

Rural Health Information Paper No:1

“Best Practice for Rural and Remote Health Services”

December 1997

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**“Best Practice for
Rural and Remote
Health Services”**

December 1997

National Rural Health Alliance 1997

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Introduction

The National Rural Health Alliance is the peak non-government body working to improve the health of people living and working in rural and remote Australia. It has nineteen Member Bodies, each of which is a national organisation in its own right. They represent the consumers of rural and remote health services and most of the professions involved directly with health services in country areas.

One of the aims of the Alliance's work is to increase the profile of issues that matter, and the level of discussion and understanding about them. 'Best Practice' is one such issue. The term connotes something desirable for health services. It is referred to in the National Rural Health Strategy, a critical document for those concerned with health outcomes in rural and remote areas. The Alliance is currently involved with the revision of the Strategy.

The focus of this Paper is best practice in the structure and administration of health services. It explains what best practice and 'benchmarking' are, and how organisations should set about becoming 'best in class' performers. It includes lessons from organisations outside the health field.

Improving rural and remote health outcomes is an important national goal. It can be achieved with the help of organisational best practice in health.

We commend to you this work on what best practice is and how organisations can work towards it.

John Lawrence
Chairperson, NRHA

Best Practice for Rural and Remote Health Services

Executive Summary

In today's environment of competing pressures on resources and the need to improve performance and productivity, the Australian health sector is experiencing demands for increased and better quality health services. The demands placed on the system call for an immediate and creative response from all managers within the system. One such response, which has a proven track record internationally as a successful way to improve service delivery, is the best practice approach to continuous improvement to management and work organisation.

Best practice is a comprehensive and integrated approach to continuous improvement in all facets of an organisation's performance. Best practice is like a jigsaw with many pieces, each of which is an element of the other. For rural and remote health organisations to successfully pursue best practice, all elements need to be addressed in the change process. This Information Paper captures the integrated nature of best practice and the ways to develop best practice approaches. Pages 5-7 of the Paper outline the key principles that are important to the success of an organisation's achievement of best practice. The major part of the Paper identifies and explains in some detail the three critical drivers of best practice that can assist rural health services in improving health care delivery and which are critical to the issue of staff retention and recruitment:

Benchmarking, the enabler of best practice and the tool that will allow rural and remote health services to measure the gap that separates them from 'best in class' performers. Benchmarking fosters and institutionalises an external focus within an organisation and, irrespective of the location and size of organisations being benchmarked, rural and remote health organisations will gain ideas and methods for best practice change. Staff involvement in designing benchmarks and their commitment to the best practice process are critical issues for rural and remote health organisations pursuing best practice, as is the establishment of benchmarking partnerships.

Much of the learning necessary to achieve best practice can be gained through improved *customer focus*. Close links with customers, both internal and external, and with suppliers, can provide the basis for improved organisational processes and service quality.

Effective *people practices* create the co-operation and trust that underpin efforts to achieve best practice and improve service delivery. Commitment to teamwork, training, effective communication, occupational health and safety and staff morale foster this co-operation. *Staff empowerment* means that all levels of staff are involved in the decision making and

developments that affect both their own work and the organisation's performance. In this way, quality becomes a shared responsibility. Best practice and total quality are inseparable.

Best practice is a dynamic tool for change and a learning journey. Rural and remote health organisations that take this journey will find it a difficult and twisted one. Traditional heretical structures, the demarcation between health professionals and the resistance of middle management and clinicians are some of the many stumbling blocks that will be met along the journey to best practice. The Appendix to this Information Paper gives some insight into how health and other industry organisations have overcome the stumbling blocks and put best practice principles into action.

Best practice is about continuous improvement, where each organisation must diagnose its own strengths and weaknesses and find ways of improving health service delivery based on its own organisational culture. There is no one recipe that can be applied across all organisations.

Best Practice for Rural and Remote Health Services

INTRODUCTION

This Information Paper has been developed by the National Rural Health Alliance (NRHA) to promote a wide understanding of the principles of best practice and benchmarking and how these can be used to improve the delivery of rural health services.

Best practice in this Paper is about organisational best practice rather than clinical best practice. Quality health service delivery requires that both these need to be in place to result in a best practice health care service for clients.

As recruitment and retention of health professionals to rural and remote areas are major factors in maintaining effective delivery of health services, the Paper will include how a best practice approach can assist in these areas.

The Paper will also explain how a communications strategy aimed at disseminating best practice information is a necessary part of a best practice approach for rural health services.

Attached to the Paper is an Appendix which provides a number of short case studies to illustrate some of the best practice approaches organisations have taken, particularly in relation to benchmarking, community consultation, multi-disciplinary self-managed teams, staff retention and communication.

The case studies will include some of the learnings of these organisations on their journey to best practice.

BACKGROUND

National Rural Health Strategy (NRHS)

Proposals 5 and 9 of the 1994/96 NRHS identified workforce issues, particularly those concerning recruitment and retention of the non-medical workforce, as critical in achieving effective health services capable of ensuring the optimal health of all people in rural Australia. NRHA is concerned that, to date, little progress has been made on these two proposals.

Proposal 9 recommends the use of best practice models in providing a multiskilled and multi-disciplinary approach as a means to achieve effective delivery of rural health services. Implementation of Proposal 9 requires, therefore, an understanding of a best practice approach and how this can be applied effectively within rural health services.

Such an approach is also congruent with the increased emphasis by Federal, State and Territory Governments on the use of sound business practice in the delivery of health services.

Context

The pressures on the health care industry generally are similar to those in wider industry. They come from a variety of sources, including budget cutbacks leading to a reduction in resources, the move to more commercially-oriented and competitive structures (including privatisation, tendering and contracting out), the unrelenting demand for increased productivity (more output/less cost/better quality) and the changing needs of health care consumers. These pressures, along with rural Australia's ongoing difficulties of overcoming vast distances, small sparsely distributed populations, harsh environments and the problems of staff shortage and excessive staff turnover, only add to the growing concern about the need to urgently address implementation of best practice.

There has already been a great deal of work undertaken by government and individual health organisations, both public and private, in exploring new and innovative ways to improve health care delivery. However, to date, there is little evidence of individual rural and remote health services using best practice as a method for taking their own organisations forward into the twenty-first century.

Using best practice to achieve improved performance has been demonstrated by many Australian organisations, including those in the health sector, as one way of meeting the challenges and demands of recurring change and quality service.

BEST PRACTICE

Best practice has been used by Australian organisations as a means of achieving excellence in service delivery and increased productivity since 1990. It had its origins in the Australian Manufacturing Council's *The Global Challenge* Report, which warned that if Australia was to remain competitive in the global market, then organisations needed to change the way they worked.

In response to *The Global Challenge*, the Federal Government announced its *Building a Competitive Australia* policy statement of March 1991 and the establishment of the *Australian Best Practice Demonstration Program*. This Program, together with the *Best Practice in the Health Sector Program*, were effective catalysts for a wide range of efforts to accelerate the spread of best practice reforms in Australian organisations.

