

The Evaluation of the Best Practice in Health Program

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PREFACE

The following paper is a summary of a three volume Report of the external Evaluation of the Best Practice in the Health Sector Program undertaken by ACIRRT on behalf of the Commonwealth Department of Health and Human Services between 1994 and 1996. John Germov of the Employment Studies Centre at the University of Newcastle also contributed to the case study research and the final Report

The Best Practice in the Health Sector program was part of the Workforce Issues Project of the National Health Strategy and was announced as a \$4,000,000 program in the 1993/1994 Budget Papers. The program was administered by the Workforce Reform Section of the Department in conjunction with an industry advisory group. The program consisted of 22 Best Practice projects at 30 sites and was broadly based on the successful first two rounds of the earlier Best Practice Demonstration Program administered by the Commonwealth Department of Industrial Relations which targeted the manufacturing industry.

The release of the main findings in a summary by ACIRRT was undertaken with the permission of the Department as a means to disseminate the findings beyond the Health sector.

The researchers this project would like to take this opportunity to thank all those in the funded projects who assisted with the field work and in particular the Best Practice Advisory Committee, Trish O'Connor, Don Lambert, Gerry Van Wyk, Martin Jarman, and George Neale who gave great personal support to the aims of Best Practice and actively monitored the program from its inception.

1. OVERVIEW OF THE BEST PRACTICE IN HEALTH SECTOR PROGRAM

1.1 *The Concept of "Best Practice"*

Best Practice may be understood as a comprehensive, integrated and cooperative approach to the continuous improvement of all areas of an organisation's operations. For the Best Practice in Health program the factors associated with best practice organisations were taken to include:

- a shared vision of world class performance supported by a change strategy which brings about continuous improvement;
- a strategic plan;
- a commitment to change throughout the organisation;
- flatter organisational structures;
- cooperative and participative industrial relations environment;
- a commitment to continuous improvement and learning;
- innovative human resource policies;
- customer focus. both internal and external;
- closer relations with suppliers;
- pursuit of innovation in technology, products and processes;
- use of performance measures and benchmarking;
- integration of environmental management into all operations.

1.2 *Aims of the Best Practice in Health Program*

The Best Practice in the Health Sector initiative was designed to facilitate the adoption of international Best Practice standards of care and workplace organisation throughout the health sector through a nationally focussed program. A specific aim was to facilitate workplace and structural reform in the health sector through a nationally focussed program. This aim was based on a recognition that the pace of workplace reform in the sector had been slow. The program drew both on the accepted definition and concept of Best Practice and built on the objectives, rationale and experiences of the earlier Commonwealth Department of Industrial Relations managed Best Practice Demonstration Program.

1.3 *The Specific Program Objectives*

The specific objectives of the program were:

- to stimulate the Australian Health industry to adopt Best Practice;
- to identify and develop innovative workplace initiatives which will be of benefit to the health industry nationally. These initiatives should:
 - encourage a participative approach to workplace reform in the Australian health workplace;
 - demonstrate a commitment to customer focus;
 - result in measurable improvements in efficiency and effectiveness; and make jobs more fulfilling and rewarding.
- to encourage benchmarking in the health industry and;
- to provide a wider understanding of Best Practice in Australian health workplaces

The Following Broad Areas were Targeted in the First Round of the Program:

- medical, nursing and allied health workforce reform
- service delivery in rural and remote hospitals
- establishment of mutually beneficial, cooperative relationships between hospitals and other health care organisations
- instituting methods of work which ensure the best use of existing hospital facilities
- health information and administrative procedures
- case management approaches to facilitate the transition between primary, acute and community care

The Following Areas were Targeted in the Second Round of the Program:

- linkages between primary, secondary and tertiary service providers and consumers
- working arrangements
- management systems
- occupational health and safety

1.4 *The Research Components*

The evaluation research process consisted of

- interviews with stakeholders from industrial organisations (unions and employers), State and Territory Departments of Health, and

- Two national surveys of a random stratified samples of the health industry based on the *Wellbeing* data-set purchased by the Department of Health and Community Services
- a survey of 100 unsuccessful applicants
- case studies of each of the funded projects

In addition four comparative site visits were undertaken of organisations which had not been funded but which were recognised as having demonstrated significant components of Best Practice

1.5 *Best Practice in Australia - Manufacturing Models*

The introduction of concepts of "Best Practice" in Australia has been strongly influenced by the experiences of the manufacturing industry. A Best Practice Demonstration Program was announced by the Federal Government in the March 1991 industry statement, *Building a Competitive Australia*. Its aim was the acceleration and dissemination of a new Workplace culture based on international Best Practice. The program was managed by the Commonwealth Department of Industrial Relations in association with the Australian Manufacturing Council and included inputs from the Departments of Employment Education and Training and the Departments of Industry, Technology and Regional Development.

The program drew heavily on the concepts outlined in the Australian Manufacturing Council's report *The Global Economic Challenge; Australian Manufacturing in the 1990's* from which the characteristics of Best Practice cited above were drawn.

In order to stimulate the broader adoption of these characteristics in Australian Manufacturing industry the Department of Industrial Relations Best Practice Demonstration Program specified the following objectives:

- To stimulate Australian enterprises to adopt international best practice;
- to identify effective methods and approaches for the implementation of international best practice in the Australian enterprises; and
- to promote a wider understanding of international best practice and the benefits of its adoption by Australian enterprises

The provenance of the aims of the Best Practice Program in the Health sector from this manufacturing based program are immediately apparent, and represented an extension of Commonwealth aims to link workplace reform to quality and productivity improvements. As such, both programs may be placed within a wider framework of Commonwealth initiatives to encourage industry reform.

2. WORKPLACE CHANGE AND THE INTEREST IN WORKPLACE REFORM IN THE HEALTH SECTOR

2.1 *The Perceived Need To Introduce Best Practice In The Health Sector*

The health industry has been under increasing pressure to balance sustained and/or improvements to the level and quality of services with the need to contain cost increases. This pressure has manifested itself in the range of changes in funding processes. For example, the introduction of case-mix, and organisational changes, forced amalgamations of Health Services introduced by state and federal governments, all of which continued at an accelerating rate during period of the Best Practice program.

This pressure to introduce change and the uncertainty felt by staff as a result of actual and potential change was apparent during the research phase and it was noticeable that morale in the sector was not high. The pressure was felt in both clinical and administrative areas with the effect that some of the potential innovations, and the motives for innovations, of individual project and the best practice program itself were at times treated with some cynicism by staff. This provided an overarching external constraint on the program which, although unrelated to the program's aims, possibly compromised the programs overall effectiveness. Notwithstanding this caveat however, the aim of the best practice program to link clinical quality issues with organisational change was generally perceived by the funding recipients as useful in assisting them to address the issues they were facing as part of the overall reform of the health sector.

2.2 *The Extent Of Change Which Has Occurred In The Industry*

A feeling for the breadth and variety of change which has occurred in the industry can be seen the results of the national surveys conducted in 1994 and 1995. The nature of these changes may be categorised into *clinical* and *organisational* change.

The two national telephone surveys reported that with respect to *clinical changes* an average of:

- 71 percent reported the introduction of new clinical procedures or protocols in the preceding 12 months; and
- 67 percent reported the use of new technology and equipment
- while with respect to *organisational change*
- 82 percent reported the introduction of quality improvement schemes (which included issues associated with clinical practice as well as accreditation);
- 63 percent reported the introduction of new management information systems; and
- 49 percent reported major restructures of work tasks.

The full results given in table 2a (below) provides evidence that the type of restructuring occurring would benefit from the application of Best Practice principles. The magnitude

and scope of workplace change is demonstrated in a range of items in the two surveys. For example, the items 'major restructure of work tasks', 'change in the number of job classifications', 'planned reduction in the number of employees', and the 'introduction of major new training programs', as well as the 'change in number of standard hours' all show the extent of workplace change under way in health.

Table 2a Types Of Restructuring Undertaken In The Last Two Years

	FIRST WAVE				SECOND WAVE			
	%				%			
	Yes	No	Already in place	Don't know	Yes	No	Already in place	Don't know
New Technology and equipment	70	25	4	0	63	29	8	0
New management information systems	68	27	4	1	57	37	6	1
Introduction of joint consultative committees	45	43	11	1	50	26	21	3
Major restructure of work tasks	52	41	6	1	45	43	11	1
Change in the number of job classifications	49	47	3	1	43	54	2	1
Planned reduction in the number of employees	45	52	2	1	30	63	6	1
Introduction of major new training program	45	43	11	1	38	51	11	1
Change in number of standard hours worked	43	54	1	1	31	66	3	1
Changes in penalty rates / annualised of salaries	24	71	1	4	17	79	2	3
Reduction in number of awards	15	83	0	2	6	89	2	3
Reduction in number of unions	9	88	0	3	5	93	1	1
Introduction of incentive-based payment schemes	13	84	1	2	13	84	2	1
Provision of workplace-based child-care	8	89	3	0	3	90	6	1

Table 2a Types Of Restructuring Undertaken In The Last Two Years (continued)

	FIRST WAVE				SECOND WAVE			
	%				%			
	Yes	No	Already in place	Don't know	Yes	No	Already in place	Don't know
Increased use of contractors	29	68	2	1	26	69	5	1
Increase use of part-time staff	53	40	6	1	47	44	8	2
Increased use of casual staff	37	59	4	1	27	65	7	2
Introduction of new clinical procedures/protocols	72	19	6	3	69	20	7	4
Quality improvement schemes	85	8	6	1	78	9	12	1
Reduction in the levels of management	46	50	4	1	45	45	8	2

Source: ACIRRT, Best practice in the Health Sector Evaluation, National Surveys, 1994, 1995

2.3 *Interest In Workplace Change*

Evidence of the interest in introducing workplace change - and the potential role of government in achieving it through program initiatives - was the high rate of application by health services for workplace change program funding. In the two national surveys it was shown that:

- approximately 47% of respondents were aware of funding programs which were related to "best practice" and/or workplace reform;
- approximately 40% of surveyed health services were aware of funding for workplace reform and had applied for funding under one of the various state or commonwealth funding 'best practice' programs.

2.4 *Stakeholder Support For The Introduction Of Workplace Reform*

Stakeholder interviews suggested that workplace reform has become a necessity for a number of reasons. First, health services are experiencing ever-increasing pressure from the community to meet ever-going demands for improved quality and quality service provision.

Second, a feature of the health sector is the rapid rate of medical and technological advance, requiring the acquisition of new equipment or upgrading of existing technologies. While this may result in increased service provision, it was suggested that new technologies were increasing the average cost-per-procedure or treatment disproportionately to other health sector costs.

Third, both State and Federal governments are facing increased pressures to reduce budget deficits. In some states this has led to funding declines in real terms, while elsewhere funding has not grown at the rate of increase of service provision costs. Stakeholders representing service managements, state health departments, trade unions and community organisations all reported that in their experience health services are confronted by the need to carry out 'more with less'. Despite budgetary constraints however, health remains a priority area for state and federal governments, with increased governmental demands for improved performance.

In this context, the workplace reform programs in the majority of the funded project reflected genuine attempts to reorganise work arrangements to increase performance within the constraints of increasing demands and finite resources.

For example, the introduction of "critical pathing" or similar programs whose object was to identify "variation" from standard procedures (eg; Warringal, St George, Epworth) can be seen as applications of general principles aimed at reducing unnecessary duplication of services, through targeting the provision of additional clinical support *only* to those patients with an identified need. The overall effect of each of these programs was to increase bed utilisation. Many programs were also involved in developing standardised patient histories (St Vincent's Sydney; St George, Liverpool Anaesthetics) which would then be available to all relevant providers, including referring General Practitioners, Allied and Community Health Workers and Hospitals. In these examples, the intention was to streamline administrative and record keeping arrangements, again with the intention of avoiding duplication but also with the significant advantage of providing better quality through continuity of care.

None of the "technical" issues could be said to have been completely solved in any of the projects, indeed it is not likely that there are complete solutions. The concept of "continuous improvement" in any case suggests the importance of introducing an on-going process rather than the arrival at a perfect final outcome.

The individual needs of patients means that clinical procedures, particular those in emergency areas, are not able to be standardised in the sense understood in the production of a tangible good, while geographic mobility and issues of patient confidentiality means that no complete and centralism record keeping is possible. Improvement, rather than solution, is the issue. In every funded project it was apparent that despite the superficial attraction of a "technical solution" - such as the use of a new clinical or administrative protocol - to every identified challenge it was rather the changes to the organisation of work associated with the new initiative that was the key to its efficiency and effectiveness. The coordination of services for example is not possible without the cooperation of the services, and new clinical procedures can not be implemented without administrative and nursing support.

Those stakeholders who did identify workplace reform as a critical issue for maintaining or increasing both the quantity and quality of health care were supported by the objectives and actions of the majority of the projects.

2.5 Constraints On Reform

The Relationship Amongst Stakeholders

Several stakeholders, representing unions and hospital managements indicated that a source of opportunity and resistance can be seen from how various occupational groups seek to achieve their goals within the workplace. One consequence of the fluctuating power relationships within hospitals is that no one group can entirely dominate decisions about the organisation of work. Consent is required of the stronger parties, before change can be introduced and change through unilateral management action has limited effectiveness.

Stakeholders identified the dominant group in most health services as the clinicians, who provide the medical services, and who control the admission, treatment and discharge activities of the service. As doctors are the only agents able to provide medical services, this group can determine organisational priorities on the basis of medical need, subject to available resources.

The next two dominant groups are seen to be the administrators and the nurses. The nurses play a significant role as the primary care-givers within the service, and have significant community support. Interviews with stakeholders suggest that maintaining and enhancing professional standing is a significant goal for this group.

Stakeholders drew attention to the difficult role of administrators in the operation of a health service. In a period of declining funding, relative to community demand, administrators seek to impose a bureaucratic-rational approach to resource allocation. Stakeholders reported that some clinicians may have certain approaches to treatment that may be relatively resource-intensive, without commensurate increases in patient outcome. For example, some clinicians may routinely require patients to stay in hospital significantly in excess of the average period. While it appears that there is a growing awareness of clinical staff about the implications of such practices, there is an enduring hesitancy of professionals to comment or correct another professional in the performance of their duties. This has implications, not only for the quality of service provision, but for resource allocation across the health service.

