# Analysis of Provider Payment Reforms on Advancing China's Health (APPROACH)
# World Management Survey Questionnaire

## Basic information

City _____

County _____

Name of health facility (based on registration record) _____

Postcode □□□□□□

Hospital ID □□

Questionnaire ID □□

Department【1：Orthopedics , 2: Cardiology , 3 : Surgery ,4：Other (specify) □ _____

Job title 【1：Director，2：Charge nurse，3：Vice director，4：Other (specify) □ _____

University administering the survey【1：GZU，2：ZYU】 □

Interviewer 1 ID □□

Interviewer 2 ID □□

| ITEM | Possible questions | 1 | 1.5 | 2 | 2.5 | 3 | 4 | 5 |
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| **1. Layout of Patient Flow** | | | | | | | | |
| 1.1 What does the patient journey feel like? Is it a smooth progression or are there several roadblocks? | a) Can you briefly describe the patient journey or flow for a typical episode? | There is no thought-through layout. Patients are often lost and delays abound. Manager cannot understand the question. | The layout of the hospital and organization is not conducive to patient flow. There are signs marking where wards and theatres are, but patients often get lost. | The layout of the hospital is not good and has not been optimized, but there are signs and not too many roadblocks along the way. Patients and staff are generally able to find their way, albeit it is long. | The layout of the hospital is not good and has not been optimized, but someone did put related departments close to each other such that patients and staff would have less distance to travel. If the hospital has elevators, one is a dedicated patient elevator to ensure patients flow as easily as possible. | The layout of the hospital has been thought-through and optimized as far as possible. There are, however, (real or perceived) constraints that make it impossible to fully optimize the layout and patient pathway. | The layout of the hospital has been configured to optimize patient flow. Considerable efforts are made to overcome hurdles to change and any constraints to achieving long-run efficiency. | Hospital layout was *designed* to be as efficient as possible. Old units are refurbished to align well with brand new buidllings/units. |
| 1.2 How closely located are the different "points" of the journey and any consumables that might be needed? | b) How closely located are the wards, theatres, diagnostics centres and consumables?<br>c) How long on average would a patient have to travel from, say, waiting room to pre-op to the OR? | Everything is where it was initially built, and the initial building was not well thought through. Theatres and wards are not close at all. Consumables are generally all in one spot and not easily accessible. | Wards are on different levels from theatres or consumables are often not available in the right place at the right time. | Wards and theatres are on the same level and walkable distances, but not very easily accessible from the hospital entrance. Consumables are often not available in the right places. | Wards and theatres are on the same level and walkable distances, but not very easily accessible from the hospital entrance. Consumables are, however, rather easily accessible. **OR** Consumables are easily accessible, but wards and theatres are on different levels/difficult to reach from one to the other. | Wards and theatres are relatively close to each other, and there are consumables stations spread out across the hospital. These are not, however, systematically restocked and can sometimes be difficult to refill. | Wards and theatres are relatively close to each other, and there are consumables stations spread out across the hospital. These are systematically restocked though they can sometimes be difficult to refill. | The different points of the journey have been set to have the least amount of distance possible, and consumables are available and refilled at every floor at strategic points. |
| 1.3 How often are there problems with this pathway? Does improvement come from it? | d) How often do you run into problems with the current layout and pathway management? | There is no thought-through layout and/or the one that exists is not ever challenged. | The layout of the hospital does not get challenged regularly, but people are open to making suggestions. These are not, however, documented properly and often not followed up on. | The layout of the hospital does not get challenged regularly. Every 10 years or so someone from the government audits the pathway. Staff suggestions are made once in a while but it is very informal. | The layout of the hospital does not get challenged regularly, but when problems happen it gets questioned (albeit not systematically). Changes can be suggested and have to go through a bureaucratic process to be implemented. | Patient flow is not regularly challenged but there is a signficant effort to improve. Staff is encouraged to make suggestions and these are taken seriously by senior management. | Workplace organization is regularly discussed in meetings with different staff involved. Regularly means at least once a quarter. | Patient flow and workplace organization are challenged regularly by a multidisciplinary team with complete authority to implement changes whenever necessary. Regularly means at least monthly. |

| ITEM | Possible questions | 1 | 1.5 | 2 | 2.5 | 3 | 4 | 5 |
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| **2. Rationale for introducing standardization and pathway management** | | | | | | | | |
| 2.1: What was the rationale for implementing operational improvements to the pathway? | a) Can you take me through the rationale for making operational improvements to the management of the patient pathway? Can you describe a recent example? | There are no changes implemented. | The rationale for improvements is purely to meet bare minimum government regulatory demands. | The rationale for improvements is purely to meet full government regulatory demands (rather than just bare minimum). | The rationale for implementing operational improvements to the pathway is mainly relating to regulation imposed by the government. Hospital takes the opportunity to improve pathway to decrease costs as well. However, patient satisfaction and overall efficiency are not even mentioned. | The rationale for changes is ultimately to improve performance, however, they are motivated *mainly by financial* reasons or to meet regulatory demands. | The rationale for changes was to meet *clinical and financial* outcomes. The clinical outcomes impetus behind the changes went beyond regulatory demands. | The rationale includes clinical and financial motivations, in a good balance. The aim is to improve overall efficiency in every hospital level. |
| 2.2: How *often* is the pathway challenged? What *factors* drove this change? | b) How often do you challenge/streamline the patient pathway?<br>c) What factors led to the adoption of these practices? | The pathway is never challenged, even if problems happen. | The pathway is rarely challenged, even if there are problems or accidents. There might be an audit if the accident was very serious. | The pathway is rarely challenged, and generally only happens if there is some sort of accident (even if minor). If they are very serious, it will *definitely* trigger a review of the incident. | The pathway is not challenged very often, but there is a small review every time there is an accident - big or small - as wel as a near-miss. It is very much a reactive approach (rather than proactive) but there is a system in place to handle the problems. | The pathway is challenged every time there is an accident, near-miss or someone in management notices (or is advised) that something could become a problem. Pre-emptive suggestions are taken on board as an important factor, *but this is not fully formalized* and sometimes take a while to get attention from senior managers. | The pathway is challenged every time there is an accident, near-miss or someone in management notices (or is advised) that something could become a problem. Pre-emptive suggestions are taken on board as an important factor. This is *a formal process* though sometimes the process can be rather long. | The pathway is continuously challenged with all staff members having access to an intranet documentation system they can access from any computer terminal in the hospital. There is a "quality team" dedicated solely to the task of reviewing issues, problems and suggestions to improve the pathway and operations within the hospital. |
| 2.3: *Who* within the hospital drives the changes? | d) Who typically drives these changes? | Nobody ever drives any changes. | The government or board members dictate changes, but staff rarely take it seriously (including senior management within the hospital) | Changes are dictated top-down and senior management is generally on board with them. The staff, however, do not pay much attention and simply "do as they are told" as long as they have to. | Changes are dictated top-down, but senior management tries to communicate the changes to the staff in a way that they can understand why the changes are being implemented. This tends to get a bit of traction with employees in implementing the changes. | Changes generally come from the top, but the senior level managers have a stake in the process. Senior management discusses with middle management on an informal basis to get some feedback. | All staff groups in the hospital are *expected* to drive improvement changes. Ideas are encouraged from both senior managers, though no rewards exist for good ideas that were implemented. | All staff groups in the hospital are *responsible* for driving improvement changes. Ideas are encouraged from both senior managers and junior staff members, with appropriate rewards when ideas are implemented. |

