



# High performance: Walking backwards on sand



# We meet on the traditional lands of the Kulin nation

And national health reforms have not (yet)  
addressed the role of the Aboriginal Community  
Controlled Health Service sector within the  
health system

# Outline

- ❑ What does high performance mean?
  - Competing concepts: take your pick
- ❑ Why it's good (and bad) for you
  - The lightbulb has to want to change
- ❑ And how will we know when we get there?
  - Top down and bottom up views
- ❑ Looking back, moving ahead = hard work

# Context

- ❑ National health reforms aim to address some well known and entrenched problems in health care
- ❑ Medicare Locals will enjoy the benefits of more accountability, including public reporting on performance
  - Healthy communities reports
  - But we don't know what that will look like

# Restructuring doesn't drive performance

*Innovation (in care) is less likely to work when there is structural change (in the organisation); and when there is high turnover (or absence) of managers*

Carlfjord et al 2010. Key factors influencing adoption of an innovation in PHC, *BMC Family Practice*, 11:60.

# Competing Concepts

- ❑ Accountability: obligation to account for activities (services, money, property), accept responsibility for them, disclose the results
- ❑ Quality: extent to which service achieves its intended purpose (ACSQHC)
- ❑ Performance: extent to which organisation achieves its purpose (management literature)

# Question: what is the purpose?

- ❑ Defined in mission statements and policies
- ❑ Some form of ‘deliver good services efficiently’ and/or ‘improve the health of the population’
- ❑ There are of course many other purposes:
  - Make money/collect salary
  - Be well regarded
  - Get into heaven, or perhaps the golf club

# What is the purpose?

- ❑ According to stakeholder theory, it is in the eye of your major stakeholders
  - Patients, owners, staff, community
  - Funders, colleagues, colleges, boards
  - The National Health Performance Authority
- ❑ And the question is: How do we add value for stakeholders?

# Proposition 1:

## Clarity about purpose

- ❑ This is more than a semantic issue
- ❑ Clarity about purpose is the basis for assessing your own performance
  - External assessors have their own ideas of your purpose, and well as their own purposes
- ❑ And mix of purposes is important
  - Generally, you need to perform in all of them

# World Bank categories

- ❑ Quality – clinical, managerial, patient experience
- ❑ Efficiency – ratio of inputs to outputs
- ❑ Utilisation – volume of capacity and need
- ❑ Access – availability, affordability, acceptability
- ❑ Learning – acquiring and using knowledge
- ❑ Sustainability – keeping needed services viable

Source: Bradley EH et al (2010) *Developing Strategies for Improving Health Care Delivery: Guide to Concepts, Determinants, Measurement, and Intervention Design*, The World Bank, Washington

# ACSQHC on Safety and Quality

- Accessibility
- Appropriateness
- Acceptability
- Effectiveness
- Coordination of care
- Continuity of care
- Safety

Source: Practice-level indicators of safety and quality for PHC Consultation paper 2011

# High performance is good for you

## □ It's a human thing

- We like goals and achievement
- Satisfying job: When the person *learns* that they *perform well* doing *something they care about* (meaning, achievement, feedback)

## □ It's an accountability thing

- NHPA, your College, Medicare etc

## □ And if we're serious we need data

- And there's lots of guidance...

# On the down side...

- ❑ There's lots of guidance...
- ❑ Better performance might not mean better performance data (eg adverse events)
- ❑ It is difficult to integrate the data needed to monitor your organisation's performance and the data needed for external accountability
  - And the more sources of funding, the more data definitions, the more reports etc

# Evidence-based care is not achieved 'top down'

- ❑ UK EBHC policy has been top down, formalised and prescriptive..; consistent with the direct management style of control and performance.
- ❑ Local context is an important modifier of success in implementing EB changes; transfer from a more positive to less positive context is difficult
- ❑ 'so the favoured UK NHS policy or linear and national EBHC 'roll out' from early leading edge sites is problematic'

Ferlie, Dopson, Fitzgerald and Locock, 2009. Renewing policy to support evidence-based health care, *Public Administration*, 87(4): 837-852

# What about performance targets and KPIs?

- 'Formal performance (eg activity or finance metrics) provides a safety net for poorly performing organisations but offers weak incentives for high performing organisations. Informal performance (eg reputation, trust) ...complements formal performance offering rich insights but lacking consistency.'

# Goodhart's law

- ❑ *Any observed statistical regularity will tend to collapse once pressure is placed upon it for control purposes*
- ❑ That is, any measure that is used as an indicator with (dis)incentives will become distorted and cease to work
- ❑ Charles Goodhart, former advisor to the Bank of England and Emeritus Professor at the London School of Economics

## Strategies in 19 Victorian emergency departments to meet KPI targets\*

KPI target	“Virtual wards” used (%)	Data changed (%)
Admission to ward by 8 hours	37%	26%
Admission to ward by 24 hours	37%	26%
Discharge from ED by 4 hours	5%	11%

ED waiting time: 64% of hospitals misrepresented waiting times as time from patient’s arrival either to triage or to placement in a cubicle with no clinical contact.

Source: Results of a survey undertaken by Victorian Faculty of ACEM, Oct 2007. Nocera 2010, Performance-based hospital funding: a reform tool or an incentive for fraud?, *MJA* 192:4(222-224)

# The 'dead hand' of best practice

- 'There is a strong danger that centrally-determined standards and targets may ossify as an incentive and/or that the dysfunctional effects of targets remain potent barriers to local reform. This potential has been identified as the 'dead hand' of best practice'

Exworthy et al, 2010. *Decentralisation and Performance: Autonomy and Incentives in Local Health Economies* Research report  
Produced for the National Institute for Health Research Service  
Delivery and Organisation programme Queen's Printer and  
Controller of HMSO, London.