There are other groups, such as the allied health professionals and the 'general staff', involved in catering, lower level administrative services and cleaning. Stakeholders indicated that the allied health professionals, as a group, are significant to the operation of the service by virtue of their role as provider of radiography, dietetic and similar services, but do not represent sufficient numbers to significantly influence resource allocation.

Union officials in states where governments are adopting substantial 'contestability' and 'contracting-out' programs have identified 'general staff' as the least influential group within the health service, and the groups most prone to experience 'contracting out' and redundancy schemes.

Inter-Service Competition & Assistance

The effectiveness of the dissemination of 'best practice' workplace reform will depend on the degree of assistance or competition between health services. The transmission process of 'best practice' work reform initiatives relies on the readiness of one health service to accept the example of another service.

The national survey data did not clarify the nature of inter-service competition or assistance, however stakeholder interviews and case studies revealed a wide range of views on the nature of the relationship between services. For example, while one employer representative maintained that the health care sector was typified by the easy interchange of information from one service to another through journals, seminars, conferences and personal interaction, other employer representatives argued that the sector was notable for the absence of such networks.

It remains unclear how effective the existing transmission mechanisms are. It has been variously suggested that information sharing on inter-service workplace reform occurs only:

- within occupational strata, that is, from nurse to nurse, or clinician to clinician; or
- through the movement of personnel from one service to another.

It has been also argued that the transmission of ideas and practices across health services is limited by the perception by staff of the exceptional nature of their particular service. What may work in one institution may be perceived to be irrelevant or inappropriate to another, due to service-specific features.

According to some stakeholders, particularly in the private health sector, services are consciously competing with each other to maximise both the quantity and quality of service provision as well as to minimise the cost of service delivery. This would act to prevent some services providing other services with access to their internal records or successful techniques. It has also been argued that the limited opportunities for advancement within the senior management labour market prevents the free exchange of effective management techniques: some managers may not divulge successful practices in an attempt to maximise their competitive advantage for subsequent career advancement.

Finally, workplace reform is influenced by the existence and operation of groups that have influence or legal standing both inside and outside a health service. Examples of such groups are trade unions, community or industry groups such as the Australian Council on Healthcare Standards, who can influence, assist or constrain the adoption of certain types of workplace reform, either through statutory forms such as award response, or through professional endorsement.

For example, the existing system of industrial regulation that exists at both state and federal level, with its reliance on awards, agreements and trade union responsiveness, provides trade unions with the capacity to intervene in the work arrangements of health services irrespective of the extent of workplace union organisation.

Stakeholder interviews suggest that enterprise bargaining is one area where this difficulty is likely to occur. If workplace reform is to result in restructured industrial instruments such as awards or agreements, then both managements and unions need to agree on the new terms of employment. It appears that enterprise bargaining is seen by local managements as the means through which 'best practice' workplace reform is negotiated and codified. From the perspective of the various unions, workplace reform will only be entertained to the extent that it results in improvements in the wages and conditions of their memberships. Accordingly, to a degree, union support for 'best practice' is based on a strategy to maximise the bargaining position of union members during the enterprise negotiations.

Similarly, the role of the unions as both an internal and external body within the service can have significant consequences on the spread of workplace reform. One management representative believed that the current set of mirror industrial agreements regulating nursing work across NSW, which arose out of a campaign by the NSW Nurses Association, would act to prevent any workplace adopting service-specific workplace reforms. This view was countered by an official of an ANF branch in another state, that nurses have traditionally played a role in spreading effective ideas across the services. Perhaps the centrally structured system could actually facilitate the spread of workplace reform, through the adoption of specific workplace reform provisions in agreements?

2.6 Other Factors Influencing 'Best Practice' Workplace Reform.

There was a perception from some union stakeholders that some applications for funding were 'pet projects' emanating from middle management, with limited real applicability. However, this view was countered by another union official who argued that a positive feature of the program was its ability to attract innovative but untried projects;

The provision of funds to assist workplace change enables services to take greater risks on new work arrangements. With the current pressures on service budgets, many administrators appeared to be "risk averse to projects" which may not succeed, irrespective of possible benefits. Viewed in this context, 'Best Practice' offers (i) minimised financial risk of failed workplace reform; (ii) spreading successful restructuring concepts and practices with a minimum of risk to other workplaces, by reducing start-up and development costs.

The start-up costs for some reforms also appeared to act as disincentives, even if the restructured work practices may have been anticipated to quickly pay for themselves. For example, one service sought to reduce costs arising from using two people for lifting patients, with its attendant workers compensation on-cost, by introducing hoists into the wards. Unfortunately, while the investment would have saved enough money within the year to recoup the start-up costs, the service decided that it was unable to introduce it due to insufficient funds. In the area of cost-benefits to individual services there was a strong perception amongst state level employee associations - and informal comment from individual health services that some services - and indeed state treasuries - saw "best practice" type funding sources as a form of cost-shifting of training and reform from the service to the Commonwealth.

The development of trust and confidence about the purpose and outcomes of the workplace reform between the parties is essential to successful programs and attaining this trust

requires staff support. Where management was intent on reform it was necessary to involve staff in the process and several stakeholders indicated that where programs had been initiated by staff, using staff experience and understanding of the impediments to work performance, they appeared to have been relatively quickly implemented and embedded into everyday practice.

3. IDENTIFICATION AND DEVELOPMENT OF INNOVATIVE WORKPLACE INITIATIVES WHICH WILL BE OF BENEFIT TO THE HEALTH SECTOR NATIONALLY

The effectiveness of the best practice models relies significantly upon the perceptions by the Health sector of their relevance, credibility and the extent to which the experience of projects are capable of generalisation.

Underlying this is a more general question of whether or not any discernible change can be attributed to the funded projects themselves, or whether such changes would have occurred in any case as a response to cost, technological and other pressures under which the sector is operating.

3.1 *The Transferability Of Lessons From Projects*

The ability to transfer lessons from a project is dependent on the capacity of the industry to generalise from a project and secondly, on the of receptiveness the industry to lessons from other organisations.

There was a general acceptance within the sector about the utility of transferable knowledge and experiences. The overwhelming majority of respondents to the national surveys indicated that they considered using the techniques and experiences of other organisations. The reasons, based on an analysis of open-ended responses in the two national surveys, given for a willingness to adopt the successful experiences of other organisations is summarised below.

Table 3a **Reasons for health organisations using the experiences of other organisations**

Reasons For Using Others Experience	percent
We can learn from the experience of others	36
Why re-invent the wheel?	12
Need external comparison	15
Quality improvement	13
To enable cost reduction	1
Lack of resources with which to experiment	3
Our service is unique	3
Don't know/other	17

These reasons for borrowing work reforms appeared to be reasonably consistent across states, and across organisational types. However, organisations employing over 500 people were more likely to want to use the experience of other organisations to avoid duplicating mistakes. In general, the results of the surveys indicate an environment in which organisations would be receptive to the experiences of others.

The Limitations Imposed By The Introduction Of A Competitive Environment

A caveat must be placed on the survey data however, as stakeholder interviews and the case studies both identified areas in which the demonstration effects may be limited. While the data and the interviews both show that organisations - and particularly large organisations - are willing to learn from the experience of others *they are also, at times, reluctant to share their own experiences so that others can learn from them in case they loose a "competitive edge"*.

In general this reluctance to share information and experience with others appeared to be a result of the competitive environment within which the Health Sector is increasingly operating. Reluctance to share information was noted at the organisational level, where organisations at times expressed concerns that they may loose a "competitive advantage" [especially with case-mix funding], and at the personal level where management - and particularly senior management - were concerned that they would not get full recognition for their own "good ideas" if they were generalised elsewhere. Chief Executive Officers in particular, were under pressure to perform - and gain recognition for their performance - as amalgamations threatened senior management jobs.

This is not to imply that all organisations were so affected, however it does show that the cost environment of the health sector itself places limitations on individual and organisational willingness to allow absolute free transfer of their experience to others.

3.2 The Transferability Of Best Practice Experiences

The survey data in the table below suggests strong support for the funded project model from those who applied for funding. Overall, 88 percent of applicants indicated that they thought such programs were "appropriate" with 32 percent expressing some degree of qualification to their answer. Significantly however, only 9 percent stated definitely that they believed the funded project model was "inappropriate".

Table 3b Support for funded projects as an appropriate way of demonstrating 'workplace change'

Support for the Funded Project Model	Percent
appropriate	43
appropriate (but with reservations)	32
appropriate, provides incentive for change	13
inappropriate	9
don't know / other	3
Total	100

This support is somewhat qualified in table 3c (below) with respect to perceptions of the effectiveness of the Best Practice in Health program itself in encouraging workplace change with some 33 percent of respondents indicating support for the proposal that the program was "effective in encouraging workplace change", 53 percent not being prepared to state a definite position (23% "unsure"; 29% "don't know") and another 8 percent stating that it was "too early to tell".

Table 3c The Effectiveness Of The Best Practice In Health Service Program In Encouraging Workplace Change

Effectiveness of the Program	Percent
very effective	9
moderately effective	24
not effective	4
unsure	23
too early to tell	8
don't know	29
other	3
Total	100

Although only 4 percent claimed that the program had not been effective, respondents who had been short-listed had reservations about aspects of it. These reservations are given in table? below.

Table 3d Reservations about the effectiveness of the 'Best Practice in the Health Sector' program [short-listed applicants]

Reasons for perceived ineffectiveness of the program	Percent
insufficient funds to introduce change	3
minimal information provided about other service	12
only benefit is to small services	1
benefits larger services	1
other	8
not applicable/missing	75
Total	100

Open-ended questions in this section of the survey also indicated that respondents had some reservations about the spread of information around the sector, with a reluctance by some to consider that benchmarking activities outside the health sector could be a significant benefit.

Interestingly, comments in the case studies from participants who had visited non-health sector organisations as part of a benchmarking exercise were almost always positive. The aspect most remarked upon in benchmarking visits *outside the health sector* - and in particular in visits to manufacturing and hospitality organisations - was the difference in the approach of management in leading edge organisations which were seen as demonstrating best practice principles of communication with the work force. Health sector organisations in general and public hospitals in particular were not seen as performing as well as non-health organisations in this area.

However, although it seems that health organisations could benefit from the experiences of non-health organisations in areas such as consultation and "client focus" - and indeed funded projects which did so benefited - the national surveys demonstrate that there remains an overall reluctance to consider that benchmarking outside the sector would be relevant with only approximately one third of those involved in benchmarking in the last two years considering that they would benchmark with non-health organisations. The transfer of successful experience in this area would seem to be a significant potential benefit of the projects.

In general, the national surveys indicated that there had been an increase in a two year period of knowledge of the strategic aims of best practice by almost 5 percent (volume 2, table C15), and the methods for its introduction. While the reported increase in knowledge of best practice (Volume 2, tables C16 - C18) cannot be said to have been solely the result of the program, the development of best practice within the funded projects can be largely attributed to the selection process itself. The funding guidelines and the selection process were both designed to result in a more complete understanding of the term amongst applicants. In practice, projects were initially short-listed from those which reflected a best practice approach and subsequently developed - in conjunction with the Advisory Group - to more effectively incorporate best practice principles. This increased the chances of effective

demonstration models arising from amongst funded projects and of the models themselves later being accepted by the sector as credible examples of effective practice.

4. THE DEVELOPMENT OF INNOVATIVE FEATURES

4.1 *Management Commitment To Best Practice*

Site visits to all the funded projects confirmed that for best practice principles to be adopted, it is important for them to be adopted by management and disseminated throughout the organisation. Best practice workplace change at the individual project level works *best* when it is adopted as an organisational goal. Therefore, whilst the success of individual best practice projects is not completely dependent upon management and organisational support, for best practice initiatives to prosper there is a need for the organisation to adopt best practice as a strategic goal, not just units within it.

Strong management support and commitment was necessary for projects to "get off the ground". Best Practice funded projects which were integrated into an overall strategic approach of management to introduce change complemented changes already under way in individual organisations. A common theme arising from the site visits was that the funding assisted, or provided a focus, for change. Management commitment was required to support coordination activities, provide staff release and allow the development of effective communication strategies which explained the program and its objectives. However, management support was also required at all levels in an organisation, from Chief Executive Officer to supervisor level, and in projects where this was missing, aspects worked well, but the overall project faced problems.

The Homes of Peace Customer Focus for Young Patients Project is an example of strong management commitment, where the project was aided by a strategic decision to include the particular program within the overall business objectives of the group. The explicit intention to use the best practice program as a pilot for other wards shows that it was not seen as an isolated fund raising exercise. The involvement of the General Manager of Medical Services and the General Manager of Hospital Services on the Steering Committee significantly influenced the input and ownership of senior management of the project and its likely continued support.

4.2 *Consultation And Communication*

There were a number of projects which sought to improve consultation and communication in the work place. Models which were effective used team based work organisation and the regular dissemination of reports and newsletters. In terms of introducing workplace change, projects used planning days for information exchange and staff consultation and the involvement of staff in 'change teams'. Effective projects also involved all stakeholders (internal and external) in the change process through various structural consultative frameworks.

The effective best practice models of consultation and participation with internal and external clients used broad definitions of consultation which encompassed all staff, patients, relatives and suppliers. The integration of the views of relatives was often necessary where long-term care was required. Such an inclusive 'partnership' approach, extends the concept of client beyond the patient. Proper consultation and participation of clients/consumers/customers means more than a satisfaction survey delivered after service provision. Best practice consultation means the involvement of all stakeholders in the

change process from planning, piloting and through to evaluation. Needs analysis surveys and focus groups were common methods used to elicit information and encourage participation. A number of these methods are briefly overviewed below.

An Example Of A Communication Audit

The Hospital Communication Project at Princess Alexandra Hospital represented an ambitious best practice model for hospital communication which can be used by any health care facility. The project assesses communication from an *organisational* perspective rather than purely in terms of interpersonal communication. The project investigated how communication occurs, the way information flows, what information is wanted by staff and patients, how information is obtained and where information is obtained. A communication audit was undertaken among staff and patients to determine the effectiveness of current processes. The next phase involved extensive site visits to other organisations which resulted in draft performance indicators.