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| **3. Standardization and protocols** | | | | | | | | |
| 3.1: Standardization of protocols and clinical processes (MAIN clinical processes - common cases such as hip replacement surgery, triple bypass sugery, knee surgery, catheters, etc.) | a) How standardized are the main clinical processes? What share of your processes have you standardized? (Examples to check for: pre-surgery checklist, "wrong side wrong patient wrong procedure" protocol, transition between units and shifts, etc.) | There is no standardization. A patient could come in and receive two completely different treatment protocols from two different doctors. | There is a general agreement amongst clinical staff on how they should proceed on the most common cases, but this is not formalized anywhere. Less than 25% of processes standardized. | There is a general agreement amongst clinical staff on how they should proceed on most common cases, but this is agreed in meetings and might live in "minutes" somewhere, only half-formalized. Less than 50% of processes standardized. | There are a set of standard protocols given to the hospital by regulatory agencies. They are posted on walls and could serve as a guide but are very often ignored. About 50% of processes standardized. | There are a set of standard protocols for only the most common of cases, but they are not "user-friendly" or easily available (ie. only available on a website or in a clunky manual). About 75% of main processes standardized by now. | There is a set of standard care protocols for the key diseases/surgeries/treatments, and the protocols are based on clinical evidence. All major processes have been standardized, and they are updated every year or two. | The hospital has a set of standard care protocols for many diseases/surgeries/treatments, as well as standardized work-ups, tests and prescriptions. These protocols were created based on clinical evidence and are regularly updated. All major processes have been standardized. |
| 3.2: Clarity of process and procedures | b) How clear are the clinical staff members about how specific procedures should be carried out? | There is no clarity of processes and procedures as there is no standardization. A patient could come in and receive two completely different treatment protocols from two different doctors. | Heads of departments are aware of the understanding and believe procedures are being followed, but more junior clinical staff are not aware of any protocols. | Clinical staff know about the existence of protocols, but are unclear on how they are supposed to implement their use on a day to day basis. | Clinical staff are clear on the existece and use of protocols. Some try to follow them, but not consistently. | Clinical staff are clear on how to use the protocols and that they exist. They understand them and are expected to use them. They use them once in a while when convenient and time allows, but don't believe these must be followed. | Protocols are well known and used by the clinical staff quite frequently. | Clinical staff know and make use of protocols daily. This is second nature to everyone. |
| 3.3: Monitoring tools, resources and protocols (Note this is about TOOLS for monitoring standardization, not about level of standardization) | c) What tools and resources does the clinical staff employ (ie. checklists, patient barcoding) to ensure they have the correct patient and/or conduct the appropriate procedure?<br>d) How are managers able to monitor whether clinical staff are following established protocols? | There is no monitoring as there are no tools, resources and protocols. A patient could come in and receive two completely different treatment protocols from two different doctors. | There are very basic tools available to identify patients and procedures. There is no monitoring of processes as these do not exist. | Clinical monitoring and protocol tools are not available to all staff, but middle managers have them in their induction manuals. There is no monitoring of the usage of protocols, formally or informally. | Written (physical or electronic) clinical monitoring and protocol tools are available to all staff, *but not easily accessible*. They are seen as a guideline only. There is no formal monitoring of the usage of the protocols, but senior managers keep an eye on what is happening informally. | Written (physical or electronic) clinical monitoring and protocol tools are available to all staff and *are easily accessible*, but the protocol is seen as a guideline only. There is minor monitoring of the usage of the protocols though senior managers will review incidence reports. | Written (physical or electronic) clinical monitoring and protocol tools are available to all staff and *are easily accessible.* Protocols are seen as a *requirement* and there is a monitoring system that identifies discrepancies. | There is a standard procedure and other members of staff would notice if someone was not following the agreed protocol. Further, there are clear tools such as checklists, patient bracelets and monitoring forms to be filled out by the clinical staff. This data is regularly monitored by a "clinical quality" team who is looking for deviations in order to improve and refine the protocols. |

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| **4. Continuous Improvement** | | | | | | | | |
| 4.1: Finding and documenting problems | a) When you have a problem in the hospital, how do you come to know about them?<br>b) What are the steps you go through to fix them? | Problems are never exposed. The manager is not aware of any problems (or they say they haven't had problems for years - means they just didn't know!). | The manager rarely finds out about issues within the hospital. He/She thinks all is well most of the time, when in reality it is not. | The manager is often informed about problems when they are happening, but never documents the issues after the fact. | The manager is often (but not always) informed about problems when they are happening, and sometimes documents the issues after the fact. The manager does not look back at these notes to try and prevent further issues. | The manager is always informed about problems when they are happening, and always documents the issues after the fact. The manager does not look back at these notes to try and prevent further issues. | The manager is always informed about problems when they are happening, and always documents the issues after the fact. The manager will sometimes look back at these notes to try and prevent further issues. | Exposing and solving problems (for the hospital, patients and staff) in a structured way is integral to individual's responsibilities. There is an online reporting system which all staff have access to and follow up on a daily basis. |
| 4.2: Who resolves problems | c) Who is involved in resolving these issues, that is, in deciding what course of action will be taken to resolve the issue? | Nobody gets involved as there are no issues to be solved. | There is no set person/staff group who follows up with problems. This is done by whoever wants to see the issue resolved, very ad-hoc. | There is only one staff group involved in solving the issue, usually just the manager. (S)he might ask a third party to perform a task so the problem can be fixed, but ultimately, the manager decides how the problem will be solved. | Only one staff group (ie. the manager, the dept heads, nursing leadership) gets involved in solving the issue, but he/she does ask for informal feedback from other staff groups. | Most of the appropriate staff groups are involved in solving the issues (ie. the head of cardiology and the porters get together to solve an issue of turnover time when patients are discharged) | All of the appropriate staff groups are involved in solving the issues. | All of the appropriate staff groups are involved in solving the issues. There is also an advisory committee composed of different representatives (doctors/nurses/admin staff) to address problems within the hospital. |
| 4.3: Who improves processes | d) Who is involved in improving/suggesting improvements to the process so these issues do not happen again? | No process improvements are ever made. | There is no set person/staff group who suggests improvements. If there are any improvements, these are done by whoever wants to see the issue resolved (very ad-hoc).The manager rarely implements suggestions to improve processes. | Only one staff group (ie. the head of dept/nurse manager) gets involved in improving processes, but this is done in a unstructured way (only when the manager feels the need to improve it). No feedback is asked from other staff groups. | Only one staff group (ie. the head of dept/nurse manager) gets involved improving processes, but he/she does ask for informal feedback from other staff groups. | Only one staff group (ie. the head of dept/nurse manager) gets involved improving processes, but he/she does ask for formal feedback from appropriate staff groups during meetings and other formal functions. | All staff groups get involved in improving processes (e.g. through and other formal functions. All staff are expected to contribute. | Improvements are performed as part of regular management processes. Clinicians are encouraged to discuss process improvements with their peers and dept. heads during dept. meetings and to implement process improvements previously discussed and share more effective processes with the hospital in regular meetings. There is also an advisory committee composed of different representatives (doctors/nurses/staff/patients) to address problems and suggest improvements within the hospital. |

