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This report is part of the final evaluation report on Care Net Illawarra, one of the Australian Coordinated Care Trials based in the Illawarra. Each of the national trials addressed the same primary hypothesis:

Coordination of care of people with multiple service needs, where care is accessed through individual care plans, and funds pooled from existing Commonwealth, State and joint programs, will result in improved client health and well being within existing resources.

A summary of the key elements of the Care Net Trial is contained in Appendix 1 of this report.

There are 10 reports in this evaluation series:

Report Number 1	The Care Net Trial – What it was and How it was Managed (this report)
Report Number 2	The Care Net Intervention
Report Number 3	Care Coordination in the Care Net Trial
Report Number 4	The Use of IT in the Care Net Trial
Report Number 5	Client Experiences in the Care Net Trial
Report Number 6	The Care Net Trial – Impact on General Practitioners
Report Number 7	The Care Net Trial – Impact on Health and Community Care Providers
Report Number 8	The Care Net Trial – Impact on the Wider System
Report Number 9	The Care Net Trial – Value for Money?
Report Number 10	The Care Net Trial – The Evaluators Conclusions

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Report Number 1

The Care Net Trial – What it was and How it was Managed

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1.1 An overview of the Illawarra Coordinated Care Trial

The Illawarra Coordinated Care Trial, or Care Net Illawarra, was established as part of a National series of demonstration projects that aimed to assess the benefits of coordinated care in the context of the Australian health care system. The primary hypothesis to be tested by the trials was that:

That coordination of care of people with multiple service needs, where care is accessed through individual care plans and funds pooled with existing Commonwealth, State and joint programs, will result in improved client health and well-being within existing resources.

Fund pooling was a key component of the coordinated care trials. The established, program-based organisation and funding of health care services was thought to be a principal factor in frustrating flexible service provision and service substitution. The way to overcome this issue was believed to be the pooling of funds from Commonwealth, State and joint Commonwealth-State programs (Pekarsky 1999). Trials would be allocated a budget from which they could purchase services for clients, with funds for the budget coming from the finances of existing service providers. But there would be no additional money. A key Commonwealth requirement was for trials to be cost-neutral.

The Illawarra trial encompassed three local government areas: Wollongong, Shellharbour and Kiama, the area being located south of Sydney, NSW. Its principal stakeholders were the Illawarra Area Health Service (IAHS), the Illawarra Division of General Practice (IDGP) and the NSW Home Care service.

The trial aimed to coordinate the care of people aged 65 years and over with either a risk of falling or who had complex medical or social problems that required multiple services from more than one health care service provider. During the 1997 planning phase of the trial, roughly 1800 eligible residents were referred to the trial by the 100 GPs participating. 1200 clients were allocated to an active group and would have their care coordinated by the trial, while the other 600 were allocated to a control group.

After the planning phase, the trial went live on 1 November 1997. It finished on 31 December 1999, a total period of 26 months over 3 financial years.

The coordination of care was undertaken by 15-16 care coordinators, in collaboration with the client's GP. The GP maintained control of the medical aspects of the client's treatment, while the care coordinator organised access to other services, purchasing services agreed to with the participant and GP. The care coordinators performed a systematic assessment of their clients initially every three months and subsequently in response to need. These assessments were intended to inform the creation of the clients' care plan that, among other things, included the goals of care for the client. Finally, a service plan was created that described the package of services to be bought by the trial in order to address the clients' goals was created.

Thus, the trial adopted a commissioning model of service provision. It secured services mainly from community care service providers, having access to both public services (those in the IAHS and the local HACC agencies) and private services. Medical (GP, specialist), pharmaceutical and hospital services were also within the funding pool, but these services were largely determined by GPs.

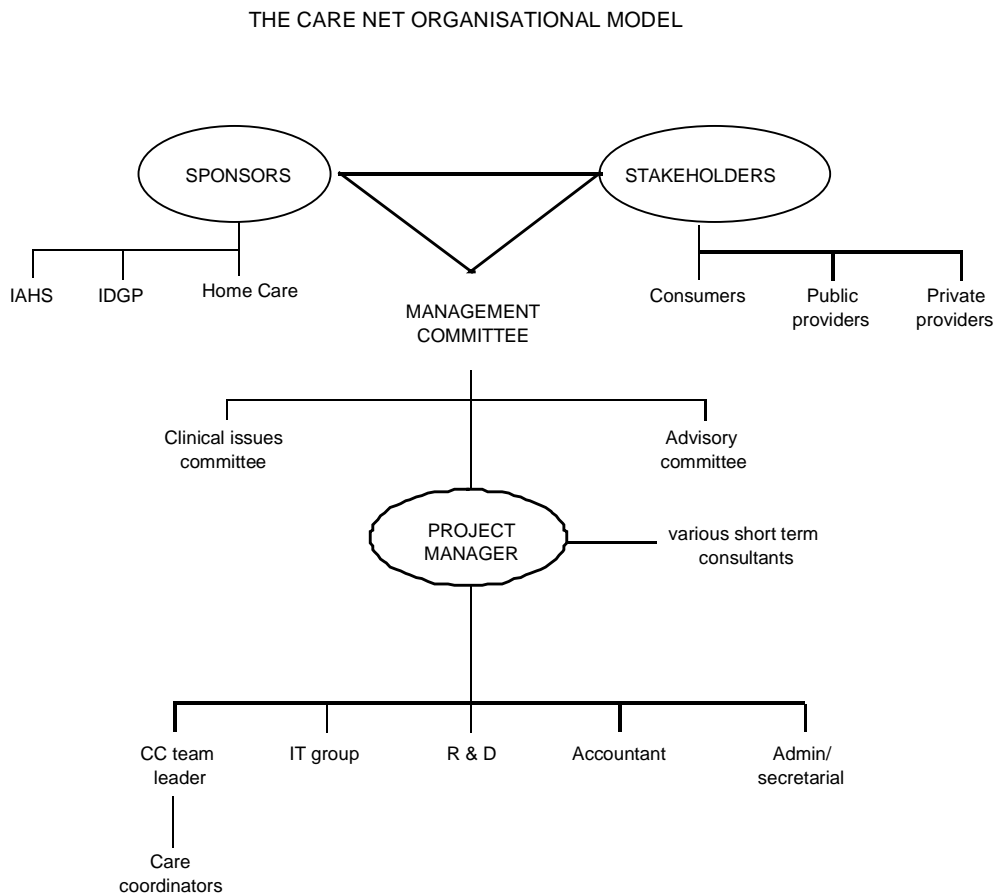
The trial used State and Commonwealth funds to develop an information system. Based on an intranet structure, the system supported email, client records, service utilisation, and financial data. This system did not support full communication between providers but significant steps included the increased use of computers by GPs.

1.2 Management of the trial

Governance means the way in which the sponsors/stakeholders ensure that the organisation is managed to best achieve their legitimate interests (this section includes material from Perkins & Owen, forthcoming). The focus on governance in this report addresses the organisational model and the role of governance systems to ensure that the organisation is managed properly, that it pursues agreed policy objectives, that performance is monitored and, if necessary, action is taken.