The project provides a number of lessons. The key aspect of the project was its focus on an organisational or structural approach to communication, instead of merely improving interpersonal communication skills. However, the project has faced a number of constraints, particularly trying to introduce change in an unstable environment of funding pressures and low staff morale. The identification of communication problems requires management support to introduce structural changes to overcome the problems, often related a lack of resources and wider industrial relations issues. As this project shows, the possibility of successfully introducing structural change is greatly aided by the involvement of both union officials and union site delegates in project management.

It is likely that the long term benefits of the project will be strongly contingent on the commitment of senior management to the implementation of the recommendations of the project after the life of the project; and a commitment to change communication structures such as reporting relationships, devolvement of decision-making and committee structures where appropriate. Moreover, it will be important that the results and initiatives which emerge from both the audit and the pilots are well integrated with other ongoing initiatives within the hospital such as Quality Assurance, Enterprise Bargaining and Human Resource Management. The caveat, highlights the importance of undertaking communication audits in conjunction with other organisational issues such as reward and recognition structures, training, industrial relations, and resource issues.

Client Focus Groups & Consumer Advocacy

Focus groups proved a popular and effective method of consultation among a number of projects. Focus groups are a group interview technique, moderated by a facilitator and a semi-structured interview protocol. Such a method enables the canvassing of views of relatively large numbers of staff and clients (through groups of eight to twelve at a time) to discuss issues relevant to the work of the project.

The *Mental Health Residential Project* provides a good model for client participation in mental health services and provides solid evidence of the benefits that client oriented service provision can bestow. The central feature of the project was its philosophical commitment to patient empowerment and its willingness to introduce structural changes which put in place the processes needed to ensure that client participation was effective. Prior to the project, there was little client involvement in the workplace. The project introduced a regular Residents' Forum facilitated by an employed consumer representative. The independence of

this person allowed the residents (mental health patients) to freely discuss a range of issues. The commitment to client participation extended to relatives and the paid involvement of two representatives of the residents on decision-making committees. The Forum was also used to develop and review all policies and procedures affecting clients. The project is responsible for a culture change which is likely to be on-going for some time and has developed a generic model of client participation that can be adopted by other mental health rehabilitation services.

Time was the main constraint on the project. It was unable to fulfil its objectives within the twelve month time frame. In hindsight, it has been unrealistic to expect projects such as this to develop, pilot and evaluate their initiatives within twelve months. This is especially the case in the mental health field, where the nature of the client base and service delivery entail a longer time frame to introduce effective changes to work processes.

4.3 *Customer Focus: Internal And External*

A Service Delivery Agreement

The Quality Use of Pharmacy Project at John Hunter Hospital involved a number of workplace changes, but the most significant innovation was the development of the Service Delivery Agreement. The document is a customer focused quality improvement tool based on a cooperative agreement between internal supplier and customer departments on the service expectations, standards and restrictions on resources. This involved the identification of the current service provision and resource utilisation of an identified department; the development of a Service Needs Assessment form and the conducting of focus groups to determine any gaps, expectations and suggested improvements in services provided by the Pharmacy Department. Similar Agreements are being pursued by the Department with other units within the hospital.

An Effective Model For Indigenous Consultation And Participation

The Child Health Project at Port Augusta provided an innovative model for the extensive involvement of, and consultation with, indigenous communities. For example, the project leaders used extensive local knowledge of their communities, and the services and individuals in them to enhance and strengthen the cooperation of local communities. Where appropriate they contacted community leaders, and built up levels of trust before embarking on their consultation. The project team also returned to the communities both for validation of their original perceptions and to encourage input into the draft recommendations. Importance of having indigenous people involved in the project planning, management and coordination of any project which has, as part of their focus, indigenous clients, services or issues.

The *Mental Health Residential Project* (described above) is an excellent example of providing the structural changes to facilitate consumer advocacy. The success of consumer consultation and participation depends on the way it is pursued, that is, whether it is client or staff driven. Best practice consultation involves the empowerment of clients/consumers and is not simply about conducting satisfaction surveys.

A key lesson from some projects was that whilst they had good intentions to be consumer driven, that in reality most decisions were decided *a priori*: staff decided what was best for clients and then surveyed them. Best practice is based on meeting the needs of consumers needs, which can only be properly achieved by their involvement in every stage of the work

process: planning, delivery and evaluation. In some projects, there was still a level of paternalism about clients and 'protecting' them by not involving them fully. A customer focus must not place the needs of staff or the service first.

4.4 *Cooperative And Participative Industrial Relations Environment*

Staff involvement was the another attribute of successful projects. Staff involvement was most apparent where the project had sought genuine support from the relevant union. Although the funding guidelines required union endorsement in many cases this was perfunctory. Unions indicated that they were concerned that they were "consulted" with only hours to spare before the application deadlines and were concerned that consultation may only have occurred at the workplace delegate level, or indeed may not have occurred at all.

Failure to consult adequately was noticeable in several projects which - although incomplete at the time of the site visits - are likely to face industrial action as a result of a [deliberate] failure to liaise with the state branches of unions. Consultation and staff involvement was required therefore at two levels, first at the state branch level of the union(s) and second at the workplace level. Where this occurred relationships of trust appeared to be able to be developed even when external pressures operated on an organisation. Where these two levels of consultation did not occur, problems seemed to arise.

One of the strongest lessons from the projects is the strength which can be afforded a project where the industrial relations environment is stable, and the industrial parties are actively involved. For example, the strength of the *Hospital Communication Project at Princess Alexandria Hospital* represented was its success in involving both union officials and union site delegates in project management. The presence of both can give the project a legitimacy which may be lost if only delegates or officials are involved.

4.5 *Innovative Human Resource Policies*

Individual And Team Development Agreements

The Skill Development for Performance in Functional Teams Project developed to solve recruitment and retention problems (among allied health) encountered by a rural health service such as Whyalla Health Services. The project has developed individual and team 'development agreements' (IDAs and TDAs) which aim to identify the key performance competencies needed in individual and group settings and to identify the key training needs of participants. The agreements were designed not only to enhance career paths for existing staff, but also to improve the recruitment and retention of staff in a rural allied health setting.

Through a series of facilitation workshops, staff determined what their needs, problems and competencies were. Performance Indicators were introduced and covered changes in skill levels, increased job satisfaction, objectives measures of performance of functional teams and increased consumer satisfaction. The project has developed a marketable Development Agreement Kit that is readily transferable for use by rural functional multi-disciplinary teams.

4.6 *Commitment To Continuous Improvement And Learning*

The Development Of A Training Plan And Package

South Eastern Sydney Area Health Service Hospital Homecare Equipment Project involved a substantial commitment to the on-going training of staff. The project developed a training

plan and materials such as a competency standards document which will be submitted for national accreditation along with an educational package to be marketed to interested parties. The project surveyed and visited other homecare equipment sites and established a number of working parties which involved all key personnel as well as conducting staff and client satisfaction surveys.

4.7 *The Use Of Performance Measures And Benchmarking*

Critical Pathways

The Critical Pathways Project at John Hunter Hospital developed a pathway to improve communication between acute hospitals, rehabilitation centres and the community, ensuring better discharge planning and continuity of patient care for stroke victims. The project placed central importance on internal and external customers so that a customer focus determined professional practice, not vice versa. The development and transference of the pathways will allow benchmarking between identified sites, and continuous improvement should eventuate as departments work toward best practice outcomes. The project developed a transferable critical pathway tool which allows objective measures of treatment outcomes to identify ineffective treatments and pathway variations and includes a measure of customer satisfaction. The tool was developed by conducting a SIPOC (Suppliers, Inputs, Process, Outcomes, Customers) analysis.

The Case Management and Critical Paths Project at Warringal Private Hospital charted the progress of patients against an expected outcome at different stages of recovery, which enabled nursing staff to clearly identify a change [either positive or negative] in patient documentation, with nursing staff commenting that work practices have changed. For example, previously patient case notes were viewed as a record of how good or comprehensive the nurse had been in providing care. Now, with patient recovery charted against the stage of the clinical plan, the focus has shifted through documentation and identification of variation in expected outcomes to patient progress.

Some projects suffered from not incorporating adequate performance measures or evaluation into the structure of their change process so that while the participants may have believed, for example, that training in the area of change was worthwhile, there was frequently no way of determining whether this had in fact either resulted in change on the ground or effectively contributed to such change.

A general lesson for organisations intending to develop performance measures is that such measures, whether quantitative, qualitative or a combination of each, need to be clearly developed prior to implementing new procedures or processes. The specification of performance measures in itself assists in the development of a project, and in identifying what is critical and what is less critical to the outcomes. Evaluation and measurement of performance invariably will be subject to on-going refinement, however the specification of an initial base for measurement - not matter if it is somewhat imperfect - is required so that lessons can be incorporated into the change processes and their effectiveness monitored.

5. THE ENCOURAGEMENT OF BENCHMARKING IN THE HEALTH SECTOR

Benchmarking is considered to be a key aspect of best practice, often used to distinguish it from other management techniques such as total quality management. The essence of benchmarking concerns a commitment to continuous quality improvement by comparing the

performance of various aspects of the work process to identified 'leaders' in the field. This is done not only to discover what the 'best' actually do, but is meant to become a regular feature of work organisation by continually comparing processes and outcomes to encourage innovation and ensure 'best practice'.

In this sense, benchmarking can involve conflicting incentives; the need for organisations to openly share information can be restrained by the need to maintain a 'competitive edge'. Evidence from the funded projects suggests these tensions exist in the health sector and may pose obstacles to benchmarking various aspects of service provision.

5.1 *The Extent Of Benchmarking*

The national survey data and site visits indicated wide interest in benchmarking, with 47 percent of services in the 1994 survey indicating that they had undertaken benchmarking within the past two years which by the time of the second survey had increased by 7.4 percent to 54.8 percent.

Workplace size and industry sector were strong predictors of the incidence of benchmarking with large organisations and the public sector more likely to undertake benchmarking than community sector organisations. As the Second Wave Survey had a higher proportion of small workplaces in the sample the increase in the incidence of reported benchmarking activities probably slightly understates the increase over the period.

Table 5a Involvement In Benchmarking Activities In The Last Two Years

	FIRST	WAVE	SECOND	WAVE	% Change
	freq	percent	freq	percent	
yes	153	47.4	165	54.8	+7.4
no	152	47.1	125	41.5	-5.6
don't know	18	5.6	11	3.7	-1.9
totals	323	100.0	301	100.0	

However, as table 5b (below) shows, even those health services with the most understanding of best practice - that is those that actually applied for Best Practice funding - did undertake benchmarking, the majority of services underwent a benchmarking process with similar health services.

Table 5b Benchmarking Partners (Applicants for Best Practice Funding)

Benchmarking Comparator	Percent Of Sampled Workplaces
Other health services	66
State departments or state bodies	8
Against national standards	4
Internal benchmarking	5
With non-health organisations	2
Don't know or other	14

The high figure reported for benchmarking with other health services probably reflects the strong previous experience in the health industry - and particularly the experience of the hospital sector - to undertake clinical benchmarking as a component of ongoing programs of measuring "*clinical best practice*" while the figure for bench-marking outside the health industry perhaps understates the willingness of health administrators to undertake generic benchmarking. However, of those who had undertaken benchmarking, 33 percent would consider benchmarking outside the industry. Table 5c (below) gives a breakdown of the types of activities benchmarked both inside and outside the health sector:

Table 5c Proportions of Activities Benchmarked

Benchmarking Activity	Percent
Clinical activities	12
Specific medical procedures/services	12
Nursing related activities	9
Total service measures	9
Maintenance work	5
Cost ratios	30
Support services	3
Don't know/other	20

5.2 *The Extent Of Benchmarking Among The Projects*

Whilst many of the funded projects intend to benchmark their best practice workplace initiatives only a small number of the projects have undertaken *formal* benchmarking. In some cases, the innovative nature of the reforms mean that the project sites are likely to be the 'leaders' in their field and benchmarking will be depend on the dissemination and transference of project reforms to other sites.

For the projects which had undertaken benchmarking it was generally agreed that the exercise had been valuable in highlighting areas which needed to be addressed within their own organisations. Benchmarking which was undertaken involved internal and external partners in mostly the health industry, even though some different industries were used, such as the hospitality and motor vehicle industries.

Benchmarking in the funded projects consisted of both quantitative and qualitative measure. These included:

- Quantitative measures
- sick leave comparisons
- workers compensation levy
- injury rate and time lost for injuries/accidents for staff and patients
- staff turnover rate
- industrial disputation
- effectiveness of discharge planning
- staff/client satisfaction

Qualitative measures

- human resource management planning
- employee involvement
- education and training
- well-being and morale
- communication
- consumer participation

The Application Of Benchmarking

Amongst the funded projects examples of international and national site visits provided the initial information exchange needed for many funded projects to develop best practice protocols which could be benchmarked in the future. Site visits to 'institutions of excellence' were usually determined through professional reputation or literature review, and were more prominent in the private sector than the public sector. These visits allowed access to innovations and current practices at other sites.

The Critical Pathways project at John Hunter Hospital for example used this process to gather information and establish networks for the transference of its critical pathways tool for stroke victims. In cooperation with its partner sites, it has established a common reporting format to collect and compare data as part of initiating the benchmark process. This has been made possible by incorporating performance indicators in the critical pathways tool as a normal part of recording patient treatment information so that information is collected as work roles are performed.

The Warringal project investigated the practices of a number of US private hospitals to establish benchmarking partners and also to identify what practices were not appropriate in the Australian environment. Foremost amongst these were the penalties imposed by the US funding system for the re-admission of patients, with hospital costs not reimbursed by US funds for the re-admission of discharged patients with the same clinical problem. This process was seen by Warringal as either a disincentive for early discharge programs or as a process which inevitably leads to what was described by one Warringal nurse [who had worked in the US system] as "creative diagnosis" on re-admission. This experience and the data gathered in the Best Practice project both within the hospital and from benchmarking and liaison with US hospitals, was useful to Warringal in negotiating a payment structure for home care support after discharge.