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| **5. Good use of human resources** | | | | | | | | |
| 5.1: What happens when one area of the hospital becomes busier than the other | a) With respect to your staff, what happens when different areas of the hospital become busier than others? | Nothing happens. The different areas of the hospital are not linked. | Nothing much happens - staff rarely moves around. If there is a dire emergency unit managers will call around to their colleagues to see if there is anyone wh ocould sub or come help out. | Managers allocate some staff across units, but this is not coordinated at all. There is no register or skills so allocation is done very informally based on superficial knowledge of skills. | Senior staff try to use the right staff for the right job when it is simple to do so, but this rarely happens. For example, it is not uncommon to see nurses doing jobs that porters should be doing. | Senior staff try to use the right staff for the right job, but they do not go to great lengths to ensure this. This is often done in an uncoordinated manner. | Senior staff always use the right staff for the right job using a database of skills and competencies. This is done through one person or department. | Staff recognize human resource deployment as a key issue and will go to great lengths to make it happen. Shifting staff from less busy to busier areas is done routinely and in a coordinated manner, often before ward managers have to call with an 'emergency.' |
| 5.2: What tools exist to help managers best allocate human resources across the hospital | b) How do you know which tasks are better suited to different staff? | There are no tools and no way to know what staff are better suited for what tasks. | Managers have some knowledge of the staff and try to allocate them where they might be best suited, but their knowledge is limited and not used most of the time. | There are no formal tools, but the senior managers tend to have an idea of the broad area of speciality of the staff in some departments. | There is a register of staff skills, but it is not comprehensive. This register consists solely of basic job description qualitifcations rather than specific skillsets. | There is a register of staff skills, but it is not easily searchable. This register consists mainly of the job posting skillset description and qualitifcations, but does not list extra qualifications the staff may have. There is a "nurse bank" they can reach out to in an emergency. | There is a register of staff skills, competencies and qualifications, which is accessible and easy to use. This is used to allocate staff to different areas/ tasks. | There are extensive lists with all employees and their specialties in an easily searchable format. These go beyond job descriptions and include skills that staff may have that were not required for the job they have, but can be useful elsewhere. There is also a register for affiliated staff who are not full time staff but can be called in an emergency. |
| 5.3: How is the flow of the staff coordinated | c) What kind of procedures do you have in place to assist staff flow between areas; for example, is there one central person or centre which coordinates this process? | There is nobody in charge of coordinating the flow of staff around the hospital. People do not move around, ever. | There is nobody in charge of coordinating the flow of staff around the hospital, but this might happen through a series of two-way calls/conversations. | Many senior managers take care of the flow independently if necessary. This is often uncoordinated and through series of phone calls or running around the hospital. | There is not a designated position that is in charge of coordinating staff around the hospital, but people know to generally call the front desk to alert more staff is needed. It is not a formal process or coordinated, but eventually staff is distributed where necessary. | There is a designated position that is in charge of coordinating staff around the hospital, and all know to call this person when they need more staff. This person might not always be available or know which areas have excess staff, as people rarely call to report low volume. | There is a central office/person that coordinates the movement of staff around the hospital. Managers can request more people or offer them when they are not busy, although this is not done routinely. | There is a central office/person that coordinates the movement of staff around the hospital. It is easy for departments to request more people or offer them when they are not busy. |

| ITEM | Possible questions | 1 | 1.5 | 2 | 2.5 | 3 | 4 | 5 |
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| **6. Performance Tracking** | | | | | | | | |
| 6.1: Types of parameters (such as quality of care, infection rates, time spent in A&E, admission to surgery times, leadership performance, staff engagement, service quality, etc.) | a) What kind of Key Performance Indicators do you use to track hospital performance?<br>b) What documents are you using to inform this tracking? | Only government-required metrics are tracked, such as patient volume and basic costs/expenditures numbers. | One main indicator in addition to patient volume and basic costs/expenditures numbers, but it does not show how well the hospital is doing overall. | Two main indicators in addition to patient volume and basic costs/expenditures numbers are tracked, but it does not show how well the hospital is doing overall. | Three main indicators in addition to patient volume and basic costs/expenditures numbers are tracked, but it does not show how well the hospital is doing overall. | There are a large number of indicators in addition to patient volume and basic costs/expenditures numbers, but they mostly cover operations and patient satisfaction. The indicators do not show how well the hospital is doing overall. | A large set of indicators are tracked. They *do cover a range* of types to show how the hospital is doing overall (ie. patient volume, patient satisfaction, infection rates, A&E average wait times and budgets). *However, because of the large number of indicators, it is not straightforward to name the "key" ones.* | There are 5-7 key indicators that are tracked and can be recited off the top of senior management's head. They cover a range of types to show how the hospital is doing overall (ie. patient volume, patient satisfaction, infection rates, A&E average wait times and budgets). |
| 6.2: Tracking and compilation frequency (note the difference between daily eletronic tracking available every day vs. data available monthly that details day to day indicator activity) | c) How often are these measured? | Government metrics are compiled quarterly and cannot be checked in the mid-term. | Government metrics are compiled quarterly and cannot be checked in the mid-term. Other indicators are tracked annually. | Government metrics are compiled quarterly and cannot be checked in the mid-term. Other indicators are tracked quarterly as well. | Government metrics are compiled quarterly and cannot be checked in the mid-term. Other indicators are tracked monthly. | All main metrics are tracked and compiled weekly. The data is not available in real time, but can be compiled at the end of the week. | All main metrics are tracked and compiled daily and weekly. The data is not available in real time, but can be compiled at the end of the day/week. | All indicators are tracked continuously throughout the year and are accessible at *any point in time* (real time). |
| 6.3: Communicated to whom and how | d) Who gets to see this data?<br>e) If I were to walk through your hospital, could I tell how it is doing compared to its main indicators? | Data is only officially seen by directors and top level management. | Data is only officially seen by directors and top level management. It is available to department heads upon request. | Data is only officially seen by directors and top level management. Basic reports are sent quarterly to departement heads only. | All management team has access to the data. Reports are compiled quarterly and sent to staff. | All management team has access to the data. Reports are compiled monthly and sent to staff. | Records are automatically updated in computer systems that all staff have access to. | Records are automatically updated in computer systems that all staff have access to. There are various visual systems displaying the targets and hospital performance against it (ie. dashboards). |