Figure 1 shows the organisational structure adopted for the management and governance of the trial.

Figure 1:



1.2.1 The Care Net Management Committee

The key mechanism for governance was the Care Net Management Committee. The pattern of membership remained the same for the planning phase and the duration of the trial but some individuals changed, notably the consumer representatives and one of the IAHS members. In Year 2, the local evaluators were invited to attend meetings as observers.

The basic membership of the Care Net Management Committee was two representatives of IAHS, two from Home Care (NSW), two from IDGP, and two consumers. A representative of the Advisory Committee joined in Year 2. A minutes secretary was provided from the trial's staff and the team leader of the care coordinators attended on a regular basis. Trial staff attended on occasion to provide particular information or present papers.

The committee included members with experience in service provision, operational service management, financial management, planning, and consumer representation crossing the health and community care sectors. They were employed as service managers, board level directors, and, in some cases, were also members of other management committees.

For the first six months of the trial there was an active debate about whether Care Net should have its own separate legal status or whether IAHS should act as legal agency. This may have adversely affected the performance of the management committee in year 1.

Apart from the Project Manager, one member had been a member of the clinical issues sub-committee of Care Net and two were members of the 'wind down' committee concerned with ensuring that clients were provided with appropriate care when Care Net finished. One of the consumer representatives was a member of the communications committee, which advised Care Net internal management on communications with clients.

1.2.2 The Care Net Project Manager and staff

Day to day management of the trial was undertaken by the Project Manager. The Project Manager was appointed by the Management Committee. The formal arrangements provided for a structure in which the Project Manager reported on a regular basis to the Management Committee and took advice from two advisory committees – a clinical issues committee and an advisory committee of local service providers. The advisory committee was formally represented on the Management Committee.

As shown in Figure 1, there were five staff sections within Care Net. A team leader coordinated and managed the care coordinators on a daily basis as well as undertaking other tasks within the trial. The IT group provided IT support to the trial itself and to the participating GPs. A Research and Development (RD) group was established with the task of assisting the trial to implement evidence-based practice and sustainable service substitution. The RD group was also responsible for 'internal evaluation'. Finally the trial had an accountant, although the position was not established until the trial was already well in progress, and staff who provided administrative and secretarial support.

1.3 Analytical methods

1.3.1 Relation to hypothesis

The key hypothesis discussed in this report is National Hypothesis Number 7 which states that the success of coordinated care, as tested in the primary hypothesis, will be affected by "*the characteristics of the trial administrative arrangements*". We examine this hypothesis in a number of reports since the term administrative arrangements can be used to refer to the trial's structure, its organisation, its systems and its methods of coordination.

The other specific hypotheses that relate to the Care Net organisational model are identified in Appendix 2. This report examines the planning, governance, and management functions of the trial. The client thematic report (Report Number 5) discusses the participation of clients in care planning and their empowerment in the coordination process, while Report Number 8 deals with the wider system impact of the trial, its aims and its community development activities.

The organisational model has a broad impact since it was the vehicle chosen to deliver the results to test the primary hypothesis. Care Net had to create a new organisation, recruit GPs and clients, undertake a trial, and provide a care coordination service to patients.

1.3.2 Methods and types of data

Data in this report come from four sources: documentary analysis, observation, interviews, and surveys.

Types of documents

Care Net commenced with an expression of interest which led to Commonwealth funding for a planning phase. The subsequent proposal was supported by the trial sponsors and assessed as capable of evaluation by the independent local evaluators. This plan sets out an organisational model and component systems with which to implement coordinated care and so is a key document in our analysis. Various business plans were developed by the Project Manager during the life of the trial.

Other papers were prepared for management and governance purposes. Internal management documents outline the Care Net organisational structure and changes which took place during the trial occasioned by the changing needs of the organisation and by individual staff movements. This category includes budgetary information and various forms of correspondence. Governance papers are defined as those papers which were submitted to the Management Committee composed of trial sponsors and stakeholders. Some of these papers were also submitted to the NSW Health Department or the Commonwealth Department of Health and Aged Care.

In addition Care Net published some papers for wider audiences including a newsletter, chapters in Commonwealth publications and papers for conferences and similar audiences.

Observation

The independent local evaluators attended various management and governance meetings. For example in the second year of the trial the evaluators were invited, as observers, to the Management Committee and to internal executive management meetings. This category also includes the observation of a number of "critical incidents" in the life of the trial such as the response to the mid-term local evaluation, the financial assessment against the pool estimates in

year 2, the substitution debate, and the resignation of the Project Manager. There were also participant observation opportunities at national workshops sponsored by the Commonwealth.

Interviews

Interviews were conducted with Care Net employees, Chairman and members of the Management Committee, local sponsors and stakeholders.

Surveys

Two surveys are of particular relevance: a self-administered questionnaire to members of the Management Committee (November 1999); and the survey and feedback session with Care Coordinators (August-September 1999).

1.4 Findings

The Care Net organisational model was that of a new, hybrid organisation sitting between the sponsor organisations. Formally it was part of the lead agency, the Illawarra Area Health Service (IAHS), for purposes of legal accountability. Its task required the setting up of a new organisation, the conduct of a trial, and organising the care of clients through individual assessment, care planning and the purchase of services.

It had to address a series of complex problems, some of which were identified in the trial planning documents and others which were identified as they arose in the live phase of the trial. It required systems to permit the management of a large volume of transactions with clients and a variety of agencies. It also had to collect a large volume of data for both internal trial management and evaluation purposes.

In the mid term report on the trial, the local evaluation included the key observations under section 5.8 on the effects of the project culture on the Trial:

Care Net is a new organisation in a separate building established especially for the Trial. Not surprisingly, it has developed a very strong culture aimed at proving that its interventions are successful and that it represents the new pattern for community care services in the Illawarra and further afield.

The culture closely resembles a new service culture rather than the research culture of a controlled trial in the clinical sense. Values such as innovation, creativity and experimentation take precedence over the systematic substitution envisaged in the Trial design.

The fixed term nature of its task and the explicitly-expressed wish of its staff for their jobs and the Trial to continue, creates a culture that is very difficult to reconcile with a 'scientific' approach to the Trial as a whole. Such a culture would be unsustainable in a normal service-based organisation.

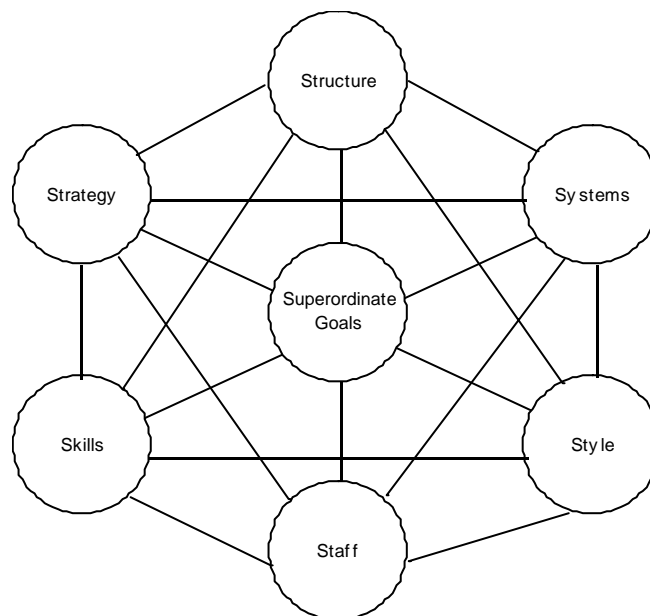
Two consequences emerge. First, the extent to which outcomes can be accurately attributed to interventions is limited and, second, the model of Care Net does not translate easily to a service for a large population (Eagar, Owen et al. 1998).