5.3 *Obstacles To Benchmarking*

A number of obstacles were encountered by the funded projects in their benchmarking attempts:

- the learning curve in knowing what to benchmark and how
- the lack of established networks
- the competitive environment for health funding which engendered secrecy
- the drive for competitive advantage may lead some hospitals to exaggerate the positive aspects of their reforms as well as not promoting obstacles encountered
- the difficulty of benchmarking qualitative aspects of service provision
- the lack of a coordinating or advisory body to facilitate project dissemination and the transference of project outcomes to enable benchmarking

The general view from the funded projects was that state health issues such as increasing competition between hospitals for funding has engendered secrecy over service provision and hindered the willingness for an open exchange of information. Nonetheless, a number of projects were able to successfully initiate benchmarking. The Maryborough project provides a good example of extensive benchmarking, but also of the obstacles faced in the health sector. The project benchmarked areas such as sick leave, staff and patient injuries/accidents and effectiveness of discharge planning. Benchmarking against other health institutions and outside industries such as at the Sheraton Wentworth were undertaken. These activities have proven to be constructive and the project has generated detailed information. It is worth noting however, that the project experienced instances where other health services were reluctant to talk about the details of their services and their practices because of the state health initiatives which effectively make services 'compete' with each other. Maryborough's experience was that some services appeared secretive about what they are doing, and feared being publicly exposed about what they were doing in case it did not meet expectations or accepted standards.

Some of the funded projects found it difficult to benchmark their services due to the qualitative nature of handing patients, particularly for community and mental health services. Whilst standard quantitative measures for the number of patients seen and time spent could of have been implemented, these were seen to be of little benefit to improving the quality of service provision. For example, both the Hornsby Ku-Ring-Gai mental health project and the Melbourne Clinic initiated extensive client focused mechanisms which facilitated client participation in the planning, delivery and evaluation of services - a significant development in the field of mental health. Therefore, any attempt to quantify this process would diminish its achievements. The project team is presently investigating a simple measure of client participation and satisfaction which may be used to benchmark with similar services in the future.

There was a common view from the stakeholder survey and the site visits that the drive for competitive advantage may lead some hospitals to exaggerate the positive aspects of their reforms as well as not promoting obstacles they encountered. This perception is likely to affect the credibility and hence the success of transferring best practice models from the funded projects to other sites. Therefore, it is essential that the dissemination of models include the problems and obstacles encountered by the projects to ensure the legitimacy of best practice in the health sector.

Feedback from some of the projects suggests the Department will need to take a proactive role to facilitate the dissemination of project models. Some projects do not have the funds or the networks to effectively disseminate their models and will therefore require further assistance to do so.

6. THE PROMOTION OF A WIDER UNDERSTANDING OF BEST PRACTICE IN THE AUSTRALIAN HEALTH SECTOR

A key objective of the *Best Practice in the Health Sector Program* was to increase the level of awareness and understanding of Best Practice and to thereby assist in facilitating best practice initiatives in the sector. The role of funded projects can be seen as a means to achieve a wider understanding of best practice and therefore the projects are not *in themselves* primary outcomes, but rather the conduits for awareness raising of best practice.

There were a range of strategies associated with the 'promotion of a wider understanding of best practice', such as:

- The process of applying for funds for the projects in Round 1 and Round 2, where a wide range of services may be exposed to the concepts associated with best practice for the first time through program guidelines and selection criteria
- Departmental dissemination about the announcement of the successful funding rounds and the progress the funded projects, using media releases, flyers, and other Departmental information about the successfully funded projects
- Other ongoing program initiatives such as seminars, conferences, briefing sessions, and workshops
- Through encouraging and facilitating the internal dissemination activities of the projects themselves, for example through site visits, benchmarking, local, industry and service networking, and public speaking opportunities.

In addition, there are a number of *measures* which can be assumed to assess the success of these strategies, whereby understanding, awareness and knowledge of best practice in the health sector has been enhanced. Some of the *measures* may include:

- increased recognition and understanding of the concept of 'best practice'
- knowledge of the Best Practice in the Health Sector Program itself, including awareness of the funded projects
- evaluation of the effectiveness of some of the promotional activities including conferences and seminars
- some assessment of the level and "reach" of the dissemination activities of the funded projects themselves.

6.1 Awareness And Recognition Of The Term

One of the key aims of the "first wave" national survey undertaken in the program evaluation was to collect baseline data about the level of awareness, recognition and activity associated with Best Practice in the health sector. There was an assumption that workplace reform, as opposed to clinical reform, had been sluggish in the sector.

However, as the following two tables drawn from the results of the national survey, indicate, there was a high level of awareness of the *term* best practice in the industry. There were variations in the levels of awareness in different sectors with recognition strongest amongst the hospital sector and weakest in the nursing home sector.

Table 6a Recognition Of The Term 'Best Practice' By Establishment Type

	FIRST WAVE				SECOND WAVE			
	Heard the term	Had <u>not</u> heard term	Did not know	Row Totals	Heard the term	Had <u>not</u> heard term	Did not know	Row Totals
Private	42	2	-	44	49	2	-	51
				13.6				16.9
Public	183	8	1	192	194	2	-	196
				59.4				65.1
Community	47	3	-	50	50	-	1	51
				15.5				16.9
Nursing	29	7	-	37	2	1	-	3
				11.5				1.0
Column	301	20	2	323	295	5	1	301
Totals	93.2	6.2	0.6	100	98.0	1.7	0.3	100

Table 6b Recognition Of The Term ‘Best Practice’ By Establishment Size

	FIRST WAVE				SECOND WAVE			
	Heard the term	Had <u>not</u> heard term	Did not know	Row Totals	Heard the term	Had <u>not</u> heard term	Did not know	Row Totals
No Beds	36	3	-	39	40	-	-	40
				12.1				13.3
1-50	122	11	2	135	140	4	1	145
				41.8				48.2
51-150	80	5	-	85	62	1	-	63
				26.3				20.9
151-300	39	1	-	40	27	-	-	27
				12.4				9.0
More Than 300	24	-	-	24	26	-	-	26
				7.4				8.6
Column	301	20	2	323	295	5	1	301
Total	93.2	6.2	0.6	100	98.0	1.7	0.3	100

In summary

93% of organisations had heard of the term ‘best practice’.

In terms of *establishment type*, recognition averaged 95% with the exception of nursing where the figure was 78%.

A *state* breakdown revealed that all states recorded a level of recognition around 93% with the exception of NSW where the figure was 85%.

Size emerged as the most significant factor in terms of level of recognition, with larger organisations more likely to recognise the term ‘best practice’ than smaller organisations.

6.2 Source Of The Term “Best Practice

While services could recognise the term “Best Practice” this did not necessarily mean that the term had been derived nor based on the DSH’s meaning of Best Practice. Indeed, subsequent evaluative work within the sector revealed that “Best Practice” and “benchmarking” is seen to mean a number of things within the sector.

However, the following table gives a breakdown of where respondents thought they had first been exposed to the term 'best practice'. While only indicative, it does give some insight into what the effective *transmission* mechanisms for the health sector may be.

Table 6c First Source Of The Term "Best Practice"

	FIRST WAVE		SECON D WAV E		Percent Difference
	Frequency	Percent	Frequency	Percent	
A Journal	48	14.9	43	14.3	-0.3
Through Departmental Publications	53	16.4	38	12.6	-3.8
Through Call For Funding Applications	1	0.3	3	1.0	+0.7
A Seminar Or Conference	83	25.7	75	24.9	-0.8
Through Discussion With Peers	44	13.6	42	14.0	+0.4
University/Studies	-	-	19	6.3	+6.3
Other/Previous Occupation	7	2.2	1	0.3	-1.9
Health Industry/Department	8	2.5	17	5.6	+3.1
Health Commission/In	3	0.9	4	1.3	+0.4
Media	3	0.9	5	1.7	+0.6
Program	3	0.9	1	.3	-0.6
Union	2	0.6	1	.3	-0.3
Workplace	5	1.5	10	3.3	+1.8
Quality Associations	-	-	9	3.0	+3.0
Cannot Remember	22	6.8	23	7.6	+0.8
Other [Not elsewhere included]	8	2.5	4	1.3	-1.2
Totals	323	100.0	301	100.0	-

Sources of information were fairly constant across organisations of different size, with seminars, conferences, departmental flyers and circulars being the most popular irrespective of size.

There were some state variations with respects to sources of the term best practice, although these are likely to be a result of differences within individual state samples rather than any

difference which could be validly attributed to differences information channels amongst states.

6.3 How 'Best Practice' Is Defined In The Health Sector

Survey respondents were asked to define the concept of 'best practice' to ascertain the level of understanding of the concept. The national surveys indicated a *wide range* of definitions of 'best practice' and while few of the definitions could be considered "comprehensive", it is interesting to note that for the most part they did touch on the various components of the definition as put forward in the Departmental Guidelines.

Table 6d (below), based on the combined totals of the responses from both national surveys, consolidates respondents definitions of 'best practice'.

Table 6d Definitions of Best Practice (Consolidation of both National Surveys)

	Percent
Best Practice shows the best way to do something	15
Achieving the best result with the available resources	10
Quality improvement	12
A way to achieve productivity & efficiency improvements	9
A way to achieve quality and efficiency improvements	8
Improvement through comparison/benchmarking	19
A way to improve customer outcomes	12
No idea	5
Other (unclassifiable answers)	11

It is interesting to note the large number who defined Best Practice as relating to measurement through comparison/benchmarking which - while certainly not unknown in the health sector, particularly in terms of clinical benchmarking - is still significant for the large number of respondents who clearly associated this with The Best Practice in the Health Sector Program.

6.4 Awareness And Knowledge Of Government-Funded Programs Promoting 'Best Practice'

Part of the strategy for raising awareness was through the promotion of the funding program and the exposure to Best Practice ideas through the program guidelines, selection criteria and definition of Best Practice.

While there are a number of programs associated broadly with the term "Best Practice" the survey respondents were asked to indicate first their general knowledge of these programs and then their specific knowledge and awareness. As the table below indicates the apparent knowledge of "best practice" funding programs had increased by over 10 percent, which is a similar - although slightly higher rate - to the apparent increase of knowledge of the term "best practice" in the same period (See Volume 2; National Survey Results)

Table 6e Respondents Knowledge of 'Best Practice' Funding Programs

	FIRST WAVE			SECOND WAVE			percent change
	freq	percent	valid percent	freq	percent	valid percent	
Yes, Aware	154	47.7	52.7	183	60.8	63.1	+10.4
No, Not Aware	138	42.7	47.3	107	35.5	36.9	-10.4
Don't know	9	2.8	-	5	1.7	-	-
missing	22	6.8	-	6	2.0	-	-
Total	323	100.0	100.0	301	100.0	100.0	-

6.5 Knowledge Of Specific Funding Programs

While almost 50 percent of respondents to the national surveys had heard of government programs promoting best practice, only a smaller number (23 or 7% in total) knew specifically about the Best Practice in the Health Sector Program.

However, the Best Practice in the health Sector program registered highest among the specific programs which suggests that while the overall knowledge of the program was not high, relative to other specific programs it performed well. Stakeholder interviews suggested a number of reasons why the program may not have been as well known as might have been desired and these may be summarised as follows:

There is a range of competing programs within the sector which diffused the impact of the Best Practice program

The relatively small size of the program was of relatively small size compared to other programs - particularly those associated with capital works or the introduction of new clinical equipment

6.6 The Transmission Process

Transmission of ideas can also occur across the applicant base, between the funding rounds and between the funded projects and others in the sector. The Survey of Unsuccessful Applicants indicates the effectiveness of transmission within the funding program itself, some of which was facilitated by the project team and the Advisory Group.

Applicants from the second round of funding were asked whether they had contact with previous applicants. In total some 20 applicants, which represented 43 percent of the sample of second round applicants said that they had made contact with first round applicants. This can be considered to represent substantial communication about Best Practice between the funding rounds.

However, some stakeholders did indicate some concern about the level of information provided, remarking that little had been heard about the success of the various funded projects in the first round, and that almost nothing had been heard about second round successful applicants. One stakeholder argued that the lack of feedback was undermining the potential success of the program. Others commented that while the information flowing through was quite good at the beginning of the program, that it had dropped off and they had lost touch with what was happening. One professional organisation commented that transmission of the program had been poor, but that this reflected problems with transmission in general within the sector.

Some specific comments relevant to the role of the program and the projects in promotion of a wider understanding of Best Practice were:

“Not penetrating consciousness, it is competing with other initiatives and programs”

Industrial organisation

“Information sharing and dissemination has not been adequate and much more is required. People have to have basic information such as who is funded and how is it going”. **Industrial organisation**

“Very little feedback from the Government department; dissemination is poor; feedback on what is/what is not working well is not flowing through. For example, no information about the second round, or about evaluation about the first round progress”

State Department of Health

However, these comments must be qualified by the fact that several stakeholders appeared to have no substantive understanding of the details of the program, or had confused it with other programs.

More positive suggestions associated with improved information dissemination included the following:

“In order to improve transmission, dissemination needs to be managed rather than for it to occur randomly. For example, regular reports should be generated which are then widely distributed to interested networks”. **Industrial Organisation**

In summary, the findings show high general levels of awareness of the concept of best practice within the Health industry, with larger organisations more likely to recognise the term than other establishments.

This indicates that the program - or other future initiatives - have a strong base on which to build. The challenge will be to provide models which can build on this generally high level of awareness of best practice and go on to demonstrate that best practice in a organisational sense is not incompatible with best practice in a clinical sense, but rather has as its strategic aim the delivery of increases in both the quantity and quality of Health Services to the community.

6.7 Ongoing Promotional And Dissemination Activities

As part of the ongoing dissemination and promotional activities the DSHS undertook a range of activities. These included:

- National Best Practice Conferences,
- Smaller targeted seminars where case studies were presented
- Written material about the funded projects from round 1 and 2 and progress of these projects
- Feedback about these activities from the surveys, the stakeholder surveys and the funded projects are outlined below.
- Conferences And Seminars

Respondents to the Applicant Survey were asked whether they were aware of the Best Practice seminars and conferences and also whether they had attended them. As is outlined in Table 6f (below) the majority of respondents were aware of both the seminars and the conferences, although more reported that they attended the conferences than the seminars.