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| **7. Performance Review** | | | | | | | | |
| 7.1: Frequent discussions | a) How often do you have meetings to review the indicators? | Performance is reviewed annually. | Performance is reviewed bi-annually. | Performance is reviewed quarterly but limited items are discussed. | Performance is reviewed monthly but limited items are discussed. | Performance is reviewed in *monthly* meetings and all key items are discussed. | Performance is reviewed in *weekly* meetings and all key items are discussed. However, there are no clear links between this performance review and day to day operations. | Performance is continually reviewed in a series of weekly meetings with links to staff daily 'huddles' |
| 7.2: Who is involved in these meetings and how are results communicated to the hospital | b) Who is involved in these meetings?<br>c) Who gets to see the results of these meetings? Are details of the meeting shared with other staff? | The meetings are informal and include only top level directors. Staff never get feedback. | The meetings are informal and include only top level directors. Staff only get feedback if there is an audit. | Meetings include directors and most senior managers of key departments. They are informal and details of meeting are not well communicated to other staff. | Meetings include directors and senior managers of all key departements. Nobody cares to get feedback from junior staff. Results are not generally communicated to all staff, though they are available if asked for. | Meetings include all key departments but only senior managers are expected to attend. Senior managers do try to get feedback from junior staff, but it is done on an ad-hoc basis. Results are not generally communicated to all staff but are available upon request. | Meetings include all key departments but only senior managers are expected to attend. Results are always communicated to all other staff. | Senior managers of all key departments and some junior managers (on a rotating basis) are involved in review meetings. Results are always communicated to staff using a range of tools (such as newsletters and handouts for stand-up staff meetings) |
| 7.3: Action plan follows the meeting | d) After reviewing these indicators, what is the action plan you leave these meetings with?<br>e) What steps would people take after?<br>f) Who is responsible for carrying out the action plan? | There is no systematic action plan. If it is made because of an audit, it is only relating to senior staff. | There is no systematic action plan, but people are expected to take note of what they have to do. | There is no sistematic action plan put in place. Take-aways are informal and not generally followed up on, but taken down in meeting minutes. | There is no sistematic action plan put in place. Take-aways are very informal but are generally followed up on by senior management. | There is no clear action plan in place after meetings, but it is noted in minutes and senior management can refer to those if necessary. | Action plans are detailed with responsible people noted, deadline and expectation from the meetings. They stay within senior management, however, and are not regularly communicated to other staff. | Action plans are detailed with responsible people noted, deadline and expectation from the meetings and published via the hospital intranet system or staff board. |

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| **8. Performance Dialogue** | | | | | | | | |
| 8.1: Follow a clear agenda | a) Can you tell me about a recent review meeting you have had? What topics did you discuss in this meeting? Was there an agenda? | There is no set agenda for the meeting. | There is a list of topics to talk about that the manager brings along, but he/she does not share it with others previously and it is not clear what the discussion will be about and people do not know what to expect. | There is no formal agenda for the meeting, but the manager tends to always follow the same topics in the meetings so people know what to expect. | There is a formal agenda for the meeting, but it is not always clear what the topics are and it only sometimes gets circulated to staff before the meeting. | The manager holds set meetings with a clear agenda. The manager circulates the agenda before hand so all know what will be discussed and can come prepared. | There is a clear, formal agenda for the meeting. The manager circulates the agenda in advance so participants know what will be discussed and can come prepared. Staff can add items to the agenda if they wish to do so, but do not do so often. | The manager holds set meetings with a clear agenda. The manager circulates the agenda before-hand so all know what will be discussed and can come prepared. All staff are encouraged to add relevant items to the agenda and often do so. |
| 8.2: Meetings have appropriate data present | b) What kind of data or information about the indicators do you normally have with you? | There is no data available for the meeting. | The manager brings some basic hospital admissions data to the meeting. | The manager brings some detailed hospital stats on admissions and some financial data, but no other type of data. | The manager brings a small set of good data to the meeting, but it is limited and only helps in part of the discussions. **OR** Manager brings too much data to the meeting so it is not useful. | There is an appropriate set of data available for the meeting, though not in a very easy format to read. (ie. No charts/graphs, just numbers/comments) | There is an appropriate set of data available for the meeting. The main indicators are displayed in an easy format to read (e.g. charts/graphs). They are not organized/displayed in a way to promote debate, though. | There is an appropriate set of data available for the meeting, and it is displayed in a very easy format to read such as in charts/graphs, summarizing the indicators collected *which reflect the performance of the hospital.* The indicators chosen to discuss are displayed in a way that facilitates discussion. |
| 8.3: Get people involved in constructive feedback | c) What type of feedback do you get during these meetings?<br>d) How do you get to solving the problems raised in the meetings? | The manager only tells staff about the issues and does not expect or encourage feedback on how to solve the issues. It feels more like a lecture rather than an interactive meeting. Since there is very little interaction, conversations do not lead to root causes of issues. | The meeting is mainly about ad-hoc problems that came up during the time since the previous meeting, and nothing of value gets discussed. The manager discusses the issues with staff, but does not encourage suggestions. If suggestions are given, they are done in an unstructured way and the manager does not take note of possible solutions. | The manager mainly acknowledges the problems they are discussing in the meeting and listens to any feedback offered without encouraging it, but does not actively request it or write down comments. He/she also rarely implements others' suggestions. | The manager actively listens to any feedback given and encourages it. He/she does not write it down, but does make an effort to implement some suggestions when reminded. | Those present in the meeting know they are expected to contribute to the dicussions and do so actively. It is an open forum where the manager encourages open feedback and creative solutions to problems. The manager takes notes of feedback given. There is an open discussion of problems but it is done in an unstructured way, and as a matter of course the conversations do not drive to the root cause of problems. | Those present in the meeting actively contribute to discussions in a structured way, using a range of techniques to find the root cause of problems. The manager takes notes of feedback given. | Those present in the meeting actively contribute to discussions in a structured way, using a range of techniques to find the root cause of problems. The review focuses on both successes and failures in order to idenify what is and what is not working in the hospital. Meetings are an opportunity fo constructive feedback and coaching. |

