CASE STUDIES

Benchmarking and supplier networking – best practice approaches

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ABSTRACT

This article examines the approach adopted by a health service to benchmark outside the health industry and to network with its own suppliers in its quest for best practice. The Maryborough District Health Service was selected for funding under the Commonwealth Government's Best Practice in the Health Sector Program. This rural health service is setting a fine example of how generic benchmarking can be used to increase efficiency and improve outcomes in an environment of change, increasing demands and contracting resources. The organisation has networked with its suppliers with a view to ensuring that, as a customer, it has access to the best quality goods and services. The objective is to improve the services and quality of patient care provided by the health service and to minimise its cost structures.

Introduction

The Australian health industry is no stranger to demands for increased efficiency and improved quality service delivery in times of diminishing resources. Indeed all sectors of Australian industry are experiencing the same pressures. One organisation funded under the first round of the Commonwealth Government's Best Practice in the Health Sector Program is the Maryborough District Health Service. Formed in July 1993 with the amalgamation of four disparate health provider organisations, the health

service has, through a best practice approach, faced the challenge in part by benchmarking outside the health sector. It has compared itself with a large modern hotel which for some two years has adopted a best practice approach. The health service also benchmarked within the health sector and examined operations quite different from its own.

Most best practice organisations use benchmarking as a means to improve organisational performance. By examining how other industry leaders approach the same problems or processes, best practice organisations gain the edge and progressively forge ahead. Many business and support functions can and (for best results and fresh approaches) should be benchmarked *outside* the health industry as well as within.

Successful benchmarking needs the involvement of relevant representatives of frontline staff in benchmarking team(s). Conscious and visible support is needed from executive and management levels to ensure that this happens. This will maximise the contribution and commitment from staff when benchmarking data are analysed and it will go a long way to ensuring that the implementation of changes will be smooth and effective.

The Maryborough District Health Service has found considerable value in its approach to benchmarking which has set a positive tone for continuous improvement.

The health service has also networked with its suppliers and discussed with them their attitudes and approaches to best practice and quality assurance. This action is aimed at ensuring that the Maryborough District Health Service, as a customer, has access to the best quality goods and services from its suppliers. When suppliers deliver on time and to the health service's specifications, the results are improvements in the quality of services provided, efficiency and productivity gains and a minimisation of cost structures.

While these measures are but two of the many best practice activities that Maryborough District Health Service has undertaken, it is clear that the outcomes have been well worth the resources invested.

Benchmarking and supplier networking at Maryborough District Health Service

Australian health industry organisations are undergoing massive changes: they are experimenting with processes, service delivery systems, budget allocations, technological advances, and networks and links. Some organisations have dabbled in benchmarking but many of the 'studies' have fundamental weaknesses which have resulted in disappointing outcomes. Quality assurance programs are known to be fragmented; some are applied differently within organisations and certainly applied differently between organisations. As noted by Dr Michael Stanford:

> One of the problems in benchmarking in the health care industry is that in many ways the information sources in Australia are not yet well developed…there are a number of areas in which benchmarking data is just not available…(Stanford 1993)

The Maryborough District Health Service embarked upon a benchmarking exercise as part of its best practice project and the following is an account of our experience.

Benchmarking within the health sector

We accept that some processes like morbidity rate and rates of return to operating theatre can only be benchmarked against medical agencies. In our experience it is better to benchmark against remote medical agencies which, because we are seen as being less of a direct competitor, are more likely to be more candid in their responses.

Benchmarking outside the health sector

However, in terms of service delivery, team process, staff satisfaction, customer satisfaction, absenteeism and staff turnover rates, training strategies and many other elements, we decided to look to other industries for our benchmarking partners. Industries outside the health sector are far more adept at marketing themselves as producers of quality goods and concentrating on customer satisfaction because in that competitive world customers are their lifeblood. Furthermore, industries outside the health care sector do not see us as competing for the same customers and are therefore much less guarded in their responses than are other health care organisations.

Maryborough District Health Service benchmarked against both manufacturing and service industries, particularly in the area of developing effective team processes. We chose this as one of our study areas because the health service faced the challenge of unifying four separate health care organisations which amalgamated in 1993. We were not seeking statistics, but information on change process and effect.

> Databases can be useful, and performance indicators and targets are essential aspects of any well managed benchmarking approach. However, they will only be used effectively if combined with a change program based on shared and detailed understanding of the practices and structure which produce exemplary performance levels (Anon. 1994).

Other aspects of our best practice project were common assessment, case management and common records. These basically involved simplifying communication and cooperation processes and enabling common information to be shared between sites and services.

The benchmarking team

A major emphasis in benchmarking is the empowerment of staff to have input into the process and the changes it brings. This commitment to change, the willingness to submit one's work to measurement and evaluation and the acceptance of an established format of quality improvement are critical, and this involves staff at *every* level of an organisation. In this setting it can

> enhance democracy and empower people, by involving them in the task of setting collective, community goals…Benchmarking is a futile exercise unless it is driven by an empowered work force…Collection, monitoring and evaluation of data usually occurs at the shopfront level (Forte 1993).

Our benchmarking teams consisted of staff from management, nursing, allied health and community health. All team members were trained in benchmarking by a consultant and further meetings helped us to develop questionnaires and the process for our self-evaluation. These were sent to the sites we were to visit.