Table 6f Awareness and involvement in Best Practice seminars and conferences

Awareness/Attendance	Seminars %	Conferences %
Awareness	66	80
Attendance	35	48

Respondents were also asked to rate the usefulness of the seminars and the conferences and as Table 6g shows seminars below seminars were likely than conferences to be rated “very useful” or “useful”.

Table 6g The relative usefulness of seminars and conferences

Rating of seminar/conference	Seminars %	Conferences %
Very useful	34	20
Useful	37	20
Average	3	25
Not useful	17	13
Don't know	6	20
Other	3	2

Stakeholder feedback and interviews conducted with the funded projects suggest a similarly high level of interest in the conference and seminars, but some mixed responses about the quality of both. However, an examination of participant responses collected as part of the Departmental evaluation of the conferences and the seminars suggest a high overall level of interest and satisfaction with the information and approach of these forums.

In summary, there was strong awareness of both the seminar and conferences held by the Department with reasonably strong positive feedback about the usefulness of both the seminars and the conferences

6.8 *Dissemination Activities Of The Funded Projects*

The effectiveness of the dissemination activities of the projects has been mixed, as has the effectiveness of the Consortium models which were meant to facilitate dissemination and networking.

While each of the funded projects had dissemination activities expected of them as part of their funding projects, outcomes have been mixed. Some projects have been extremely active and have performed over and above their requirements. Others, however, have been extremely sluggish and have been involved in minimal activities.

There has been a range of internal and external dissemination activities that the projects have undertaken, such as:

- Industry and service forums and seminars
- Flyers and newsletters within their services and hospitals
- External dissemination to partners sites, professional associations and conferences
- Publication in well known journals such as the *Australian Health Review* and *Benchmarking Australia*
- Visits to other sites within and outside of the health industry
- Visits from other services (some projects have been extremely active in this area)
- Benchmarking activities
- Training initiatives
- Presentation of papers at conferences

Overall, despite the efforts to build this process into projects, there has not been as much networking between some of the projects as may be desirable. It was claimed by some that limited time frames meant that some projects could not meet their objectives in this area and a considerable degree of scepticism was noted by stakeholders about the "credibility" of the material actually distributed by some funded projects. There was strong feedback that for the projects to be effective in disseminating ideas and initiatives they had to be believable.

The scepticism noted by individual projects - and by stakeholders with some knowledge of particular projects - about the legitimacy of the dissemination process was a result of a perception, right or wrong, that there was a tendency for projects to 'market' their projects in the most favourable light, often ignoring problems encountered or objectives which were not met or needed to be modified in light of research, piloting and evaluation.

For this reason, it is recommended that in future all projects include a section in their models on 'problems and obstacles to best practice' encountered in their case. This would lend greater credibility to the dissemination of best practice models and has the opportunity of adding to the learning experience of those who take up models or best practice initiatives in general, where they will be able to learn from the mistakes of others, and thus avoid repeating them.

6.9 The Importance Of Commonwealth Funding

Many of the projects expressed the fear that unless there is further Commonwealth funding for the purposes of dissemination, that successful initiatives will only lead to the incremental promotion of best practice models. The competitive pressures on hospitals means that the most likely potential for information exchange and benchmarking will come from inter-state, rather than intra-state, networks. It is unreasonable to expect individual projects to have the resources, in terms of time, money and expertise, to effectively disseminate and benchmark best practice initiatives. The Commonwealth needs to be proactive and help to facilitate networks for dissemination. Coordination with state bureaucracies would enhance the dissemination process, for example, through the joint funding of state-based conferences.

Most projects also noted that without Commonwealth funding, they would not have involved other sites for dissemination and benchmarking. A number of projects, such as the QUOPS project at John Hunter Hospital and the Whyalla project have both developed training kits to facilitate the transference of their models to other sites. Other projects would benefit from advice on how to market and promote their model.

Many of the project participants commented on the lack of further best practice funding. There is a general perception among the projects that the Best Practice Program has a good reputation in the health sector and many of the staff who participated in the projects would like to apply for grants or know of others who would if further funding was available. Some staff remarked that funding is provided for devising the project, but there are no funds to implement or transfer/disseminate the project. It was suggested third and fourth grant rounds be planned to capitalise on the 'trickle down effect' the program has generated about workplace reform. It was also noted that the best practice program potentially represented a pool of funding for health workers who do not have access to NHMRC grants because of the lack of clinical experience and research.

6.10 Increasing Effectiveness In Transmitting Innovation

The competitive pressures placed on health institutions within states mitigates against the free exchange of information and benchmarking intra-state. However, site visits and consultations suggested that inter-state information exchange and benchmarking is more likely.

The most effective dissemination of best practice is likely to best achieved through a national focus which suggests a continued role for the Commonwealth in ensuring that best practice models are transferred to other sites in the health sector.

7. OBSTACLES TO THE IMPLEMENTATION OF BEST PRACTICE

While it is too early to tell whether the models developed by the funded projects will have a significant long term impact on the health sector, the evidence strongly suggests that the industry itself is potentially responsive to best practice models which provide transferable experiences. The value of the experiences of the funded projects will depend upon the ability to build on strengths of individual projects and an awareness of the specific constraints that appear to operate within the health sector.

There were a number of factors which appeared common across the funded projects which were revealed in the site visits. All successful projects demonstrated management support; clear objectives; an understanding of Best Practice principles and fitted into an overall strategic approach of the organisation. In addition, they demonstrated significant levels of staff and consumer involvement, including the involvement of the relevant union.

A number of lessons can be gained from the experiences of the projects in their attempts to introduce workplace change: These include

- Problems with consortium models
- The need for evaluation
- Credibility
- The need for flexibility
- Best practice cynicism
- The lack of performance indicators
- State level cost pressures and industrial issues
- Work intensification
- Change fatigue
- The role of consultants and project officers
- The dynamics of size and the importance of Commonwealth funding

7.1 Examples Of Potential Obstacles To The Introduction Of Best Practice

Difficulties With The Consortium Model

The VicHealth project investigated different aspects associated with organisational health within each of its three hospital partners, the Royal Melbourne Hospital, the Royal Melbourne Children's Hospital and St Vincent's Hospital. The consortium approach had both strengths and weaknesses. By coordinating performance measurement across the participating institutions the project was able to ensure a measure of consistency in the approach and comparability of measurement. The weaknesses of the project is that the objective of developing best practice in "organisational health" is rather undefined and as each individual partner had a significantly different focus, it may difficult to integrate the individual outcomes in a coherent manner.

The National Allied Health Best Practice Consortium (NAHBPC) was intended to provide an infrastructure for mutual support through shared information and learning, providing a continuous outlet for dissemination of best practice principles in different areas of allied health. The Consortium has not met the expectations placed upon it and has ceased to function for all practical purposes.

To avoid the pitfalls of failing to gain agreement amongst consortium partners, future Consortium models will need to agree to a strategic plan and develop a contract of understanding of each participants role, particularly the decision-making structure, with agreed consortium outcomes as well as project outcomes.

Issues With Structured Evaluation

The projects which appeared likely to meet or surpass their aims and objectives were also those who had thought carefully about the evaluation of their projects and had taken early steps to identify and/or develop Performance Indicators. The projects which had built evaluation into the design of the project, had gathered baseline material to be used for comparison or benchmarking seemed to be more integrated and cohesive. Conversely, those projects where evaluation had been "tacked on" to the end of the project lacked the focus and cohesion of other projects.

Credibility

The major constraint which may affect the impact of the demonstration models is the credibility of the models. Stakeholder interviews and the site visits noted reservations held about how individual projects had promoted themselves. Interviewees stressed that information which was sent out needed to be "believable" for it to be really effective.

While it is inevitable that all projects would wish to show themselves in the best possible light, the responses indicate that experiences of the demonstration models would need to be shown "warts and all". In this regard, one of the advantages of demonstrations or pilots is, frequently, to show what is not possible, and in this sense "failures" in any individual pilot can be seen as a positive outcome for the best practice project as a whole.

Flexibility

St Vincent's Private, Sydney, significantly changed its project once data had been gathered. The project objectives were based on the introduction of smart card technology to transfer data on patients between general practitioners, specialists and hospitals. Needs analysis revealed that few doctors have computers or use them regularly, so the project was changed to developing a fax proforma to aid admissions and discharge. This example shows there is a need to maintain flexibility in any project, where initial objectives may have to change or be modified in line with needs analysis, piloting and evaluation.

A Level of Cynicism Among Staff Toward 'Best Practice'

Some staff involved in the funded projects noted there was resistance to the phrase 'best practice', particularly the word 'best' and would prefer to use 'effective' practice instead. They believe some people are threatened by the term due to its claimed link to economic rationalism and 'best practice private industry' which has failed in many cases to translate the rhetoric into reality at the workplace. One staff member commented: 'every company now promotes itself as the icon of best practice'.

The current environment in certain states make some staff suspicious about Best Practice initiatives. For example, some staff thought the project was about making them worker harder for the same money, or that it may mean working themselves out of a job. One worker stated that: "*There is a suspicion that there is an agenda associated with Best Practice*".

The tendency to equate the notion of "best practice" with a hidden agenda to cut costs, contract out and reduce staff levels was a theme not just within many projects. It seems that in those states where there has been a strong agenda to introduce case mix and where there has been a level of perceived "upheaval" in the sector, and a level of work intensification, the notion of "Best Practice" has come to be seen as synonymous with cost-cutting and staff reduction agendas. This is problematic for the program because it compromises support for the projects among staff who become suspicious of the agenda. It will therefore require an effort on the part of the project and the DSHS to ensure that the program is clearly differentiated from state agendas.

Work Intensification And Work Pressure

Workload pressures and expectation of commitment was difficult for staff to sustain.

The perception is that changes in states such as Victoria have led to work intensification, especially through unpaid overtime, in particular among management and professionals staff. The Best Practice project has made additional calls on time and commitment of staff. As one manager commented:

"There is an element at the moment of "working on the goodwill of the staff" and we do not know how long this can last. In a sense, the commitment of the staff is "subsidising" the project because we only have enough money to employ people for X hours and yet more hours are put into it. In addition, the services for patients are subsidised by worker goodwill and you only hope that the staff provide the service to patients whether this is outside work hours or not."

Other staff interviewed expressed anxiety over the fear of job loss, fear of performance appraisal and a fear that the "hidden agenda" of the state government was to promote and increase the level of voluntary work among staff. As another staff commented: "*With the Best Practice project you get sucked into running the agenda of the government*".

"Change Fatigue"

Many of the staff interviewed commented that that it was difficult to focus solely on the Best practice project as there were so many other initiatives occurring at the same time, such as accreditation, strategic planning, regionalisation and so on which acted to both stretch the existing workers in terms of time and resources and also diffuse the focus of the project. Some staff were also opposed to the concept of continuous improvement, believing there needed to periods where change was consolidated to avoid prolonged periods of 'unsettled' workplaces including on project where a version of the famous *Dirty Harry* movie poster was modified with the words 'Go ahead, make one more change!'

Consultants And Project Officers

There should be caution in assuming the similar skills, resources and knowledge exist in each of the projects. This is particularly the case with rural projects where outside and/or Departmental expertise may be highly appropriate, especially in the critical early phases of the project. In such cases, the role of consultants, particularly to train staff who lack skills was crucial for many projects. Some of the projects would have benefited from early Department support to fill in the gaps in local knowledge and skills. More consideration of the available resources within projects and better support from the Department may have strengthened smaller projects from the outset.

One potential problem with consultants is where they are employed as project officers. Once the project officer leaves after funding has expired, the projects may falter unless the implemented work processes cannot function on 'auto-pilot'. The role of a management consultant was highlighted as fundamental to some projects' success. The consultant was able to introduce staff to best practice principles, consultative processes and performed the training function necessary for the project's success.

The Dynamics Of Size And The Importance Of Commonwealth Funding

The large majority of projects held the belief that Commonwealth funding was instrumental in 'fast tracking' the reform process and freeing up time and resources to implement innovative ideas. Funding clearly provided the opportunity for many good ideas to be developed and implemented by allowing benchmarking visits, staff relief and training. For projects in smaller or rural organisations it is important to not assume that the resources and expertise available in an urban setting are available in smaller health services which are "resource poor". While larger services may have existing staff and expertise which could be freed up to supplement developmental projects it was clear that without funding many of the smaller projects would never have occurred due to the limited resources in smaller health services

Feedback indicates that the funding really has made a significant difference in terms of being able to trial new initiatives and release direct service staff to undertake developmental work which may never have occurred.

8. SUMMARY AND CONCLUSIONS

There are three general criteria which are useful in evaluating the outcomes of a program. These are the *appropriateness* of the program, or the extent to which the program objectives meet needs and priorities; *efficiency*, or whether the program inputs maximise program outputs; and *effectiveness*; whether the program outcomes achieve stated objectives.

8.1 The Appropriateness Of The Program

International experience and the earlier Commonwealth Department of Industrial Relations Best Practice Program identified that organisational change is *one means* of optimising quality and cost. In practical terms the commonwealth has a responsibility to assist in the provision of quality outcomes in health within its own budget constraints, with health consumers not always distinguishing between commonwealth and state constitutional and legal relationships.

In terms of the needs and priorities of the Health Sector the program may be therefore be considered to be an appropriate response by the commonwealth where the commonwealth has a significant financial role.

8.2 The Efficiency Of The Program

The overall efficiency of the Best Practice in Health program was assisted by the relatively small expenditure compared with other programs and the funding guidelines which required funded projects to contribute to the program. This, combined with a quite rigorous culling and selection process ensured that the program was targeted at projects which were genuinely engaged in attempts at workplace reform and were not simply seeking additional commonwealth funds for either additional staff or for capital expenditure.

In addition the funding guidelines, the proposal development processes (which involved consultation with the Best Practice Advisory Group) and the project level and departmental level evaluations were designed to ensure that projects engaged, as broadly as possible, in fundamental best practice principles such as consultation, benchmarking and information exchange.

However, the overall efficiency of the program may be compromised by changes in Department towards the end of the funding period which meant that the Best Practice Advisory Group and the Departmental executive officers were unable to follow-up all second round projects with site visits.