1.4.1 Analysing the organisation and management of the trial

Our approach to examining the organisation and management of the trial at its final stage uses Waterman's 7-S framework (see Figure 2) which highlights 7 key organisational factors and examines how they interrelate with an organisation's strategy. It highlights the interdependence of the factors which is particularly important in a trial of integrated or coordinated care processes (Waterman, Peters et al. 1991).

The 7-S approach describes the mix of organisational factors but also enables analysis of the integration of these elements and the synergy, or otherwise, with the goals and policies of the trial sponsors. This approach is helpful in looking at how the organisational model assisted Care Net to direct its activities to achieve what are identified as its superordinate goals.

Figure 2: Effective Organisational Change



1.4.1.1 Superordinate goals

An attempt to identify the superordinate goals, or shared values, of the trial is not as simple as might at first appear. The trial proposal addressed the national hypotheses which were supported by a set of local hypotheses which formed the rationale for the trial (Leigh, Tyson et al. 1999).

In response to a question in the trial proposal form, '*what are you proposing to do that is different and cannot be done outside Coordinated Care trial arrangements?*', the proposal identifies the following items:

- *Provide service funds from all sources into single funding pool.*
- *Provide a care coordinator allocated to GP practices with the ability to:*

Purchase services when and where required without the current referral and assessment restrictions;

Utilise funds for a range of services without the current restrictions applied by funding source.

- *Evaluate total health and community care costs against client health and well being outcomes.*

(Care Net Illawarra, June 1997, p3)

These key elements of the trial fitted well with the national philosophy of the trials which is not surprising given the objective of the proposal – to obtain Commonwealth backing to conduct the trial.

Writing in the early months of the establishment phase, the Project Manager described the approach in this way:

“The planning process has taken a community development approach focussing on extensive consultation with community representatives including health consumers, general practitioners, health services and community support agencies. As general practitioners were recruited to participate, they were also involved in small focus groups to identify specific practice issues for the project to address.

This approach has therefore seen the national hypotheses as secondary to using the process as an opportunity for managing change. However the national trial hypotheses were significant and the development phase produced a series of local hypotheses within the framework of the national ones.”

This theme of using the trial as a mechanism for achieving change in existing services continues:

“Care Net Illawarra has created a trial in coordinated care that manipulates the environment of general practitioners and their patients to bring about change in practice and health outcomes.”

At an early stage of the trial we can see that change in the local health care system became the superordinate goal. The Project Manager pointed to three key change factors: the provision of a care coordinator, the introduction of a new IT system and the involvement of clients in the management of their conditions (Foulstone and Macdonald 1999).

1.4.1.2 Strategy

The project proposal clearly stated that policy development was the role of the Management Committee whose terms of reference included the following statement of aims and objectives:

The aim of the management committee is to provide for the interests of the trial sponsors and key stakeholders in Project policy direction

*Its objectives are to provide the project management team with policy direction by:
Reviewing and commenting on reports provided by the project management team on the development and implementation of the Project.*

(Care Net Illawarra 1997)(p 59/60)

This committee was to meet at least monthly and was comprised of representatives of the sponsors IDGP, IAHS, and the Home Care Service, elected consumer representation, and the Project Manager.

While the Management Committee was charged with the development of Care Net policy, in practice there were a number of processes by which policies and strategies emerged during the trial. Four sources of emergent strategy can be identified:

- decisions taken by the Project Manager;
- the internal project executive;
- regular meetings between Project Manager and care coordinators; and
- responses to developments in the wider policy/service system.

The effect of these multiple processes was to dilute the impact that could be made by governance structures, since most of the strategies used by the trial were not formally mediated through the committee structure.

1.4.1.3 Structure

Care Net took the form of considerable hybrid organisation suspended between the sponsoring organisations and the trial stakeholders. While formally it was part of the lead agency IAHS, it had separate premises and was given a degree of autonomy. The IAHS was keen to avoid any accusation that it was “taking over” the smaller stakeholders within the system, what Leutz calls his fifth law of integration: “the one who integrates calls the tune”(Leutz 1999).

The formal arrangements provided for a structure in which the Project Manager reported on a regular basis to the Management Committee and took advice from the advisory committee who were also represented on the Management Committee. In day to day management the system was a lot less formal with the Project Manager having considerable autonomy to make decisions and take actions without direct reference to higher authority.

From the point of view of ... , we have nothing but praise for the Care Net staff. In practice it was the manager who made all the key decisions - everyone else seemed reticent to play a leadership role. (quote from wider system informant interviews)

1.4.1.4 Systems

As a new, hybrid organisation, Care Net required a variety of systems to permit the conduct of a trial and to enable the new organisation to run efficiently. Some of these systems were available in the sponsoring organisations, some were purchased from commercial or other sources and used with minimal adaptation, while others had to be developed locally to meet the needs of the trial. These systems could not be set up and fully tested before the trial due to pressure of time and limited resources. A significant proportion of systems were designed and redesigned throughout the trial as their limitations became apparent.

The extent of investment in IT systems was a distinctive feature of this trial and included the provision of computers to participating GPs. An investment of \$800,000 was made by NSW Health and this enhanced IT capacity added another level of complexity to the management of the trial especially in its establishment phase.

Since Care Net was an organisational vehicle designed to increase the integration of its sponsors and other stakeholders, the efficient operation of systems required cooperation and appropriate skills from those partners. This required the installation of computing capacity in some cases and the development of existing systems to meet Care Net requirements in others. For instance it was planned to install computers in local Home Care offices to enable electronic communication and

permit a more responsive service to Care Net clients. A proposal was also put forward from local government sources to connect to community care agencies through Council-based servers. This was not implemented. Detailed discussion of the IT systems issues can be found in Report 4.

Complex systems implementation issues were not limited to IT systems. The project proposal identified a number of systems to be developed: to recruit patients to the trial; to ensure consents were obtained; to ensure appropriate randomisation; to develop protocols for the development of care plans and for the purchase of services; as well as mechanisms for evidence based substitution.

Other systems such as governance systems were required to ensure that Care Net was managed properly. Central to the governance system was the Care Net Management Committee (see page 3). The Care Net Management Committee reported through its members to local sponsors and stakeholders.

Another key feature of governance was the Monitoring Committee at state level, which met to consider financial performance and reports from the NSW trials. This committee appeared to focus on monitoring the financial risk borne by the IAHS and Home Care which are both funded at the State level. The operation of these governance systems had to be undertaken outside Care Net since they were necessary to ensure its proper management. They were critically dependent on Care Net management for regular information on which to make their judgements and had no other sources of information on which to form a judgement. The Monitoring Committee reported to State and Commonwealth Departments and included senior officers from central agencies.

