change such as digital innovation, see the Implementation of Complex Interventions in Health Services chapter.

Investment in Digital Solutions

Advanced and emerging economies are facing challenges in ensuring that health and social care is affordable, safe, accessible, sustainable, provide value to their funders and the community, and meet the needs of the community and individuals. So how can we identify technological solutions for 'better' health outcomes that impact positively upon the population and individual health? A good place to start is with a known problem or challenge that requires a solution, and examination of all **possible** solutions, including the role that technology might play. If we wish to achieve and sustain a healthy population, we need to invest in new ways of working and technology can support this. Many challenges are faced by health systems across the world, including a growing burden of chronic disease and aging populations (Australian Institute of Health and Welfare, 2021). According to the WHO, in 2019, chronic conditions caused almost three in four, or 42 million deaths, globally (Australian Institute of Health and Welfare, 2021). Globally, there are challenges to funding digital health solutions, and it is difficult to demonstrate a return on investment using routine economic measurement techniques (Woods et al., 2022). The WHO (2020) stated that progressing digital health is a dynamic process, dependent on the needs and constraints of the country as requirements change over time. However, the building blocks and foundations must be in place, as shown in the figure below. The WHO (2020, 2022, n.d.) has a variety of tools to progress the use of digital health, including frameworks and

guidelines to support investment choices and to support the deployment of digital solutions.

Banking, agriculture, retail, and other sectors invest heavily in digital solutions and recognise technology as integral to the achievement of their strategic intentions. These industries have made investments to acquire hardware, software, human resources, and development of digital applications such as online banking, self-service portals, and mobile apps to deliver anywhere, anytime access to services. Sufficient resources are required to protect digital assets and customer data from fraud and theft for all organisations implementing digital technologies and information systems, and safeguarding against data breaches is a strategic priority for all industries. This is particularly relevant in the health industry due to the sensitive and personal nature of data held by health care information systems, apps, and patient records. Many countries, such as Australia, have regulations in place to ensure that data breaches are reported.



Essential building blocks and foundations for national digital health implementations (This figure is licensed under CC BY-NC-SA 3.0 IGO, 'Fig. 1.1.4' in WHO (2020))

Activity

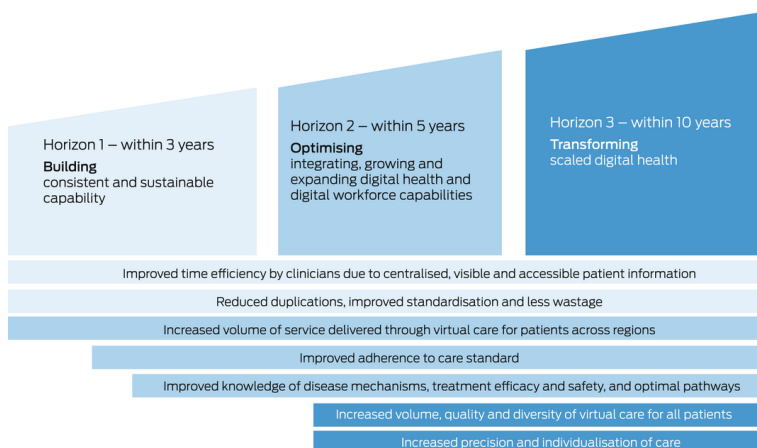
To understand the different ways to measure the benefits of digital health, read the paper by Woods et al. (2022)

<https://onlinelibrary.wiley.com/doi/10.5694/mja2.51799>

Reflect on the proposed alignment of electronic medical record benefits and achievement of the quadruple aims of:

- enhancing the patient experience,
- improving the health of the population,
- reducing per capita costs of hospital services and tertiary care, and
- improving the work life of health providers (Coleman et al., 2016)

Alignment of digital health acquisitions with strategic priorities and having both short- and long-term horizons to realise benefits of information systems, for example, the electronic medical record (EMR) described by Woods et al. (2022), is a realistic and pragmatic approach.



Identified impacts of electronic medical records over a 10-year time frame. This figure is licensed under CC-BY 4.0, 'Box 2' in Woods et al. (2023).

Digital Health Applications in Health, Social and Aged Care Sectors

Digital health can play an integral part in managing the needs of an aging population and the associated increase in chronic diseases (Isakovic et al., 2015). The table below provides a summary of example uses for different types of technologies; however, the possibilities are extensive, and this list is not exhaustive. In the immediate future, self-driving cars, leveraging machine learning, artificial intelligence, and sensors will transport the elderly and poor to appointments. Progress has been made in using robotic technologies to support amputees, clean and deliver supplies in hospitals, and as social companions in aged care settings. Swallowable cameras the size of capsules can take pictures of the intestine and sensor devices can monitor vital signs such as temperature and mobility (Olano, 2019). Hospitals and universities already use simulation tools for

education and training. Simulation allows learners to refresh or practice skills in real-time and supports skills development before assessments, interviews, or treatments are attempted on patients using sophisticated mannikins that can be programmed to respond as humans with certain diagnoses. Virtual reality technology has huge potential for medical training and education and for rehabilitation after a stroke or accident, or for therapeutic intervention, such as hip replacement, and other many other applications.

Facilitated by augmented reality, virtual reality, mixed reality, and extended reality – the metaverse is a universal and three-dimensional immersive virtual world (Bansal et al., 2022). Domains for metaverse applications in the healthcare industry include telemedicine, education, clinical care, and physical fitness (Bansal et al., 2022; Thomason, 2021). An example in a paper by Thomason (2021) described a metaverse, where 3D avatars of health workers have spaces to collaborate using tools such as digital whiteboards, and the ability to meet face-to-face without conferencing equipment. In the metaverse, digital twins will detect faults and vulnerabilities in procedures, systems, and machines (Thomason, 2021). Applications for the metaverse include surgical training, anatomy learning, gamified learning, and emergency response training (Bansal et al., 2022; Thomason, 2021).

Digital transformation of the healthcare system is reliant upon interoperability and data sharing. Blockchain and tokens are being used to enable the secure sharing of data and intellectual property (Thomason, 2021). Blockchain is a critical component as it is a sharable, unalterable ledger for tracking assets and recording transactions (IBM, n.d.). Blockchain promotes trust and support for digital identification and verification (Gupta, 2018) characteristics that are extremely important in protecting individuals' sensitive health data.

Artificial intelligence (AI) is now a mainstream application with huge potential in healthcare to support diagnosis, reduce waste, optimise workforce capacity, improve the reliability of diagnosis, and improve health outcomes (Scott et al., 2021). A simple definition of artificial intelligence is systems that have the ability to mimic human brain function, such as problem-solving and knowledge generation, and importantly, can act as a result of environmental inputs (Lawry, 2020; Russell and Norvig, 2022).

According to Russell and Norvig (2022), the most critical difference between AI and general-purpose software is the ability to act and “take actions”.

Management applications for AI include:

- Communication and support tools – virtual assistants and chatbots in clinics, reception areas.
- Administrative support using process automation – scheduling and optimisation (e.g., theatre and bed usage).
- Identification and flagging of inappropriate utilisation.
- Report writing for routine report writing.
- Automated ICD and other coding.
- Clinical applications for AI.
- Medical image interpretation.
- Decision support for predicting risk of disease, likelihood of response to treatments.
- Rehabilitation support using altered and virtual reality, robots for stroke and other injury.
- Clinical guideline development.
- Estimating dosages for complex drugs (Scott et al., 2021).

Digital transformation has accelerated due to the Internet of Things (IoT). This term is used to refer to the physical devices connected to the internet used as part of our daily lives. Wearable devices, vehicles, medical technologies, and other objects

are embedded with software, sensors and electronics that allow these 'things' to share and exchange data (NSW Government, 2019). Examples include fleet management, fitness trackers, connected monitoring devices for delivery of care in the home, connected logistics, and resource location; for example, locating assets such as wheelchairs, intravenous pole stands, and other medical/physical aids.

Example applications for digital health by sector

	Artificial Intelligence and Machine Learning	Virtual Digital Assistants and Chatbots	Robots	Wearables and Implantables	Information Kiosks and Portals	Mobile Computing and Apps	e-services
Sector	Example applications						
Primary care	Billing Coding Medication management Management plans	Information seeking Triageing		Self-management and monitoring of chronic disease	Health promotion and self-management	Digital prescriptions Telehealth Behaviour change apps Self-management	Scheduling appointments Information seeking
	Disease coding Medication management Medical image interpretation	Rehabilitation Triageing	Rehabilitation Care assistants Medication delivery	Diagnosis Personalised treatment Bionic limbs Bionic vision	Wayfinding Health promotion and self-management	Telehealth	Appointments and referrals Health information and self-management
Hospital							

Aged Care	Medication management		Care assistants		Wayfinding		
Social and Disability Services			Care assistants				
Population Health	Predictive planning and forecasting	Not applicable		Personalised medicine	Performance reporting on waiting times Access Equity	Surveillance and reporting Behaviour change (e.g., smoking cessation)	

Health Data and Information Governance

Health information generated by digital health technologies is an organisational asset to be valued throughout the entirety of its lifecycle, from its creation as data through to the destruction or archiving of information. This means due consideration needs to be given to the way health data and information is managed, which requires robust information governance structures to be in place.

