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IMPACT OF THE INTRODUCTION OF NATIONAL  
PERFORMANCE INDICATORS ON DIVISIONS OF GENERAL  
PRACTICE PLANNING PROCESSES

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## EXECUTIVE SUMMARY

National Performance Indicators (NPIs) are a key component of the National Quality and Performance System for Australian Divisions of General Practice (NQPS), introduced by the Australian Government Department of Health and Ageing in March 2005. This study investigates the early impacts of the introduction of NPIs on the planning processes of Divisions of General Practice.

A report of the study has been provided to the Divisions of General Practice Network and to the Australian Government Department of Health and Ageing.

### Method

In-depth interviews were conducted with CEOs from 28 Divisions of General Practice, randomly selected to reflect state, size and rurality of Divisions nationwide. ADGP and SBOs were also interviewed. Five areas of interest were covered relating to the Divisions' experiences in responding to and utilising performance indicators in the planning process. Interviews with ADGP and SBOs were designed to provide contextual information and to assist in interpretation of the findings of the interviews with Divisions, and are not directly reported in this report.

### Results

Results are organised into three broad categories relating to impacts on planning, impacts on program delivery, and anticipated use of performance information in future.

### Impacts on planning

All CEOs interviewed reported support for the concept of national performance indicators and have incorporated the

requirement to report against them into their planning processes. Although a number of CEOs reported initial concern that the new requirements would be too ambitious, they appear to have finished the first planning cycle confident that they could meet expectations in the first year. Planning tended to be more internally focused, more internally inclusive and more time consuming than usual. The process itself did not appear to have changed significantly but there was a greater focus on planning to meet national objectives. For some Divisions, this required extensive review of their role and current program activity, for others it was more a repackaging exercise to transfer information from one template into another. Some Divisions have restructured staffing and budget arrangements as a result of having to meet NPIs. CEOs were confident that their planning processes would result in the Division meeting at least the minimum requirements in the first year.

#### Impacts on program delivery

The emphasis of activity within programs is changing to accommodate the need for accreditation and data collection and analysis related to meeting national performance objectives. There is a widespread view that these requirements are putting pressure on core funding and resulting in the diversion of resources away from local programs. There is a concern that satisfying the points requirement of compulsory indicators into the future may necessitate channelling resources further away from local programs, particularly if expectations are too high. In the main, the fit between local programs and national objectives is perceived to be good but there are issues relating to priorities and relevance, particularly in rural and remote areas where the specific contexts at the local level are not well reflected in the current focus of some performance indicators.

### Use of performance indicators in future

All CEOs interviewed plan to use performance information to inform their own activities in future. The extent to which this data will assist them to better evaluate and improve program delivery, measure outcomes and identify achievements will depend on the coverage and quality of the data. Most CEOs expect to have a better idea of the value and potential uses of performance data following a full year planning and reporting cycle. Most Divisions are looking toward feeding back performance data to general practice, provided it can be analysed and presented in ways that are meaningful at the clinical level. Some already do this. There is a widespread perception that the quality of chronic disease data in most general practices is currently poor and that much work remains to be done to build relationships with GPs and improve the quality of data to demonstrate the value of performance information. Consequently there is a view amongst many CEOs that feedback of performance data to general practices is a longer term objective. Fewer CEOs see a role for feeding information to consumers, although a number do so already and are considering further strategies for how this might be improved. Some CEOs see great potential for using indicator data in regional planning forums and all believe that PHIDU profiles will be of great assistance for program planning.

### Conclusions

The sector has positioned itself to respond to the NQPS and there appears to be broad support for the concept of national performance indicators. There is a perceived tension between national performance measurement and local program delivery and responsiveness. The challenge for the NQPS at this early stage is in supporting the system to develop in a way that strikes a balance between national priorities and local needs.

## 1. BACKGROUND AND RATIONALE

This study was conducted by the Australian Primary Health Care Research Institute (APHCRI) as part of its research into the development, implementation and use of national performance indicators in the Australian Divisions of General Practice Network.

National performance indicators were introduced into the Divisions of General Practice Network in March 2005 by the Australian Government Department of Health and Ageing under the auspices of the Review Implementation Committee

(<http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/health-pcd-programs-divisions-ricinfo.htm>) as a core component of the new National Quality and Performance System (NQPS). The introduction of the NQPS followed a major Review of the Role of Divisions of General Practice which identified a number of problems in the network, including a lack of clarity in government expectations, variability in performance across the network and a lack of capacity in the program to demonstrate achievements and value for money. The Review recommended that a national quality and performance system be implemented to drive continuous improvement across the Divisions' network.

The NQPS introduces, for the first time, a core set of nationally consistent performance indicators for Divisions (<http://www.adgp.com.au/site/index.cfm?display=4424>) as well as a quality system leading to accreditation, a planning and reporting process and a process for recognising and improving performance. Its stated aims are to provide clear expectations for the performance of the network and provide a framework for continuous quality improvement that improves the capacity of the entire network, including through promoting best practice, rewarding strong performance and supporting under-performance.