1.4.1.5 Staff

As a “new organisation” Care Net had to appoint a wide range of staff and it did this through a combination of secondments, fixed term appointments, and various consultancy arrangements. As a small organisation, staff were used flexibly since Care Net did not have the resources to employ specialists in each role as might be expected in a larger organisation.

The biggest group of staff were the care coordinators, responsible for assessing clients and purchasing services for them where appropriate. Since there was no single occupational group with a unique claim to this skill, coordinators were appointed from a number of backgrounds. Of the 15 care coordinators selected, 9 had nursing backgrounds. Three care coordinators had backgrounds in human movement or health education. One care coordinator had been a medical scientist and another had had specific training as an industrial chemist. A further care coordinator had worked as a rehabilitation aide. This mix was justified as an informal ‘natural experiment’ to see how coordinators with different skills and experience performed.

Care Net needed varying levels of expertise and the multiple tasks had different time lines and intensities. Consultancy arrangements were used to obtain scarce skills required in IT, systems design and research activities. Some staff were given tasks as additions to their normal duties or as short projects where the trial needed to investigate a particular issue, for example client co-payments and hospital discharge arrangements for trial participants.

The Project Manager had considerable autonomy in appointing staff and commented to the evaluators that he sought staff who were sufficiently flexible to undertake tasks in new ways. This resulted in a profile of administrative and support staff that included some with relatively limited work experience. There were, of course, a number of exceptions to this general profile. It also caused some problems for the care coordinators who were regarded as very competent but as relatively less qualified than the community care staff in the public sector with whom they were expected to cooperate.

To cement the relationship with GPs, the trial employed the CEO of the IDGP on a part-time basis. Much of his time was spent on issues of computer links with GPs. He was also the chairman of

the trial Management Committee, which placed him in a position of considerable (potential) power within the trial.

1.4.1.6 Skills

The Care Net trial was established to investigate a number of problems which had not been satisfactorily addressed in the normal health and aged care systems. These problems were to be *addressed simultaneously* under an ambitious time frame. For instance, the trial was trying to employ evidence based protocols in care of the frail elderly, to encourage GPs to use computers for clinical purposes, to link information services between a variety of public and private provider agencies, to cross the boundaries of health and social care, and to collect data on client outcomes which would permit program evaluation.

It follows that they required sophisticated skills both to design and develop systems and to engage stakeholders in a trial that was an additional workload and, in some cases, perceived as a threat. Success depended not only on the skills of Care Net staff but on the *skills and goodwill of other participants*, particularly the GPs. The trial had to run computer skills courses for GPs and to support the processes by which they learned to use the computers provided for them. GPs were not paid for their participation and continued their normal workloads throughout the trial.

The trial required a significant *managerial and operational capability* in what was a relatively flat organisational structure undertaking a new and unprogrammed task. Much of this requirement fell on the shoulders of the Project Manager who could not call on the range of functional specialists who would be available to a larger organisation. One GP reported that when he called to report a difficulty in running trial software at his second surgery, he was surprised to see the Project Manager turn up to address the problem.

Some skills were lost to the trial at an early stage as staff chose to return to their employer organisation or took up new jobs. Other skill shortages became clear later when the trial chose to appoint a part-time accountant to track finances more accurately.

There is some evidence from the GP survey that staff did not have the necessary experience to undertake sophisticated tasks such as the development of evidence-based substitution protocols and guidelines. This element of the trial was regarded by GPs as relatively unsuccessful and was no doubt beyond the capabilities of such a small organisation with an ambitious and complex agenda for change (see Report 6).

Some important tasks such as the maintenance of data quality and the creation of reports useful for managing the trial were key concerns, but were not adequately addressed within the available resources. The employment of an experienced Health Information Manager would have prevented many problems that developed as a result of having well-motivated but inexperienced staff attempt to manage a large and complex data set.

1.4.1.7 Style

We noted in our interim report that Care Net adopted the style of a new organisation. It demonstrated many of the features of a young and small organisation such as informality of style, flexibility of systems, limited number of rules and high task commitment.

Evidence from coordinator interviews and surveys throughout the trial showed a high commitment to the organisation and to the Project Manager. Care coordinators were under the impression that the very continuation of the Trial depended on the evaluation of the 'success' or otherwise of the Trial. Several coordinators expressed the view, at a late stage in the trial, that they thought that the trial would be extended because they were sure it was making a positive contribution to the quality of life of the active group participants:

"... the perception, correct or otherwise, that despite almost universal acclaim from the G.P.'s, clients and their families, and the public for Care Net Illawarra and its tangible achievement, it appears to have been branded as having failed. This perception and labeling as a failure has caused considerable mystification amongst the staff at Care Net Illawarra, as we have seen and read the large number of letters of congratulation and 'thank you's' from clients, and heard many times from G.P.'s how well they think the Trial has worked.... In fact, many of the staff would simply like to know what criteria were used to arrive at the perception of the Trial having failed when so many see it as a real success."

The combination of resource availability and a deliberate lifting of the rules governing mainstream agencies meant that coordinators could spend money and provide services for clients who they assessed to be in need. Since they could buy from public or private providers, they could ensure the availability of services very quickly in most cases. This was in distinct contrast to the mainstream agencies who were bound by rules and restricted by scarcity of resources. So the ability of Care Net to act quickly and decisively was perceived by mainstream agencies as a contravention of principles of equity, ie clients with similar needs being allocated similar levels of service.

A useful indicator of the approach adopted was that coordinators were not assigned individual budgets since the Project Manager did not want to prevent a positive investment in client health and well being due to budgetary constraints. It was therefore difficult for Care Net to demonstrate a rationale for expenditure decisions given the informal nature of its planning and control processes.

1.4.2 The Care Net goals

The 7-S framework has been used to describe the mix of organisational factors and the integration of those elements with the goals and policies of the trial sponsors. The organisational model is now examined to see how it assisted Care Net to direct its activities to achieve its superordinate goals:

- To undertake a trial of coordinated care;
- To move from a reactive model of care to a pro-active model based on health investments in clients designed to prevent or delay physical deterioration; and
- To set in process a project that would change the pattern of care in mainstream organisations, and in the Illawarra as a whole, for frail elderly persons.

1.4.2.1 Undertaking the trial

Undoubtedly, the organisation was able to undertake key elements of the trial through the model described above.

It was able to create and maintain a "consortium of stakeholders" who pooled resources or nominated patients and this consortium was maintained throughout the two year live phase. Care Net was able to recruit clients, allocate them to active and control groups, undertake assessment and reassessment, and secure services where care coordinators thought they were appropriate. It was able to create systems for collecting data on trial activity, monitoring expenditure and enabling a measure of electronic communication between individual and organisational providers.