Service sector study

We chose as one benchmarking partner a major hotel which had adopted a best practice approach. There are similarities between many of our health service functions and those of the hotel: while we admit people in pain and bleeding, they admit people who do not speak English and who have lost their luggage.

We found that staff training by the hotel at the time of employment was both more extensive and intensive than ours and that there was more training in problem-solving. Staff had to make decisions themselves even if money was involved and they could not pass problems on to their supervisor. The hotel also had a stronger emphasis on customer service.

Our study of team-based work arrangements revealed that, like our health service, the hotel had departmentally based teams which were issue-specific. However, once the issue was resolved the hotel disbanded the particular team whereas our teams are relatively permanent. Multi-skilling and multi-department service was expected of the staff at the hotel.

The hotel placed far more emphasis on feedback from staff about customer comment on service. Written response from customers was generally poor so the hotel concentrated on oral comment by customers to staff which was then written up and distributed. The health service provides an opportunity for written feedback and we have also developed an interview-based questionnaire for random sampling. We decided to adopt the hotel's practice of writing to customers who had commented on service to inform them of action taken as a result of their comments.

Hotel staff surveys had an 88 per cent return rate which made our performance in this area look very poor. The hotel arranged for staff individually to complete surveys in working time in a room provided for that specific purpose. Our next staff survey will be conducted along similar lines to the hotel approach and hopefully it will produce the same return rate.

We are also establishing a staff satisfaction team to allow staff the opportunity to have direct input in changing their working conditions. This approach was taken by the hotel and it proved to be very successful.

On the admissions issue we found that our admission documentation was as simple as theirs and our discharge processes were similar. We did not consider that their express system was suitable for our operation.

Manufacturing industry study

One of the prime obstacles to change in the health industry is the very strong historical structure which involves rigid lines of responsibilities with a linked career structure. The change in the education systems and the massive expansion in postgraduate education has helped to challenge this. However, while workers are the people who have the direct contact with the patient, enabling them to assess the service provided and the patient response to it, they are rarely placed in a position where they can use this knowledge.

We believed that it was very important to find an industry group which has changed from an hierarchical structure to a team-based one and to investigate the change process undertaken. Manufacturing is one such industry and we visited a manufacturing plant.

The manufacturing company's key objectives are as follows:

- a participative workforce
- multidisciplinary teams
- self-control
- personal growth
- a fair reward system
- a responsive, flexible, innovative workplace
- a focus on quality
- integrity
- information sharing
- exceeding customer expectation
- environmental responsibility.

Our own goals revealed strong links on most of these objectives, making this company an excellent benchmarking partner. While their time frame for change was set in 1990 with a target date of the year 2000, we hope to achieve change much more quickly.

As a result of organisational change in the manufacturing company, a number of middle managers were redeployed or affected by necessary downsizing. While we too had been forced to reduce our workforce, we had not focused on any group, but rather sought to maintain services in particular areas. We did, however, find that our managers needed assistance to embrace the implications of change and our approach was to run specific sessions for them to examine and explore their new roles.

The manufacturing company placed a very strong emphasis on education and training as ongoing priorities in the change process. Downtime was used to run meetings and for staff training. While the manufacturing company was able to benefit from this flexibility, this approach is much more difficult to implement in many areas of a health service which requires continuous service to be maintained and where the cost of staff replacement is high.

When we looked at team organisation, it was clear that teams in the manufacturing company did not set their own goals, nor did they have any budgetary control. Our teams do both and it may be that the level of education and training in the health service has probably influenced this. We have found that giving teams the responsibility for budgets has been a major motivator in the change process and an equally important empowerment tool.

The workers in the manufacturing company were empowered to make decisions, with peer group leadership replacing traditional styles of management. Given the clinical nature of our service, this management format is not realistic for us in all areas. Our discharge planning team, used as the health service model for team development, also works along similar lines. However, it is recognised that in most areas the leader will remain the person with the necessary training and experience for that role.

The change process in both the health and manufacturing industries requires the same staff attitudes, knowledge and involvement. Equally, both have individual department quality assurance processes in place, with each department monitoring its own performance.

The manufacturing company decided that a vision statement and a business plan were essential. Since that site visit we have undertaken a strategic planning process involving the community and staff. We now have a five-year plan in place which will equip us to achieve our goals in the ongoing change process.

Supplier networking

The Maryborough District Health Service, like all other hospitals and health services, has a large number of suppliers of food, equipment and medical supplies, and a range of services as well.

Given that our health service is striving to achieve best practice, we decided that it was important that our suppliers had goals to improve their own performance and were working towards best practice in their own operations. If we receive our supplies when we need them, to our quantity and quality specifications, then it is that much easier for us to reach the

levels of quality service we seek. We will be that much further along the continuous improvement path if our suppliers can deliver a quality service.

We approached all of our suppliers and with only one or two exceptions they are working towards quality assurance recognition. In our discussions with the other two we explained what we were doing and encouraged them to do likewise.

Conclusion

The benefits the Maryborough District Health Service has gained through a benchmarking approach which took it outside the health sector have been well worth the effort. The involvement of staff at various levels in the change process, particularly in benchmarking, enhances their understanding, enthusiasm and commitment during the difficult times accompanying such change. The site visits to enterprises outside the health sector extended the insights already obtained by the Maryborough District Health Service, and surprised several of those involved as to the degree of commonality.

Project officers are more than happy to discuss their progress and plans for the future. Please forward any enquiries directly to:

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