In relation to the health sector, all States introduced policy to encourage best practice approaches in health service delivery. The range of mechanisms included the development and adoption of standard treatment manuals, use of enterprise agreements to gain quality service outcomes, development of a rural information technology strategy to assist in monitoring the impact of best practice models at the local level, clinical practice guidelines,

and adoption and implementation of best practice protocols, procedures and accreditation standards. These mechanisms provide the sector with tools to help organisations to achieve improved health service, however, individual organisations also need to implement organisational best practice to complement these efforts.

Best practice has been proved and accepted both nationally and internationally as an effective way to improve performance. The 1994 Australian Manufacturing Council study, *Leading the Way*, which covered 200 Australian and New Zealand firms, found robust evidence that best practice is clearly linked to improved and sustainable business performance. The study confirmed that best practice has a positive impact on the business and operational performance of individual organisations - best practice works!

What is it?

Best practice is the pursuit of excellence in service delivery. The pursuit of excellence can only take place in a culture where staff and their managers work together to improve the quality of all facets of their operations. The concept of **continuous improvement is integral** to the achievement of best practice, for best practice is about continually looking for the best way of doing things to achieve successful outcomes in all key processes and practices of an organisation.

Best practice provides a powerful mechanism to deal strategically with reform and budget constraints. It is the adoption of a managed approach to change and quality improvement, learning from the leaders in the field and applying lessons in an appropriate and sensitive way to an organisation, recognising the needs of customers and staff, and working within the culture of an organisation to initiate change. It recognises the value of leadership, the contribution of staff and emphasises the need to look externally to achieve best outcomes. Achieving best practice refers to the way in which organisations manage and organise their operations to deliver world class performance. Best practice is therefore a key management tool.

There is no single recipe for pursuing a best practice approach; rather, individual organisations must diagnose their strengths and weaknesses and then look at ways that best suit their needs and circumstances.

There are many ways to develop best practice approaches, depending on the organisation's particular needs, but all are based on some key principles and processes:

- A **shared vision** of world class performance. This vision is supported by a comprehensive, integrated and co-operative change strategy within an organisation, that brings about continuous improvement in cost, quality and timeliness.
- **Leadership**, which by its nature is difficult to describe and measure, is essential in building shared vision, in challenging the ways things are done and in building commitment to the change process.

- A **strategic plan**, developed in conjunction with the workforce, that encompasses all aspects of an organisation and that sets out short, medium and long-term goals.
- A **commitment** to change throughout the whole organisation driven by the full and public support of the Chief Executive Officer. This principle is true for organisations which are managed by a council or governing body - ie the full and public commitment by members of the council, etc.
- **Flatter organisational structures** supported by the devolution of responsibility, the empowerment of staff and improved communication within the organisation. This often involves team-based work organisation (rather than the traditional hierarchical approach) where responsibility and accountability for the provision of a service or product is with the members of the team who provide the service.
- A **focus on customers**, both internal (ie staff in other units or areas of the organisation) and external. Much of the learning necessary to achieve excellence can be gained through improved customer focus.
- A **co-operative and participative industrial relations** culture that incorporates effective communication and consultation throughout the organisation.
- A commitment to **continuous improvement** and learning, with a highly skilled and flexible workforce and recognition of the value of all people in the organisation. Quality becomes a shared responsibility for all people in the organisation.
- **Effective people practices** create co-operation and trust that will underpin efforts to improve in all areas, including a commitment to teamwork, training, effective communications, occupational health and safety and equal employment opportunity. In many respects, the capacity of any organisation to pursue the best practice path to performance improvement is limited or extended by the effectiveness of how it treats its people.
- The development of more co-operative relationships between management and staff is the glue that holds best practice together. Teams and teamwork are increasingly common ingredients in successful change processes.
- **Closer relationships with suppliers.** Leading edge organisations involve their suppliers as an integral part of the change processes.
- The pursuit of **innovation** in technology, products and processes.
- The use of **performance measuring systems and benchmarking.** The use of performance measurement of different aspects of the organisation's performance (retention of staff or customer complaints for example) provides a tool to assess areas for

improvement and in combination with benchmarking, forms an effective tool for continuous improvement.

- The integration of environmental management into all operations - ie understanding the impact activities/operations may have on the environment.
- Involvement in external relationships (networks) to enhance the capabilities of the organisation.

Practical steps to best practice

The journey to best practice can begin with two people in a rural health service sitting together talking about the need for change or it can begin with the management team. The essential element is commitment both by the staff and the management of the organisation to the change process. Without this, best practice will fail.

This journey is a learning process for all members of the organisation. Organisations must diagnose their own strengths and weaknesses and formulate their own approach that best suits their needs. There are many examples from the Federal Government's Best Practice in the Health Sector Program of how health organisations undertook best practice change and the difficulties that they encountered. These examples show why, for some, change was not sustainable and why others were successful.

Not all of the best practice principles can be incorporated into an organisation at first, particularly if the culture of that organisation is resistant to change. Changing the culture of an organisation is not easy because it means learning new behaviours and discarding the known, more comfortable ways of doing things. Without a commitment across the whole organisation to the change process, best practice will not succeed.

One framework for best practice change that has been widely adopted in both the health and other industries as a strategy for change is that of the Australian Quality Council (AQC). The AQC has published *The Australian Quality Awards Criteria 1996: Guide to Interpretation for Health Services* which is designed to assist organisations of all types within the health industry to undertake a self-assessment of the culture of the organisation as a starting point for the best practice journey.

NRHA believes that rural health services need to look at both successful and unsuccessful examples from both the health and other industries on their journey to best practice to gain knowledge of their processes to achieve best practice change.

Some key factors in introducing best practice

- Change is about people doing things differently, thinking differently and interrelating in new ways with each other and the organisation.
- Staff need to actively participate in the culture shift if change is to be successful. All staff need to understand the big picture and its influence on their everyday work.

Without staff fully involved (that is, not just being consulted) in the process, best practice will fail.

- There needs to be a very planned approach. Methods of managing cultural and process change must be integrated into core business and everyday areas of accountability and responsibility. Best practice needs to become part of how the organisation operates, just as budgeting is part of an organisation's operational performance. This means training and support - people need to be trained, for example, to have the skills to measure whether performance in their own work has improved as a result of a new approach to their job; or how to undertake a customer satisfaction survey for their clients so that they can make improvements in the delivery of their service; and how to work in a team and take responsibility for the team's performance.
- Best practice strategies need to be tailored to the cultural maturity of the organisation or service, for example the extent to which staff can take ownership in problem solving issues and effect real change - this is a learning process and requires training and the support of management and peers.
- Leadership and communication are absolutely vital to a successful change process. Without them best practice will fail.
- Rural and remote services/organisations need to look at forming group, regional or intersectoral partnerships for best practice. Learning from the experiences of others, exchanging information and ideas with other health services or with other community services in their region will help organisations in their own change process.
- Benchmarking and networks are vital to best practice change.