1.4.2.2 Investing in prevention

The key problem for goal attainment at this level was that the trial was not able to demonstrate systematic patterns or programs of substitution that could be linked to clients and their outcomes. It did not have sufficiently developed systems to identify or construct systematic care protocols or ensure that they were implemented in a consistent fashion. This could be attributed to the limited capability (skills and volume) of internal trial resources, the lack of systems to monitor coordinator and GP activity, the failure to implement the recommendations of the clinical issues committee, and/or the failure of consultant-led activities to introduce evidence based substitution.

Thus the trial intervention was essentially that of providing care coordinators who acted cooperatively and intuitively, had resources to spend, and were permitted to act outside the rules governing mainstream providers.

1.4.2.3 Changing the mainstream provider system

This broader goal could be achieved in a number of ways, but measuring such achievements within the time and resources available was always going to be a tall order.

There were several underlying assumptions in relation to this goal. Superior outcomes of Care Net interventions might have become self-evident through the trial. The trial might provide new systems that could be incorporated into existing mainstream services. Providers might develop new patterns of working within the trial, which would then spill over to mainstream service provision. Provider organisations might decide to develop alliances on the basis of the experience of cooperative working in and around the trial.

It is important, and difficult, to come to fair conclusions about the nature of any changes which came about in the wider system and might be attributed in whole or in part to the trial. It should not be forgotten that there were a number of other processes in train that might have caused changes to mainstream services. These issues are discussed in more detail in Report 8.

1.4.3 Management of the trial: the views of Management Committee members

1.4.3.1 Purpose

In examining the impact of the Management Committee on the trial and its testing of hypotheses, a questionnaire was administered in November 1999 where members were asked to rank a series of possible purposes of the Management Committee.

Members attributed first priority to the setting of policies for Care Net, securing of accountability and the monitoring of financial and organisational performance. Second priority was attributed to providing technical advice on management matters, promoting consumer interests and fostering stakeholder interests, while third priority was given to ethical and clinical considerations.

In response to an open question asking members to describe the purpose of the Management Committee from their own perspective the following responses were received:

To oversee the overall trial management

Should have overall carriage of the trial on behalf of the stakeholders

Should ensure policies are developed so that the objectives of the trial can be met, consumer and staff rights/responsibilities are upheld

To advise and assist the trial management in relation to stakeholder interests

Should monitor all areas of the trial through reports etc and address any issues identified according to policies developed

To advise the IAHS in relation to matters referred by them or determined as significant. That advise to be given via the IAHS representative/chairman of the committee.

I only joined the committee in mid-1999; my views on management committee is that they set the policy and philosophy for the executive to implement. Also to overview the "smooth" running of the organisation; with Care Net the representation from each partner were there to ensure appropriate problem solving.

Managing the trial project.

Varied over times and was the subject of considerable difference of opinion. Initially HACC representatives wanted a NGO type structure i.e. all decisions made by Management Committee. Not supported by IAHS. Settled on Board of Management structure with Trial Manager responsible to board for Policy, financial accountability.

These responses largely reinforce the findings from the closed question on ranking the committee's purpose. The Project Manager adopted a different perspective and stated that the Management Committee's purpose was

... to provide support to trial staff in the form of leadership and strategic direction.

Our conclusion is that the Management Committee role was not clearly set out or agreed and that this provided considerable room for misunderstanding and ambiguity in the governance process. In the latter stages of the trial, it caused particular tension between the Management Committee and its Project Manager.

1.4.3.2 Process

The pattern of Management Committee meetings was generally thought to be appropriate although a minority thought that more meetings were needed at intensive phases of the trial such as when decisions were being made about whether to extend the trial and during the wind up phase. It could be argued that these activities were largely dealt with outside the framework of the formal Management Committee meetings since the monthly meeting could not cope with matters of detail or urgency.

The final trial proposal stated that the Management Committee would base its policy making on papers and information provided by the trial and so a series of questions were asked about the quality of financial and other information provided by the trial.

In respect of the *financial information* it should be noted that the trial did not employ an accountant (part time) until the end of 1998 when the evaluators in the mid term review were forecasting a shortfall of approximately \$1m. In response to the question '*How do you rate the quality of financial information received at Management Committee meetings?*' members, with one exception, rated the information as of limited quality and intelligibility. The Project Manager pointed out that this question did not allow for the systems difficulties experienced in Year one of the trial. Three members were not able to make a judgement about the accuracy of the financial information and four saw the presentation of financial information as of limited quality.

The practice of the committee was that financial information was tabled at meetings and members had to respond within the confines of a single agenda item. One respondent commented about the accuracy of the financial information:

Not confident at time of presentation and less confident in retrospect e.g. significant assumptions made about 'expected' income not eventually forthcoming.

This member concluded that the usefulness of such information was low.

1.4.3.3 Problems

This raises questions of where the problems lay. Was the information poorly presented and untimely? Were the members unable to make sense of complex financial information? Were the financial IT systems problematic in Year one of the trial, meaning that members did not understand the finances of the trial at the most important stage, ie when decisions to invest in health promotion strategies were being made?

A general question about the quality of client and service information provided to the trial drew the response that it was of low (3) and poor quality (2). The Project Manager and consumer representative took a more positive view. A similar view with two exceptions was presented of the agenda and minutes papers, and also of the internal policy and research papers, again thought to be of limited quality.

A number of explanations can be put forward to account for these shortcomings including the limited trial resources, both time and expertise, when taking into account the complexity and size of the agenda facing Care Net. These issues are discussed as *issues of scale* in Report 8.

Another question concerned the impact of the Management Committee on the testing of the primary hypothesis. In summary, respondents felt that the committee had little impact on the core purpose of the trial. The Project Manager concluded:

Very little. The management committee been more driven by stakeholder wants – I believe the fact that it 'was a trial was lost very early'.

The comment highlights the ambiguous nature of Care Net trial governance. Another member focussed on the role of the Project Manager:

Limiting the broad and ambitious focus of the project manager

The clinical issues committee came closest to understanding the trial component of the project but a comment suggests that the respondent thought they were not heard:

I haven't been on the committee for a long enough period, but the advice of the clinical issues committee was largely ignored – was it communicated to the management committee?

Another member responded as follows:

Very limited. Quality of the management committee partly responsible for this. Ratio of 'experienced' to 'inexperienced' managers a key factor. Management Committee members not clear or united in their view of the purpose of the trial. IDGP serving their own purpose; Home Care protecting themselves, IAHS considered too bureaucratic.

Additional comments from Management Committee members are to be found in Appendix 3. This Appendix covers the answers to additional questions concerned with the *effectiveness of the committee*, including the extent to which resolutions were implemented, the *relationship* between

the committee and the trial executive, how arrangements should *be changed*, the role of *local evaluation* and *summing up* the overall effectiveness of the Management Committee.

1.5 Discussion – What is governance?

The foregoing discussion has focussed on the relationship between Care Net goals and its organisational form. In this section we discuss corporate governance as the over-arching framework, and look at the component elements of clinical and/or care aspects and scientific governance in the particular context of the Care Net trial.