As the demonstration effect of the program would be the major output the overall efficiency (and also effectiveness) may be compromised if final dissemination activities are reduced or remain incomplete as a result of departmental restructuring which might lead to a commonwealth withdrawal from the program.

8.3 *The Effectiveness Of The Program*

The research evidence is that, with minor exceptions, the program assisted or facilitated change *at the project level* which, although it may have occurred anyway would probably not have occurred as quickly. Program funding facilitated these changes by freeing staff and thereby providing a focus to the project within the funded organisations. The majority of funded projects did attempt to incorporate the best practice principles defined in the guidelines and therefore addressed the objectives of the Program.

The effectiveness of the Program in achieving its stated objectives *at the national level* is, however, necessarily unresolved. The implementation of best practice involves the integration of its components in a (relatively) harmonious and reinforcing system. While individual projects exhibited individual components the health system as a whole is not at a stage where it will uncritically embrace "best practice" principles.

The Best Practice in Health Program should not be expected to change this situation overnight - this was not its intention. The prime intention was to stimulate and facilitate change and there is some evidence that this has occurred. The two national surveys showed an increase in knowledge of the term between survey periods and this combined with increases in components of best practice such as benchmarking, customer focus and consultative processes indicates that the sector as a whole is moving in the desired direction. The importance of Departmental publications and the interest shown by attendance at Best Practice Seminars run as part of the program similarly imply that the program has had an effect.

In summary, it is too early to identify the final effectiveness of the program at national level. The evidence suggests that it has had an impact greater than might be expected given the relatively small scale of the program. However, for full effectiveness lessons will need to continue to be transmitted across the sector past the completion date of the project.

Optimal national effectiveness is therefore unlikely to be achieved unless the transmission of the experiences and lessons of projects are available in a credible form, acceptable to the health sector. This implies that a mechanism for transmission and coordination will be required beyond the life of the funded projects.

8.4 Summary And Conclusions

The Best Practice in Health Program may be considered to have been efficient and effective within the limitations of the scale of funding and the external constraints within which it operated.

Positive Results From Targeting

The program was targeted and the *process* of selection of projects to fund, which involved liaison with the Department and the Best Practice Advisory Group ensured that projects were directed towards workplace reform rather than overcoming short-term staffing or capital works shortages. (Many of the projects rejected for short-listing showed these features). The *outcomes* of the majority of the funded projects were generally positive and provide useful models which could be taken up more broadly across the health industry.

External Constraints

However, the program was also affected by external constraints, most notably the major changes occurring at state system level. This has produced an overall industrial environment which is not conducive to the development of trust between management and staff which is an essential prerequisite for the implementation of best practice principles. In addition, there was an underlying tension between state and federal departments (quite independent of the Best Practice Program itself) which led to a questioning of the motives of the program at both the state system and individual organisational level.

The Need To Support Communication Of Project Experiences

Notwithstanding these caveats, the program has been able to provide a range of models of change which could be used to facilitate workplace change providing organisations take advantage of the opportunity to build on the individual project experiences. There was some suspicion amongst health organisations about the utility of published accounts of success and optimal effectiveness will require communication channels which encourage and allow direct access by interested parties to the participants.

APPENDIX

Overview of projects funded in the first round

1. National Allied Health Best Practice Consortium
2. Maryborough District Health Service - Victoria
3. Territory Health Services
4. St Vincent's Hospital, Melbourne, Victoria
5. Port Augusta Hospital and Regional Health Service Inc(SA)
6. Victorian Health promotion foundation Consortium
7. Warringal Private Hospital (Vic)
8. Homes of Peace Inc (WA)
9. St George Hospital and Community Services
10. St Vincent's Private Hospital (NSW)
11. Princess Alexandra Hospital (Qld)

Overview of projects funded in the second round

12. Bendigo Health Care Group - Anne Caudle Care Campus
13. Centre for Development and Innovation in Health
14. Geelong Community Health Service Inc (Vic) December 1995
15. Hornsby Ku-Ring Gai Hospital & Community Health Services - NSW
16. Richmond Health Service (NSW)
17. The Melbourne Clinic
18. Royal Perth Rehabilitation Hospital
19. South Eastern Sydney Area Health Service - NSW
20. Wentworth Area Health Services - NSW
21. Women's and Children's Hospital - Adelaide
22. The Women's and Children's Health Care Network

The following summaries of the Best Practice in Health Project are available on the Department of Health and Family Services web site and have been reproduced with permission.

John Hunter Hospital

The project is called "The Use of Financial Incentives to Drive Clinical Behaviour in Devolved Pharmacy Budgets". The Pharmacy Department is working cooperatively with

an internal customer (clinical unit) to develop an effective model of financial management in relation to pharmacy services. The project is documenting changes in both service profile and the professional role of the pharmacist deployed in clinical units operating under devolved budgets.

Key results of the project have been identified as:

- negotiated service profile creates enhanced mutual understanding of needs and improves integration of services and lines of communication;
- improved quality of management information to identify efficiencies and support decisions on how resources are best used in patient care; and
- an educative and empowering process for health personnel working in a multi-disciplinary management team.

Contact: Ms Kerry Deans Chief Pharmacist (049) 213 634

Hunter Area Health Service

The project involves a cooperative and critical examination of current service practices and the coordination of customer focus groups to incorporate customer needs. The project brings together the acute care, rehabilitation and community care sectors in the treatment of stroke patients.

A physiotherapy critical pathway for the treatment of stroke has been developed following a series of focus groups and a literature review and is now being trialed.

Variances from the pathway are being recorded and will be used to inform improvement decisions. Instruction sheets and training packages are currently under development.

A number of partner hospitals have been identified as part of the project. The pathway will be implemented and results compared between partners, as part of a collaborative benchmarking exercise.

Contact: Maureen Robinson Director of Physiotherapy (049) 213 700

Whyalla Hospital and Health Service (SA)

Whyalla Hospitals' Skill Development for Performance in Functional Team Structures Project is implementing a training and professional development framework known as a Development Agreement. The project was developed in response to the difficulty of recruiting senior allied health staff with competencies in advanced clinical and management practice to rural settings with minimal support systems.

The draft Development Agreement tool, which identifies key performance competencies and training needs, is currently being trialed for use in domiciliary care teams at Whyalla

Hospital and Health Services. The tool is also being trialed in the Physiotherapy Department at the Adelaide Women's and Children's Hospital, which is working in partnership with Whyalla on this project.

Following these trials, the tool will be further refined and will be available in kit form for use throughout the industry early next year.

Contact: Ms Marg Nihill, Director, Community & Allied Health Services (086) 488 190

Maryborough District Health Service (Vic)

The Maryborough District Health Service (MDHS) in North-West Victoria is an amalgamation of two hospitals, a hospice and a community health service. The hospitals include acute care, nursing home, day surgery and day hospital facilities. An accommodation service will be amalgamating with the Health Service later this year.

The aim of the Best Practice Project is to:

- establish a team-based organisational model to enable integration through inter-campus communication and task focus;
- train staff from all campuses and most departments in work team organisation; and
- benchmark the Health Service against other health agencies and with non-health industry workplaces using self-managed teams.

The Health Service has entered into collaborative benchmarking with Sheraton-Wentworth Hotels and hospitals in Western Australia in such areas as sick leave, staff/patient accident rates, discharge planning meetings, approaches to improve the response rate to staff satisfaction surveys, and the organisation of the engineering department.

Inter-agency and inter-department protocols have been developed relating to discharge planning for the Admissions/Discharge Team and for the wider Health Service. The Council on the Ageing's eight principles of discharge planning have been adopted and form the basis of the development of team performance indicators.

The Common Assessment Information and Referral Record developed by Home and Community Care is being used by Health Service staff.

Case Management, used in acute care settings and in the community health area, has been adapted for use for patients being discharged and identified as being at risk. Early results indicate that case management, especially the in-the-home-care element, has been cost effective and efficient in reducing re-admissions and boosting customer satisfaction.

Home based records have been developed for District Nurse and Personal Care clients and are being trialed in the field.

A computerised Common Record System, accessible by all carers/providers is being developed and software is being chosen which will be compatible with other health provider organisations in the district. Confidentiality protocols have been developed and the system is expected to be operational shortly.

In a positive approach to best practice networking, the MDHS has approached all of its suppliers to ascertain which of them are adopting continuous improvement programs. Some 40% were found to have quality accreditation and most are seeking ISO 9000 accreditation. The health service was able to provide some incentive to a number of their suppliers which were yet to embrace the notion of continuous improvement and customer focus.

Client satisfaction survey formats are ready for use, staff surveys have been undertaken and community information displays have been created. The unions have been involved throughout the project.

The Health Service has been actively disseminating information through direct contact with other organisations, television, radio and press publicity.

Maryborough's Best Practice Project outcomes will provide a model for rural health services striving to deliver a comprehensive and integrated range of services in a competitive environment.

Contact: Mr Bernie Waixel (054) 611 277

Territory Health Services

Aboriginal people comprise 24.5% of the Northern Territory's population and most live in remote areas with limited access to health services. In contrast, 95% of the Territory Health Services (THS) staff are non-Aboriginal.

The Best Practice Project forms part of the Aboriginal Cultural Awareness Program, initiated by the THS in August 1993. The project seeks to develop a workforce with a better understanding and awareness of Aboriginal people, their culture and their unique needs in respect to healthcare.

The project has been developed through consultation with Aboriginal communities, Aboriginal community health services, professional groups and Aboriginal and non-Aboriginal staff.

The project aims to:

- change the delivery and quality of service provided to Aboriginal clients through improved communication between non-Aboriginal staff and Aboriginal clients;
- improve working relationships between Aboriginal and non-Aboriginal staff in remote communities and within the THS; and
- reduce staff turnover in remote communities and reduce stress leave and stress related workers' compensation claims of staff dealing predominantly with Aboriginal clients.

The project has involved orientation workshops for 135 staff in Alice Springs, and continues with one day of training every month. Similar workshops commenced in Tennant Creek in July 1995.

Measurements of outcomes against the objectives of the Project are currently being assessed.

Contact: Ms Maria Palmer-Thompson (089) 517 808

St Vincent's Hospital, Melbourne

St Vincent's Hospital is a 450 bed teaching hospital with a staff of 1,720 and a budget of \$120 million. In the second half of 1995 St Vincent's will occupy a new \$146 million inpatient facility.

St Vincent's has taken advantage of the unique opportunity of a 'green field' site to thoroughly review its organisational structure and goals, and to develop a new model of patient care which will be fully implemented in the new hospital.

To maximise staff ownership of the change process, a project team was established in 1993 to develop recommendations for organisational reform. The project team, comprising junior and senior staff members working in partnership with a consultancy, has involved more than 200 staff in working parties and held more than 300 consultative sessions with staff and key unions.

Funding from the Best Practice in the Health Sector Program was used to pilot an integral part of St Vincent's change process the new Patient Care Model in the Care Centre. The new Patient Care Model has been implemented in the existing hospital building in preparation for the move to the new hospital.

Results of the pilot are currently being assessed.

Contact: Mr Michael Roberts (03) 288 3290

Port Augusta Hospital and Regional Health Service Inc (SA)

This Best Practice Project is developing a model of child health services delivery through which users and service providers can access services that are culturally appropriate, easily accessible, worthwhile and meet the needs of children and their families.

The Project's objectives are:

- to develop a model for the trans-disciplinary delivery of effective, efficient, quality health services to children which facilitates greater access by families to more coordinated and culturally appropriate services;
- the identification of training needs for service providers so the appropriate referrals can be made; and
- that services are increasingly aware of opportunities for providing programs and services which are child focused and designed to meet the changing needs of the children within their communities.

The project is in four stages: community consultation, report on child health within the region, implementation, and project evaluation.

Stage One, is almost complete, with the change process involving wide consultation with and participation of a large number of stakeholders, including staff, unions, Aboriginal communities, carers, service providers, children, government and non-government agencies and a wide range of community groups.

The project team has surveyed 14 communities, with over 85 consultations having taken place. Information has been obtained through focus groups, interviews and questionnaires. Analysis of this data is currently in progress and will provide an overall picture of the health needs and services in the area.

To date, the analysis has identified gaps in service delivery in the areas of child psychology, dissemination of information, communication and transport access to services (health of children and their families is effected by quality of infrastructure such as roads).

Stage Two, which commenced in August 1995, will outline the current health services available to children in the area and contain individual recommendations for each community.

This project has involved strong collaboration and cooperation between both communities and service providers, and for this reason, a real improvement in children's health is envisaged through best practice management of more accessible and targeted services.

Contact: Ms Glenise Coulthard (086) 485 820

Best Practice in Organisational Health (Vic)

The Victorian Health Promotion Foundation, Royal Melbourne, Royal Children's and St Vincent's Hospitals.

This partnership project is providing a best practice model for other organisations seeking to approach change in a way which enhances staff well being and organisational performance. Each of the hospitals is taking a distinct but interrelated project: employee assistance (Royal Melbourne), nurse rostering (Royal Children's) and attendance management (St Vincent's Melbourne).

The "Best Practice in Organisational Health in Hospitals" project is currently focusing on the development of the assessment tools for the quantitative and qualitative benchmarking of each element of the project. Performance measures have been collated from each hospital and are now available as benchmarking data in the areas of WorkCover Premium, sick leave, injury incidence rate, average time lost, staff turnover and industrial disputation.

The best practice team have arranged benchmarking site visits with ICI Pharmaceutical and Sheraton Hotels as a next step in the process.

Warringal Private Hospital (Vic)

Warringal Private Hospital is a modern, 106 bed, acute surgical/medical facility employing 300 staff in Heidelberg, Victoria. Part of the HealthCare of Australia (HCOA) group of hospitals, the Hospital provides advanced services including cardiac surgery, oncology, orthopaedics, day surgery and gynaecology.

The concept of Case Management was first introduced to the Quality Council at Warringal in 1990. By 1993, the hospital had embarked upon Critical Pathing and Case Management as keys to improving the process of clinical care and better outcomes for patients.

Through its Best Practice Project, Warringal is taking the case management approach to its change process and has appointed case managers for orthopaedics, oncology and general surgery. The case managers oversee the patient's stay in hospital and they actively meet the patient's pre and post-discharge needs.