The National Performance Indicators (NPIs) cover six domains in four national priority areas. Domains relate to the management of diabetes, mental health and asthma in general practice; access to care for older Australians in residential care; integration and multidisciplinary care between hospitals and general practice; and prevention and early intervention (immunisation) in general practice. The indicators are fitted to a conceptual framework for performance assessment in primary health care developed by Sibthorpe ([http://www.anu.edu.au/aphcri/Publications/conceptual\\_framework.pdf](http://www.anu.edu.au/aphcri/Publications/conceptual_framework.pdf)) within each domain there are indicators at four levels, including indicators of organisational structures and processes in Divisions (Level 1) and General Practices (Level 2), processes of care for patients, families and communities (Level 3) and intermediate health outcomes (Level 4). Divisions can report at the level at which they are able and compulsory indicators identify areas of core government interest.

It is anticipated that NPIs will assist the Divisions program to build a national picture of the network's achievements, allowing funders and governments to obtain an objective, evidence-based view of what the network achieves and provide data to assist general practice to implement better patient management systems.

This study aims to evaluate the early impacts of national performance indicators on Divisions' planning processes during the first cycle of planning after their introduction. Findings will be made available to the Divisions' network and will be used to inform the Australian Government Department of Health and Ageing planned evaluation of the NQPS.

## 2. METHOD

The study involved in-depth interviews with CEOs from Divisions, SBOs and ADGP to assess the impact of the introduction of the

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national performance indicators on Divisions' planning activities.

### 2.1 Ethics Approval

Ethics approval for the study was obtained from The Australian National University Ethics Committee. All study participants were offered the opportunity to review and comment on the draft report to ensure that their views were accurately reflected.

### 2.2 Research Questions

The primary question of interest for the research was: What was the impact of the introduction of the national performance indicators on Divisions' planning? Related sub-questions were as follows:

1. What impacts have the performance indicators had on the nature and quality of Divisions' planning?
  2. Did the introduction of the national performance indicators alter the balance of emphasis within Divisions' programs/activities? If so, to what extent was the balance altered, and how?
  3. What has been the impact, both positive and negative, of this on the fit between perceived local needs and current program/activities?
  4. What are Divisions' plans in terms of using the performance information to:
    - i) Inform its own activities;
    - ii) Provide feedback to general practices / GPs;
    - iii) Provide feedback to consumers?
  5. Looking ahead, how are performance indicators likely to influence planning in future?
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### 2.3 Sample Selection

The sampling strategy aimed to select around one fifth of Divisions that reflected location, size and rurality of Divisions nationwide. Table 2.3 (below) sets out the sampling strategy showing that around 20% of Divisions were proportionally selected at random across the following strata within each State - metro, metro/rural, rural, rural/remote, remote. Where a Division declined to participate, another Division was randomly selected from Divisions with the same characteristics in that State.

*Table 2.3 – Sampling Strategy*

	WA	QLD	NT	SA	VIC	TAS	NSW	ACT	TOTAL SAMPLE	No. of Divisions
<b>Metro</b>	1	2	0	1	3	0	4	1	12	53
<b>Metro/rural</b>	0	0	0	1	1	1	1	0	4	12
<b>Rural</b>	1	1	0	1	2	1	2	0	8	34
<b>Rural/remote</b>	1	1	0	0	0	0	0	0	2	14
<b>Remote</b>	1	0	1	0	0	0	0	0	2	5
<b>TOTAL</b>	4	4	1	3	6	2	7	1	28	
<b>No. Divisions</b>	14	18	2	14	30	3	36	1		118

In addition to interviews with Divisions, interviews were also held with ADGP and State Based Organisations (SBOs) to ascertain their perspectives on the impact of performance indicators on Divisions' planning.

### 2.4 Telephone Interviews

Semi-structured in-depth interviews were conducted by telephone. These were designed to provide an understanding of Divisions' experiences and activities in responding to and utilising performance indicators in the planning process. Interview questions focused on the five areas of interest outlined above. Open-ended questions with standard prompts were used to explore particular issues, with no specified limits on time or length of answers. The specific questions asked in Division interviews are contained in Appendix 5.4. The SBO and ADGP interview

questions are contained in Appendices 5.5 and 5.6, respectively. SBO and ADGP interviews were designed to elicit contextual information and to assist in interpretation of the findings of the interviews with Divisions, and are not directly presented in this report.

A pilot was conducted with 3 Division CEOs to determine the validity of the questions and refinement undertaken.

### 2.5 Comparative Audit of Division Plans

It was initially intended that the study would also incorporate a comparative audit of Division plans from 2004-2005 and 2005-2006 to capture differences in strategies and emphases before and after the introduction of performance indicators. However, this component was of very limited value after it became apparent that the data yielded were of questionable validity and meaning.