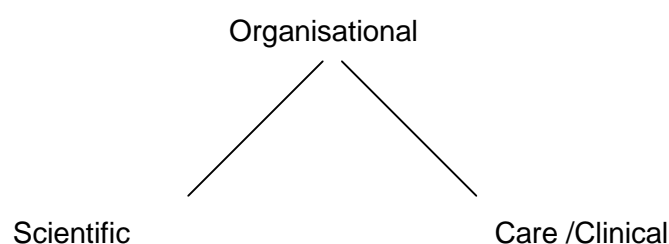
Corporate governance refers to the processes by which stakeholders ensure that an enterprise is managed to best meet the interests of all legitimate stakeholders. It has become the subject of a vast literature in the private sector and more recently public sector stakeholders have introduced and developed their own systems of governance. In New South Wales members of Area Health Boards have been reminded of their legal and ethical responsibilities to ensure that their services are properly governed (NSW Health Department, 1999).

There is also a worldwide interest in how to effectively build clinical governance into the design of health systems. This stems from instances where health services have demonstrably failed to meet the best interests of their patients or populations (Bristol Inquiry, 1999).

To examine the issues more clearly we identify three domains for governance which cover the more general area of organisational governance, the governance of care, and in particular because of the evaluation requirements of trials and the ambiguities that can arise as a result, the area of scientific governance.

Different stakeholders will have different interests in the three types of governance. Patients will be mainly concerned with their care, as will GPs, who might also be concerned with the scientific grounds for care coordination decisions, while small community care agencies, and large AHSs will have different concerns at the organisational level.

Figure 3 Domains of Governance



1.5.1 Organisational governance: what are the issues?

“Collaborative governance” of one new organisation, by three organisations of different types is a complex task

IAHS is the public health authority, a population focussed body with legislation that covers the functions of care coordination (Unsworth 1986), it is a health provider and also the lead agency. IDGP is an organisation which “represents” independent GPs, and the NSW Home Care Service is an organisation with a central structure, regional, and local branches which account for about half of HACC program funds. Each of these organisations could be described as shareholders in that they made a financial contribution to the funds pool.

Collaborative governance in this context proves to be more difficult than governance within a unitary organisation with a single Board of Directors. Appropriate delegation of powers to the trial's executive management becomes a vital, yet complex, task.

The trial represented a peripheral activity for each of the stakeholders since it constituted a small proportion of their total budget and involved a small number of their clients. As a peripheral activity, the investment made by each shareholder in governance activities and vigilance about them was necessarily small. Good governance processes would have been an efficient investment in Care Net outcomes.

Also the trial consisted of a large number of individual transactions with provider agencies and individuals which could not be approved individually. It was therefore necessary to agree on policies to enable the proper use of delegated powers.

1.5.1.1 *The learning curve for the governance committees.*

The Management Committee was unusual in that it was made up of representatives of distinctive organisations and resembled more closely the steering committee of a strategic alliance (Pfeffer 1976). It faced a steep learning curve due to the largely un-programmed nature of the collaborative activity that was the object of the trial. Some members of the Management Committee had been involved in the trial's planning stage but this did not diminish the complexity of the learning and in many cases, only a minority of members understood technical issues such as finance, clinical assessment, management information systems, or other technical issues presented to them.

In bringing together questions of substitution of care, care planning, purchasing of services, and client assessment/reassessment, the trial was attempting to find solutions to a number of "hard problems" simultaneously and so the complexity of issues was significant. It should also be noted that the Care Net trial did not follow a consistent protocol as might happen in a drug trial. Care Net attempted to innovate and test new ideas throughout the trial in order to best pursue its key objectives.

The Management Committee members were highly dependent on the trial executive to whom they had delegated powers and any doubts were either suppressed or resolved by reference to others outside the Management Committee. Thus, in Year 2 questions of the financial position of the trial required the advice of independent third parties.

1.5.1.2 *Dependence on the trial's management information system*

During the planning phase the Project Manager had two key tasks: to achieve sufficient political support to create a partnership of shareholders, and to plan the management and governance systems such that the Commonwealth sponsors and the local shareholders would approve movement to the live stage.

The information systems were critical to the operational management and governance functions and needed to be developed and reliable as soon as possible in the life of the trial. This implied a reporting system and a governance structure to manage a complex set of relationships and relevant meetings, the identification of mechanisms by which disputes could be resolved, and the interpretation of complex data. Effective governance processes required the collection and reporting of relevant data and a Management Committee able to review and interpret those data.

1.5.1.3 *The incremental development of the management information system*

The information systems developed by Care Net were unique and set out to permit electronic communication between all partners in the trial. Structural features of the trial meant that while it was possible for the main system architecture to be sketched out in the planning phase, much of the practical development took place during the trial itself. The limitations of resources, (time, expertise, and money) meant that software solutions were purchased off the shelf and compatibility and user problems dealt with as they arose. Some capabilities became available only in the last months of the trial. In practical terms this meant that it was not always possible to check an invoice against a service order, or to examine commitments against expenditure.

1.5.1.4 *Asymmetry of information*

Stakeholders had limited access to data about the trial and limited time for interpretation when compared to trial management. They were therefore obliged to focus on what they saw to be principal issues of policy and performance. Members of the Management Committee obtained their main information through monthly committee papers and papers tabled at the meeting. They had various other sources of information though their own organisation or through experience as a provider or a consumer within the trial. There were few instances where the Management Committee sought or received information from trial management apart from questions to be answered verbally, or at a subsequent meeting.

1.5.1.5 *Setting up an efficient process for a collaborative form of organisational governance*

The Management Committee members charged with governance of the trial were mandated by their organisations to represent their organisation and the partnership. This implied familiarity with the views of their employer or constituency and a willingness to negotiate with others to develop shared views and policies that would be acceptable to each stakeholder. Thus, while stakeholders might take similar views on questions of service quality, the duty of care to trial participants, and questions of privacy and confidentiality, they might take different views on the acceptability of particular financial risks for their organisation.

1.5.2 *Scientific governance: what are the issues?*

1.5.2.1 *Governance of a trial*

The term 'trial' was adopted deliberately and distinguished the coordinated care trials from other demonstration projects in coordinated or integrated care (Perkins, 1999). The adoption of a national set of hypotheses with extensive investment in independent evaluation implied that answering the questions contained in the hypotheses was of interest to the Commonwealth as sponsor and also to the local stakeholders (Eagar, Owen et al. 1998).

This was an unusual type of trial. It has been described as a Random Controlled Trial of administrative/ organisational arrangements (Commonwealth Department of Health and Aged Care 1999). It was a national trial with a wide range of interventions in varying contexts related to a primary hypothesis that could be interpreted many ways.

The trials simultaneously addressed a variety of distinct and complex activities including funds pooling, purchasing of services for individual clients (as opposed to population based purchasing),

substitution of clinical or care procedures, care coordination, the use of new MIS, and electronic communication systems between agencies and practitioners.

Successful implementation of these interventions required the development of a new organisation. Local trials were required to develop a new hybrid organisation, manage a consistent set of interventions for an active group of participants, and measure the impact on active and control groups.