Governance is top-down and establishes organisational goals, direction, and limitations, while management is bottom-up and addresses “how to get it done” (i.e., the oversight of day-to-day operations) (Empel, 2014). Therefore, the information governance structure is an “organisation-wide framework for managing information throughout its lifecycle and supporting the organization’s strategy, operations, regulatory, legal, risk, and environmental requirements” (Empel, 2014, p 30).

There are many information and data governance frameworks in existence that vary in response to industry and business functions. For example, in the Australian healthcare sector, such governance frameworks differ between federal and state health authorities and public and private healthcare organisations. Despite individual variations, what matters is that each is built upon sound guiding principles that serve to ensure an organisation’s data is secure and has integrity, quality, and usefulness.

The American Health Information Management Association’s ‘Information Governance Principles for Healthcare’ (IGPHC) were written to guide organisations that interact with and manage healthcare information, both clinical and non-clinical, and in electronic and hardcopy formats (Empel, 2014). The prin-

ciples cover eight areas for information governance, including accountability; the integrity of information; compliance with relevant laws, policies and standards; retention; protection from breach, corruption, and loss; and secure processes to dispose of information that is no longer to be maintained according to law and/or organisational policies (Empel, 2014)

As we move to an increasingly interconnected digital environment, the use and protection of health data and information takes on new complexities and dimensions. Electronic data requires not only a bottom-up approach to information management, but also a top-down approach through information governance. Three important elements that tie into information governance are the ethical use of health data, cybersecurity, and privacy considerations in digital health.

Activity

Watch this short video on the WHO health data atlas.
Consider the global use of data.



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://oercollective.caul.edu.au/leading-in-health-and-social-care/?p=404#oembed-1>

Digital Health Atlas: An Overview. Created by Digital Health

Atlas by WHO Source : <https://youtu.be/qEFzi0OtJMQ?si=b6mY3EWVYIYCxX3d>

Ethics

There are many ethical challenges with the introduction of digital health technologies into the health and social care sectors and the caring professions are oriented by strong ethical principles relating to respect for human life and dignity, autonomy, care and justice.

While these principles serve to guide practice and behaviour relating to health data and information, the design and widespread use of digital technologies is beginning to broaden the complexity of ethical dilemmas encountered in healthcare.

A review of contemporary literature focusing on the ethics of digital health tools was reported by Caiani (2020), who identified issues such as the impact of social media/networking and health information sites on doctor-patient relationships, integration, and use of applications for self-management, data collection, sharing of images, the validity of information sources, health inequalities and accessibility. Health and social care leaders should include organisational policies and procedures and outline expected behaviours in codes of conduct to ensure the appropriate use of social media, sharing of health information and images.

As digital technologies continue to evolve further, more issues of moral concern will invariably be added to this list of ethical challenges in the digital health space.

Cybersecurity

The recent hacking in October 2022 of the Australian private health insurer Medibank Private by Russian cybercriminals highlights the vulnerability of any organisation, regardless of size, to have sensitive health data stolen and exposed in the public domain.

A Health Snapshot report from the Australian Cyber Security Centre, (2020) promoted an awareness of key threats and encouraged enhancements to cybersecurity across the sector. It revealed that other than the government or individuals, the health sector reported the highest number of incidents (Australian Cyber Security Centre, 2020). Cybersecurity is an increasingly significant challenge for the health and social care sectors.

Health and social care organisations can prepare themselves by addressing eight essential mitigation strategies, known as the 'Essential Eight' (Australian Cyber Security Centre, 2022). Whilst there is no guaranteed approach, the 'Essential Eight' are regarded as a baseline (Australian Cyber Security Centre, 2022). It is important to understand that health workers and professionals all play a role in the protection of digital health information.

The baseline eight approaches to mitigate against cybersecurity risks are shown in the table below.

The Essential 8 – Baseline Strategies to Mitigate Against Cyber Threats. Adapted From Australian Cyber Security Centre (2022)

#	Mitigation approach	Explanation
1	Application control	Regularly checking programs installed against a pre-defined approved list and blocking all programs not on this list.
2	Patch applications	Ensuring that all patches to software are applied and up to date. Not permitting the use of applications that are out-of-support or do not receive security fixes.
3	Configure Microsoft Office macro settings	Only allowing Office macros (automated commands) where there is a business requirement and restrict the type of commands a macro can execute and monitoring the usage of macros.
4	User application hardening	Configuring key programs (office, web browsers, PDF software, etc) to apply settings to make it more difficult for an attacker to run commands that will install malware on systems.
5	Restrict administrative privileges	Administrator privileges are the 'keys' and limit the way that accounts with privileges administer and alter security and system settings can be used and accessed.
6	Patch operating systems	Ensuring that all patches to operating systems are timely and up to date (48 hours). Remove operating system versions that are no longer supported, superseded or out of date.
7	Implement multi-factor authentication	Using methods to validate user logins by applying additional checks, separate to password such as fingerprint scans or codes from SMS/mobile application.
8	Regular backups	Ensuring that regular backups occur should an attack occur to support rollback and restoration. Testing the restoration process when a backup is implemented, annually, and when software or IT infrastructure is changed.

Privacy

Information privacy is one of the most significant consumer and citizen protection issues in the digital age. Information pri-

privacy is concerned with how an individual's personal information is handled and the ways of promoting the protection of information (Office of the Australian Information Officer, n.d.)

Each country will be bound by their own privacy legislation; however, in Australia, the Privacy Act of 1988 introduced a set of Australian Privacy Principles (APPs). These principles apply widely and provide a framework for privacy protection, noting that organisations can adapt their data and information management practices to suit their practices.

There are 13 APPs relating to standards, obligations, and rights for:

- the collection, use and disclosure of personal information,
- an organisation or agency's governance and accountability,
- the integrity and correction of personal information, and
- the rights of individuals to access their personal information (Office of the Australian Information Officer, n.d.).

The Office of the Australian Information Commissioner (n.d.) is the key federal government agency charged with providing resources, advice, and guidance about privacy principles and privacy management practices.

However, health and social care data and information is particularly sensitive; may be collected, stored, and disclosed by multiple entities in multiple locations; and has a long 'shelf-life'. For these reasons, higher standards for privacy and confidentiality of health data are required, meaning that the maintenance of privacy is more complex in health than in other sectors (Hovenga and Lloyd, 2006).

This federal privacy legislation in Australia covers generic privacy principles, and jurisdictions such as NSW, Victoria and the ACT have enacted legislation explicitly related to health data.

Data Use and Analytics

Digital transformation creates a rich data foundation for health and social care services and new information and data can provide insights and support decision-making in new ways.

Leaders and managers of health and social care services are faced with making decisions related to resourcing, workforce, asset management, risk, and quality and safety. Leaders set the direction for their organisation to deliver on mission, vision, strategy, and goals. They draw on their experiences and, where possible, operational information and reports to reflect on performance, and make decisions about where to direct resources and if priorities require adjustment on this basis. Operational data collected in health information systems have informed healthcare leaders' decision-making. As the use of digital health solutions increases, there is an increased capacity to capture, use, and analyse volumes of data.

Advances in digital health have redefined the value of information and the capacity of healthcare services to operate as *intelligent* organisations and draw on information in real-time, and be agile and more responsive.

One of the strengths of digital innovation is the capacity for data analytics and visualisation techniques. These can provide new insights, intelligence, and increased organisational resilience (Gopal et al., 2019). A systematic review of the value of big data analytics in healthcare found that the capabilities that can be developed from the use of big data analytics include:

- Better diagnosis for personalised care that allows services and therapeutic approaches to be tailored to individuals.
- Supporting professionals' decision making with algorithms that can categorise symptoms and clinical results

and provide recommendations for possible diagnoses and treatment through analytics.

- New models of care and different ways for consumers to interact with healthcare.
- Enabling experimentation that can test “what-if” scenarios, expose variability, and improve performance.
- Healthcare information sharing and coordination.
- Create data transparency.
- Identify and predict risks.
- Reduce expenditure while maintaining quality.
- Protecting privacy when data is extracted by eliminating ID recognition from electronic medical records (Galets, Katsaliaki, and Kumar, 2020).

Implementation

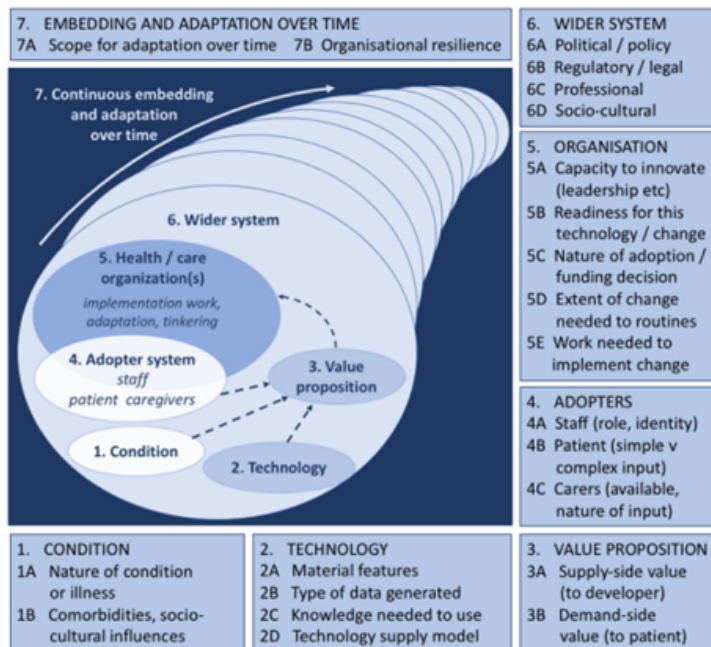
Leaders can support the implementation of digital technologies by providing an environment where innovative ideas can be trialled, tested, refined, and spread at scale. Greenhalgh et al. (2017, p1) conveyed that “many promising technological innovations in health and social care are characterised by non-adoption or abandonment by individuals or by failed attempts to scale up locally, spread distantly, or sustain the innovation long term at the organisation or system level”. Given a case for the introduction of the technology, a focus on change management, choice of implementation approach, project management, and an understanding of organisational readiness for adoption of digital solutions are all factors of successful uptake. Understanding the impact of politics and power are essential when implementing digital health technologies.