# Propositions 2 and 3

- ❑ Don't focus only on clinical quality
  - Other 'upstream' measures more sensitive
- ❑ Use, but don't rely on, externally set KPIs
  - They're good for finding your problem areas
  - But not for finding innovative solutions
  - And they don't get to the 'soft measures'

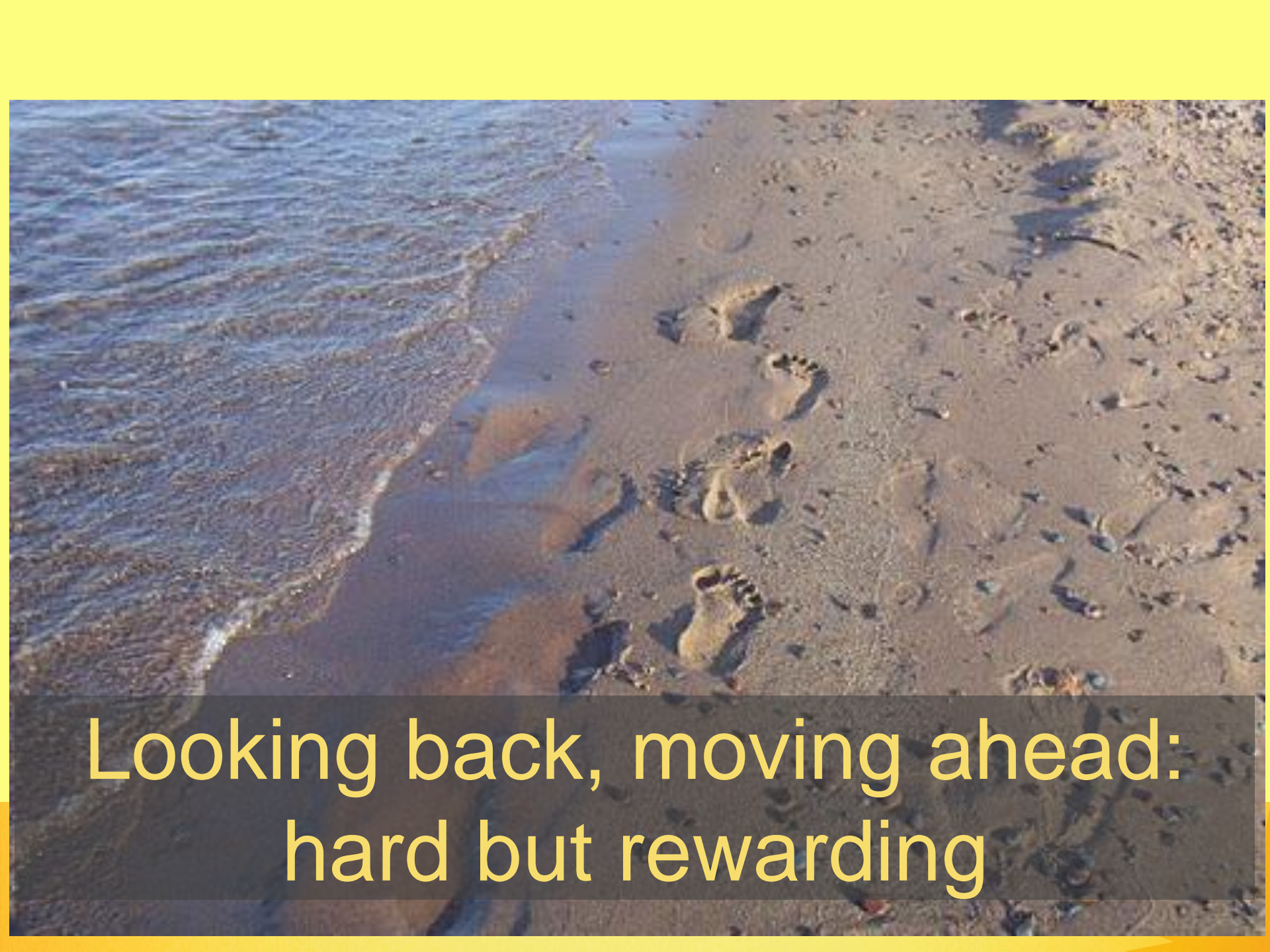
# What do we know about performance from the patient viewpoint?

- ❑ Patient satisfaction not very useful
  - Not very related to quality
- ❑ But understanding expectations and experiences is useful for improvement
  - These measures don't replace clinical process and outcome measures
  - Information won't make a difference without a system for its use

Source: Kalucy et al (2009) Patient Experience of health care performance, PHCRIS, Adelaide.

# How will we know when we get there?

- ❑ Data is necessary – or we kid ourselves
  - Frameworks are needed, even if the lists, and the number of them, make you cross
- ❑ But data is not sufficient – not everything that matters can be counted
  - Quality of respectful listening, of touch
  - The ‘feel’ and sense of purpose among staff
- ❑ Achieving high performance is not an exercise in compliance

A photograph of a sandy beach with footprints leading away from the water's edge. The water is on the left, and the sand is on the right. The footprints are arranged in a line, suggesting a path taken. The overall scene is bright and clear.

Looking back, moving ahead:  
hard but rewarding