The staff at Warringal have been organised into multi-disciplinary work teams and have developed and implemented many critical paths including in orthopaedics, ophthalmology, oncology, general surgery, cardiac surgery and varied medical conditions. Critical pathing data in a range of areas was analysed to identify trends in patient care and to identify improved care protocols.

The education and training of staff at the unit level is a high priority, and integral to changes within the hospital has been the decentralisation of nursing administration.

Warringal Hospital participated in benchmarking with a number of HCOA hospitals which resulted in the development of key service indicators for the admissions process; the network then conducted benchmarking of other hospital processes. Warringal provides a leadership site for continuous service improvement within the HCOA group.

As part of its Best Practice Project, Warringal established benchmarking partnerships with a number of facilities in the United States of America who are recognised leaders in the field of Critical Pathing and Case Management.

Outcomes from this project to date include reduced length of stay, reduced infection rates, lower use of analgesics and improved patient satisfaction with seamless health care from pre-admission to post-discharge support in the home.

Warringal's success in introducing Critical Pathing and Case Management techniques demonstrates that smaller hospitals, through a best practice approach, can work in partnership with their staff and unions to reach the forefront of innovative service delivery.

Contact: Ms Fiona French, Executive Officer (03) 274 1300

Homes of Peace Inc (WA)

The Homes of Peace provides residential and community based care to 600 residents in Commonwealth and State funded nursing homes and hostels in Perth. It has a reputation for providing leadership in aged care and care for the young with disabilities.

The Best Practice Project is in two stages. The focus of the first stage is the Young Disabled Unit at Inglewood which accommodates 30 young people, all with a severe disability.

A model of care has been developed and implemented by:

- consultation with residents, relatives and staff to determine service outcomes which were combined with a rehabilitation approach to develop a holistic model of care;
- extensive staff education on aspects related both to best practice and the model of care;
- team identification of individual resident goals and strategies to achieve them; and
- quantification of resources required to deliver the model of care (ongoing).

Data has been collected on the level of activity and community involvement prior to implementation of the care model. This will shortly be repeated.

Other forms of evaluation include:

- documentation audit to identify care priorities before and after the new model;
- staff knowledge of model of care (questionnaire); and
- self audit by staff to compare actual practices against documented principles.

A new management model has been implemented to support the new model of care. Traditional barriers between departments have been reduced by the appointment of a Unit Manager. Staff empowerment is optimised by the formation of a Unit Management Committee consisting of the Unit Manager and representatives from all areas within the unit. This group meets on a regular basis.

A group of staff from within the unit will shortly embark on a benchmarking exercise to other facilities, in order to identify further improvement opportunities.

The second stage involves the introduction of a quality culture throughout the organisation.

All managers and executive members have undertaken a management development program to assist them in creating a quality environment. An initial outcome of this

All managers and executive members have undertaken a management development program to assist them in creating a quality environment. An initial outcome of this training has been the completion of a staff satisfaction survey across the whole organisation. Subsequently a survey has also been conducted for residents and relatives. Both surveys provide objective data which indicate improvement opportunities and enable the effectiveness of ongoing change programs to be monitored.

Managers and the executive have also received training in the quality management tools and techniques of process improvement. The majority of these senior staff are now acting as facilitators for quality improvement teams within the organisation.

A Quality Management Group has been formed and consists of the executive, two quality coordinators and three management representatives.

This group has used the Australian Quality Awards Questionnaire to assess its current performance and plan its ongoing quality initiatives.

Contact: Dr Penny Flett (09) 382 3200

St George Hospital

The primary focus of this Best Practice Project is to prevent unnecessary hospitalisation, reduce congestion in the Emergency Department (a major entry point to hospital for the elderly) and ensure adequate support for acutely ill, older people in the community.

St George Hospital is a major teaching hospital in South Eastern Sydney Area Health Service. The Hospital has over 600 beds and employs nearly 3,000 staff. St George district has the highest number of elderly people in Metropolitan Sydney and the second highest proportion of aged persons in New South Wales. Over half of all patient days and long stays at St George Hospital are patients aged over 70 years.

With an aging population, there is an increased pressure to improve ways of providing health care services to older people. Maintaining older people in their homes through acute episodes of illness, or an exacerbation of a chronic condition, is an emerging public health agenda item.

Hospitals often do not cater for the special needs of older people and iatrogenic risk such as immobilisation, hospital acquired infection, falls and adverse drug reactions should be taken into consideration in the decision to admit.

The project is being managed by a Committee comprising management, union, staff and key stakeholder representatives.

Four project teams have been established to implement the key components of the project and to involve staff in planning, monitoring and evaluation.

A key component of the project is the Quick Response Program (QRP) which has been developed to target those older persons who traditionally would have been hospitalised or discharged from the Emergency Department without adequate support.

St George is currently trialing the model which involves a QRP Coordinator located in the Emergency Department to:

- determine suitability of patients for the program (criteria developed);
- assess patients (mobility, social, mental status);
- liaise with the Emergency Department medical staff and patient's general practitioner; and
- develop a care plan and arrange services.

A critical pathway for patients on the QRP is being developed during the period of this project.

Contact: Sharyn O'Grady (02) 350 2109

St Vincent's Private Hospital (NSW)

St Vincent's Private Hospital, Darlinghurst, will develop a model delivery system for a managed continuum of health care. In particular, the project focuses on improving communication and information flow between key providers in an episode of health care so as to enhance patient care and reduce inefficiencies.

Two strategies were envisaged to achieve this outcome. Firstly, the establishment of a General Practice Network with negotiated support systems and agreed patient information protocols and secondly, the establishment of a Patient Services Centre to coordinate an episode of patient care ensuring consistent pre-hospital, in-patient and post-hospital services.

Data was gathered from general practitioners, specialists, hospital personnel and patients using interviews, focus groups and surveys. An analysis of the data revealed the critical information needs of each of the stakeholder groups, current mechanisms used for collection, storage and transfer of data, and inefficiencies and inadequacies currently in the continuum.

The Australian experience was compared with that in the USA and UK and similar trends emerged, including:

- industry consolidation with fewer and more complex providers;

- re-focusing on general practitioners as the gatekeeper in terms of both health expenditure and quality of service;
- focus on continuity of care, not only during an inpatient episode, but also in the community before and after that episode; and
- emphasis on information technology as fundamental support for whole-of-life holistic care.

Options for information technology to provide improved internal linkage within hospital departments and external linkage with general practitioners and specialists, in both the short and long term, have been assessed and improved systems based on on-line and faxing facilities are in the process of development.

General practitioner networks are developing in Sydney's eastern suburbs and Wagga Wagga, with trials currently underway in both locations between the hospital and general practitioners to improve information flow on admission and discharge of patients.

The establishment of a Patient Services Centre has been delayed due to major hospital renovations.

At this stage of the project, the project team believes all the desired outcomes are in place in an embryonic form. The task now is to consolidate and improve the initiatives.

The Best Practice Project has enabled St Vincent's Private Hospital to make a significant start on a long term project that will require ongoing commitment to ensure that the vision of a model delivery system in a managed continuum of care reaches fruition and can be transferred to the industry nationally.

Contact: Dr Jim Wall (02) 332 6790

Princess Alexandra Hospital (Qld)

The Princess Alexandra Hospital is one of Brisbane's major teaching hospitals employing 3,200 staff, servicing 900 beds and treating 1,000 outpatients daily.

Presently, Princess Alexandra is integrating with the Queen Elizabeth II Jubilee hospital to form a dual campus hospital with approximately 1,050 beds.

The Best Practice Communication Project will provide the Princess Alexandra Hospital and other providers of health services with a best practice model for communication which can be used by any health care facility. The project commenced in late March 1995.

This 18 month project consists of four phases information gathering and analysis; benchmarking; redesign and pilot implementation; and evaluation and dissemination of information from the pilot project within the organisation to health care providers nationally.

The project is being managed by a committee comprising representatives of management, medical officers, nurses, unions and allied health professionals, and includes a Project Management Team (13 representatives from all areas of the hospital affected by the project) which directs the activities of the project. Management team training on the principles of best practice and the importance of the communication project to Princess Alexandra Hospital has commenced. Workshops of relevant personnel have defined the areas in which the project will be piloted and the aspects of communication to be considered.

Phase One of the project included:

hospital-wide awareness sessions about the Best Practice Communication Project in conjunction with the Enterprise Bargaining Agreement training;

- the measurement of current channels, systems and levels of communication; and
- a communications audit conducted by specialist consultants.

The Best Practice Project at Princess Alexandra Hospital will be strengthened by the commitment of Queensland Health and the combined health unions to a best practice approach in the Enterprise Bargaining Agreement.

The second major phase, between May and December, seeks benchmarking partners with health organisations and other service industries. This will develop benchmarking parameters and allow analysis of gaps between these measures and the situation at Princess Alexandra Hospital. There have been difficulties identifying organisations which have undertaken major communications studies/reforms and the Project Management Team would value information from other organisations which have examined aspects of communication with staff, clients and patients.

Contact: Ms Katrina Horsley (07) 240 7039

Bendigo Health Care Group - Anne Caudle Care Campus

Access to rehabilitation services for amputees in a regional area.

The Anne Caudle Campus of the Bendigo Health Care Group provides a comprehensive range of inpatient, outpatient and community rehabilitation programs. The centre has a reputation for excellence in developing innovative rehabilitation approaches equal to the best in Australia.

The centre focuses on achieving the best possible outcome for each person treated. To ensure this occurs, the centre has developed best practice management techniques with an emphasis on communication and quality improvement through teamwork and involvement of clients.

The Project

The Best Practice Project is to develop the Regional Amputee Rehabilitation Service into a demonstration project for the whole of Australia by:

- developing a new management information system;
- implementing critical paths;
- developing and documenting the integrated clinical process which covers all stages from pre-operative counselling to discharge into the community; and
- conducting a benchmarking exercise to compare the centre with other best practice organisations.

This process revolutionises amputee rehabilitation by using state of the art computerised technology for manufacturing and fitting artificial limbs and incorporates 24 hour team-based rehabilitation on the wards.

Amputees in regional areas have historically had limited access to rehabilitation services and the Best Practice Project aims to overcome these problems.

The centre will develop a comprehensive range of resources to educate patients and staff and will provide a model for other amputee rehabilitation units throughout Australia.

Contact: Dr Bernard Street, Deputy Medical Director (054) 44 6111

Centre for Development and Innovation in Health

Strengthening primary health care through better links between agencies and with communities.

The Centre for Development and Innovation in Health (CDIH) has collaborated with the North Richmond Community Health Centre, Mackay Community Mental Health Service and The Parks Community Health Service to form the National Consortium for Best Practice in Primary Health Care.

These three community health services will benchmark best practice in three discrete areas of primary health care practice. CDIH will further develop these benchmarks to provide a generic model which will be widely applicable to the industry.

These benchmarks are to:

- improve the linkages between service providers that will ensure continuity of care and high quality services;
- increase the role of community health services in facilitating change; and
- provide mechanisms for community and consumer participation in service delivery and service development.

Contact: Ms Gai Wilson, Centre for Development and Innovation in Health (03) 482 2127

The Projects

a) North Richmond Community Health Centre (NRCHC)

North Richmond's project will establish a best practice Shared Care Birthing Program that is responsive to the needs of all of its customers (particularly women of non-English speaking backgrounds (NESB)), to document the processes in re-orienting staff in the course of developing this service, and to develop benchmarks for the development of shared care programs particularly for NESB women.

The NRCHC will coordinate discussions between local service providers to determine their different ways of operating, develop detailed plans for the new Program and its implementation, and formally implement it through joint training workshops, a community education program and consultation with local General Practitioners.

The Shared Care Birthing Program will be monitored in terms of quantitative indicators of throughput and established performance indicators, for example, antenatal attendance rates, breast feeding rates, obstetric intervention rates and contraception, and consumer feedback.

Benchmarks in primary health care will provide a best practice process of change in health care delivery in relation to the development of shared care birthing services, developing effective collaboration between community health centres and hospitals, and working with NESB communities to more effectively define and meet their needs.

Contact: Mr Demos Krouskos, Chief Executive Officer (03) 429 5477

II. Mackay Community Mental Health Service

The objectives of this project are to develop a mobile mental health assessment team (MAT) which provides effective support for consumer, families and local generalist primary care services; document the processes of reorienting staff, consumers, families

and other primary care providers to newer ways of providing this service; and develop benchmarks for the development of a mobile MAT.

The project includes a training needs analysis, and the development of competencies and a computer assisted learning package to support the on-going training of staff wanting to be part of the MAT. Progress of implementation of the MAT will be reviewed by the Community Consultative Group.

Contact: Mr Brodie Melvin, Manager, Mental Health Services (079) 51 5385

III. Parks Community Health Service

The objectives of the project are to increase access by Aboriginal people to mainstream health and community services in the Adelaide region through collaborative relationships between service providers and Aboriginal community organisations and members; to document the processes involved in building these stronger links; and to develop benchmarks in primary health care on the change needed for mainstream service providers to become more responsive to the particular needs of Aboriginal people.

The project will develop, review and evaluate strategies used in bridging the access barriers, develop a range of models through which agencies can increase links and access, and negotiate agreements among the partners to implement on a pilot basis the most promising models.

These pilot projects will be evaluated and a model developed that is applicable nationally (incorporating the strengths and experiences of the successful pilots). That model will then be marketed to training institutions.

Contact: Ms Clare Shuttleworth, Director (08) 243 5611

Geelong Community Health Services Inc. (Vic)

The enhancement of linkages between the consumer and health care sector through a primary health worker model of care.

The amalgamation of five community-based health care agencies in Geelong in July 1993 created Geelong Community Health Services (GCHS). The Agency is complex, providing a broad range of both primary and specialist services to four differing catchment areas, from six different locations, with a radius of 200kms. GCHS employs 100 staff and has identified a team-based model of management as its vehicle for best practice.

Since amalgamation, GCHS has implemented its team-based organisational structure, completed a needs analysis, strengthened the linkages with other health care agencies and has embarked on a strategic planning process.

The amalgamation experience has provided staff with exposure to a wider range of health care disciplines and has enabled them to broaden their thinking and practices from their traditional roles, to become more responsive to client needs.