All of the best practice principles are important to the success of an organisation's achievement of best practice. However, there are three critical drivers of best practice which can provide the tools to assist rural health services in improving health care delivery. These are:

- benchmarking;
- customer/client focus; and
- staff empowerment.

All of these are key components in the issue of staff retention and recruitment.

BENCHMARKING

What is it?

Benchmarking is a simple process about finding new ways of doing things. **It provides the necessary external and customer orientation that organisations need to achieve best practice.** Benchmarking is described as:

“an ongoing, systematic process to search for and introduce best practice into your organisation , in such a way that all parts of your organisation understand and achieve their full potential. The search may be of products, services or business practices and processes, of competitors, or those organisations recognised by leaders in the industry that you have chosen”.

The power of benchmarking resides in its objectivity. Management is no longer setting targets and determining change strategies alone; rather, targets are a function of what a third party has achieved and which cannot be disputed, and the benchmarking team itself develops the plan for the implementation of change.

Benchmarking is a futile exercise unless it is driven by an empowered workforce. Benchmarking is the key to best practice when linked to the service/organisation’s core business objectives.

Benchmarks are not just another form of performance indicator. Collection, monitoring and evaluation of data for benchmarking should occur at the ‘shop floor’ level. Staff involvement in designing benchmarks and their commitment to the best practice process are critical issues for organisations pursuing best practice.

Benchmarking **is not** database consultation or number fixation. Relying on these avenues for evaluating performance, especially on customer service performance, does not take into account the culture of the organisation. Databases can be useful and performance indicators and targets are essential. However, they can only be used effectively if combined with a change program based on shared and detailed understanding of the practices and structures which produce exemplary performance. Neither is benchmarking just playing ‘catch-up’ .

Benchmarking is like a turning wheel, an ongoing business practice like strategic planning, budgeting and continuous improvement - it is a cycle which repeats itself rather than something done once and for all.

Why do it?

Organisations use benchmarking to achieve a range of complementary objectives, the most common of which are:

- to identify and implement best practice by making valid comparisons with other organisations;
- to overcome complacency about the future of the organisation or service, and to highlight the need for change;
- to reinforce and galvanise commitment to change through the involvement of all levels of the organisation in analysis and target setting and empowering them to design and implement change;
- to achieve quantum leaps in improvement - implementing change that have been demonstrated to succeed in other organisations can happen at a faster pace; and
- to develop a shared vision for the organisation or service. Benchmarking fosters the development and communication of a shared vision for the future throughout the organisation and a deep understanding of key processes.

Best practice requires cultural change in an organisation and benchmarking is a vehicle for driving that change. **It fosters and institutionalises an external focus within an organisation**, enabling that organisation to develop strategies for improvement learned from the experience of others. Benchmarking enables organisations to measure their own levels of performance against 'best-in-class' examples so as to identify gaps and opportunities for improvement. It also enables organisations to identify the practices driving the best performers so as to develop strategies for achieving sustainable levels of performance - like a farmer looking over the fence at a better crop! How does my neighbour have higher yields? Why is he/she able to market his/her product more effectively?

For example, in the area of retention and recruitment, there are opportunities for rural and remote health services to establish benchmarking partnerships with other service industries which operate in the same environment - for example, teaching services, National Parks and Wildlife Service, hospitality and tourism. All of these sectors experience the same difficulties of retention and recruitment of staff - how are they dealing with the problem? What processes have they put in place to reduce turnover and staff shortages?

Types of Benchmarking

There are a number of different types of benchmarking. Fundamental distinctions are whether benchmarking is done internally or externally and whether the main focus is on numbers or processes.

Internal or external:

Benchmarking can be undertaken internally by comparing yourself with other areas, units or locations within your own organisation or service, or it can be external against:

- others in the same industry (**industry benchmarking**); or

- organisations in other industries (**generic benchmarking**) - that is, industries that have similar needs to employ similar processes. This type of benchmarking is very effective, although is the most difficult. There are many health organisations that have undertaken generic benchmarking with exceptional results (eg Maryborough District Health Service, in rural Victoria which established benchmarking partnerships with Southcorp Wines and Sheraton Hotel, Sydney).

Many rural and remote services may have difficulties in seeing any value in using metropolitan health services for industry benchmarking. However, when undertaking benchmarking of a process (for example the setting up a multi-disciplinary team or multiskilling approach or a process for consultation of clients to improve customer focus, or methods of empowering staff) it does not matter whether the organisations being benchmarked are large metropolitan hospitals or small rural services. Irrespective of their location or size, the process of how these changes were developed and implemented will provide ideas and methods for best practice change.

What can you benchmark?

Benchmarking can be undertaken on all aspects of a service or organisation - for example: performance indicators such as morbidity rates, patient/staff satisfaction, absenteeism rates, staff turnover. Work practices which drive performance indicators can also be benchmarked - how you deliver services more effectively; how you develop a new service; how you manage to meet client needs or improved response times.

To check whether the areas chosen to be benchmarked are important, it is useful to ask :

Do your clients/customers notice the difference if you implement best practice in your service/organisation?

If the answer is no, then, although important, the area chosen to benchmark is not important enough for the first benchmarking project. The only exception to this is if the overall cost structure of the organisation is affected significantly by the implementation of best practice. In rural and remote health services, the area of retention and staff turnover would fall into this category.

It is important to put a greater emphasis on processes rather than numbers when benchmarking. Numbers are necessary to establish the size of gap and measurable goals but they do not provide information on the factors and processes behind their achievement. In cases when concentration is heavily on numbers rather than how the best do it, the scope of improvement is severely limited.

An Ongoing Process

Each service or organisation's approach to benchmarking will be different, but those which do benchmarking best share several common elements by using a systemic process which is integrated with other initiatives to improve:

- involving the right people (staff) so that preparation and implementation are supported effectively and wholeheartedly;
- choosing the right things to benchmark, ie those things that are most important to the success of the organisation;
- having a common understanding of just what is involved so that the process can be managed, people know what is expected of them and managers allow them the necessary time away from normal duties to fulfil their benchmarking role properly;
- gaining an understanding of your own situation so that when you compare your processes and practices to somebody else's, you are not doing it from a position of ignorance. Thorough preparation is essential;
- choosing suitable partners - this requires careful consideration of what organisations are most likely to offer value for the effort you put into visiting them; and
- turning ideas into improving your organisation's processes/practices. This is where it is critical to have staff who are involved, empowered and committed.

The Benchmarking Process

There are a number of steps in the benchmarking process.

The first stage is to gain the commitment of all levels of the service or organisation to the need for change - it must be seen as an essential component of the change process.