The major source of these concerns was the coding method, which involved firstly selecting categories of indicators from a Primary Health Care Research and Information Service (PHCRIS) review of Divisions' 04-05 plans, and then assigning a value of '1' to those plans which contained that indicator type and a value of '0' to those that did not. The variability of Division plan structures, particularly the level of abstraction at which objectives were pitched, made it difficult to objectively determine whether many indicator types were included, either expressly or by implication. Hence there was a significant degree of subjectivity in assessing whether, for example, a 'risk factor management' objective also indicated an intention to address 'cardiovascular disease', and vice versa, where only one was expressly mentioned. Moreover, because the structure of Division plans changed so markedly after the NQPS performance framework was implemented, it was difficult to assess whether an

indicator type had been added, discarded or rolled up into some broader category. This query was borne out in the CEO interviews, which sometimes revealed changes in focus but other times simply confirmed that previous indicators had been repackaged into prescribed national objectives. Indeed, in many instances apparent differences emerging from a plan audit directly contradicted statements made by the Division CEO, who took the opportunity to explain the context and reasoning behind planning under the new framework.

The combined effect of these issues was that coding had a significant arbitrary element, which could not be overcome by cross-checking and consensus processes between investigators. In particular, having collected the data themselves, the investigators were acutely aware of the uncertainties and thus reluctant to draw any meaningful conclusions from the data. It was decided not to proceed with this part of the study.

## 2.6 Analysis of Interviews

Notes recording the points made by respondents were taken simultaneously by two investigators during the course of the interview. After the interview, the notes were compared to clarify particular points and ensure that all information was captured in a single record.

Once all interviews had been completed, the information was divided up according to research question, and the responses from all Divisions were pasted into a summary table relating to each question. These data were then analysed to identify common themes, outlier perceptions and other issues. These were then reviewed by two investigators to ensure consistency in analysis and interpretation under the broad headings:

- Impacts on Planning

- Impacts on Program Delivery
- Anticipated use of performance information in future

### 3. RESULTS

In total, 35 interviews were conducted. Twenty eight of these were with Division CEOs and a further 8 interviews with CEOs of SBOs and ADGP. Twelve Division CEOs declined to participate and were replaced by other Division CEOs, selected at random from within each of the categories of interest. One SBO also declined to participate. Two reasons were given by Division CEOs for not participating in the study: i) Lack of time, which could have been related to proximity to Christmas in some cases and in others, CEOs reported having high staff turnover which was a priority that prevented their involvement; and ii) CEOs who were new to their positions felt they were not best placed to participate.

Results are described below.

#### 3.1 Impacts on organisational planning

There was unanimous support amongst Division CEOs interviewed for the concept of national performance indicators. While there are concerns about the nature and specific requirements of some indicators, as well as concerns about the current capacity of Divisions to obtain data required to report them, and questions about the methods by which performance will be assessed (described in more detail later), CEOs endorsed

- the clear statement of direction and expectation in relation to performance that is embedded in the NPIs;
- the underlying approach to indicator development that is outcomes focused but spans process and intermediate outcomes;

- the concept of a standard core set of national indicators for national programs against which Divisions performance will be assessed and compared across the network; and
- the retention of choice for local program initiatives.

Divisions have clearly incorporated the requirement to report against performance indicators into their planning processes. At the time of interview, all CEOs were working toward identifying which indicators would be reported and how program delivery and administrative arrangements would be organised to achieve this. Although a number of CEOs reported initial concern that the new requirements would be too ambitious, they appeared to have finished the first planning cycle confident that they could meet expectations in the first year. A number of CEOs attributed this to the developmental approach that has prevailed in implementation to date and suggested that the success of performance indicators would be dependent, in part, on the approach to performance assessment adopted by the Department as a next step. They noted that the Department would need to ensure consistency in its approach to assessment at the State Office level to facilitate a fair process, and that time would be needed before data capture would be adequate to allow reporting at higher levels for many Divisions. Most were adopting a "wait and see" approach, reticent to comment yet on whether performance indicators would turn out to be a positive thing for the network.

Most CEOs reported that planning had been more tightly focused around ensuring the Division could meet specific indicators. This was seen by some as resulting in a less strategic process than usual, aimed entirely at meeting prescribed goals. A few CEOs perceived the framework as too prescriptive, indicating that the Department is "micro managing" Divisions' internal affairs, leaving little room for innovation and resulting in

reduced scope for creativity in planning. Others reported that more streamlined and focused planning had improved the overall quality of the process and that it had resulted in more strategic thinking about what the Division would need to be doing in future to facilitate the multidisciplinary practice and consumer involvement that they perceived as underpinning the framework.