The Project

GCHS' Best Practice Project aims to further enhance the linkages between the consumer and the health care sector by focusing on working arrangements that will provide health workers with a greater range of skills to assist them to work more effectively within service delivery teams.

Initial successes following amalgamation in this area will be consolidated and a more methodical approach to service delivery will be achieved.

The primary health worker approach involves an extensive assessment by the first contact health worker, and follows through with a comprehensive response and continuing management strategy. It requires the availability of that worker to the client from admission to discharge.

The primary health worker will need to draw on a broad range of skills from within and across teams and also skills held external to the agency. The Primary Health Worker Model of Care approach will better enable a holistic, integrated and streamlined service to consumers.

The project will address two main areas:

- the continuing development of team functioning; and
- a review of programs and practices with a focus on the primary health worker model of care.

The project will include the development of performance indicators and measures by each team and the identification of benchmarking partners. Other outcomes will include increased staff skills, a profile of skills held in a readily accessible format and the development of a comprehensive training program.

Contact: Mrs Gai Hewitt, Chief Executive Officer (052) 222 477

Hornsby Ku-Ring Gai Hospital & Community Health Services - NSW

A holistic and customer focused approach to successfully maintaining people with chronic psychiatric disability.

The Hornsby Ku-Ring-Gai Hospital and Community Health Services (HKHCHS) forms part of the Northern Sydney Area Health Service and provides services to 240,000 people

residing in the Hornsby and Ku-Ring-Gai municipalities. The HKHCHS' Residential Support Team (RST), which provides a range of supervised accommodation from 24 hour supervision to unstaffed group homes, focuses on improving clients' mental health, management of symptoms, and daily living skills in preparation for independent living.

The RST has thoroughly examined and analysed the whole of its residential rehabilitation service from a customer focus perspective, including service delivery, allocation of resources, staff needs, client needs, client level of functioning and policies.

From this systematic analysis, important baseline information has been obtained identifying current work practices, current client level of functioning and key areas for improvement. These areas include the need to further develop client centred policies and procedures, and to further develop assessment instruments in order to effectively measure clients level of functioning and match adequate levels of mental health and rehabilitation support.

The Project

The HKHCHS's Best Practice Project aims to create a holistic, comprehensive, integrated and co-operative residential rehabilitation service of the highest quality that successfully maintains people with a chronic psychiatric disability in the community. The project will be customer focused, striving to continually improve service delivery through a co-operative approach across the organisation.

The project has the following objectives:

- develop an infrastructure within the RST that is client centred, accountable and affords consumers the opportunity to work with staff in the planning and evaluation of services; and
- maximise clients' opportunities to acquire the skills and confidence needed to live as independently as possible in the home of their choice.

In terms of the critical areas identified for improvement, the RST will undertake a wide literature search and form benchmarking partnerships with a number of organisations providing high quality residential and rehabilitation services to people with special needs, reviewing areas of service delivery relevant to best practice developments within the RST.

Performance indicators and outcome measures will then be developed to ensure staff proficiency (via a training package) in the areas of functional assessment and client centred management plans. Best practice policies and procedures will be documented in the form of a procedural manual for use by the RST.

A report will be formulated, with recommendations regarding those residential and rehabilitation services provided by the RST which need improvement and the process by which best practice results were achieved. The report will be discussed with staff and clients of the service, ensuring their full involvement in the process.

The recommendations will be implemented and evaluated at the end of six months.

Contact: Ms Wendy Corliss, Mental Health Rehabilitation Co-ordinator (02) 477 916

Richmond Health Service - NSW

Integration of general practitioners into an existing sexual assault specialist counselling service.

The Richmond Health Service on the Far North Coast of New South Wales provides health care through the Lismore Base Hospital as well as nine District Hospitals and Primary Health Care Centres, to a diverse population of approximately 140,000. The Sexual Assault Service provides 24 hour counselling and medical/forensic services to adult and child victims of sexual assault and their families throughout the Health District.

The Sexual Assault Service provides a very high quality counselling service. The current change program is directed at meeting the needs of the services' customers across a whole district, not just via a major hospital, but through local hospitals, and to create access to a specialist service at the local level.

The model being implemented entails the integration of general practitioners into the existing specialist consultant response, thereby seeking to address gender issues and facilitate the involvement of medical practitioners with a specific commitment to working with victims of sexual assault.

The Project

There are several components to the Best Practice Project:

- the development and evaluation of a multi-disciplinary team approach (medical, nursing, social work) through the introduction of debriefing, regular mechanisms for communication, supervision and training;
- the determination of areas and processes to benchmark, as well as the achievement of levels of quality service provision already established by state wide standards;
- the promotion of a change of culture around medical service provision; and
- the transfer to other areas of the Richmond Health Service of the client and staff focus aspects of the counselling service.

An important aim of the project will be to address workforce issues affecting GPs' and VMOs' preparedness to undertake forensic examinations. This has been a problem in the past with court appearances, as well as a lack of training to cope effectively with the trauma associated with sexual assault.

These are issues the project is addressing. Medical personnel have been included in counselling training and considerable progress has been made already, with six GPs (some female) now actively supporting the service.

Particular areas of focus in the project are: stress management, family friendly policies, flexible work arrangements, team building and a high level of teamwork, development of a capacity for appropriate social action and mechanisms to ensure staff satisfaction through continuous improvement in professional practice.

Project outcomes will have application both in rural and metropolitan centres.

Contact: Ms Bronwen Myers, Co-ordinator, Sexual Assault Service (066) 202 131

The Melbourne Clinic

Critical care pathways for treatment of common psychiatric disorders.

The Melbourne Clinic is Australia's largest private psychiatric hospital and part of the Healthscope group of hospitals situated in three States and the Northern Territory. The hospital has 131 beds and is situated in Richmond. The Melbourne Clinic employs 130 staff and has almost 200 affiliated psychiatrists, many of whom practice in the adjacent consulting suites. The clinic has recently established a professional unit affiliated with the University of Melbourne.

Over the past 15 months the Melbourne Clinic has been undergoing significant organisational change aimed at improving efficiency, effectiveness, customer focus and marketing edge. This has resulted in restructuring at management level, education in best practice techniques and a focus on skills development.

A number of multi-disciplinary teams have been set up to foster process improvement. These teams have assessed both clinical and administrative processes, leading to more customer focused processes being implemented throughout the organisation.

The Project

The Clinic's Best Practice Project involves the further development of a critical pathway model for patients suffering from the most common psychiatric disorders (such as depression, schizophrenia, bipolar disorder, anxiety and personality disorders). These patients may have either an acute or chronic presentation.

The project will further develop, implement and evaluate the effectiveness of the critical care pathway for a pilot group of ten to 15 patients. If successful, the approach will be implemented more generally across the Clinic.

The critical care pathway has been developed to improve the therapeutic process from pre-admission to reintegration back into the community.

Emphasis is on ensuring continuity of care and providing individualised, focused 'whole person' assessment and management.

To date, the project has involved considerable consultation with key stakeholders both inside and outside the Clinic and this will continue throughout the life of the project.

Benchmarking is integral to the project and will be used to establish international best practice in critical care pathway processes.

The model developed and trialed will be fully transferable within both public and private sectors and parts of the model, such as the admission process, will also be transferable outside the psychiatric sphere.

The project will be led by a psychiatrist and coordinated by a project officer. The whole process will be overseen by a multi-disciplinary implementation team with union representation. An important facet of the project will be its focus on research and evaluation, both long and short term.

Contact: Dr Lee Gruner, General Manager (03) 429 4688

Royal Perth Rehabilitation Hospital

An Occupational Health and Safety project to reduce staff injury and improve patient care and rehabilitation through more consistent and appropriate handling.

Royal Perth Hospital (RPH) is the major teaching hospital in Western Australia and Royal Perth Rehabilitation Hospital (RPRH) is its associated rehabilitation centre with a combined total of 870 beds. Patients treated at RPRH include those with acute spinal and head injuries, neurological disorders and a variety of acute and chronic orthopaedic conditions.

Sprain and strain (primarily lower back) injuries caused by inappropriate patient handling are by far the major cause of time lost by nursing and support staff. Decreasing manual handling injury will significantly reduce both direct Workers' Compensation costs and indirect costs associated with the employment of relief staff. There is evidence also that patient rehabilitation is enhanced when consistent handling and transfer techniques are used at all times.

The Project

This project will develop a model of best practice in the handling of patients. The project aims to:

- reduce the risk of staff injury due to repetitive manual handling (especially unnecessary lifting associated with patient care) by promoting more detailed and accurate assessment by all team members;
- improve quality of patient care and rehabilitation relating to patient's physical capacity to move by facilitating improved communication between staff (including between shifts), and more consistent physical movement and handling by a variety of staff; and
- improve overall quality of care by reducing the length of time experienced staff are absent from duty due to work related injury.

The Best Practice Project will enable the implementation and evaluation of a new tool in manual handling risk management called a "Mobility Chart".

The Chart is a new design and its introduction and use will be trialed in RPRH over a twelve month period.

Project planning includes development of a final package for use by other health care institutions. The package will include all materials to manufacture the charts and symbols as well as a stand alone staff education package.

Contact: Ms Angela Summers, Occupational Health Ergonomist (09) 224 3430

South Eastern Sydney Area Health Service - NSW

Development of a model hospital home care equipment delivery system.

South Eastern Sydney Area Health Service (SESAHS) is responsible for providing primary and secondary health care. The area is also responsible for providing specialist tertiary care to both its local population and to significant numbers of people residing in other parts of the State.

The increasing demand for health services to be provided in the home is due to a number of factors, including a rise in the number of early discharge programs, an ageing population, the AIDS community and new health home care technology. All of these factors are placing pressure on SESAHS to more efficiently and effectively manage its resources.

The SESAHS recognised that it had to rethink the way in which hospital home care equipment supplied to clients in their homes is selected, delivered, maintained and monitored.

The Project

The primary focus of the Best Practice Project is to develop a model hospital home care equipment delivery system which is client oriented and can be transferred to other health organisations.

Outcomes for the project are the establishment of a best practice model for other organisations providing hospital home care equipment, which will include competency levels for health professionals, carers and clients involved with the use of high tech equipment in the client's home, and the establishment of educational guidelines for clients and carers using the equipment.

Some of the components of the project will be benchmarked, for example, "just in time" inventory management and the delivery of equipment.

Project staff from SESAHS will work with clients, carers, union representatives, general practitioners, manufacturers and equipment suppliers (public and private) to develop a best practice model hospital home care equipment delivery system.

Contact: Ms Sally Torr, Deputy General Manager, Community Health Services and Programs (03) 360 3133

Wentworth Area Health Service - NSW

Development of guidelines for the early identification and management of postnatal depression.

Nepean Hospital, located in Penrith on the outer Western edge of Sydney, is the largest hospital in the Wentworth Area Health Service (WAHS) with an average of 3,000 births per annum.

The hospital is undergoing major development from district level to that of a tertiary referral centre. This redevelopment has included the adoption of a Total Quality Management approach leading to a flatter organisational structure, innovative service delivery and a quality improvement program.

The Project

The Best Practice Project for the Maternity Unit at Nepean aims to develop best practice guidelines for the early identification and management of women thought to be at risk of Postnatal Depression.

The system in place at WAHS at present ensures that all women attending the Early Childhood Centre at eight weeks postnatally are offered screening with the Edinburgh Post Natal Depression (PND) scale. A comprehensive management approach has established an extensive referral network involving primary, secondary and tertiary health tiers and offers a broad safety net for women with PND.

Research recently undertaken at Nepean estimating the incidence of PND in a Western Sydney population, noted an association between obstetric intervention (in particular instrumental delivery) and risk of PND. A possible mechanism could be that intervention induces a reaction similar to post-traumatic stress disorder. Such a response may well benefit from an early postnatal debriefing intervention along the lines of critical incident stress debriefing.

Presently midwives at Nepean offer informal debriefing to women on an ad hoc basis and without a clear counselling and referral framework. The Best Practice Project will benchmark the most appropriate postnatal intervention, establish a referral network linking the hospital and the community, enhance the counselling and debriefing skills of midwives and develop best practice guidelines.

Contact: Ms Elizabeth Andrew, C.N.C. Midwifery (047) 242 525

Women's and Children's Hospital - Adelaide

Review of organisational structures and the training of staff with a focus on health and care of patients through a team approach.

The Women's and Children's Hospital, formed by the amalgamation of the Queen Victoria Hospital and the Adelaide Children's Hospital, was fully amalgamated on the North Adelaide Site of the Children's Hospital in May 1995, after a six year program of organisational change and building construction.

As a teaching hospital associated with the University of Adelaide and funded by the South Australian Health Commission, it provides a broad range of paediatric and adolescent medical, surgical and mental health services, as well as gynaecology and obstetric services. In 1993/94, there were 27,870 inpatient admissions and 190,485 outpatient services provided with a budget of \$97.3M.

The Change Process

The amalgamation of the two institutions provided an opportunity to review structures and work processes. In 1992, a vision and principles for service development were established through a strategic planning process in which some 200 staff and 65 consumer and community organisations participated.

The principles, broadly concerned with a focus on the health and care of patients and a team culture amongst staff, provided the backdrop for review of organisational structure

which was undertaken by external consultants as stage one of the Organisational Design Project.

The Hospital Board and Chiefs of Service became committed to a devolved clinical management model at the end of 1993.

The second stage of the project entailed the detailed design of the new structure, clarifying the new management structure, the new decision making forums, the roles of the new management positions, and developing new multi-skilled roles at the senior nursing level and in ancillary and administrative functions.

The Project

The Best Practice Project builds on this change process through staff training in customer service skills to achieve a multi-skilled and flexible workforce.

Specific competency based training will be in such areas as group and communication skills, cleaning and environmental management, time management, infection control and understanding grief and loss. The outcomes of the project will be assessed by a specific evaluation strategy incorporating performance measurement tools.

Other training will be in clinical pathing which will have its own evaluation process.

The outcomes of the evaluations will be disseminated by the hospital to any interested Australian hospitals and will be submitted for publication in a range of health journals.

Contact: Dr Kathy Alexander, Director of Service Development (08) 204 6002

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