Once commitment has been gained the next step is the establishment of a benchmarking team. Benchmarking teams should be made up of appropriate people representing a management and non-management cross-section of the whole organisation, and would include clinicians and other professional groups. Although all members of the organisation need to be involved in the development of the benchmarking project, a core benchmarking team is used to undertake the details of the exercise.

The next step is self-analysis - organisations must understand their business objectives, functions, processes and clients, otherwise the benchmarking visits will be merely 'tourism' visits. Once an organisation or service understands its own operations and key performance areas have been identified and agreed upon, they become the basis for comparison against best practice performers.

The organisation can now start to identify areas to benchmark.

The next stage is the identification of best practice partners within and/or outside the organisation's own industry or sector. Building a good relationship with prospective benchmarking partners is of paramount importance.

Once an organisation has detailed information and a knowledge of its partner's current processes, it can identify and analyse the gaps between best practice and its own organisation's or service's processes.

It is important to develop on-going relationships with these benchmarking partners. This will provide the important external link for rural and remote services in their journey to best practice.

Benchmarking Partnerships and Networks

The search for good benchmarking partners can be very time consuming. It can take several months and must be undertaken by a person who has a thorough appreciation of the topic being benchmarked and a broad understanding of a wide variety of industry sectors. Areas of search and methods can include:

- literature sources;
- trade and professional associations;
- consultants;
- major suppliers; and
- using technology.

The temptation will be to use existing professional associations as a vehicle for establishing benchmarks. However, when looking at process or generic benchmarking there is a need to explore partnerships both inside and outside the health industry. For rural and remote health services, there may be a short-term need for a co-ordinating body, perhaps ones which can act as brokers. For example, the Rural Health Training Units could be of use in this area or other existing best practice networks in both the health and other industries (for example, the Centre for Best Practice, the Australian Quality Council, the Australian Council on Health Care Standards, and the Community and Health Accreditation and Standards Program (CHASP)).

Rural and remote health services can also make use of existing best practice networks of organisations which participated in the Federal Government's Best Practice in the Health Sector Program and in other best practice programs funded by State Health Departments.

The establishment of regional best practice networks would also help rural and remote health services to pursue best practice. Such networks enable knowledge, information, experiences and leanings to be shared. Each network establishes its own objectives, but objectives typical of networks include:

- to facilitate the exchange of best practice information amongst members of the network;
- to assist the development of best practice; and

- to promote awareness of the adoption of best practice in the region.

Existing partnerships

In rural and remote areas there are already some informal health teams comprising general practitioners, nurses, community pharmacists, Aboriginal health workers, allied health personnel, hospital and other health professionals who communicate and work together. Formalising these teams can be achieved through a best practice approach and this has the potential to improve the delivery of health care. The critical best practice principles to achieve this in this case are customer focus and communication. These two elements are essential to achieve this partnership.

CUSTOMER/CLIENT FOCUS

A focus on customers or clients is vital and, for health care services, the single most important aspect of best practice change. It is therefore necessary to identify the 'customer' of a service: is it the patient, the funder, the doctor? Organisations which focus closely on customer requirements are much more likely to be able to react quickly to change. Customer focus is also the driving force for an organisation's cultural change - external focus, staff empowerment and satisfaction and benchmarking. Having an external focus is particularly relevant for rural and remote health services which in general have become introspective.

As mentioned earlier, customer focus is a key tool in the issue of staff recruitment and retention. A focus on the customer has led many health care services/organisations to look at the use of multi-skilling and multi-disciplinary team approaches to achieving best practice in health service delivery.

For example, the NSW Ambulance Service has been multi-skilled since 1976. From 1969, an emergency cardiac ambulance service operated in the eastern suburbs of Sydney. When a cardiac crisis occurred, the nearest ambulance would proceed to St Vincent's Hospital, collect the cardiac team and then proceed to the scene, stabilise the patient and then return the patient to hospital. In 1976, a decision was taken to enhance the skills of ambulance officers by providing advanced training which would enable them to initiate intravenous therapy, recognise arrhythmias and where necessary, defibrillate and intubate patients and to administer a limited range of drugs. **This multi-skilling of the service was directly related to the needs of the customer.** At the same time it also resulted in increased job satisfaction, and hence an impact on staff retention. There are many other examples within the health industry, such as the creation of Patient Care Assistants, which involves the amalgamation of cleaning, portering and food delivery duties and is designed to provide a wider variety of work and improved advancement opportunities for ancillary staff.

Multi-disciplinary Teams

The establishment of multi-disciplinary teams is a customer driven best practice approach (that is, leading edge organisations use multi-disciplinary, self-managed work teams as the

means to providing improved customer satisfaction). The use of multi-disciplinary teams also impacts on the job satisfaction of people working in the organisation. Using the contribution of people through teams produces multiplied opportunities for people to enjoy their work and to feel empowered. It also results in increased customer satisfaction and, for the organisation, increases in productivity levels. Developing multi-disciplinary teams is a best practice method of addressing the recruitment and retention problems in rural health services.

For rural and remote health services, the concept of forming teams across sectoral lines, between the community, health and other services will lead to better outcomes for health care delivery. There are many examples of health services that have used this approach to improve health care delivery - for example, the Maryborough District Health Service in Victoria established self-managed, multi-disciplinary teams which represented each of the Health Service's areas to provide a more integrated, co-ordinated and effective structure. A component of the approach was to introduce protocols with agencies external to the service.

STAFF EMPOWERMENT

Successful benchmarking and best practice have, as their cornerstone, staff empowerment.

Staff empowerment means that all levels of staff are involved in the decision making and developments that affect both their own work and the organisation's performance. Empowerment, therefore, can only occur in organisations where co-operation and trust exist between staff (both professional and non-professional) and between staff and their managers, and where traditional hierarchical structures have been replaced by flatter structures. However, achieving this change of culture in an organisation takes time, persistence and continual nurturing by both the staff and management.

Empowering and involving staff in the operations of an organisation has a twofold effect:

- (a) it allows change to be implemented quickly because of the 'ownership' effect - the Evaluation of the Best Practice in the Health Sector Program reports that "*where programs had been initiated by staff, using staff experience and understanding of the impediments to work performance, they [the reforms] appeared to have been relatively quickly implemented and embedded into everyday practice*"; and
- (b) it provides a motivating effect and a sense of ownership and accountability to achieve best outcomes and high levels of performance. Empowerment is therefore a key component for rural health services in addressing recruitment and retention.

To illustrate the beneficial effects of empowerment, in 1991-92 Australian Resorts, which runs facilities at several locations off the North Queensland coast with 500 staff, reduced staff turnover by one third from the previous financial year and improved productivity by 18.9% for the third quarter of 1992 as a result of the involvement of staff in the operations of the company. Australian Resort's best practice approach involved the development of

structures, processes, attitudes and skills of staff to support a customer focused and shared ownership philosophy. There were a number of steps in introducing these concepts and a great deal of training and culture change was needed to achieve these outcomes.