The NASS framework is an evidence-based tool developed by Greenhalgh et al. (2017, p.1) that has “several potential uses:

(1) to inform the design of a new technology; (2) to identify technological solutions that (perhaps despite policy or industry enthusiasm) have a limited chance of achieving large-scale, sustained adoption; (3) to plan the implementation, scale-up, or rollout of a technology program; and (4) to explain and learn from program failures". The figure below shows the framework that provides a set of domains and questions that should be considered in the non-adoption, abandonment, scale-up, spread, and sustainability (NASSS) framework for health and care technology (Greenhalgh et al., 2017). The framework recognises the complexity of the health environment and that reducing complexity in as many domains is necessary to maximise the success of technology projects, (Greenhalgh and Abimbola, 2019). To manage complexity, Greenhalgh and Abimbola (2019) suggested that the following approaches be applied

- Strengthen leadership of the initiative. Leaders can support adopters and model the vision.
- Have a clear and compelling vision for the initiative that is co-developed with stakeholders.
- Understand and talk about uncertainty, especially when it cannot be resolved.
- Recognise that change is hard and develop individuals to manage change and support the actions they take when implementing the technology.
- Work with front-line staff to refine the details (needed to adopt the innovation) and to achieve broad organisational objectives.
- Provide some slack in resourcing and dedicated time to lead and manage change and complete the tasks required in the implementation.
- Build relationships/partnerships to manage and resolve conflict. Relationship management with vendors for IT/IS solutions is critical

- Co-design work routines with intended end-users of the innovation. Involve them early and through the adoption. Small tests and pilots can be successful.
- Respond to emerging issues. Innovation will most always result in some unintended consequences and be alert and adaptive when these arise.
- Understand and work with credentialling, policy and/or regulatory requirements.



The NASSS framework for considering influences on the adoption, non-adoption, abandonment, spread, scale-up, and sustainability of patient-facing health and care technologies. This figure is licensed under CC BY 4.0, 'Figure 2' in Greenhalgh et al. (2017).

Workforce

Digital health implementation often proceeds without the specialised workforce development required to deliver successful outcomes and benefits (Gray et al., 2019). The workforce for a digitally enabled healthcare system remains a challenge and impacts digital health adoption and implementation.

Healthcare is information intensive, and as healthcare strives to maintain high levels of service to cope with demand and curb increasing costs, digital transformation requires preparation and planning for the change impacts on the workforce, workflow and resources. In the United Kingdom, a report explored how the healthcare workforce should be prepared to deliver the digital future and noted that “There is little point in investing in the latest technology if there is not a workforce with the right roles and skills to make use of its full potential to benefit patients” (Topol, 2019).

Internationally, the digital health workforce is not well understood or described, and the roles and competencies required to work successfully in digital health vary depending on the application. Research conducted in Australia identified no readily recognisable, specialised, professional health workforce available to govern and manage digital health (Gray et al., 2019). The World Bank (2023, p. 82) states that “no curricula on digital health exist at preservice or in-service levels. There is low maturity across most countries. Greater investment and standardization are needed in preservice and in-service training for health professionals, the professionalization of digital health and career paths within the public sector, and gender representation within the digital health workforce and governance”.

A scoping review of frameworks for digital health competencies identified the frameworks available to inform the devel-

opment of digital health curricula, education, and training initiatives (Nazeha et al., 2020). Key frameworks identified were Health Information Technology Competencies (HITCOMP), which provides a tool and repository to compile information on skills and competencies needed for a variety of healthcare roles, levels, and areas of knowledge. HITcomp uses five domains and documents more than 1000 competencies. The five domains are: direct patient care, administration, informatics, engineering/IS/ICT, and research/biomedicine. The competencies are also aligned to a particular level of skill (baseline, basic, intermediate, advanced, and expert). Competencies are also mapped to over 250 health IT-impacted roles in acute care and other healthcare settings in each of the five domains (HIT-Comp, 2020).

The Technology Informatics Guiding Education Reform (TIGER) coalition produced a set of competencies for those providing direct patient care, including communication, documentation, quality and safety management, teaching, training/education, and ethics in health information technology (Hübner et al., 2019).

A digitally capable health workforce will have the following skills:

- Confidence in the use of technologies and systems to capture data, present, interpret and share information.
- Ability to apply data science techniques to enable evidence-based decision-making and informed planning.
- Knowledge of information governance and security.
- Ability to work with vendors and specify requirements for systems that can support workflow management and support the interdisciplinary team and consumers of healthcare.
- Business skills to create the case for technologies and identification of benefits (Australian Digital Health

Agency, 2020; Australian Institute of Digital Health, 2022).

The below table shows a diverse range of professions and associated digital competencies.

Example digital competencies by profession

Profession	Digital competencies
Health service managers and leaders	<p>Manages business and clinical requirements using digital tools.</p> <p>Advocates for the use of digital health solutions to support innovation, quality improvement, research, and health service management.</p> <p>Aligns corporate, clinical, and information governance.</p> <p>Ensures digital health solutions meet functional and user requirements.</p> <p>Uses digital health solutions safely, minimising unintended consequences.</p> <p>Uses advanced analytics methods and visualisation techniques for information representation.</p> <p>Promotes digital health literacy.</p> <p>(Australasian College of Health Service Management, 2022)</p>
Health information managers	<p>Domains of:</p> <ul style="list-style-type: none"> • General professional skills • Language of healthcare • Healthcare terminologies and classification • Research methods • Health services organisation and delivery • Health information law and ethics • E-Health • Health information services organisation and management <p>(Health Information Management Association of Australia, 2017)</p>

Profession	Digital competencies
Health informaticians – Australia	<p>The CHIA exam covers six areas:</p> <ul style="list-style-type: none"> • Information and Communication Technology • Health and Biomedical Science • Information Science • Management Science • Core Principles and Methods • Human and Social Context <p>(Australian Institute of Digital Health, 2022)</p>
National Nursing and Midwifery Digital Health Capability Framework	<p>Domains addressing</p> <ul style="list-style-type: none"> • Digital professionalism • Leadership and advocacy • Data and information quality • Information enabled care • Technology <p>(Australian Digital Health Agency, 2020)</p>
Allied health professionals	<p>Domains addressing:</p> <ul style="list-style-type: none"> • Digital Workplace (technology and tools, legislation and policies governance) • Digital professionalism (digital profile, professional and ethical responsibilities, communication, collaboration, patient-centred care, professional development) • Data and Informatics (concepts and characteristics, digital integrity and lifecycle, analytical concepts, knowledge creation) • Digital Transformation (digital innovation, build and test, implementation, evaluation) <p>(Victoria. Department of Health, 2021)</p>

Profession	Digital competencies
Primary care professionals	Optimal use of EMRs, basic computer and internet use, knowledge about digital administrative and organisational competencies, artificial intelligence, and smartphone applications for monitoring care (Jimenez et al., 2020)
Digital Capability Framework for Health and Social Care for Ireland and Northern Ireland	<p>Domains addressing</p> <ul style="list-style-type: none"> • Digital professionalism • Leadership and advocacy • Data and information quality • Information-enabled care • Technology <p>(Health Service Executive and Digital Health and Social Care Northern Ireland, 2022)</p>
Competency framework for clinical informatics in the United Kingdom	<p>Domain 1 Health and wellbeing in practice</p> <p>Domain 2 Information technology and systems</p> <p>Domain 3 Working with data and analytical methods</p> <p>Domain 4 Enabling human and organisational change</p> <p>Domain 5 Decision making</p> <p>Domain 6 Leading informatics teams and projects</p> <p>(Davies et al., 2021)</p>

Options for Building a Digital Health Workforce

A workforce to support digital transformation requires planning to ensure that the right skills are available in the right place at the right time. In the 21st century, all health profes-

sionals need to be able to use digital technologies in their roles. However, a variety of specialised skills are required to support digital transformation, including clinicians, systems analysts, engineers, programmers, web-application developers, enterprise architects, integration specialists, data scientists, health informaticians, health information managers, health economists, and cyber analysts. This list is not exhaustive, and training and education are required to develop the required workforce.

Within healthcare organisations, a plan that includes the digital health workforce and that identifies how the workforce can be attracted, retained, and developed is an essential component of organisational strategy and planning. (See the chapter on Talent Management, Recruitment and Selection). Elements of a digital workforce plan might include a range of elements, including those outlined in the table below.