Most CEOs reported that the planning process itself had not changed dramatically, but there was considerable variation in the extent to which CEOs perceived the impact of the change that was involved. There were those, on the one hand, who reported that what was involved in planning was primarily a "repackaging exercise involving transfer of information from one template into another", to those who found the process "more intensive but not significantly altered in relation to the way the Division plans or the stakeholders who are involved", all the way through to those who commented that they had had to "rethink the whole plan to take account of the increased workload created by the need to collect data". Notwithstanding this difference in perspective, most Divisions reported having conducted a more internally focused but internally inclusive process of planning this year, involving CEOs, staff and Boards in working together to reach a thorough understanding of the new requirements and in determining how the Division would aim to meet them. There was unanimous agreement that the process was more time consuming than usual and some felt that the time constraints had impacted detrimentally on the quality of the planning process. A few Divisions reported having also engaged their membership in a discussion about which chronic disease indicators would form the initial focus of activity in the first year, but this was not common. A number of others indicated that their Divisions were not yet ready to discuss the data collection aspects of Levels 3 and 4 chronic disease indicators with general practices and that a lot of relationship building

would be needed before GPs were likely to consider providing access to Divisions to chronic disease data. One CEO reported that mental health data was seen by GPs as particularly sensitive.

Some CEOs perceive the framework as a stabilising force for Divisions, promoting maintenance of strategic directions, particularly during times of organisational change. A number of Divisions have used the framework as a template for budget allocation to outcomes specified by the performance indicators and as a focus for structuring work in the Division. One CEO mentioned that the requirement to report on chronic disease indicators had brought about some internal restructuring of roles and responsibilities, another mentioned that a redundancy had been offered as a result, and several CEOs commented that they felt the framework would be used as a basis for the development of duty statements and job descriptions. Amongst those who adopted this approach, there seemed to be a view that the performance indicators put the Network on a more professional footing as both external and internal stakeholders would have a clearer understanding of the role of Divisions and what they could be expected to achieve. One CEO commented that the performance indicators had improved the Division's perception of itself as an organisation and another reported that it would enable staff to have better buy in to the Division because they better understood expectations for performance and could see how their work fitted into that context.

Considerable attention was also given to how Divisions would be able to meet the points system. CEOs were confident that their planning processes would result in the Division meeting at least the minimum requirements in the first year but concern was expressed about how future requirements for points might impact on program delivery (discussed below).

### 3.2 Impacts on program delivery

Performance indicators have focused attention on what Divisions do and how programs and activities will be structured to meet national priorities. Most impact to date appears to be on refocusing strategies and activities within programs. Broad programs remain but will be refocused to meet requirements for data capture. Many CEOs reported that the requirement to focus on data collection, governance and accreditation objectives had stretched core funding to its capacity, and as a result Divisions will be reducing their focus on some programs and activities, at least in the first year. Those most mentioned were Continuing Professional Development (CPD), general practice support and local programs.

In many instances, CPD programs have been honed back and Divisions intend to reduce the number of education sessions offered to GPs under these programs. Some will focus education on national priority areas only. While no particular concerns were expressed about the cutbacks to CPD, as there is a perception that this can be provided by others, several CEOs expressed the view that many Divisions had built good relationships with general practice on the basis of CPD programs and they questioned whether reduced levels of responsiveness in this area would adversely affect relationships.

Practice support programs will be refocused on data collection activities related to reporting chronic disease indicators. One CEO had negotiated a preferred provider arrangement with a local IT company to ensure the provision of services to general practice that they would no longer be providing. New ways to work with general practice on practice register/recall/reminder systems, data entry, retrieval and analysis processes are being examined. Those involved in Collaboratives commented that they provided a good model for supporting practices in data entry,

analysis and feedback. One Division was using their experience in EdQUM as a model for small group practice learning. Many CEOs referred to the need for the rollout of the IM/IT strategy to support this work. Most Divisions appear to be focused on reporting Level 2 data and current effort is in raising awareness and skill levels in general practice and in Divisions in preparation for reporting at the higher levels. A number of CEOs reported that resourcing is a major limitation in the Division helping practices to develop IM/IT capacity to produce meaningful data. Others referred to the difficulty in getting staff with the necessary skills. A small number of Divisions reported already having developed their own extraction tools or used systems like CARDIAB to extract data and provide feedback on clinical management to GPs. They argued the need to ensure that deidentification and aggregation of data is conducted at the local level, in ways that ensure general practices and their representatives retain control over preparation and reporting, and develop feedback loops that provide meaningful data in the clinical context. One commented that performance indicators in chronic disease management would drive a multidisciplinary teamwork approach simply as a result of the work required for data input, analysis and feedback. GPs will not have the time to do this work on their own, so there will have to be work within general practice teams to deliver on the requirements.