One of the most effective ways of empowering staff is the introduction of self-managed, multi-disciplinary teams. This, together with some of the strategies that have been developed by Federal, State and Territory governments such as the Rural Health Training Units and the establishment of University Departments of Rural Health, will provide mechanisms to improve retention and aid recruitment in rural and remote areas.

COMMUNICATIONS/DISSEMINATION PLAN

As with any industry sector, introducing best practice in rural and remote health services requires a structured approach (rather than a haphazard one), to ensure that best practice will progress and become institutionalised in rural and remote health service delivery. The use of a dissemination or communication strategy to spread the concepts effectively across rural and remote health services is therefore critical to the spread of best practice into the sector.

The following three-pronged approach is suggested:

1. initial circulation of the Paper to key stakeholders with a feedback mechanism to determine areas of difficulties;
2. follow-up focus group activity at key rural/remote locations, for example, interactive workshops and discussion groups to provide a forum for discussion of ideas, issues and methods on the implementation of best practice. These workshops could be incorporated into existing rural health and community service forums
 - items on specific aspects of best practice could also be incorporated in existing rural and remote health newsletters; and
3. incorporate best practice sessions into rural health conferences and forums, including using information booths, to raise the awareness and understanding of best practice and to disseminate practical information to participants.

It would also seem essential that some central best practice clearing house be established for rural and remote health services to access up to date best practice information and ideas. This could be housed for example in a Rural Health Department of a University or rural health association.

SUMMARY

Best practice is not an easy journey. Commitment across the **whole** organisation by **all people** involved in the delivery of the service and leadership by senior management are critical elements in starting the process. An in-house champion, coupled with management support, will provide the necessary drive and motivation in the change process. There are, however, many stumbling blocks encountered, the most prominent of which include:

- lack of management commitment;
- resistance from middle management, clinicians and supervisors;
- demarcation between health professionals;
- a sceptical minority hindering the change process;
- excessive expectations during the initial stages of the process; and
- lack of resources for training and development.

Several of these are due to personal fear of the outcomes of implementing a best practice approach.

However, many Australian organisations, including health organisations, have achieved best practice both in elements of and/or throughout their organisations despite these difficulties (all industries encounter similar barriers!). There is therefore a wealth of information, ideas and knowledge available from these organisations to help others implement best practice into their organisation.

Isolation and distance are only two of the many difficulties that rural and remote health services will face in implementing best practice; however, regional networking will help to overcome some of these. Critical to the success of implementing best practice into rural and remote health services is communication and dissemination of the experiences and learning.

Appendix

The following short case studies illustrate how health and other industry organisations have put best practice principles into action, the paths travelled and the lessons learned.

MARYBOROUGH DISTRICT HEALTH SERVICE, VICTORIA

The use of Self-Managing Teams to Achieve Improved Quality of Service

Maryborough District Health Service is located in central Victoria and services a population of 16,900. The city of Maryborough is the central point of the health service and the Central Goldfields Shire Council. Maryborough undertook a program to refine delivery of care and replace a fragmented system of delivery using a best practice approach. This was approached through the use of self-managed teams and case management.

Since 1989, the Service had been subjected to a significant amount of change - declining resources, increasing workloads, voluntary amalgamation, the introduction of case mix and a significant shift in emphasis from acute to community care. It also included a shift to devolved budgeting, voluntary redundancies, increased contracting out and an emphasis on productivity savings.

Customer Focus

Between 1995 and early 1996, a strategic plan was developed by the Maryborough District Health Service. Staff, community organisations and the general public were consulted to ensure the plan would meet everyone's needs. Staff and management developed a customer satisfaction survey to highlight areas needing improvement and to give positive feedback to staff about areas in which they were doing well.

Communication and Staff Involvement

Communications was key to the introduction of Maryborough's change program. A best practice committee was selected on the basis of the best possible representation across all staff functions. Unions and associations were involved in the development of the change program and working groups were established to develop specific areas of the program.

Information on Maryborough's vision of change was disseminated throughout the Service and a number of strategies were employed to keep staff informed and involved in the process. These included staff focus groups, monthly newsletters, monthly best practice meetings, informal meetings/chats, education workshops, handouts, demystifying the language sessions and developing a library of relevant books. Evaluation was ongoing throughout the program and included assessment of staff attitudes and knowledge, aspects of the program as they were trialed and implemented (for example, team training) and the impact of the program on the Health Service's overall functioning.

Staff were fully involved in the operations of the Service. Department budgeting was introduced in 1994 and staff receive up-to-date information on current government policies/directions in health care provision. Management visibly subscribes to the belief that people delivering the service are the best persons to highlight gaps and develop new ideas on service delivery.

Training and Support

Maryborough used the admission and discharge planning team as the model for developing its self-managed team approach. Because the teams would be required to review methods of delivering care and procedures and identify ways of improving delivery, a training program for all staff was set up. This covered aspects of best practice, benchmarking and team structures. The information was provided in written form, through discussions and meetings and via formal training sessions. Performance indicators were also developed within teams to help team assessments. Workshops were conducted to help staff understand the processes involved.

The team training process brought staff from all areas of the Health Service and helped them realise that they experienced the same difficulties and had similar goals and expectations of best practice. This process laid the foundations for a desire for change.

Benchmarking

Site visits were undertaken by key staff to compare structures and best practice with other regional and remote Health Services and with organisations outside the health industry. These included visits to Southcorp Wines, West Australian Health Services, Sheraton Hotel, Sydney, and Bundoor Extended Care. Before the site visits were made, presentations and questionnaires were developed and provided to both Health Service staff and the proposed sites. The process helped to identify key issues for discussion and comparison and to identify benchmarking partnerships.

Maryborough benchmarked service delivery, team processes, staff and customer satisfaction, absenteeism, staff turnover rates and training strategies outside the health sector. The Southcorp Wines visit, for example, provided an excellent example of how a system moved from a hierarchical structure to a team-based structure.

Lessons

The key elements which contributed to the success of the best practice program for Maryborough were the commitment to training in team development; performance indicators; benchmarking with areas other than health care agencies; the spontaneous support of staff and the strong support to the process by senior management and unions.

Maryborough encountered many problems and barriers during their best practice journey, for example:

- staff were suspicious that best practice was another government means of cost cutting;
- at times staff were overloaded with information;

- the new language was difficult to grasp and didn't always seem relevant at ground level; and
- survey responses were poor.

Some tips from Maryborough's best practice journey:

- communications needs to be ongoing;
- maintain a positive attitude;
- look at process rather than looking at individuals;
- there will always be blockers but run with the people that have the skills to change; and
- deliver information in as many different forms as possible - we all learn in different ways.