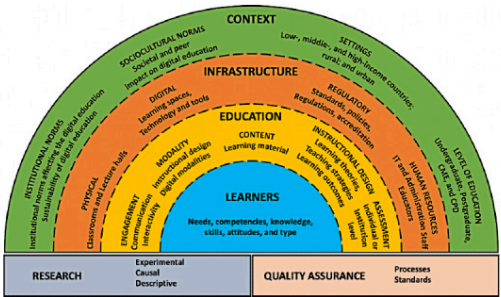
Elements for a Digital Workforce Plan

Approach	Explanation
<i>Recruitment, retention, and talent management</i>	Ensuring that the health care organisation attracts, retains, and develops the skills required to implement, continually improve, and align digital health technologies with organisational mission, vision, and strategies.
<i>Retrain and upskill</i>	One approach can be to support the workforce to retrain and learn through education and training provided by registered training organisations or vocational education and university sectors. Programs can be tailored to the needs of the organisation or specific skills or deficits.

A digitally enabled healthcare system also requires that users and receivers of care are equipped with both the technology and skills to successfully participate in managing their health

and receiving treatment. Implementing digital health solutions may have unintended consequences for health equity, as lack of access to devices, poverty, and digital health literacy are some factors that contribute to poor health outcomes (Crawford and Serhal, 2020; Kaihlanen et al., 2022).

To address the challenge of health professional digital education, Car et al. (2022) developed an evidence-based conceptual framework. The framework defines the need for a supportive and enabling context, sound infrastructure, and the optimal use of educational tools and processes. Learners have their own needs, preferences, prior experience, and competencies, and this should shape how education is delivered. For example, EMR training that demonstrates to clinicians user shortcuts, optimal use of the system, and approaches that shift from the traditional classroom teaching to techniques such as interactive and workflow-based content and hands-on rehearsals in simulated work environments can be effective (Scott et al., 2018; Ting, Garnett, and Donelle, 2021). The figure below shows a framework and the elements that should be considered when educating health professionals for digital technologies and information systems.



Conceptual framework for digital health education for healthcare professionals. This figure is licensed under CC BY 4.0, 'Figure 3' in Tudor Car et al. (2022).

Conclusion

Digital health offers prospects to achieve sustainable, high-quality, safe health outcomes for all. Globally, many nations are experiencing challenges with workforce shortages, aging populations, and an explosion in chronic diseases. As health leaders, we need to think for the 'information age', as described in this chapter, and link digital health solutions to strategy to solve real problems. There have been examples of large-scale investment in digital health solutions; for example, the electronic medical record to replace paper-based record keeping; however, workflows and service design have remained largely unchanged.

For the future, it is imperative that we think differently when implementing digital technologies in complex health and social care settings. We need to avoid 'bolting' technology onto the edges of traditional, place-based care delivery, and make a paradigm shift from what Greenhalgh et al., (2010) described as paternalistic, disease-focused models of care in health and social care to one of the self-managing consumers, with their health at the centre. While there will always be a place for tertiary-level care by hospitals and other services, the benefits to be realised from the digital era are to rethink how and where care is delivered. Health and social care leaders who set a compelling vision and direction for digital health, that build the foundations and plan for digital health, and who apply digital health solutions to solve the problems and challenges faced will seize the opportunities that digital health promises.

Key Implications for Practice

Leaders in health and social care can assure the best use of digital health by focusing on the following:

- Foundations – ensuring that the foundations to build a digital health system are in place.
- Vision, leadership, and culture – aligning digital health acquisitions to achieving strategic goals and objectives to improve care and the delivery of health and social care services. Planning for and investing in digital solutions that can solve a real or identified challenge to the delivery of high quality and safe care.
- Governance and ethics – adopting strong information governance frameworks, policy and procedures and ensuring information is managed securely.
- Implementation – Providing resources to implement digital health projects well; understanding the context, political situation, and stakeholders; evaluating technology projects; and learning and improving.
- Workforce – planning for and ensuring that the workforce is prepared and trained to use technologies to help them to complete their work safely.

The success factors are summarised in the table below.

Success factors in digital health

Foundations	Vision, Leadership, and Culture	Governance and Ethics	Workforce	Implementation
<p>High speed internet and communications</p> <p>Hardware</p> <p>Software</p> <p>Applications</p> <p>Storage</p> <p>Standards</p>	<p>Clear vision for role of digital transformation.</p> <p>Alignment of digital strategy with organisational goals and priorities.</p> <p>Investment in digital solutions and infrastructure.</p> <p>Culture supports new ideas and learns from mistakes.</p>	<p>Strong information governance.</p> <p>Policy and procedures.</p> <p>Management of the digital assets.</p> <p>Information security.</p>	<p>Right mix and number of skilled and digitally capable people.</p> <p>Workforce plans that include the digital workforce.</p>	<p>Resources</p> <p>Change management</p> <p>Project management</p> <p>Evaluation and learning</p>

Key Takeaways

For leaders, you will know you are successful if....

- Your organisation has a clear vision as to how digital technologies will support the organisation to achieve its mission and deliver on strategy.
- Leaders at all levels are promoting the vision for and the integration of digital technologies to solve workplace challenges and support individuals with innovative ideas to implement them.
- Employees within the organisation are comfort-

able suggesting and trialling new ideas and learn from any mistakes.

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Evaluating Health and Social Care Programs

RUTH MACKENZIE-STEWART AND HANAN KHALIL

Introduction

Evaluating health and social care programs is important for multiple reasons. These include, but are not limited to:

- ensuring the organisation is delivering the best programs and services while addressing community needs;
- making programs, services, and systems more efficient and effective;
- informing future directions and strategic service planning;
- producing context-specific and robust evidence to support funding applications;
- strengthening and informing communication and marketing efforts;
- and providing feedback to the community about the value of services and programs.

Program evaluation is a systematic process to examine the value of a program or project, including effectiveness, efficiency, and appropriateness. Patton (2012) defined evaluation as *“The systematic collection of information about the activities, characteristics, and outcomes of program, services, policy, or processes, in order to make judgments about the program/process, improve effectiveness, and/or inform decisions about future development”*.

Significant resources are invested into the development of clin-

ical pathways, guidelines, interventions, and innovations aimed at improving health and social care outcomes; however, systematic and appropriately scaled evaluations of such innovations receive less attention. Evaluation capabilities are required across all levels of health service management and leadership roles to continue to drive innovation, ensure consumer voices are heard, and build evidence-based responsive, appropriate, and effective health services. Several approaches, (frameworks, models, concepts) can be used for evaluation. This presents a challenge to those undertaking evaluations. The approach and methods used for evaluation can depend on factors such as practitioner experience, the discipline, funding body requirements, consumers and community needs, and the setting. It is crucial to ensure the methods used are fit for the problem at hand and generate evidence that can inform future decision-making.

Background

Evaluation is an applied inquiry process for collecting and synthesising evidence before, during, and after the delivery of real-world policies, programs, and interventions that results in passing judgment about the value, merit, worth, significance, or quality of a program, product, policy, proposal or plan against pre-determined goals, aims, objectives or intentions (Scarth, 2005, Bauman and Nutbeam, 2014). Evaluation is most effective when the needs of the users of the system are placed at the forefront (Patton, 2012); however, this needs to be balanced with rigorous design within constrained resources. Investment in designing robust evaluations for existing and new health service policies, programs, and interventions that seek to enhance community health and well-being or health service performance (which contributes to better health out-

comes for populations) is fundamental to ensuring we are delivering the intended outcomes. If not, it allows us to answer the fundamental questions of why not and how we can do this better (Bauman et al., 2014). The primary focus of an evaluation is to determine what is working, what does not work, or what can be done to make improvements.

When evaluating change for complex health initiatives, services, and programs it is important for health service managers to keep in mind small incremental changes over time can make a huge impact. Evaluating these incremental changes contributes to identifying the program components driving the change, thus contributing to sustaining longer-term public health and health service impacts (Steckler and Linnan, 2002). When evaluations of complex health service programs are designed at the outset, pathways to change can be better established through multiple evaluation approaches and methodologies (Bauman et al., 2014). Early evaluation can prevent larger-scale implementation barriers and failures and allows for the lived experience of participants to be appreciated through participatory evaluation methodologies (Scarth, 2005, Bauman, 2014, Patton, 2012).

Evaluation theories and approaches

When planning an evaluation, consideration must be given to the paradigm (and theory) along with the evaluation approach that will be adopted. A paradigm refers to the beliefs about the nature of reality and the types of knowledge required to facilitate an understanding of reality (Fox, Grimm, and Caldeira, 2016). The paradigm being used for an evaluation will inform methodological and data collection choices.

The literature concerning paradigms, theories, and approaches

in evaluation is extensive, and continues to be an arena for considerable debate. Lucas and Longhurst (2010) provided a useful introduction to different perspectives that can be brought to evaluation and the approaches associated with these. In a widely cited monograph, Stufflebeam (2001) provided a description of 22 program evaluation approaches. These approaches are distinguished by factors such as their purpose, scope, engagement with stakeholders, methods, timing, and applications. Most can be seen to have foundations in the evaluation paradigms described in this section. This section introduces two commonly used paradigms, and their associated evaluation approaches that assist in operationalising these paradigms when planning a health and social care evaluation.