1.5.2.2 Skills mix

The skills available to the trial were limited by the extent of national funding and by what could be obtained on an informal basis from the sponsors. Considerable effort went into the planning phase, which was separately funded and in many cases involved a wide range of specialist skills. Some of these skills were not available to the same extent in the delivery phase.

1.5.2.3 Levels of evaluation

In effect, a local trial and a national trial were being conducted at the same time addressing local and national hypotheses. There were evaluators at both levels who were expected to work together but had no formal relationship. The local evaluator was appointed by, and was responsible to, the local trial and had no formal relationship with either the national evaluator or the Monitoring Committee. Both evaluators made use of raw data provided by the trial and the national evaluators also benefited from interim reports from each of the local evaluators. It might be argued that there was a meta-trial alongside a series of local trials. This presented a series of difficulties since there were significant differences in context, target population and intervention between the local trials.

1.5.3 Care governance: what are the issues?

Adequate arrangements for care or clinical governance should be built into all coordinated care projects under the broader umbrella of organisational governance as discussed above. Many of the issues relating to organisational governance are also relevant to care and clinical issues and are not restated here.

Care or “clinical” governance has been described as a framework through which 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” (Baker, Lakhani et al. 1999).

The basis of care governance are three underlying assumptions applicable to any organisation or collaborative arrangement:

- Care/clinical governance encompasses both quality improvement and accountability – systems for both must be developed fully if the highest levels of quality of care and professional performance are to be shown to have been achieved;
- Quality improvement and accountability depend on effective methods of changing performance; and
- Governance must meet the needs of the project as a whole as well as the teams and individuals associated with it.

Some care/clinical governance structures and processes that could be incorporated within a project include:

- the use of clinical audit;
- clinical effectiveness;
- risk management strategies; and
- quality assurance and the development of staff and organisations¹.

The key issue for the care domain of governance in the CCT was that many of these structures and processes were not directly applicable to the care coordination role because that was not a role primarily concerned with direct care provision. But care coordination had to ensure that such processes were applied to the services that were contracted to provide direct care.

Many potential problems with this model were circumvented by the early and pragmatic decision that Care Net did not need to incorporate as a separate organisation but could be developed and guided under the functions and organisation of IAHS. These were introduced in October 1986, with the objectives enshrined in the legislation of the Area Health Services Act, 1986. The relevant objectives were:

- (a) to promote, protect and maintain public health, and for that purpose to provide health services for residents of its area;
- (b) to achieve and maintain adequate standards of patient care and services;
- (c) to adopt and implement all necessary measures (including systems of planning, management and quality control) as will best ensure the efficient and economic operation and use of its resources in the provision of health services;
- (d) to provide for the effective co-ordination of the planning, provision and evaluation of health services, including services provided by the public, private² and voluntary sectors;
- (e) to establish and maintain an appropriate balance in the provision and use of resources for health protection, health promotion, health education and treatment services.

The effect of this legislation as an umbrella for both the organisational and care provision and coordination activities of Care Net was that it could be seen as part of a gradual evolution of public responsibility for managing a range of both hospital and community based health services for a population in a given geographical area.

The decision not to create a formal free-standing organisation, but establish Care Net under an existing auspice, meant that although the governance of care activities had sufficient structural support and legislative backing to safeguard the client's interests, several important tensions around issues of care management were not resolved. These included the formalising and detailed negotiation of the expectations of the contracted care providers, and the creation of effective methods of changing performance where it did not meet expectations.

As an example, it seems that little impact was made on hospitals because of the relatively small numbers of people in the trial. If systematic change did not occur, then there needed to be mechanisms to address the care-related issues that arose. This in turn would be a way for the trial to address what would be more sustainable changes in the long term beyond the limited life of the trial.

Care Net clearly sought to achieve more systematic and structural changes in line with its status as an experimental structure within the local area, albeit within the larger remit of the Area Health

¹ A useful description of a clinical governance application is found at: <http://www.open.gov.uk/doh/intro/cgov.htm>
² The private sector was excluded in an amendment to the Act in late 1987.

Service. Its efforts at mobilising different elements of the service system with care protocols, activating clients, publicising the model and seeking the most competitive pricing of services to maximise the convenience to clients, were all part of the broader aims of the trial (Foulstone and Macdonald 1999).

1.6 Conclusion: what can we learn from the Care Net experience?

1.6.1 Complexity of governing a trial of a service innovation

Following a demanding planning phase it is all too easy to relax when trials go live since there is a new organisation, a legitimate business plan, and a set of governance arrangements to ensure progress. Insufficient governance puts a trial in a dangerous position given the complex context of trials, the range of stakeholder interests and the hard problems which trials seek to solve. Executive governance could restrict innovation.

1.6.2 Difficulties with the high resource, high discretion model

In comparison with normal services, Care Net had a high proportion of uncommitted resources and the Trial Manager had significant discretion as to how those resources were spent. It is a serious mistake to conclude that trials have a relatively small budget and therefore governance of these resources is unimportant. As pooled funds, these resources are drawn from other services and so, in the case of capped allocations, reduce funds available for use elsewhere in the local system.

1.6.3 Limits of the conventional Management Committee

The Management Committee model of governance needs to be examined closely. While it fulfils a representative function, it is important to be sure that it has the expertise and resources to fulfil a governance function.

1.6.4 Significance of MIS and reporting systems

The stakeholders need to be sure that they are obtaining relevant and quality information to permit efficient governance to take place and to be clear that the trial is on track. Clear thought should be given before a trial goes live to ensure that appropriate systems are in place to provide quality information in relation to the three domains of governance.

1.6.5 Need to directly address organisational, scientific and care related governance

There is a danger in trials that pragmatism takes priority over the empirical questions that the trial is designed to address. To prevent this happening again stakeholders require governance structures that address each element of governance and have matching management and information systems to support the process.

Appendix 1 National Hypotheses and Care Net Adaptations

The National Evaluation Reference Group established a primary hypothesis and a series of secondary hypotheses that represented the likely influences on whether that statement could be supported. The Care Net trial adapted that framework into a local set of hypotheses. The national and local hypotheses that are relevant to this report are listed below.

NH1 The primary hypotheses:

Local Illawarra adaptation

<p>National Hypothesis 1:</p> <p>“That coordination of care of people with multiple service needs, where care is accessed through individual care plans, and funds pooled from existing Commonwealth, State and joint programs, will result in improved client health and well being within existing resources”.</p>	<p>Care Net Hypothesis 1:</p> <p>“if improved individual client health and well-being can be achieved within existing resources where an individual’s multiple service needs are met through an individual care coordinator, a single care plan and a single pool of funds”.</p>
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The extent to which this is achieved, will be influenced by:

NH2 The extent of substitution of services within the pool

<p>National Hypothesis 2: “The extent of substitution between services within a trial pool”</p>	<p>Care Net Hypothesis 4: “If improved health outcomes can be achieved with service substitution”</p>
	<p>Care Net Hypothesis 6: “If injury prevention can be achieved with service substitution”</p>
	<p>Care Net Hypothesis 9: “If care coordination and the purchasing of services from a central fund can reduce expected bed days in hospital. This will apply to both lengths of stay and re-admissions”.</p>