There is widespread concern that local programs may suffer in future as Divisions focus on meeting national priorities. Local programs will take a reduced focus, at least initially, but there is a more general perception that this is likely to continue into the future. A number of CEOs reported that national programs are taking a much higher proportion of resources than in previous years, reducing the resources available to provide local programs. Particularly in small Divisions, CEOs reported that meeting performance requirements had stretched core funding to its limits, and capacity to

respond to local issues is further restricted by the fact that outside core funding, all funding is tied to specific programs. Several CEOs reported that they would seek funding to support the continued provision of local programs in future.

While CEOs generally reported a good fit between local needs and national strategies currently, there are issues relating to priorities and relevance, particularly in rural areas. The current configuration of national programs like Aged Care and Hospital integration is seen as having limited relevance in some rural areas where the focus of aged care is not residential care, and integration activities are less difficult to orchestrate in areas where GPs staff the local hospital. There is a certain frustration that under a national performance framework there may be increasing incentives to take up national programs, which may not be configured in ways that best address local issues, at the expense of local issues seen as more pressing. CEOs in rural Divisions expressed surprise, for example, that workforce issues had not been taken up by national indicators, as this is perceived as a central component of work for rural Divisions.

A few CEOs, some in metropolitan areas as well as rural areas, reported that the current directions embedded in some of the chronic disease domains did not line up well with work being undertaken in the Division. The most common example provided was mental health. Where Divisions had decided to continue work in the same vein, they have repackaged this work as a local program. It is not so much that the NPIs are irrelevant but that the form of program activity taken in different areas can be very different and some PIs, as they are currently configured, may not capture the nature of the work being done. Other CEOs expressed surprise that outside immunisation, prevention was not an area of focus in the national framework. Smoking cessation

and lifestyle interventions were mentioned by CEOs as work that Divisions do.

In a similar vein, several CEOs, particularly those from Divisions with low proportions of Aboriginal and Torres Strait Islander people in their population, commented on the investment of effort and perceived difficulties and sensitivities surrounding the requirement to assist general practices to capture Aboriginal and Torres Strait Islander status patient data. Some said they would place a lower priority on this, particularly while resources are being diverted to other areas of activity required to comply with reporting on performance indicators.

With respect to chronic disease programs, a common response to meeting performance objectives has been a reprioritization of work across disease domains. Many CEOs reported having chosen to focus intensively on one or two diseases in this reporting period, whereas they previously may have been working across all areas. Most Divisions are getting systems into place to enable reporting on one chronic disease area really well and transferring lessons learned to other areas in future. The net effect of this will be a reduced emphasis on some chronic diseases in the short term.

Related to this, a number of CEOs reported having made strategic decisions to involve their Divisions in programs that would benefit them in areas of focus in the framework. For example, CEOs had opted to become involved in Collaboratives and After Hours programs, as these were perceived as providing Divisions with good experience for data related activity, relevant to performance indicators. A number also nominated the Lifescripts program as one that would assist Divisions to undertake work in prevention and risk factor management. In general, CEOs commented that the performance indicator framework had not

changed the direction of the Division's work but had brought forward areas of work that may have otherwise stayed in the background.

A few CEOs commented that planning to meet the performance objectives had led them to undertake a thorough review of the entire work in which the Division was currently engaged: what they are doing, why they are doing it and how they are going to document activity and measure outcomes, especially in relation to local programs. This begged the question in some cases, "are we stretching the boundaries too far?", bringing some Divisions to the conclusion that they will aim to work more closely with neighbouring Divisions in future, to specialise in areas of interest and expertise and examine possibilities of subcontracting successful programs.

The operation of the points system is seen as a critical factor that will operate indirectly to shape program delivery across the network in the future. There is a perception that satisfying the points requirement of compulsory indicators may necessitate channelling resources away from local programs, particularly if expectations are too high. Coupled with this is concern that increasing expectations of core funding will come at a cost to local programs previously afforded, narrowing the scope of programs across the network and reducing responsiveness to local needs.

### 3.3 Use of indicator data in future

There was unanimous agreement amongst CEOs that performance indicator data will be used at the Division level to evaluate Division activities and review progress internally where possible, further strengthening quality improvement processes. However, the quality and coverage of data in some areas will determine the extent to which this can be meaningful and the

timeframes in which Divisions might be expected to get benefit. Most CEOs expect to have a better idea of the value and potential uses of performance data following a full year planning and reporting cycle. Notwithstanding this, some Divisions have already developed systems to report performance feedback to their staff and Boards, such as through newsletters and structured Board reports. Financial reporting has been streamlined with performance information in some cases. Others will extract 6 month data and use it as a baseline for future evaluation activity. Interest was expressed in being able to evaluate impact on uptake of MBS items and using data as an aid for collaborations and joint project work across neighbouring Divisions. Because there is widespread concern about the quality of chronic disease data in general practice currently, most CEOs said they would wait and see how useful that data turns out to be for informing program development and other Divisional activities. Others, who were more confident with the data quality in their general practices looked forward to being able to use this to inform program development and to assist in targeting programs within the Division.