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| **9. Consequence Management** | | | | | | | | |
| 9.1: Clear responsibilities for action plan | a) After a review meeting, how are people aware of their responsibilities and actions that must be taken? | There are no follow up plans, tasks or list of things that need to geet done after the meetings, so there are no assigned responsibilities (ie. tasks are not assigned to people) | The manager makes a mental note of the things that need to get done after the meeting and asks members of staff to do some of them (no clear tasks as no explanation on how to get them done). Since there is no record and it is too much for the manager to remember, things rarely get done and no one is accountable/answerable for them. | The manager has a list of things that need to get done after a meeting, but it is not clear how he/she expects to achieve them (no clear tasks as no explanation on how to get them done). (S)he takes note of the list and asks members of staff to do some of the tasks. However, there is no clear responsibility and accountability set, and the majority of things end up being discussed again in the next meeting. | There are clear tasks that come out of meetings, but there are no individuals assigned to nor timeframe allocated to tasks. There are no major consequences for failure to follow through with the action plan/ tasks. | There are clear follow up plans (with assigned tasks, responsibilities, people involved, and timeframe) that come out of meetings with specific *groups* being responsible (but not necessarily accountable) for actions/tasks. They follow this up every month in the following meeting, but consequences for failure are not clear. | There are clear follow up plans (with assigned tasks, responsibilities, people involved, and timeframe) that come out of meetings with specific *people* being responsible (and only marginally accountable) for actions/tasks. They follow this up every month in the following meeting, and there are generally minor consequences for not meeting task targets. | There are clear follow up plans (with assigned tasks, responsibilities, people involved, and timeframe), that come out of meetings with specific people being responsible and accountable for actions/tasks. They follow this up every month in the following meeting, and with clear consequences for failure in completing the tasks. |
| 9.2: How long it takes to identify and deal with a problem | d) How long does it typically go between when a problem starts and you realize this and start solving it?<br>e) Can you give me an example of a recent problem you've faced? | It would take over one year for action to be taken. | It would take at most one year for action to the taken. | It would take over six months for action to be taken. | It would take three months for action to be taken. | It would take about a month for action to be taken. | It would take a week or two for action to be taken. | Action is taken immediately after a problem is identified. Manager is made aware of the progress along the way. |
| 9.3: How they avoid having the same problem again | f) How would you make sure this problem does not happen again?<br>e) If a year from now the problem were to happen again, how would you know if and how you dealt with such a problem before? | There are no measures taken to make sure the problem does not happen again. The solution to the problem is not recorded anywhere. If the problem happened again, the manager would not be aware/remembers that they faced a similar problem in the past. | The manager makes a mental note of the issue and makes sure he/she brings it up in an annual meeting, but nothing formal. | The manager brings it up in a monthly meeting to inform staff of the issue and have a record, but sees it as a problem of the past and that they should move onwards. | The manager notes the issue in a diary, but the diary is not used for anything proactive. | The manager notes the problem in a diary, and consults it from time to time when there is a problem to see if they have figured it out before. There is nothing done to prevent future problems, however. | The manager notes all problems in a diary and details how the problems were solved. This is used to help prevent similar future problems. | There is an online reporting system with all problem and action plans in detail which the department heads, nurses and other staff have access to and follow up on a regular basis. |

| ITEM | Possible questions | 1 | 1.5 | 2 | 2.5 | 3 | 4 | 5 |
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| **10. Balance of Targets/Goal Metrics** | | | | | | | | |
| 10.1: Clarity and Balance of Targets/Goal Metrics (Examples of clear and tangible goals are: "decrease infection rates by 50%" or "increase handwashing rate to 97%", or "offering two nurse development courses per year") | a) What goals do you have set for your hospital? | There are no goal metrics, so no definition either. Manager struggles to answer this question. | There is a general sense that they would like to improve one main clinical outcome measure (ie. "infection rates", "re-admission rates"), but no absolute numbers or percentages regarding how much. | There is a general sense that they would like to improve two or more main clinical outcome measures iie. "infection rates", "re-admission rates"), but no absolute numbers or percentages regarding how much. | The clinical goals are absolute and tangible, such as "decrease infection rates by 50%". | There are clinical outcome goals and financial goals, and they are defined in absolute and tangible measures. | Clinical outcome goals, as well as other types of goals such as efficiency *as well as* financial outcomes, are defined in absolute and tangible measures. | The hospital has clinical goals as well as other types of goals, such as efficiency outcomes, financial outcomes and operational outcomes. They are all defined in terms of absolute/tangible and value-added measures. |
| 10.2: Set at the district, hospital, departmental and individual levels | b) Can you tell me about any specific goals for departments, doctors, nurses and staff? | The only hospital goal metric is year-end patient volume or patient satisfaction. | There is a small range of goals for the hospital including year-end patient volume or patient satisfaction, but they are not very clear, in addition to a loose goal that is tied to a government/board target (such as improving the hospital overall ranking). | There is a small range of goals that are defined for the district and the hospital as a whole but not for levels within the hospital (including departments, doctors, nurses, staff). | There is a small range of goals that are defined for the district, the hospital as a whole, and for departments but not for individuals within the hospital (including doctors, nurses, staff). | There is a small range of goals that are defined for the district, the hospital as a whole, departments and for individuals within the hospital (including senior doctors and nurses). | There is a small range of goals that are defined for the district, the hospital as a whole, departments and for individuals within the hospital (including senior and junior doctors, nurses and staff). | A range of goals (measured in terms of absolute and value-added measures) are defined for the district, the hospital, departments, and for individuals within the hospital (including senior and junior doctors, nurses, staff). |
| 10.3: Linked to patient outcomes and defined by internal and external factors | c) How are your goals linked to patient outcomes?<br>d) How are your hospital goals linked to the goals of the health system (district, national)? | Goals relate directly to government targets. Manager cannot explain why the goals were chosen, there is not a particularly clear reason for determining these goals. | Goals relate directly to government targets. BUT manager explains or understands that these goals are losely tied to the overall system health outcomes. | Goals relate directly to government targets which are tied to the overall system health outcomes, but with some regard for a internal hospital benchmark (decided partialy based on realistic improvements on previous years' outcomes). | Goals are set based on internal targets based on a range of patient outcomes and also following government-imposed targets. The manager does not actively seek outside information. | Goals are set based on internal targets based on a range of patient outcomes, as well as government-imposed targets. The manager checks around with nearby hospitals to ensure their goals are reasonable. | Goals are set based on internal targets based on a range of patient outcomes, as well as government-imposed targets. The manager routinely checks with nearby and region-level hospitals to ensure their goals are reasonable. | Goals are set based on internal and external factors based on a range of patient outcomes. |