NH4 The characteristics of clients selected

<p>National Hypothesis 4: “The characteristics of the clients to whom services are provided”.</p>	<p>No corresponding local adaptation</p>
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NH6 The characteristics of the care coordination function

<p>National Hypothesis 6: “The characteristics of the care coordination function”</p>	<p>Care Net Hypothesis 2: “If the allocation of care coordinators to general practice surgeries improves communication between GPs and other services available to provide necessary services for their patients”.</p>
	<p>Care Net Hypothesis 3: “If the care coordinator in a role of patient/client advocate increase the patient’s involvement in care planning processes”.</p>

NH7 Particular Types of Admin Arrangements

National Hypothesis 7: “The characteristics of trial administrative arrangements”	Care Net Hypothesis 7: “If an information system communication network containing the care plan and relevant clinical information can improve the cost-effectiveness of care coordination processes and outcomes”
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NH8 Consumer Involvement

National Hypothesis 8: “The extent to which health consumers are partners in the planning of the coordinated care trial, the development of care plans and empowered through the coordination process”.	Care Net Hypothesis 5: “If consumer involvement in project management and policy development can improve the process and outcomes associated with care coordination”.
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NH9 Wider System

National Hypothesis 9: “That the primary results can be achieved without detriment to other key areas of government policy, particularly in regard to equity of access and privacy, including any impact on clients outside the trial”.	No corresponding local adaptation
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Appendix 2 The Management Committee Views

This Appendix covers answers to a number of questions concerned with the *effectiveness of the Care Net Management Committee*, including the extent to which resolutions were implemented, the *relationship* between the committee and the executive, how arrangements should *change*, the role of *evaluation*. It concludes by *summing up* the overall functioning of the Management Committee.

Effectiveness

Question 10 asked about the *overall effectiveness of the management committee* and a number of themes arose. One theme suggested that some members were not clear about what was happening in the trial

For the last 6 months I did not get through the management executive to find out what was actually happening

I personally felt ineffective. I found it difficult on numerous occasions to understand where the trial was going and what was being achieved. Most reports related to health issues in health jargon – this made it difficult for a non-health person to contribute.

One question asked about the implementation of resolutions. Responses were placed in the sometimes or infrequently category. No respondent answered that resolutions were consistently implemented. The Project Manager felt that resolutions were “mostly” implemented and members chose “sometimes” or “infrequently”. When asked for illustrative examples they pointed to:

PM not to distribute Care Net documents to public without review by management committee.

... publication of information prior to the formal review by the committee was never implemented.

*Tabling of documents prior to distribution did not always happen
Incomplete reports were never completed even though requested*

Always delays in reporting back. Poor minute taking allowed matters to be lost. Some requested reports were never received.

Relationships

In response to a question about the relationship between the committee and the Care Net executive all respondents suggested that there was room for improvement. Adjectives such as “tense” or “difficult” were used and the Project Manager described the relationship as “poor”. Other respondents commented as follows:

difficult/of differing purpose/unrelated/competitive

*The trials management could have gained more out of the members of the management committee if the attitude had been different
It seems that the executive committee was a necessary evil and it seemed to be regarded as an obstacle to the trials process*

I don't feel I know enough to comment on this. At times I have felt great tension at management committee meetings.

Difficult, Suspicious, Dishonest, Secretive

Another set of responses returned to the theme of poor relationships:

I expected more of a cooperative approach rather than the conflict management style experienced.

One respondent commented that the Management Committee was subject to some of the structural difficulties that plagued the trial as a whole.

Management committee also subject to the 'Trial' environment. Too slow in determining its role and its relationship to Trial Manager. Committee participants inexperienced although this improved I second half of Trial

What to change?

Question 11 asked what members would change about the role and activity of the Management Committee in a new trial. Answers pointed to the better definition of roles and responsibilities:

The make-up, role and responsibility of the committee must be clearly defined. Reporting requirements must be reflective of the needs of the committee and evaluators, Commonwealth etc. Policy and decision making processes/guidelines must be in place prior to "live date". If possible an independent chair.

Another member indicated that the planning of the governance of the trial suffered some of the problems of the planning of the trial itself.

*Determine the Terms of Reference and Accountabilities of Manager prior to the commencement of Trial and prior to appointment of manager
Determine the Accountabilities of Manager prior to commencement of Trial
Have National and Local Evaluators responsible to Management Committee*

The Project Manager expressed a similar idea:

Let it be more clearly defined – the term management committee being the first thing changed and refined.

The idea of an independent chairman was repeated by another respondent:

*Have the chair either the senior executive of the financial sponsor or an independent.
Define the roles/responsibilities of the sponsor, management and the committee members*

Another member pointed to the importance of clinical policy:

The management committee should monitor all aspects of the trial and sign-off clinical policy re interventions etc.

Two comments pointed to questions of relationships between the committee and the trial executive:

I don't necessarily think the committee per se needed changing – rather the framework which permitted schisms to develop (vis a vis home care vs PM; evaluators vs PM) should have been precluded from the structure – happy to comment further.

Have the manager more accountable in process as well as outcomes.

Role of local evaluation

All respondents, apart from the Project Manager, felt that the local evaluators made a positive contribution to the Management Committee in their role as observers. The Project Manager felt that there should have been:

More involvement (by the evaluators) in understanding the processes and outcomes related to attempting to achieve aspects of the hypothesis rather than the limited focus on financial here and now performance.

The evaluators could have helped the committee by undertaking other tasks such as:

*Made even greater awareness of their lack of adequate data.
Evaluate the trial finances without the cost of the IT (clinical) system or had it been held in another AHS (eg ACT)*

Two respondents pointed out that the evaluators were not invited to Management Committee meetings until year two of the trial. One might conclude that by then the die had been cast.

Evaluators should have been responsible to Management Committee not the Trial Manager.

Their contribution was positive in the sense that:

...it gave the Committee access to information the Trial manager would not have provided.

It was negative in the sense that:

... the evaluators as observers commenced at a time of maximum friction between manager and evaluator and made the Management Committee dynamic somewhat worse.

Summing up

The Project Manager concluded that:

From the staff perspective the management committee was viewed as out of touch. There was a failure to read and attempt to comprehend the difficulties experienced during development and implementation. The approach during the closing stages also reduced cooperation between the staff and the management committee. The "pseudo new trial" process also had an extremely negative impact on relations. Staff believed that the management committee did not understand nor were interested in the achievements. It appeared more interested in protecting "stakeholder patches of turf" I will close by stating my complete amazement that the local evaluators have not attempted gain from me any information relating to development, implementation, reasons for particular approaches and staff management

Another member of the Management Committee saw things in a different light:

*Management Committee did not form a cohesive view of its role until 1/2 way through the trial
Lack of leadership and accountability structures from both State and Commonwealth
Commencement of the trial was a constant shifting of the goal posts – mainly due to Commonwealth.
Trial manager considered the Commonwealth the only/primary stakeholder.
Accountabilities of Trial Manager not sufficiently well determined.
Insufficient 'management control' invested in Committee eg could not dismiss the Trial Manager without Commonwealth approval.*

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