Most CEOs think the concept of feeding back performance data to GPs and general practices will add value to chronic disease management in general practice. A few said they would have to be convinced of the benefit of doing this. Those few Divisions who already do so, expressed interest in using the new indicators as a template for developing what they already have in place. CEOs pointed out that data need to be analysed and presented in ways that are meaningful for clinical practice and that GPs would have no interest in the process unless this was the case. There seemed to be a widespread view that if this could be achieved, most GPs would be interested in receiving feedback on performance but it was stressed that there is a lot of groundwork yet to be done with GPs to build relationships and trust and to demonstrate the value of this. Good data will be

critical. Some felt other incentives would also be needed. One CEO was looking into the feasibility of an MOU to formalise an agreement with general practice that they would provide data to the Division in return for services. Many CEOs also commented that the quality of data in general practice is currently very poor, that there are problems in Medical Director and other software packages that need to be resolved, that many practices are not computerised and even those that are tend to use computers primarily for booking appointments, billing and prescribing. Consequently many CEOs believe that feedback of performance information to general practice is a more medium term objective.

A smaller number of CEOs are convinced of the benefit of feeding performance data back to consumers. A few said this was not consistent with Division policy or that they did not see a role for the Division in doing this. Of those that do see a role, all reported having active consumer involvement in the Division and there is an expectation that these consumers would receive the same information that is fed back to the rest of the members. Some are thinking through the sorts of data that could be used more broadly with consumer and community groups, and strategies that could be developed to facilitate meaningful feedback. One CEO mentioned local newspaper press regarding management of chronic disease and another that they were trialling an American tool for public consultation and feedback which could potentially provide an important vehicle for conveying performance information to consumers, if it was meaningful. Several CEOs commented that indicator data would be very useful in regional planning forums with other agencies, and one Division had had extensive discussions with their State health department about the performance indicator framework and how it would enhance the measurement of their performance and generate new information on clinical practice over time. This CEO reported that the framework had placed them in a better

position to become a preferred provider for state funded initiatives.

There was unanimous agreement that PHIDU profiles will be of great assistance for program planning. Performance data will potentially provide important information on how well existing initiatives address local needs and, as one CEO reported, will be particularly welcomed in Divisions where there are diverse communities with very different health needs and profiles.

#### 4. DISCUSSION AND CONCLUSIONS

In general, CEOs appear to have adopted a cautiously optimistic view of the performance indicators and of their impact on planning to date. There has already been a significant investment of time and resources into planning activities, preparing Divisions to meet national performance objectives. There appears to be a widespread perception that with careful planning for the future development of the entire performance system, performance indicators may provide an opportunity for Divisions to improve their capacity to better evaluate and improve programs, measure outcomes and identify achievements over time.

Impacts on program delivery are not yet extensive but the emphasis of activity within programs is changing in many Divisions to include new ways of working with general practice on chronic disease indicators, thereby augmenting a focus on data capture and reporting. Administrative burden associated with the collection and analysis of data is likely to be high. There is a perception that the combined focus of performance indicators, computerisation, accreditation and involvement in the Collaboratives and other such programs will increasingly drive momentum for improving the quality of Divisions and general practice services through the collection and analysis of

meaningful data. As data is more extensively used in planning and reporting in future, there may be a need for the Network to develop skills in information management, planning and reporting that the NQPS requires.

The system relies on feedback loops and discussion at all levels. The capacity of each of the stakeholders to benefit, is in part dependent on the quality of the relationships that exist within the network, both within and between levels. Timeliness is seen as key and there is little point in getting data or feedback about performance outside the timeframes required to implement change. Consistency in interpretation of performance reports is an important issue that needs to be carefully addressed to ensure that the system is seen as fair and people remain engaged within it.

There is a perceived tension between national performance measurement and local programs and responsiveness. This plays out in three ways. As Divisions strive to deliver on national priorities, activity within Divisions is changing and local responsiveness may be diminished. Resources required for data capture appear to be putting pressure on core funding and this is resulting in the diversion of resources further away from local programs. How the points system sets the bar on performance and values local programs in the future is likely to impact on the extent to which Divisions can continue to focus on local programs. Together these pressures interact to exert an independent influence that is likely to shape the nature and structure of program delivery across the network in future.

On balance, it appears that the sector has positioned itself and is at a good starting point to respond to the NQPS and there is broad support in the network for national performance indicators. The challenge for the NQPS at this early stage is in

supporting the system to mature in a way that strikes a balance between national priorities and local needs and responsiveness.

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## 5. APPENDICES

- 5.1 Letter of Invitation to Divisions
- 5.2 Letter of Invitation to SBOs
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- 5.5 SBO Interview Questions
- 5.6 ADGP Interview Questions

### 5.1 Letter of Invitation to Divisions

#### Evaluation study on the impacts of the introduction of the new National Quality and Performance System Performance Indicators on Divisions' planning activities

I am writing to invite you to participate in an evaluation study being conducted by the Australian Primary Health Care Research Institute (APHCRI) on the impacts of the introduction of the new National Quality and Performance System Performance Indicators on Divisions' planning activities.