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| **11. Interconnection of Targets/Goals** | | | | | | | | |
| 11.1: Motivation and clarity of goals through the hierarchy chain | a) What is the motivation behind your goals?<br>b) Are the goals clear to you and others in your hospital? | Goals do not trickle down through the health system or the hospital. | Only one overall goal gets trickled down to the hospital, though it is unclear and vague. | A set of goals get trickled down from the health system to the hospital but they are not very clear even to the manager. | A set of goals get trickled down from the health system to the hospital, but they are only clear to the manager. Senior clinicians and other staff do not have clarity on the hospital goals. | A set of goals get trickled down from the health system to the hospital, but they are only clear to the manager and some senior doctors and heads of departments. Other staff do not have clarity on the hospital goals. | A set of goals get trickled down from the health system to the hospital. Goals are clear to manager, heads of departments, doctors and other staff in the hospital. | A set of goals get trickled down from the health system to the hospital. Goals are not only clear but have significant buy-in from managers, heads of departments, doctors and other staff in the hospital. |
| 11.2: Goals are well communicated within the hospital | c) How are these goals cascaded down to the different staff groups or to individual staff members? | The manager tells staff in the annual meetings that their goal is to improve, but nothing very concrete. | The manager talks to his/her staff members sporadically throughout the year to tell them how they should be doing. ADD THINGS HERE TO DIFFERENTIATE BTW A 1.5 AND 2 | There is no formal process by which the manager communicates the hospital and individual goals to clinicians, but he/she does use an informal system of word-of-mouth by talking to them in the hallways and ad-hoc meetings. | The manager will reiterate the hospital goals in their annual meeting, and has irregular meetings with clinicians to talk about specific goals. (S)he only does this when there is a problem, and not as a matter of routine. | Once per year, doctors and nurses have professional development meetings to revise their goals and ensure they're proper. The manager keeps track of clinicians' development and their patient outcomes. | At least twice per year, doctors and nurses have professional development meetings to revise their goals and ensure they're proper. The manager keeps track of clinicians' development and their patient outcomes. | Doctors and nurses have professional development meetings every month to revise their goals and ensure they're proper. The manager keeps track of clinicians' development and their patient outcomes. |
| 11.3: Breaking down big goals into smaller ones and linking to individual goals | d) How are your unit targets linked to overall hospital performance and its goals? | There are no specific goals for staff, only large goals for the health system. | The manager knows what the hospital as a whole must achieve in terms of patient outcome goals, but (s)he does not break it down by department. | The manager knows what the hospital as a whole must achieve in terms of patient outcome goals, and (s)he breaks it down by department area only (not by individual doctors/nurses). | Clinicians have an idea of the patient outcome goals for their departments, but do not have specific goals regarding professional development. | Clinicians have an idea of the goals for their departments in terms of patient outcomes, and some specific goals regarding professional development. | Clinicians have a clear understanding of the goals for their departments in terms of patient outcomes and operational/staff development and how it affects their unit and the hospital as a whole. | Clinicians fully understand how goals are aligned and linked at system level and how they increase in specificity as they trickle down, ultimately defining individual expectations for all. |

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| **12. Time Horizon of Targets/Goals** | | | | | | | | |
| 12.1 :A range of short, mid-term, long-term goals<br><br>Short-term: under 1 year<br>Mid-term: 1 year<br>Long-term: over 1 year | a) What kind of time-scale are you looking at with your goals? | The hospital does not have a time-scale for their goals (or they do not have goals). | The hospital has annual goals that relate to the following years' basic indicators, but not more. | The hospital has mostly annual goals and a few short-term goals. | The hospital has mostly annual goals and a few short-term and long-term goals. | There is a good balance of *short-term* and *mid-term* goals for all levels of the hospital system. (ie. mid-term goals are 1-year plans to decrease 'infection rates' by x%, and short-term goals are to improve hand-washing rates to 97% by next quarter/month.) | There hospital has a range of short-term and mid-term goals, as well as at least one long-term goals. | There is a good balance of short-term, mid-term and long-term goals for all levels of the health system. (ie. Long term are, for example, 5-year plans of construction, growth rates. Mid-term goals are 1-year plans to decrease 'infection rates' by x%. Short-term goals are to improve hand-washing rates to 97% by next quarter/month.) |
| 12.2: Emphasis of goals | b) Which goals would you say get the most emphasis? | The hospital does not have a time-scale for their goals (or they do not have goals), so cannot have a focus in one time frame. | The hospital focuses only on short term goals. | The hospital focuses on short term goals, but keeps in mind the mid-term goals. | The hospital focuses on mid-term goals. | The hospital focuses on both the short and long term goals, keeping track of their short run goals to ensure they make the long run goal, though they often have to extend the long-run goal because they missed too many short-term goals. | The hospital focuses on both the short and long term goals, keeping track of their short run goals to ensure they make the long run goal. Sometimes readjustements have to be made, but it is not often. | The hospital focuses on all goals, keeping track of their short run goals to ensure they make the mid and long run goals. |
| 12.3: Interlinked goals that staircase from short to long-term | c) Are long-term and short-term goals set independently?<br>d) Could you meet all your short term goals but miss your long-run goals? | The hospital does not have a time-scale for their goals (or they do not have goals), so cannot be interlinked. | The hospital only has annual goals, so there is nothing to link to longer goals. | The hospital only has long term goals, so there is nothing to link to other goals. | The long term and short term goals are set independently, so it is possible to meet all short term goals and miss long term goals and it happens often. | The long term and short term goals are set independently but somewhat aligned with each other, so it is possible to meet all short term goals and miss long term goals but it does not happen often. | Long-term goals are translated into specific short-term targets so that short-term targets become a "staircase" to reach long-term goals. However, it could happen that long-term goals are not reached. | Long-term goals are translated into specific short-term targets so that short-term targets become a "staircase" to reach long-term goals. Long-term goals are always reached. |

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| **13. Stretch of Targets/Goals** | | | | | | | | |
| 13.1: Goals are tough but achievable (80 to 90% of the time) | a) How tough are your goals? Do you feel pushed by them?<br>b) On average, how often would you say that the hospital/department meets its goals? | The manager says that their goals are too easy (never pushed), or too hard (always pushed too much). Manager finds them ridiculous! | The manager says that the goals are very very hard, but if they push a lot they can get there. Or they say the goals are very very easy, but they do still try to get above the goals since they know this. Principal still finds them ridiculous but at least tries to do something about them! | The manager and the staff believe they have aggressive goals, but they do tend to meet them 100% of the time and be satisfied with the results. | The managers and the staff believe they have aggressive goals, but they do tend to meet them 100% of the time. Because of this, they create their own goals of slightly overreaching the goal (ie. 105%) | The manager and the staff push for aggressive goals, and find that they can't always meet them because they're genuinely hard, but they do make it 80-90% of the time. | The manager and the staff push for aggressive goals, and find that they can't always meet them because they're genuinely hard, but they do make it 80-90% of the time. When goals are easily met, goals are stretched. No re-evaluation is made for goals never met. | The manager and the staff push for aggressive goals, and find that they can't always meet them because they're genuinely hard, but they do make it 80-90% of the time. When goals are easily met, goals are stretched. If goals are never met, then there is also a re-evaluation process though it is stringent. |
| 13.2: Goals are set with reference to external benchmarks | c) How are your goals benchmarked? | Goals are set only internally and do not take into account external factors or clinicians' feedback. There are no benchmarks or comparisons with other hospitals. | The manager compares and benchmarks their goals with some hospitals he/she hears about from doctors and nurses, but doesn't look externally for meaningful comparisons. | The manager compares and benchmarks their goals with hospitals in the village/city, but not the district. | The managers compares and benchmarks their goals with hospitals in the district. | The manager compares their goals with those of the government health boards, but not beyond that. | The manager compares their goals to a limited set of internal and/ or external benchmarks. | The manager uses a wide range of internal and external benchmarks to set their goals. |
| 13.3: Goals are equally difficult/demanding for all | d) Do you feel that all the departments/areas have goals that are just as hard? Or would some areas/departments get easier goals? | The manager does not set goals for different department/areas. | The manager keeps the same goals every year and does not bother to check if some departments have easier/harder goals than others as a result of changing circumstances. | The manager tries to make goal difficulty equally distributed to everyone, but never checks if this is actually true. | Goals are demanding for a few department/areas. There are some areas which have *considerably* easier goals than others. (ie. Cardiology has easier goals than Orthopedics) | Goals are demanding for most department/areas, but there are some areas which have *slightly* easier goals than others. | Goals are demanding for most department/areas, but there are some areas which have *slightly* easier goals than others, so an effort is made to adjust targets accordingly. | Goals are equally demanding for all department/areas. |