Theories of change and the realist evaluation approach

The theories of change perspective is described as an expression of the critical realist paradigm; that is, it sets out to understand the complexity and contextual dependence of programs and services. Poland, Frohlich and Cargo (2009, p. 307) described critical realism as: *‘...a logic of inquiry that privileges neither “objective” facts nor subjective lived experience or narrative accounts, but rather seeks to situate both in relation to a theoretical understanding of the generative mechanisms that link them together, as a basis for interpreting the empirical or observable world’*.

Based on the critical realist paradigm, the realistic evaluation approach shares many elements of the theory of change perspective (Pawson and Tilley, 1997). Those adopting this approach operate from a position whereby the interventions delivered are considered working (or real world) theories concerning how a set of activities will function in given contexts

to create change and achieve the desired program and service objectives.

A key role for evaluators is to work with program managers and other stakeholders to make the theory of change inherent within a program explicit, often represented as logic models, and to use this to guide the evaluation. This approach is characterised by the purposive sampling of a wide variety of quantitative and qualitative data to shed light on the multiple mechanisms of change that take place in the program, and the contextual factors that act as enablers or inhibitors of change, both intended and unintended (Fox, Grimm, and Caldeira, 2016). Harris et al. (2020) provided a practice example of realist evaluation stages and how this paradigm can be applied to the evaluation of a recovery-oriented program in Australia for those with complex, severe, and persistent mental illness.

Within a theories of change paradigm and a critical realists approach the primary focus is on learning about how change is achieved focusing on context and unintended and intended outcomes. This makes it an appealing approach for planning an evaluation of complex health and social services.

Pragmatic perspective and the utilisation-focused evaluation approach

The pragmatic perspective (or paradigm) is guided by collecting information useful for stakeholders and communities rather than being concerned with objective measurement or proving causal pathways of change within programs and services (Patton, 2012). This approach to evaluation focuses on the practical use of evaluation findings to make decisions and improve programs. For pragmatists, questions of truth and validity are of far less importance than obtaining information

that ‘works’ for funding bodies, policy makers, service managers, and program beneficiaries.

The utilisation-focused evaluation approach is firmly ground in the pragmatic perspective. Patton (2012) argued that the utilisation-focused evaluation approach allows evaluations to be undertaken with specific users in mind. In this approach, the role of an evaluator is to undertake an analysis of program stakeholders, to identify the primary users of the evaluation findings, and determine the needs and associated questions they have concerning the program. The utilisation-focused approach is suitable for quantitative, qualitative, or mixed methods – these decisions are guided by the interests of stakeholders and their views about credible and useful evidence and data. The evaluator can facilitate this decision making by presenting a menu of context appropriate and rigorous methods to stakeholders and expert advice about the utility, validity, and cost-effectiveness of different options.

In practice, most evaluations will draw on several paradigms to ensure each evaluation question can be addressed and to recognise the interests of various stakeholders, known as a pluralist perspective (Lucas and Longhurst, 2010).

Planning for evaluation

When planning for an evaluation, decisions about the questions you want your evaluation to answer need to be developed and clarified. This will help you develop a statement of purpose or purposes.

The statement of purpose for an evaluation should address the following:

- What is the overarching rationale for evaluating this program?
- Who stands to benefit from the evaluation findings?
- How will this evaluation meet the needs of stakeholders and partners?
- What are the key aspects of the service or program that are to be evaluated and why? Note: this is linked to all previous questions.

When considering the purpose of the evaluation, it is worth reflecting on how the evaluation will meet the following needs:

- the funding requirements;
- the need for evidence in the field;
- your organisation's need to improve practice, process, and outcomes;
- the community's needs and interests;
- the interests and needs of decision makers that might be the focus for future advocacy efforts or funding applications.

Numerous frameworks and models can be used for program and evaluation planning. Some are generic in nature and can be used regardless of the paradigm and evaluation approach adopted. Regardless of which framework is adopted to assist you to plan your evaluation, it should include the following elements to ensure your evaluation is well considered:

- a description of the program;
- an evaluation preview or overview (this will include your evaluation purpose and key questions);
- the evaluation design (based on the paradigm, approach, purpose, and questions);
- data collection (the data collection plan, including data sources, indicators, and timelines);

- data analysis and interpretation (a plan for how data will be analysed and interpreted);
- dissemination plan (a plan for how you will communicate, report, and share the findings).

Levels of evaluation and the program planning cycle

Following on from decisions about the nature and reality of knowledge (paradigms and approaches), evaluators then turn their attention to further refinement of the evaluation purpose. That is, what do we want to know from the evaluation and what evidence do we want this evaluation to produce? Being clear on the purpose of the evaluation will help in deciding what level/s of evaluation, or level of change your organisation is most interested in, as this will assist in deciding the frameworks most appropriate to draw on for your evaluation.

Four levels of evaluation are commonly used when assessing the value, merit, or worth of health and social care programs; however, it should be noted that across the literature other terms are often used to describe the levels of evaluation presented here. Each level of evaluation contains several key elements that can be investigated throughout an evaluation, depending on the program or service under consideration.

Levels of evaluation and program relationship

Evaluation Level	Evaluation purpose description	Program/ project or service delivery component
Outcome evaluation	Determines whether the health or social service long term program or project goals/ long term aims have been reached.	Goals/long term aims. The long-term measurable changes in a health, social or health service issue.
Impact evaluation <i>Also known as summative evaluation</i>	Investigates whether the health or social service program or project or intervention objectives/aims have been achieved.	Objectives/ short terms aims. Short-term changes required to achieve the goals/long term aims.
Process evaluation <i>Also known as auditing and monitoring; however, auditing and monitoring do not capture the full range of process evaluation activities.</i>	Monitors the implementation of strategies. Strategy components assessed in process evaluation include: <ul style="list-style-type: none"> • delivery (recruitment, fidelity, dose delivered) • exposure • reach • dose received • context. 	Strategies/ activities The actions and activities implemented to achieve the stated objectives/ short term aims

Formative evaluation	Pre-tests strategies/ activities before they are fully implemented. This is often undertaken with participants and partners.	
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Choosing evaluation indicators

Once decisions about the level/s of evaluation and the evaluation questions aligned with the level/s have been determined, indicators need to be identified. The United States Centers for Disease Control and Prevention (CDC) described evaluation indicators as:

Measurable information used to determine if a program is implementing their program as expected and achieving their outcomes. Not only can indicators help understand what happened or changed but can also help you to ask further questions about how these changes happened (CDC, n.d).

Indicators provide a framework for data collection within an evaluation plan. These data collected against each indicator allow evaluators to determine an answer to the posed evaluation question. For example, if a program has introduced a new model of care to reduce hospital readmissions, a logical indicator might be pre- and post-data on the number and nature of readmissions to the hospital. Indicators can be quantitative or qualitative, and both are often drawn on in an evaluation. Table 2 provides a detailed example evaluation plan for a program delivered with a residential aged care setting to increase physical activity participation among residents.

Study designs and data collection options

Following identification of indicators, study design/s and data collection methods for measuring the outcomes, impacts, and processes of an evaluation must be determined.

Study designs provide a framework and set of methods and procedures used to determine whether a change in an impact or outcome of interest occurred, and to what extent (Greenhalgh, 2019). Broadly, study design can be categorised as either experimental or observational and quasi-experimental. Experimental designs have clear strengths for determining the causal effects of interventions, yet are less frequently used in the evaluation of health and social care policies, services, programs, and projects. They are most common in large, well-funded evaluations, where the intervention is novel and/or has the potential for future use at the population-wide level (for example, randomised controlled trials (RCT) and cluster RCT).

More commonplace health and social care evaluations are observational and quasi-experimental designs. These include the pre- and post-test, post-test only, controlled pre-and post-test (without random allocation to groups), and time-series designs. To understand the alignment between evaluation level, indicators, study design, and data collection methods, refer to Table 2.

The health research methods literature contains extensive descriptions, applications, and discussions of study designs and methodologies, including the strengths and limitations of each option. It is beyond the scope of this chapter to address each individual study design and methodology available for data collection within an evaluation. Head to Better Evaluation, a global interdisciplinary network that provides practitioners and researchers with accessible evidence-based and robust evaluation resources, including examples of the application of

paradigms, evaluation approaches, methodologies, and frameworks. The Evaluation Journal of Australasia publishes a wealth of interdisciplinary peer reviewed papers on evaluation theory, research, and evaluation practice.