[Source: *Australian Health Organisations Taking Up the Best Practice Challenge, Case Studies of Funded Projects*. Commonwealth Department of Health and Family Services ISBN 0 644 39702 4]

WHYALLA HOSPITAL AND HEALTH SERVICES

Enhancing Rural Health Recruitment

The Whyalla Hospital and Health Service is located in rural South Australia and, like many rural and remote health services, experienced difficulty in recruiting and retaining experienced staff. The problem was particularly serious for allied health services. Research in 1989 identified the difficulty of recruiting senior allied health staff with competencies in advanced clinical and management practice as a crucial factor impacting on the availability and quality of rural services.

Best Practice Partnership Approach

Whyalla Physiotherapy Department undertook a review which highlighted the need for a different approach to continuing to pursue recruitment by improving the skills and broadening the competencies (multi-skilling) of an incumbent clinician to a clinician manager.

A partnership was established with the Adelaide Women's and Children's Hospital to look at ways to address the problem - what was required, the current skill levels and ways to develop the skills of incumbent staff rather than relying on the outcome of recruitment to improve the skilling of clinician and clinician manager. The result of this process was the potential to develop existing staff through directed learning Development Agreements (DA).

The Process

The Domiciliary Care Team was fully involved in the strategic planning process, which included identification of their core business and customers. The process clarified the expectations of the job and targeted skill development was undertaken to improve the performance of the whole team. This resulted in an empowered and cohesive team with a much clearer understanding of service priorities.

Identification of the internal and external customers of the service was achieved through a focus group approach and the use of specific worksheet questions. Team members, particularly those involved in direct service work, such as the home helps and personal attendants, were involved in the development process which led to greater job satisfaction and a feeling of being valued.

Outcomes

The Development Agreement was extended to the development of a kit both for Individual Development Agreement (IDA) and a Team Development Agreement (TDA). The agreements were designed not only to enhance career paths for existing staff, but to improve both recruitment and retention in a rural allied health setting.

The IDA identified the key performance competencies needed in individual and group settings and identified the key training needs of participants. The TDA transposed the IDA to a team setting. Its development was undertaken through a series of facilitation workshops.

Lessons

The Whyalla project included a number of important best practice initiatives, including empowerment of staff, involvement of staff in the change process and customer focus. The training provided for in the TDA highlighted the benefits of including staff from all levels of a service.

Some tips from Whyalla on Development Agreements:

- organisational agreement is necessary to embark on such a process as it requires dedicated time and commitment from managers and staff;
- it is essential for managers and staff to agree on the purpose and value of the Agreement before commencing; and
- managers need to be supported so that they feel that they do not have to undertake the process on their own.

The Whyalla project demonstrated that Development Agreements are most successful when individual staff and/or a team are committed to improved performance through increased skill learning. The project strengthened and highlighted the benefits of rural/metropolitan partnerships in the achievement of health gain and increased opportunities to network within the State and nationally.

[Source: *National Allied Health Best Practice Industry Report*, February 1997]

NSW NATIONAL PARKS AND WILDLIFE SERVICE

Improving Staff Retention through Effective People Practices

The National Parks and Wildlife Service manages some 1,400 staff across more than 100 workplaces in NSW. It manages approximately five per cent of land in New South Wales including national parks, nature reserves, Aboriginal areas and historic sites as well as having responsibility for all protected species of plants and animals.

The Service employs people in many different areas - rangers, field officers, research scientists, technical officers and pilots. These employees often work in remote locations with limited local work support, often resulting in a high mobility of the workforce. To address this problem, staff, management and the unions developed more flexible work practices as part of their enterprise agreement.

Innovative People Practices

Key initiatives for maximising employee involvement in the workforce were provided through more flexible leave provisions, including family/personal leave. For example, female employees are allowed to return to work during maternity leave to take advantage of professional development opportunities.

Employees also have the flexibility to take their family on field trips if the length of the trip, childcare or elder care makes this necessary. This flexibility has been extended to transferring people who identify as couples to the same geographical location where practical. Couple job-sharing of a ranger position is also included.

Biannual open days are held throughout the State to give family members the opportunity to experience some of the aspects of a typical day and view the workplace and the working environment so that they better understand the employee's workplace.

Isolated partner workshops were established for family members who are employed in remote locations. The workshops help to identify and solve any problems they may be experiencing as a result of their isolation. The Service supports the isolated partners workshop through a widely circulated newsletter and financial assistance to participants for travel, accommodation, meals and, if required, child-care fees.

Outcomes

These best practice initiatives have eased the difficulties experienced by employees working in rural and remote areas by supporting staff, particularly those with families, in balancing their work and family commitments. As a result, the Service has a more stable and committed workforce.

The National Parkes and Wildlife Service won a silver medal in the 1995 Corporate Awards for Special Work and Family Initiatives for its wide range of innovative and flexible family-friendly practices.

[Source: *Benchmark, The Magazine for Workplace Reform*. Issue Number 14, February 1996]

PORT AUGUSTA HOSPITAL AND REGIONAL HEALTH SERVICE

Best Practice Consumer Consultation

Situated some 300 kilometres from Adelaide, Port Augusta Hospital and Regional Health Service covers 82 percent of the State but contains only 2 percent of the population. 12 percent of people are Aboriginal. Access to services for people in the region, many of whom are Aboriginal children, is difficult, time consuming and costly.

Port Augusta undertook a best practice program to provide children living within the catchment area of the Port Augusta Hospital with improved service delivery. To achieve this, they had to identify the needs and gaps in their service delivery, particularly the co-ordination of these services.

Process - internal and external customer consultation

Multiple strategies were employed, including personal interviews, community group consultations and questionnaires, to ensure information was gained from a cross-section of this culturally diverse population. Community members and service providers were the key people to provide this information. Feedback on the results of communities' input was provided both orally and in written format, reinforcing the collaborative process within the community.

The consultation process included the following:

- the selection of a team: the leader was Aboriginal who spoke the local Aboriginal language fluently and had an extensive background in children's services. Other members of the team included an Aboriginal with nursing background. The team was well known locally, respected, dedicated and able to communicate well within the range of cultures about children's health;

- a steering committee was formed which had broad community representation and commitment and provided support and feedback to the team and to the hospital's board of directors - an essential element of the process; and
- an analysis of community service needs and satisfaction was undertaken and community collaboration was used to recommend strategies for improving services and service delivery. Because of the diversity of the population in the region, a variety of methods of collecting information was used, including questionnaires and focus group meetings.

Prior to this broad consultation process, a promotional strategy was employed to inform and prepare people to contribute information - through local radio stations, television and print, school and service agency newsletters.

All major communities were included in the consultation process. Before visits, the team would contact key members of each community who would assist in setting up venues and organising attendance for the meetings. Some 19,000 kilometres were covered by the team in the consultation process!

Barriers Encountered and lessons learned

- the geographical challenges for the team. For example, the time it took to travel vast distances to carry out and co-ordinate the community consultation. However, energy, commitment and local expertise overcame these problems;
- the use of local personnel in a community is imperative to success and the active involvement of service providers is necessary to identify areas for improvement in services;
- communications and training is essential - guidance and instruction regarding questionnaire production and sampling techniques, recording data and reporting and analysis techniques is required to achieve desired outcomes;
- continuity of management improves the process; and
- an e-mail service or similar, rather than relying on faxes, to improve the process of communication and distribution of information.