The evaluation study aims to understand the impact of the requirements for the performance information on Divisions' planning activities. We are interested in the perceived benefits and pitfalls of these requirements on a Division's operations, including on the quality of planning and the organisation's strategic focus, its capacity to deliver local programs and intentions for use of the information generated by reporting against the indicators.

The evaluation is endorsed by ADGP and the Department of Health and Ageing and a Reference Group of key stakeholders has been established to provide advice on the evaluation design and implementation. Ethics approval has been obtained through the ethical review processes of the Australian National University.

The findings from this evaluation study will inform part of the overall evaluation of the National Quality and Performance System and the broader evaluation of the Divisions Program. Participating Divisions will have an opportunity to comment on the draft report of this study and the final report will be distributed to the Network.

We will be conducting telephone interviews with 28 Division CEOs and examining their planning documents. A sample of Divisions has been drawn to ensure that participating Divisions represent location, size and rurality of Divisions nationwide. I have attached the sample table for your information. Interviews are expected to take around one hour to complete. Attached is a list of the questions we wish to ask. Participation in the study is voluntary.

All data collected in the evaluation study will remain confidential and no Division or individual will be identified in any publication or material arising from the evaluation. Should you decide to participate in this study, your consent will be sought at the commencement of the telephone interview and recorded as part of the interview record. You may withdraw from the interview or withdraw your information from the study at any time. Any complaints or concerns you may have about the study or its conduct can be directed to Professor Nicholas Glasgow, Director of the Australian Primary Health Care Research Institute or to the Ethics Research Support Officer, ANU Human Research Ethics Committee, phone 02 6125 7945.

Your contribution to this evaluation study would be highly valued. We will contact you to discuss your interest in participating in the study and to set up a suitable interview time if you wish to do so. If you require any further information about the evaluation or wish to discuss any issues, please do not hesitate to contact Ms Karen Gardner on 6125 7875 or Dr Bev Sibthorpe on 6125 0782.

I look forward to speaking with you.

Yours sincerely,

Karen Gardner  
Researcher  
Australian Primary Health Care Research Institute

## 5.2 Letter of Invitation to SBOs

### Evaluation study on the impacts of the introduction of the new National Quality and Performance System Performance Indicators on Divisions' planning activities

I am writing to invite you to participate in an evaluation study being conducted by the Australian Primary Health Care Research Institute (APHCRI) on the impacts of the introduction of the new National Quality and Performance System Performance Indicators on Divisions' planning activities.

The evaluation study aims to understand the impact of the requirements for the performance information on Divisions' planning activities. We are interested in the perceived benefits and pitfalls of these requirements on a Division's operations, including on the quality of planning and the organisation's strategic focus, its capacity to deliver local programs and intentions for use of the information generated by reporting against the indicators.

The evaluation is endorsed by ADGP and the Department of Health and Ageing and a Reference Group of key stakeholders has been established to provide advice on the evaluation design and implementation. Ethics approval has been obtained through the ethical review processes of the Australian National University.

The findings from this evaluation study will inform part of the overall evaluation of the National Quality and Performance System and the broader evaluation of the Divisions Program. Participating Divisions, SBOs and ADGP will have an opportunity to comment on the draft report of this study and the final report will be distributed to the Network.

We will be conducting telephone interviews with ADGP, SBOs and 28 Division CEOs and examining the Divisions' planning documents. A sample of Divisions has been drawn to ensure that participating Divisions represent location, size and rurality of Divisions nationwide. All interviews are expected to take around one hour to complete. Attached is a list of the questions we wish to ask SBOs. Participation in the study is voluntary.

All data collected in the evaluation study will remain confidential and no Division, SBO or individual will be identified in any publication or material arising from the evaluation. Should you decide to participate in this study, your consent will be sought at the commencement of the telephone interview and recorded as part of the interview record. You may withdraw from the interview or withdraw your information from the study at any time. Any complaints or concerns you may have about the study or its conduct can be directed to Professor Nicholas Glasgow, Director of the Australian Primary Health Care Research Institute or to the Ethics Research Support Officer, ANU Human Research Ethics Committee, phone 02 6125 7945.

Your contribution to this evaluation study would be highly valued. We will contact you to discuss your interest in participating in the study and to set up a suitable interview time if you wish to do so. If you require any further information about the evaluation or wish to discuss any issues, please do not hesitate to contact Ms Karen Gardner on 6125 7875 or Dr Bev Sibthorpe on 6125 0782.

I look forward to speaking with you.