Example Evaluation Plan Preview/Overview

Evaluation Level	Evaluation question	Indicators	Study design and data collection methods
<p>Outcome Evaluation <i>Program Goal</i> To increase physical activity participation among independently mobile residents living in residential care home A by 20% within 3 years</p>	<p>To what extent has low-moderate physical activity increased among independently mobile residents living in residential care home A at the end of years 1, 2 and 3?</p>	<p>Minutes of low-moderate physical activity among independently mobile residents living in residential care home A at the end of years 1, 2 and 3.</p> <p>Proportion of independently mobile residents living in residential care home A that are meeting age-appropriate Australian physical activity guidelines at the end of years 1, 2 and 3.</p>	<p>Design Time-series design: taking several measures before the implementation of strategies and at yearly intervals to decide whether the strategies influenced physical activity participation when compared with its background trend-line. This design can be used effectively when there is an existing data collection system in place to obtain the multiple measurements required, such as health service user statistics, telephone helpline databases, or ongoing population health surveys.</p> <p>Data collection methods Pedometer worn during waking hours by consenting independently mobile resi-</p>

Evaluation Level	Evaluation question	Indicators	Study design and data collection methods
			dents living in residential care home A for 7 days.
Impact Evaluation <i>Program Objective</i> Increase knowledge among residential aged care staff employed at residential care home about the benefits of physical activity for independently mobile residents by 70% by the end of year 2.	To what extent has knowledge on the benefits of physical activity for independently mobile aged care residents increased among the staff at residential care home?	Knowledge of the benefits of physical activity participation among for independently mobile residents among the staff at residential care home A	Design Pre- and post-test design. Prior to the delivery of and 1 week post workforce and professional development training, data collected from residential aged care staff employed at residential care home A on the benefits of physical activity for independently mobile residents. Data collection methods Knowledge survey on physical activity benefits with residential aged care staff employed at residential care home A. survey administered prior to and 1 week post training sessions participation.

Evaluation Level	Evaluation question	Indicators	Study design and data collection methods
Process Evaluation <i>Program Strategy 1</i> Deliver workforce and professional development training for staff employed at residential care home A about the benefits of physical activity for independently mobile residents.	How many staff employed at residential care home A completed the training by the end of year 2? To what extent were all training components delivered to those in attendance in each training session?	Proportion of staff employed at residential care home A that have completed professional development training (reach). Proportion of intended training session components delivered in each session (delivery).	Design Process evaluation does not require study design selection, as the purpose is not to determine effects or change, but to monitor and understand factors around strategy implementation and participation. Data collection methods Administrative attendance data, number of staff that attended and completed training. Audit tool of session components. Facilitators to complete at the end of each session delivered.

Evaluation Level	Evaluation question	Indicators	Study design and data collection methods
<p>Formative Evaluation</p> <p><i>Program Strategy</i></p> <p>1 Deliver workforce and professional development training for staff employed at residential care home A about the benefits of physical activity for independently mobile residents.</p>	<p>Are the workforce and professional development training sessions engaging and acceptable to staff at residential care home A?</p> <p>Are the workforce and professional development training materials clearly delivered</p>	<p>Experiences of the design, perceived meaning and relevance, attractiveness, and acceptability of the professional development training from the perspective of staff from residential care home A. Facilitators' experiences of the workforce and professional development materials following the initial delivery.</p>	<p>Design No design is required, formative evaluation questions do not seek to determine effects or change resulting from the professional development session, rather seek to understand the acceptability and relevance factors influencing strategy implementation and participation. Data are collected following the delivery of one professional development session to allow for adaptations to be made ahead of the full roll out of professional development sessions.</p> <p>Data collection methods Focus groups with staff from residential care home A following participation in the first</p>

Evaluation Level	Evaluation question	Indicators	Study design and data collection methods
			<p>delivery of the professional development training to explore their perceptions of relevance, attractiveness, and acceptability of the professional development training. Semi-structured interview/s with facilitators to explore their experiences of the workforce and professional development materials following the initial delivery.</p>

Evaluation Level	Evaluation question	Indicators	Study design and data collection methods
Impact evaluation <i>Objective 2</i> Provide one additional walkable secure, supervised, and safe outdoor green space for independently mobile residents at residential care home A by the end of year 3.	Has one additional walkable secure, supervised, and safe outdoor green space for independently mobile residents at residential care home A become available for use by residents?	Availability of additional walkable secure, supervised, and safe outdoor green space for independently mobile residents at residential care home A	Design Post tests are useful when the baseline value is known (such as the number of walkable, secure, supervised, and safe outdoor green spaces at a residential care home). Data collection methods Environmental audit of residential care home A for to determine the number of available walkable secure, supervised, and safe outdoor green spaces for independently mobile residents.

Evaluation Level	Evaluation question	Indicators	Study design and data collection methods
<p>Process Evaluation Strategy 2</p> <p>Co-design a walkable, secure, supervised, and safe outdoor green space with independently mobile residents at residential care home A.</p>	<p>What barriers and enablers were experienced by independently mobile residents when participating in the co-design of a walkable, secure, supervised, and safe outdoor green space?</p>	<p>Barriers and enablers to involvement as experienced by independently mobile residents in residential care home A. Number of independently mobile residents in residential care home A who experienced barriers to initial and ongoing involvement in the co-design process.</p>	<p>Design Process evaluation does not require study design selection, as the purpose is not to determine effects or change, but to monitor and understand factors around strategy implementation and participation.</p> <p>Data collection methods Focus groups with independent mobile residents in residential care home A, held periodically (6 monthly) throughout the co-design phase to explore their experiences of barriers and enablers to participation.</p>

Evaluation Management

With any project or program, having the right mix of individuals is critical across the planning and evaluation life cycle. Begin by identifying the stakeholders, that is, people who may have an interest in the project evaluation, such as consumers, community representatives, and sponsors. It will probably not

be feasible to include all stakeholders, so you would have to decide how to prioritise who should be involved. When planning for an evaluation and bringing together a team, it is worth paying particular attention to the mix of skills, time available, resources, and credibility. These factors may result in the scale, size, or focus on the evaluation shifting to ensure it is practical to implement within the bounds of the team's skills and resources.

Stakeholder engagement is not only an important element of successful implementation, it is essential for a successful evaluation. Stakeholder engagement can be in the form of consultation, right through to active participation of stakeholders in the planning, delivery, and reporting of an evaluation (Wensing and Grol, 2019). Large evaluations will often involve the establishment of an evaluation working group or committee comprising of representatives from stakeholder organisations and groups. Stakeholder involvement in evaluation and other research strategies has been encouraged, as it is believed their engagement could increase the relevance of evaluation findings, thereby promoting adaptations in practice and helping to close the knowledge-to-practice-gap. Strategies likely to promote stakeholder engagement include the use of plain language summaries and including ongoing consultation. Barriers to stakeholder engagement include limited time and resources that may hinder the process. To date, evidence on the benefit of involving stakeholders is scarce, and future research should address this gap by having a standardised approach and defined outcome measures to determine the benefit of stakeholder engagement.

The evaluation timeline should clearly indicate the period over which the evaluation is expected to occur and the specific tasks. The timeline can serve as a communication tool to keep stakeholders and staff up-to-date and track the progress of the evaluation. When preparing a timeline for an evaluation,

it is important to ensure adequate time has been built in to allow for development and testing of evaluation data collection instruments, recruitment of participants, data collection and analysis, and dissemination of findings.

The resourcing of an evaluation is often overlooked at the planning stage or underestimated in terms of work hours and cost. Evaluation budgets should be scaled to the size and complexity of the health or social care program under consideration, realistically 15%–25% of the program's budget should be quarantined to fund an evaluation (Zarinpoush, 2006). Horn (2001) developed a robust checklist to support evaluators in planning their evaluation budgets, it is freely available here.

There is the expectation that as evaluators, we will address all ethical requirements when leading an evaluation. For example, ethical approvals maybe required if we are working with another agency/organisation in planning an evaluation of a program or service, such as a hepatitis C treatment clinic within several public hospitals, and collecting data through a survey, interviews, or focus groups. The evaluation team is responsible for including this in the plan and obtaining all required ethics approvals. There may be specificities in each jurisdiction's ethics processes and protocols and these must be complied with accordingly. In Australia, the National Health and Medical Research Council is responsible for ensuring that research is conducted ethically and with informed consent. The conduct of an evaluation often involves participation of individuals from vulnerable groups. At the planning stage, it is necessary to check the specific ethics requirements for engaging these sub-populations in the evaluation.

The ability of evaluators to anticipate risks to evaluation rigour and minimise them is an essential evaluation management skill. Threats to rigour can arise from factors such as recruitment and follow-up issues, quality of data collection instru-

ments, timing of data collection (seasonal effects), and problems with data management. Putting a detailed work plan and communication plan in place for data collectors supported by adequate training in the protocols for data collection, management, and analysis is the most adopted strategy to manage these risks. This can be further supported by ensuring supervision is readily available for data collection staff and that immediate troubleshooting with updates to the team is undertaken. The best solution for minimising risks to rigour is the employment of appropriately trained staff with the right mix of personal skills, knowledge, and qualities. Data collection staff need to be able to work systematically, be sensitive to ethical and community considerations, well versed in the potential risks to data quality, be personable, and excellent communicators.

Key Implications for Practice

In Australia, government funded programs have been initiated in health services to improve the healthcare system, with significant resources being dedicated to their implementation.

Evidence-based evaluation of these initiatives is essential to ensure that resources are used appropriately and delivering their intended outcomes. It is important to consider that there are multiple concepts, frameworks, theories for evaluation for different contexts.

The main activities of any evaluation program include: identifying the purpose of the evaluation, identifying stakeholders, assessing evaluation expertise, gathering

the relevant evidence using various methods, and building consensus, which is usually an iterative process.

Health services managers and leaders need to be engaged in all steps of any evaluation program and ensure a collaborative approach is used to achieve the required results. Other important aspects for leaders and managers are to be aware of the ethics of the evaluation, managing expectations, sharing both positive and negative findings with the team, and ensuring that the results provided are both useful and usable.