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| **14. Clearly defined accountability for clinicians** | | | | | | | | |
| 14.1: What is the role of clinicians in achieving targets | a) Can you tell me about the role that clinicians have in improving performance and achieving targets? | No role at all. Clinicians are simply consultants. | Clinicians are not directly involved and are rarely asked for advice in how to proceed with certain targets. When they are, it is not taken too seriously. It is considered to be a job of the accountants only. | There is some informal involvement of clinicians in the department, but it is ad-hoc and only when issues arise. When help is requested, it is taken seriously. | There is an annual practice of asking clinicians for input in terms of cost targets, but this survey is only sent to top level clinical managers and the response rate is not very high. | There is involvement of clinicians in achieving financial targets. They understand what the financial targets are and that they are expected to contribute to the discussions, but clinical duties are considered to be the main part of the job. | There is involvement of clinicians in achieving both clinical and financial targets. They are both considered part of the job. | Clinicians take active roles in achieving both clinical and cost targets for the hospital. They actively engage medical supplies companies to procure cheaper yet high quality materials and drugs, and sit on committees on possible usage improvement and cost reductions. |
| 14.2: What is the accountability clinicians have to targets | b) How are individual clinicians responsible for delivery of targets? Does this apply to cost targets as well as quality targets? | No accountability. They are not held responsible for anything other than clinical quality. | No formal accountability. Joining a committee on cost reduction might be a required chore given to some junior people. | No formal accountability, but informally the senior managers attribute some merit if the clinicians to do well. | No formal accountability, but senior managers *and colleagues* expect those involved to take it seriously. Performance can sometimes be informally taken into account in assessments. | Formal accountability is present at the top level, with some consequences diffused within teams for lower levels rather than at specific people. | Formal accountability is present at all levels. There are consequences for not reaching targets, although these may not be consistently applied. | Formal accountability across quality service and cost dimensions with effective performance management and consequences for good and bad performance exist. |
| 14.3: Who defines the accountability of clinicians | c) How do clinicians take on roles to deliver cost improvements? Are they selected for this role or do they volunteer? Can you think of examples? | Clinicians do not take on roles. | Clinicians only join if they are required to do by the government or the governing body of the hospital. | Clinicians get involved if top management pushes them to do so. | Clinicians get involved if top management or colleagues invite them to do so, but there is not much initial enthusiam. | There are workshops organized to explain the importance of financial targets to all staff and clinicians, and some volunteer to lead the charge for a few months as part of a team. | Clinicians and staff are fully aware of the importance of financial targets, and are expected to contribute to these as part of their job. | Clinician leadership in this regard is part of the culture of the hospital and all clinicians and staff are fully aware of this when they join the team. All staff and clinician levels (junior and senior) are held jointly responsible for achieving clinical and cost targets. |

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| **15. Clarity and Comparability of Goals** | | | | | | | | |
| 15.1: Clearly defined and strongly communicated to all | a) If I asked one of your clinicians directly about their individual targets, what would they tell me? b) How do you, as the department manager, know that the doctors/nurses/staff are aware of their targets? c) Does anyone ever complain their targets are difficult to understand? | The hospital does not define clear goals for staff, so there would be no use in asking. | The manager believes the staff know their targets, but there's no way for him/her to verify this. | The manager says some doctors and nurses should certainly be aware of their targets as they have informal conversations once in a while, but cannot say if they are all aware or not. | The managers says doctors and nurses are aware of their targets, but some do complain that they are too difficult to understand and should be simplified. | The manager says the doctors and nurses are well aware of their targets, and do not find them difficult to understand. | The manager says the doctors and nurses are well aware of their targets, and do not find them difficult to understand. These are reinforced at all-staff meetings. | The manager says the doctors and nurses are very well aware of their targets and do not find them difficult to understand. Performance measures are strongly communicated and reinforced at all reviews. |
| 15.2: Based on both qualitative and quantitative measures | d) What are the targets based on? | The manager does not define clear targets for staff. | The targets are based on metrics mandated by the government. | The targets are based on patient volume/satisfaction plus another quantitative measure that goes beyond government requirements. | The targets are a limited number of quantitative measures (2 or 3) that go beyond government requirements. | The targets are a range of quantitative measures (more than 3) that go beyond government requirements. | The targets are a range of quantitative measures (more than 3), as well as one or two qualitative measures, that go beyond government requirements. | The targets include a range of both quantitative and qualitative measures that go beyond government requirements. |
| 15.3: Everyone knows how everyone is doing and can compare | e) How do people know about their own performance when compared to other people's performance? | The hospital does not have individual targets, only a hospital-based goal on patient volume/satisfaction. | The hospital does not have individual targets, only a hospital-based goal on patient volume/satisfaction. The managers of different departments have some idea informally how other departments are doing, but all based on informal self-assessments rather than objective ones. | The manager only keeps an informal tally in his/her head of who the best departments are (not doctors/nurses), and does not publicize any data on this so other people cannot compare their performance. | The manager has an open-door policy regarding data on targets and will show scores to doctors/nurses if they wish to see them. | The manager has an open-door policy regarding data on targets and will show scores to doctors/nurses if they wish to see them. Formal conversations are held during review meetings where doctors/nurses become aware of which departments are doing better. | Information on team/ unit targets and performance metrics are made public through boards displayed in the hospital and online. Doctors, nurses, and staff have access to this information. | Information on individual targets and performance metrics are made public through boards displayed in the hospital and online. Doctors, nurses, and staff have access to this information. Patients also have access to some of this information. |