Yours sincerely,

Karen Gardner  
Researcher  
Australian Primary Health Care Research Institute

### 5.3 Letter of Invitation to ADGP

#### Evaluation study on the impacts of the introduction of the new National Quality and Performance System Performance Indicators on Divisions' planning activities

I am writing to invite you to participate in an evaluation study being conducted by the Australian Primary Health Care Research Institute (APHCRI) on the impacts of the introduction of the new National Quality and Performance System Performance Indicators on Divisions' planning activities.

The evaluation study aims to understand the impact of the requirements for the performance information on Divisions' planning activities. We are interested in the perceived benefits and pitfalls of these requirements on a Division's operations, including on the quality of planning and the organisation's strategic focus, its capacity to deliver local programs and intentions for use of the information generated by reporting against the indicators.

The evaluation is endorsed by ADGP and the Department of Health and Ageing and a Reference Group of key stakeholders has been established to provide advice on the evaluation design and implementation. Ethics approval has been obtained through the ethical review processes of the Australian National University.

The findings from this evaluation study will inform part of the overall evaluation of the National Quality and Performance System and the broader evaluation of the Divisions Program. Participating Divisions, SBOs and ADGP will have an opportunity to comment on the draft report of this study and the final report will be distributed to the Network.

We will be conducting telephone interviews with ADGP, SBOs and 28 Division CEOs and examining the Divisions' planning documents. A sample of Divisions has been drawn to ensure that participating Divisions represent location, size and rurality of Divisions nationwide. All interviews are expected to take around one hour to complete. Attached is a list of the questions we wish to ask ADGP. Participation in the study is voluntary.

All data collected in the evaluation study will remain confidential and no Division or individual will be identified in any publication or material arising from the evaluation. Should you decide to participate in this study, your consent will be sought at the commencement of the telephone interview and recorded as part of the interview record. You may withdraw from the interview or withdraw your information from the study at any time. Any complaints or concerns you may have about the study or its conduct can be directed to Professor Nicholas Glasgow, Director of the Australian Primary Health Care Research Institute or to the Ethics Research Support Officer, ANU Human Research Ethics Committee, phone 02 6125 7945.

Your contribution to this evaluation study would be highly valued. We will contact you to discuss your interest in participating in the study and to set up a suitable interview time if you wish to do so. If you require any further information about the evaluation or wish to discuss any issues, please do not hesitate to contact Ms Karen Gardner on 6125 7875 or Dr Bev Sibthorpe on 6125 0782.

I look forward to speaking with you.

Yours sincerely,

Karen Gardner  
Researcher  
Australian Primary Health Care Research Institute

#### 5.4 Division Interview Questions

1. Comparing the 04/05 planning cycle with the recent 05/06 planning cycle, what impacts do you think the national performance indicators have had on the nature and quality of your Division's planning processes?
2. Did the introduction of performance indicators lead your Division to
  - a) Strengthen or increase the Division's focus on some programs or activities?
  - b) Add new programs or activities
  - c) Weaken or decrease the Division's focus on some programs or activities?
  - c) Cease any programs or activities altogether?
3. What is your perception of the impact of these changes on the fit between perceived local needs and current program/activities?
4. What are your Divisions' plans in terms of using the performance information to
  - i) inform your own activities,
  - ii) provide feedback to general practices/ GPs
  - iii) provide feedback to consumers and other stakeholders?
5. Looking ahead to planning in 2006/07, how do you think the introduction of the Performance indicators is going to influence planning in future?

### 5.5 SBO Interview Questions

1. What have been the main impacts of the introduction of the national performance indicators for Divisions on your SBO?
2. What supports have Divisions requested to date to implement the national performance indicators? eg. IT, planning expertise, data knowledge.
3. To what extent is there variation in Division's capacity to respond to the introduction of the national performance indicators?
- 3a What is the nature of that variation and what does it depend on (Division characteristics eg. location, size (no of GP practices) , structure, population
4. To what extent have you been able to meet Division needs for support?
5. What do you think have been the main impacts on Divisions' planning?
6. What is your perception of the impact of the introduction of Divisions' national performance indicators on the fit between local needs and current program/activities in Divisions?
7. What do you think the planning and reporting issues will be in future for your SBO and your Divisions?
8. Are there any other issues you would like to comment on that haven't been covered?

### 5.6 ADGP Interview Questions

1. What have been the main impacts of the introduction of the national performance indicators for Divisions on ADGP?
2. What supports have SBOs requested to date to support the implementation of performance indicators? eg. IT, planning expertise, data knowledge.
3. To what extent have you been able to meet SBOs needs for support?
4. From your perspective as the national peak body, what do you think have been the main impacts of the introduction of the Divisions' national performance indicators on:
  - SBOs planning
  - Divisions planning
5. What is your perception of the impact of the introduction of national performance indicators on the fit between local needs and current program/activities in Divisions?
6. What do you think the planning and reporting issues will be in future for ADGP and SBOs?
7. Are there any other issues you would like to comment on that haven't been covered?