[Source: *Selected Case Studies in Best Practice, Best Practice in the Health Sector Program, Commonwealth of Australia 1996*]

ERICSSON AUSTRALIA PTY LTD

Changing to a Team Environment

The following is an extract from a presentation given by Peter Skilbeck, Change and Improvement Manager of Ericsson Australia, at the 1995 Best Practice in the Health Sector Conference. It provides some insights into Ericsson's journey to best practice and their approach to the development of self-managed teams.

What is a Team?

A small number of people, with complimentary skills who are committed to a common purpose and set of performance goals for which they hold themselves accountable. A team has:

- shared leadership roles;
- individual and mutual accountability;
- specific team purpose that the team itself delivers;
- encourages open-minded discussion and active problem solving meetings;
- measures performance directly by assessing collective work products; and
- discusses, decides and does real work together.

Where to start Teams?

In deciding where team performance might have the greatest impact, concentrate on the organisation's critical delivery points, and then get teams together, usually on a cross-functional (multi-disciplinary) basis, to work on those critical points.

Nurturing and developing Teams - success criteria

Various studies of high performing teams show the following things to be most important:

- establish a clear and worthwhile purpose;
- select members for skill plus skill potential, not personality;
- eliminate hierarchical distinctions between members;*
- set clear norms or rules for the team operation;
- set performance goals with measures of progress;
- keep creativity high by working on any fresh information and data;
- spend lots of time together; and
- recognise and reward milestones and achievements.

* this is an important criteria for rural and remote services, with the traditional clinical/other professional/management hierarchical distinctions.

Equipping Teams

Teams will often need assistance with monitoring their stages of development, with team processes and roles, and with the tools to use to achieve their purpose and objectives.

Some tools to assist this process include:

- thinking like a customer;
- making the rate of learning greater than the rate of change; and
- using solution thinking rather than problem thinking.

Barriers to Teams

A study of approximately 200 organisations across industries in the USA in 1992 found five key themes:

- employees distrust management's motives;
- there is a lack of clarity concerning what is expected;
- there is resistance to change at various levels;
- managers lack participative skills; and
- there is a lack of top management commitment.

In a health service, resistance and lack of commitment invariably comes from clinicians.

What can be done to limit the impact of these barriers?

- (a) create and communicate a statement of the bigger picture regarding the future of the organisation into which teams are an important strategy;
- (b) begin an open discussion of policies and practices which need to be reconsidered - work on what results are expected from teams and what power and authority they will need, for example;
- (c) strategies to overcome resistance to change could include: let people define new roles and identify and resolve the practical blockages which can affect teams; celebrate success and learn from the good and the bad;
- (d) if managers lack participative skills, introduce structured ways for managers to get feedback on the critical behaviors needed to support team development; and
- (e) top management commitment is essential*. To demonstrate this commitment, managers need themselves to be involved and interact in a team. For example, rather than expecting written reports from the team leader, managers can get directly in touch with teams about their progress.

* for rural and remote services, commitment from clinicians is also essential.

The above learnings for the setting up of multi-skilled, self managed teams are also true for undertaking a best practice change process in any aspect of an organisation.

WOMEN'S AND CHILDREN'S HOSPITAL, ADELAIDE

Multi-skilling for improvement in work practices and customer focus

The Women's and Children's Hospital (WCH) has around 400 beds, some 2,000 staff and provides paediatric surgical and medical, obstetric, gynecological and neonatal services to the women, children and young people of South Australia. WCH resulted from an amalgamation of the Adelaide Children's Hospital and the Queen Victoria Hospital in 1989. The amalgamation, which included moving the women's services to a new building, was completed in 1995.

The amalgamation, combined with the financial pressures of the last decade, offered WCH an opportunity to ask fundamental questions about the way work was organised and to develop new management processes and structures.

Defining the Problems

In 1993, an analysis of work practices highlighted a number of problems:

- narrow job descriptions which meant inefficient work practices, poor service levels and resource under-utilisation;
- fragmented decision making among numerous committees; and
- work structured according to professional groups rather than work processes.

These problems resulted in fragmented care, long turnaround times for services and overly complex processes. A number of improvement strategies were used in the hospital's change process to achieve more patient-focused structures and work processes:

- streamlining management;
- simplifying processes;
- moving patients and services closer together;
- multi-skilling staff; and
- devolving management authority, accountability and responsibility to staff at the patient bedside

Multi-skilling

One approach to the change process to improve the quality of care at the bedside and end demarcation issues, was the creation of a new staff position, the Patient Support Attendant (PSA). The PSA combined the roles of cleaner, orderly and nurse attendant.

The development of the PSA involved selecting staff for a three-week training course, trialling the new position in a number of wards for six months and then evaluation through a survey process and in regular meetings with the project staff, ward managers and the PSAs. Following the evaluation, the training program was reduced to two weeks and more hands-on training was used. In-service meetings were held to inform all staff about the new

role of the PSA and a kit was developed to help unit heads integrate the PSA into their ward.

Issues and Barriers

The introduction of the PSA role drew initial resistance, not only from support services staff, but from registered and enrolled nurses who saw the role as threatening. Teething problems mainly came about during PSA integration into the new ward environments, with the PSAs either being ignored or being overworked in the cleaning areas.

Integration

The PSA role not only combined the roles of cleaner, orderly and nurse attendant, but resulted in staff being able to be placed in a ward team rather than working from a centralised pool in the hospital. This meant that the ward team had immediate access to support and the level of support could be varied.

The PSA role was fully implemented into WCH in March 1996.

Leadership played a large part in ensuring that the change program was implemented. The organisation restructured into multi-disciplinary patient focused divisions, introduced management development based on people management and continuous learning and a decision making process that emphasised greater ownership and carriage of decisions for managers.

[Source: *Selected Case Studies in Best Practice, Standards of Care and Workplace Organisation*, Commonwealth of Australia ISBN 0 644-474149 November 1996]

PRINCESS ALEXANDRA HOSPITAL, BRISBANE

Best Practice in Communications

The Princess Alexandra Hospital is one of Brisbane's major teaching hospitals, employing over 4,000 staff. Patient and staff surveys identified the need to improve communication within the hospital as being a key element in patient focused care and critical to the hospital's organisational management.

Four phases were involved in the process of identifying the problems and implementing improvements in communications:

- **Information Gathering and Analysis**, including the conduct of a comprehensive audit of communication;

- **Benchmarking** a comparison of communication strategies employed by other organisations. This involved site visits to service industry organisations and the development of performance indicators;
- **Redesign and Pilot Implementation** - the design of a communication strategy and piloting these strategies at an organisational level and in a variety of clinical settings; and
- **Evaluation and Dissemination**, including evaluation of strategies and repeating major components of the communications audit.