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Richard commenced his career in health services as a registered nurse specializing in mental health, emergency, operating room, and intensive care, working clinically and teaching in each area. He has over 30 years of experience in health and social care leadership positions in Australia's public and private healthcare and social care sectors. His health services management career and experience at the senior executive and chief executive levels, with consultancy and board member experience.

Richard's executive-level health care career includes appointments at the Director of Nursing level and some twenty-five years of experience in other executive leadership roles at the CEO level at large regional and metropolitan hospitals such as Logan-Beaudesert District Health Service, Gold Coast Hospital and Health Service and Royal Brisbane and Women's Hospital and Health Services. His leadership and management experience encompasses acute, aged, and community care sectors.

Richard also is experienced in aged and community care leadership. An experienced health services management executive, Richard holds an academic appointment at Griffith University in the School of Medicine and Dentistry, focusing on Health Services Management. He has taught and researched health-care systems, health workforce, health workforce planning, applied ethics and law in health services management, research inquiry, and health services research to post-graduate health services management students.

Richard holds the post-graduate qualifications of Doctor of Philosophy (PhD), Griffith University, JurisDoctor (JD), University of Queensland, Master of Health Administration (MHA) University of New South Wales, Bachelor of Applied Science – Advanced Nursing (BAppSc-Adv Nsg) Lincoln Institute, La Trobe University, and a Diploma of Applied Science -Nursing Education (Dip. App.Sc. N.Ed.), Queensland University of Technology. His PhD thesis reported on a mixed-methods study that examined the effects of leadership style on the organisational identification and job satisfaction of aged care employees.

A Fellow of the Australasian College of Health Services Management (ACHSM), Richard holds credentials as a Certified Health Executive. He was appointed as the Chief Examiner for the Australasian College of Health Services Management Fellowship program in 2023 and previously occupied the position

of Assistant Chief Examiner, during that time, he successfully designed, wrote, and implemented the online content for Fellowship preparation. He is a co-author and a learning facilitator for the online professional development course in Professional and Social Responsibility. He is also a Director of the ACHSM National Board and the Vice-President of the Queensland Branch of ACHSM. In 2022, Richard received an Australia Day Award from the Queensland Branch of the Australasian College of Health Services Management for services supporting healthcare leadership. Richard is currently employed by Australia's largest aged care provider, Bolton Clarke where he develops and coaches existing and emerging leaders from his position as Leader Advocate.

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I am an experienced, solution focused leader with recognised local, state and national outcomes and abilities in healthcare ethics, organisational culture and professional regulation. My strengths are strategic leadership; internal and external stakeholder engagement; learning and teaching; research; and operational management. A collaborative, diligent and innovative thinker, I have 25 years' experience across a range of sectors including healthcare ethics, education, academia and professional regulation. I have grown and implemented cultural change, identifying and effecting strategic imperatives in large, diverse and complex organisations, driving sustainable

improvement in these fields. My strong multidisciplinary academic background in Philosophy (PhD, BA-Hons 1st), Education (Grad Dip Ed) and Science (BSc-Biochem) support my work across diverse fields.

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Katy Aish is the Service Design Manager at Silverchain where she co-designs services and leads innovation projects with consumers and a variety of stakeholders in community health and aged care. Mrs Aish has 20 years of experience as a Registered Nurse in both front-line nursing and management roles, in both acute hospital and community health sectors. She has co-created with consumers and stakeholders sustainable services, programs and solutions to solve for real world problems in the health industry.



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Amanda is a registered nurse with over 25 years' experience in Australia and England, she has worked in public and private healthcare settings. Her commitment to safety and quality has been the underpinning principle in all the roles she has held and she continues to share her knowledge and experience in

both the clinical and academic environment.

As an Alumni of Murdoch University having completed the Master of Health Care Management (MHCM), Amanda is continuing her own learning journey through research with a focus on quality in the health environment.

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Janelle Craig is a Health Information Manager (HIM) with over 30 year's experience working in healthcare systems in Australia and internationally, and in the tertiary education sector at the University of Sydney, Macquarie University, the Singapore Institute of Management and the University of Technology Sydney, where she is the Director of Studies for Health Services Management.

Her contribution to the chapter on Digital Health Leadership recognises the expertise she brings in ensuring leaders in health and social care sectors have a strong understanding of the importance and use of data of data for decision making, and of the opportunities and challenges they face in an increasingly digitalised landscape.

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Associate Professor Jennifer Evans, PhD

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Associate Professor Jennifer Evans is a Queer Dharug scholar with dual connections to Dharug and palawa country. They are an Aboriginal Research and Literary Fellow with research expertise in Indigenous and decolonising methodologies and health equity for First Peoples.

In 2022 Jennifer won the Tasmanian Premier's Literature Award for her academic work regarding Queer Indigenous voices. The judges agreed that 'the winning writer showed remarkable skill in helping readers relate to their own unique perspectives, while simultaneously unpacking ideas of contemporary Aboriginal culture. Their work felt fresh and more relevant than ever and was an absolute treat to read.'

Jennifer is a multidisciplinary academic who has broad research capabilities in both quantitative and qualitative methods underpinned by Indigenous and Queer Standpoints. Associate Professor of Aboriginal Health Leadership in the College of Health and Medicine, she provides Aboriginal leadership and research advice to peers widely within and external to the University of Tasmania.

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Adamm originally completed an allied health qualification at Lincoln Institute (prior to the merging with La Trobe University), following this a nursing qualification and specialisation in operating room or perioperative nursing.

For the first half of his career during the day he worked as a nurse, and as a professional musician in the evenings with the Victoria State Opera. As a theatre manager, he developed an interest in procurement of health supplies, and was invited to help establish Health Purchasing Victoria (HPV), a statutory authority that procures goods and services on best value terms for the state. This required him to take on the roles of Chief Financial Officer and Company Secretary.

He completed an MHA at La Trobe University, and was later invited to provide sessional teaching, initially teaching The Australian Healthcare System. After seven years at HPV he spent a brief period as a national quality manager for a leading health insurance organisation, before returning to a clinical role. In 2009 he was appointed as the health contract manager of correctional health services for the State of Victoria. After two years in this role an opportunity arose to join La Trobe as a full time member of staff with the China Health Program.

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Associate Professor Hanan Khalil Associate Professor is a registered pharmacist who has worked in clinical practice for several years in both hospitals and community settings in Victoria and South Australia, where she held several senior management, research and education roles.

Her research focus is on improving quality of care to patients accessing services and health services quality and performance. Hanan's research projects were recognized nationally through receiving awards and being published in the media. Associate Professor Khalil has published over 200 educational and research articles in the areas of medication management and evidence-based health care in various health care settings such as aged care, hospitals and community health services. She has also presented her work in both national and international conferences. She is an invited speaker both nationally and internationally on topics related to evidence-based health care and medication safety in health services. She is the Editor in Chief of Current Opinion in Epidemiology and Public Health.

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Ali Lakhani, BBA, MA, MES, PhD is an interdisciplinary researcher with degrees in business, economics, environmental studies and health promotion. He has a over 15 years of experience conducting community-based research focusing on the environmental determinants of health. He is currently a Senior Lecturer in Public Health with La Trobe University, and coordinates the subject, Systems Thinking and Leadership. Previously, he completed consecutive Research Fellowships, partnering with health and social service organisations providing support to ageing populations, people with a neurological disability, and culturally and linguistically diverse (CALD) people.

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Melanie is a Registered Nurse and Senior Lecturer in the School of Nursing at Murdoch University and Research Fellow with the Cancer Network of WA. She is the Post Graduate Academic Chair and coordinator of the Health Care Management suite of courses.

Melanie completed her PhD in 2019 which focuses on the insights of new graduate registered nurses during their transition from student to professional clinical practice. The findings highlight the need for appropriate leadership and mentorship and that learning is experiential. Since then, her research areas of interest include leadership, quality and patient safety, nursing workforce, and informing health policy through work with the Australian College of Nursing.

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Dr Ana Rita Sequeira is a senior lecturer in Health Policy, Academic Chair of the Health Administration, Policy and Leadership and Associate Dean of Learning and Teaching at Murdoch Business School.

Research interests include Global Health, Health Policy, COVID-19 Policies, Refugee Health, Artificial Intelligence in healthcare and healthcare workforce well-being. Sequeira's is leading and participating in research projects in collaborations in Australia (Curtin University, University of Newcastle and Notre dame University), New Zealand (Victoria University of Wellington), UK (University of Southampton) and Italy (University of Bologna).

Ana Rita Sequeira has taken part in consultancy/research contracts to public and private organisations, helping to shape organisations' strategic direction and service delivery. She has also contributed to inform policy development via the submission of policy briefs related to funded research projects, public policy submissions, and media outlets (The Conversation). She is currently part of the editorial board of the journal *Frontiers in Public Health*.