The strongest influence for the hospital's best practice communication project was customer focus involving three major target groups - patients, staff and external customers, specifically GPs. The communication audit involved these groups in surveys, focus groups and interviews.

Identifying the Problems

The audit provided a 'snapshot picture' of communications at the hospital. Questions were asked about:

- the *way* information flows;
- *what* we need to know;
- *how* we like to get information; and
- *where* we get information.

The audit highlighted major areas for improvement for the hospital and identified ten key organisational issues that needed to be addressed:

- lack of vision, values, direction;
- meetings - none in some areas, lack of structure, lack of outcome, ineffective decision making;
- lack of consultation;
- lack of feedback;
- lack of senior/middle management seen at the workplace;
- more face to face communication;
- lack of resources - staff, equipment;
- GP information;
- improve top down/bottom up communication; and
- clarity of reporting lines.

Benchmarking

Princess Alexandra found that benchmarking communications was a difficult process, compounded by the fact that organisations had measured communications differently, making comparison of results difficult. For example, some organisations had evaluated 'tools' of communications without first asking what are the **key success factors** in

employee communication or client communication. There is little value in starting a communication assessment by an evaluation of the staff newsletter if staff do not indicate this as an important source of information!

The sound understanding of their own communication issues and problems learned through the audit process provided the hospital's benchmarking visiting team with detailed information necessary for comparison with the host organisation's situation.

Major Findings

The major findings from Princess Alexandra's benchmarking exercise were:

- improving communication tools and mechanisms in isolation is insufficient;
- communication needs to be linked at the strategic level;
- communicating vision and values throughout the organisation is vital;
- role modeling effective communication behaviours demonstrates the value of communication;
- feedback mechanisms are essential;
- managers/supervisors need to be shown **how** to communicate and **what** to communicate;
- honest, open communication is expected by staff;
- messages need to relate to **me** in **my** job and be clear, consistent and repeated;
- the importance of customer focus in communication; and
- all major change processes take a long time.

These learnings, together with those found in the audit process, led to the development of an improvement strategy focused on top down and bottom up communication, consultation and feedback mechanisms.

Lessons Learned

- best practice organisations focus on the communication of vision and values to staff and the translation of these into action.
- improving communication tools and mechanisms in isolation is insufficient - communication needs to be linked at the strategic level;
- difficulties arise when an environment of continuing change and instability are associated with the implementation of organisational change and workplace reform;
- a stable industrial relations environment with involvement by union delegates and officials in the change process is critical;
- learning from other organisations outside the health industry and the establishment of networks, particularly for customer focus and cultural change supports continuous improvement and learning; and

- to be successful, best practice must be supported by staff and senior managers. It is critical that senior management support is strongly visible in providing leadership for and legitimacy to best practice change.

[Source: *Australian Health Organisations Taking up the Best Practice Challenge*, Commonwealth of Australia 1996
Communication - the Vital Link in Best Practice Organisations, Katrina Horsley, Princess Alexandra Hospital, The Best of Health Best Practice in Action Conference, Brisbane 1996]

ROYAL MELBOURNE HOSPITAL

Using the Australian Quality Council (AQC) Self-Assessment Criteria to adopt a Best Practice Approach

A Framework for Best Practice

One framework for change that has been widely adopted in other industries and is now emerging as a strategy for change in the health industry is that of the Australian Quality Council (AQC). The *Australian Quality Awards Assessment Criteria 1996: Guide to Interpretation for Health Services* was developed by the Council for use as an interpretative document designed to assist organisations of all types in the health industry as a guide to the adoption of best practice and quality approaches to organisational change.

The seven categories by which organisations can self-assess themselves are:

- **Leadership:**
the way quality principles are becoming a way of life in an organisation through a focus on a quality environment, systems and structures, involvement of all levels of management and the organisation's role in the community.
- **Policy and Planning:**
how the organisation develops its policies and plans and communicates and deploys them, involving the entire organisation, its customers and suppliers and the external community.
- **Information and Analysis:**
the way an organisation uses data, its selection, collection and analysis.
- **People:**
the extent that people at all levels are involved in continuous improvement within the organisation.

- **Customer Focus:**
how the organisation reflects the needs of its current and future customers in all of its activities, anticipating, identifying, responding to and satisfying their needs, improving the interaction with customers.
- **Quality of Process, Product and Service:**
what processes are used to supply quality products and services to customers and improving those products and services by working with suppliers and customers, both internal and external, on systems that will improve processes.
- **Organisational Performance:**
how key performance indicators and other measures are used by the organisation.

The Royal Melbourne Hospital used the AQC framework to inform and assist it in its best practice journey.

Royal Melbourne Hospital

Like many health organisations, Royal Melbourne Hospital (RMH) has undergone a number of changes (casemix, budget cuts, restructuring, etc.) which had a profound effect on the organisation. An employee opinion survey in July 1993 highlighted the impact these changes were having on staff well-being and morale. The main issues arising from the survey were:

- emotional exhaustion, or burnout;
- absence permissiveness - that is staff's perception of the attitude of the organisation towards absence from work;
- physical health; and
- external responsibilities.

Each of these issues is related to the health of the individual and to the organisation's health and culture. RMH undertook a number of activities to improve its organisational health and develop strategies to move forward. One of the tools used was the AQC self-assessment process.

RMH used the AQC self-assessment to conduct a cultural audit within several departments of the Hospital to assist in identifying and evaluating strategies which would make a positive difference to the Hospital's organisational health/culture. RMH defined culture as a 'pattern of shared values, beliefs and feelings that direct people's perceptions of the work to be done, their approach to work and how the work is completed'.

Process and Findings

The self-assessment was conducted in focus groups with a cross section of all staff using an external facilitator. Results were fed back to departments, including education on the principles of best practice, participation in best practice activities and facilitated development of improvement activities.

The RMH self-assessment exercise:

- identified how people issues fit into everyday activities;
- provided a clear picture of the gaps that needed to be addressed and also how to go about it;
- uncovered some overlooked strengths;
- was an opportunity for all staff to become involved in best practice activities, which led to increased knowledge of best practice principles; and
- created staff ownership of the issues.

It also identified what was working well and the barriers to a healthier organisational culture and how to overcome the barriers.

RMH learnt that by investigating the relationship between organisational health and the big picture, they discovered the importance of keeping organisational health issues in the spotlight in times of other pressing issues. Improvements in morale can lead to improvements in attendance, safety, turnover, productivity and quality of patient care.

[Source: *Best Practice in Organisational Health in Hospital Settings, Creating Health Hospitals in Times of Change*, Victorian Health Promotion Foundation 1996.
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The NRHA's Homepage is at www.ruralhealth.org.au Included on it are further details about the NRHA, as well as full texts of the papers presented to the 4th National Rural Health Conference in Perth in February 1997.