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Ruth is a Lecturer and Head of Major for Health Promotion in the School of Psychology and Public Health. Ruth is involved in the design, coordination, and delivery of several subjects at both the undergraduate and postgraduate levels in public health, health promotion, and evaluation. She has over 15 years' experience as a health promotion and evaluation practitioner in state and federal government, community health, the sport and recreation sectors and prisons. Ruth is a mixed methods

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Glossary

5 Whys

The 5 Whys is an iterative technique pioneered at Toyota Motor Corporation in the 1930s to explore the cause-and-effect relationships underpinning a problem. By working back the cause of one effect to another up to five times, designers can identify the root causes and explore effective solutions.

“Be ahead of the times through endless creativity, inquisitiveness and pursuit of improvement.” — Sakichi Toyoda, Japanese industrialist and inventor who formulated the 5 Whys method[https://www.interaction-design.org/literature/topics/](https://www.interaction-design.org/literature/topics/5-whys#:~:text=The%205%20Whys%20method%20is,cause s%20and%20explore%20effective%20solutions.)

5-whys#:~:text=The%205%20Whys%20method%20is,cause s%20and%20explore%20effective%20solutions.

Accrual accounting

Accrual accounting is the recognition of changes of value (earnings or expenditure) to an organisation according to date when an asset or liability is incurred.

Activity Based Funding

Activity based funding refers to a systematic method of remuneration to healthcare providers based up a predetermined episode of care payable to the provider upon the separation of the patient from the providers of the healthcare (i.e., conclusion of the healthcare service). ABF differs from fee-for-service in that all the constituent services associated with the continuum of care are bundled into the one fee payable upon completion of the care.

AI

Artificial intelligence.

Asset

Possessions (and skills) that are owned and have value that can be used to generate income in the future

Balanced Score Card

The Balanced Scorecard was developed by Kaplan & Norton in the late 1980s and refers to the method of reporting measurements associated with strategic outcomes and operational performance beyond that which can be achieved through financial reporting alone.

Block funding

Block funding refers to the remuneration for an agreed service based on prospective terms and conditions associated with the expected outcomes for that service over a specific period.

Budgets

A budget is a prospective plan that aims to predict future economic activity in terms of revenue and expenditures associated with the purpose of the organisation. Budgets are commonly expressed and conceived in financial terms but may also include plans expressed in non-financial terms (such as staff rostering) that have a financial impact on the organisation.

Burn-out

A state of chronic physical and emotional exhaustion experienced by healthcare professionals as a result of prolonged and intense stress in their work environment.

Capitation

Capitation is form of financial distribution based on the target population as a form of equitable distribution. For example, capitation funding for a service is based on a certain amount per person in that population regardless of whether every person in that population receives or benefits from that service.

Cash Accounting

Cash accounting is the recognition of changes of value to an organisation according to date when an asset or liability is paid.

Cash Flow

Cash flow refers to the differences of value over time when an asset or liability is incurred and when the said asset or liability is paid.

CFIR

The Consolidated Framework for Implementation Research

CLD

Causal Loop Diagram

Clinical Governance

Clinical governance refers to the application of Governance processes to healthcare organisations with a view to encouraging quality of care by developing resilience and reliability in the provision of health care services, by assigning responsibility and accountability for the establishment of clinical operational rules and decision-making

processes. Clinical governance delineates the separation between managerial authority and clinical autonomy.

Episode of Care

An episode of care refers to a predetermined series of specific healthcare services (continuum of care) provided to patient from diagnosis or admission to hospital until the treatment is concluded (i.e., discharged or upon death).

Fee for Service

Fee for service is form of financial remuneration based on payment for a single service.

Financial Pooling

The predetermined collection of resources (usually monetary) into a repository which can then be redistributed as the agreed demands. Universal health coverage depends on the gathering of financial resources on the widest possible basis (usually nationwide)

Goods and Services Tax (GST)

The GST is a consumption tax levied on most goods and services provided throughout Australia. Established in 2001 and managed by the Commonwealth Government, it is the discrete funding stream for states and territories.

Governance

Governance refers to the manner and method by which an organisation establishes operational rules and decision-making processes that regulate the organisation. Governance determines the underlying culture of an organisation: a just and equitable governance process is reflected in an organisational culture that ensures merit,

integrity, beneficence and respect for stakeholders, staff and customers alike.

HIS

Health information system.

Horizontal Access Equity

Horizontal access equity in healthcare refers to the principle that all eligible persons should have the same opportunity to receive (access) healthcare upon need, and that any restriction(s) to healthcare (such as defining what constitutes emergency, acute and elective care) is applied consistently across the eligible population.

ICT

Information, communication and technology.

IMS

Incident Management System. An incident management system incorporates the policy, procedure, processes and technology that supports the identification, management and resolution of incidents that occur when delivering care and services to health and social care consumers. https://www.agedcarequality.gov.au/sites/default/files/media/sirs_ims_fact_sheet_final.pdf

International Financial Reporting Standards (IFRS)

The International Financial Reporting Standards are a set of accounting rules that have been developed through international consultation and cooperation to encourage the consistent reporting of financial information and are based on the four principles of (1) revenue recognition (2) matching, (3) materiality, and (4) consistency. The impact

is that the financial reports of publicly listed companies and publicly owned companies from any country adopting these principles consistent, comparable, and reliable.

Ishikawa diagram

One of the seven basic tools of quality control and pioneered by Ishikawa in Japan and used to identify production defects. Further reading on the use and history of the Ishikawa diagram can be found here

https://en.wikipedia.org/wiki/Ishikawa_diagram

IT

Information technology

Length of Stay

The length of stay refers to the number of days or part thereof that an individual remains an inpatient and occupies a hospital bed.

Liability

Most commonly, things of value owed to other people or organisations for which a payment or trade is needed.

Medicare (Australia)

The name of the Australian government program established in 1984 that provides universal health coverage for primary, secondary, and tertiary healthcare to all citizens and permanent residents.

Organisational culture

The shared beliefs, values, attitudes, assumptions, and

behaviors that exist within an organisation and shape its overall work environment.

Outcome measures

Measures of the results, impacts, or changes that occur as a direct or indirect effect of the program or intervention.

Output measures

Measures focused on quantifying the immediate products, services, or activities delivered.

PARIHS

The Promoting Action on Research Implementation in Health Services framework

PDSA

Plan, Do, Study, Act. A technique for quality improvement.

Per diem

Per diem (literally per day) is form of remuneration based on the length of accommodation whereby a healthcare provider is paid a predetermined set fee for each day or part thereof that an inpatient occupies a bed. This model is most commonly associates with hotels/motels which charge a per diem fee for accommodation; historically private hospital remuneration was predominantly based upon per diem payments. A per diem model of hospital remuneration has the perverse impact of encouraging increased lengths of stay.

Pharmaceutical Benefits Scheme (PBS)

The Australian Government program that subsidizes and ensures access to a range of essential medicines at a stan-

dard maximum price for consumers regardless of the cost of the medication itself. If the cost of the medication is lower than the standard maximum consumer fee, then that is the price that is charged.

Psychological safety

A multi-dimensional, dynamic phenomenon that concerns team members' perception of whether it is safe to take interpersonal risks at work.

QI

Quality improvement utilises a wide variety of methods and tools to understand quality issues and causes and design solutions to solve problems.

Quadruple aim

An expansion of the triple aim (improving patient experience and satisfaction, improving population health and reducing healthcare costs) to include enhancing the well-being of healthcare providers.

RCA

Root Cause Analysis.

Separation (Hospital)

A healthcare or hospital separation is defined as the point at which the patient leaves the care of the healthcare provider.

Triple C model

Consultation, Collaboration and consolidation model

Universal Health Coverage

Universal health coverage occurs where arrangements are in place so that residents of a specific region or country have access to and receive treatment on an equitable basis according to specific need and urgency regardless of the individual's ability to pay, as the costs associated with such healthcare provision are shared across the entire community.

Vertical Access Equity

Vertical access equity in healthcare refers to the principle that healthcare provision is prioritized in terms of an individual's need compared to others that may also be demanding services, predicated upon the definitions of emergency, acute and elective care are consistently applied.

Vicarious trauma

The psychological and emotional impact of repeated exposure to the traumatic experiences of others.

Version History

This page provides a record of edits and changes made to this book since its initial publication. Whenever edits or updates are made in the text, we provide a record and description of those changes here. If the change is minor, the version number increases by 0.1. If the edits involve substantial updates, the edition number increases to the next whole number.

The files posted alongside this book always reflect the most recent version. If you find an error in this book, please let us know at sheree.lloyd@utas.edu.au

Version	Date	Change
1.0	October 11, 2023	Original book published
1.1	July 2024	Minor changes made to some image captions and book info to improve copyright acknowledgement and attribution

Accessibility Statement

Accessibility features of the web version of this resource

The web version of *Leading in Health and Social Care* has been designed with accessibility in mind by incorporating the following features:

- It has been optimized for people who use screen-reader technology.
 - all content can be navigated using a keyboard
 - links, headings, and tables are formatted to work with screen readers
 - images have alt tags
- Information is not conveyed by colour alone.
- There is an option to increase font size

Other file formats available

In addition to the web version, this book is available in a number of file formats including PDF, EPUB (for eReaders), MOBI (for Kindles), and various editable files. Here is a link to where you can download this book in another file format. Look for the “Download this book” drop-down menu to select the file type you want.

This book links to a number of external websites. For those using a print copy of this resource, the link text is underlined,

and you can find the web addresses for all links in the back matter of the book.

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This statement was last updated on September 11, 2023.