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| **16. Building a High Performance Culture/ Rewarding High Performers** | | | | | | | | |
| 16.1: Identification of good performers | a) How do you know who your best doctors/nurses are?<br>b) What criteria do you use and how often do you identify these clinicians? | There is no formal or informal identification of good performers (ie. The manager cannot tell you which doctors/nurses are good and which ones are not: "everyone is a great performer!"). | Good performers are identified only on the observed patient outcome (ie. The manager can tell who the best doctors/nurses are by looking at the patient satisfaction scores, but nothing else). | Good performers are identified on a range of observed patient outcome results, but nothing formal (ie. The manager can tell who the best doctors/nurses are by looking at the patient satisfaction scores, re-admission rates, and handwashing compliance rates, but it's all from memory or ad-hoc checking of records). | There is a formal but small/narrow range set of criteria by which good performers are identified BUT it is NOT done regularly. **OR** There is no formal and clear set of criteria, but the review is formally done regularly. | There is a formal set of criteria by which good clinicians are identified and it is done *regularly* but with a small/narrow range of criteria. | There is a formal set of criteria by which good clinicians are identified and it is done *regularly.* There is a broad range of criteria, though they mainly focus on operational duties. | There is a formal set of criteria by which good clinicians are identified and it is done regularly and with a broad range of criteria. These include operational duties as well as leadership and teamwork. |
| 16.2: Formally evaluated | c) How do you evaluate and rate your clinicians?<br>d) How often do you do this evaluation? | There is no evaluation system (that is, clinicians never sit down with the manager for face-to-face or written evaluations). | The manager individually evaluates clniicians in his/her opinion, but does not give formal feedback about it or follow a set of criteria (ie. Only say "you're doing ok," or "you're not doing ok"). | Clinicians are formally evaluated ad-hoc, when the manager feels there is a need (such as if someone is doing badly or exceedingly well, there is a formal write-up and discussion). | An annual evaluation system exists that allows the manager to rank performance (the ranking is not necessarily shared with clinicians, but the manager knows). | An evaluation system exists and happens at least quarterly, that allows the manager to rank performance (the ranking is not necessarily shared with clinicians, but the manager knows). | An evaluation system exists and happens at least quarterly, that allows the manager to rank performance and share this with clinicians, should they ask to see it. | An evaluation system exists and happens at least quarterly, that allows the manager to rank performance and share this with clinicians. As part of the culture of the organization, this is done in a positive way to encourage healthy competition. |
| 16.3: Separate reward system for individuals and teams | e) What types of rewards are given to clinicians? Any monetary or non-monetary rewards?<br>f) Are these rewards linked to the ranking clinicians get? | No reward systems at all. | Reward everyone regardless of performance. | Rewards are given to reward good performance, but given ad-hoc, whenever the manager feels like it. | A reward system exists, but they're always or never given (so clinicians don't think it is linked to performance). | A system of monetary or non-monetary reward exists, but it is informal (that is, there are guidelines, albeit not formal/written down in a rule book). | A formal system of monetary or non-monetary reward exists, but rewards are given out at most once a month. | A formal system of monetary or non-monetary reward exists. Rewards are awarded on a regular basis as a consequence of well-defined and monitored individual achievements. |

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| **17. Making Room for Talent/ Removing Poor Performers** | | | | | | | | |
| 17.1: Identification of poor performers | a) How do you know who your best doctors/nurses are?<br>b) What criteria do you use and how often do you identify these clinicians? | There is no formal or informal identification of good performers (ie. The manager cannot tell you which doctors/nurses are good and which ones are not: "everyone is a great performer!"). | Good performers are identified only on the observed patient outcome (ie. The manager can tell who the best doctors/nurses are by looking at the patient satisfaction scores, but nothing else). | Good performers are identified on a range of observed patient outcome results, but nothing formal (ie. The manager can tell who the best doctors/nurses are by looking at the patient satisfaction scores, re-admission rates, and handwashing compliance rates, but it's all from memory or ad-hoc checking of records). | There is a formal but small/narrow range set of criteria by which good performers are identified BUT it is NOT done regularly. **OR** There is no formal and clear set of criteria, but the review is formally done regularly. | There is a formal set of criteria by which good clinicians are identified and it is done *regularly* but with a small/narrow range of criteria. | There is a formal set of criteria by which good clinicians are identified and it is done *regularly.* There is a broad range of criteria, though they mainly focus on operational duties. | There is a formal set of criteria by which good clinicians are identified and it is done regularly and with a broad range of criteria. These include operational duties as well as leadership and teamwork. |
| 17.2: Methods of dealing with poor performers | e) If you had a clinician who is struggling or who *could not* do their job properly, what would you do?<br>f) What if you had a clinician who *would not* do their job, as in slacking off, what would you do then? | Bad performance is not addressed at all. | Bad performance is addressed inconsistently (ie. Sometimes the manager deals with it, but not always). | Bad performance is addressed consistently, but with not much consequence (ie. The manager will always talk to the clinicians who are underperforming, but *does not offer* coaching or support for improvement). | Bad performance is addressed consistently, and with support for improvement but still no real consequence (ie. The manager always talks to the clinicians who are underperforming, and *does offer* coaching/training to improve them but if they don't, not much happens). | Bad performance is addressed consistently and with support, and with real consequence attached to continued bad performance (ie. The manager tries to improve the clinician, but if it doesn't work, the clinician can be moved or fired after a certain time). | Bad performance is addressed consistently and with support, beginning with targeted interventions. Poor performers are given a timeframe in which to improve, but if they do not succeed the clinician can be moved or fired. | Bad performance is addressed consistently and with support, beginning with targeted interventions. Poor performers are temporarily moved out of their positions in order for the problem to be addressed immediately while they receive coaching/training to improve. Poor performers are also moved out of the hospital when weaknesses cannot be overcome. |
| 17.3: Time scale of action | d) How long would a clinician stay in his/her position while not performing well?<br>e) How long would it take to address the issue once you find out about it? | There is no action because nothing is identified or addressed. | There is no real time-scale in mind, but eventually there is some action that is taken (ie. It can take a few years). | It takes more than one year to address any issues (ie. More than one whole year goes by without any action because the manager waits for multi-year results). | Action is not taken immediately, but it is taken at some point during the year, up to one year (ie. actions could be taken throughout the year, but not immediately. However, it also does not take over one year). | Action is taken immediately, but it can take one year for a bad clinician to be removed from the position (possibly to other positions of less responsibility, not necessarily fired). | Action is taken immediately, but it can take around 6 months for a bad clinician to be removed from the position (possibly to other positions of less responsibility, not necessarily fired). | Action is taken immediately, it takes very little time for a bad clinician to be removed *from the position* (possibly to other positions of less responsibliity, not necessarily fired). |

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| **18. Promoting High Performers** | | | | | | | | |
| 18.1: Identification of good performers | c) How do you know who your best doctors/nurses are?<br>d) What criteria do you use and how often do you identify these clinicians? | There is no formal or informal identification of good performers (ie. The manager cannot tell you which doctors/nurses are good and which ones are not: "everyone is a great performer!"). | Good performers are identified only on the observed patient outcome (ie. The manager can tell who the best doctors/nurses are by looking at the patient satisfaction scores, but nothing else). | Good performers are identified on a range of observed patient outcome results, but nothing formal (ie. The manager can tell who the best doctors/nurses are by looking at the patient satisfaction scores, re-admission rates, and handwashing compliance rates, but it's all from memory or ad-hoc checking of records). | There is a formal but small/narrow range set of criteria by which good performers are identified BUT it is NOT done regularly. **OR** There is no formal and clear set of criteria, but the review is formally done regularly. | There is a formal set of criteria by which good clinicians are identified and it is done *regularly* but with a small/narrow range of criteria. | There is a formal set of criteria by which good clinicians are identified and it is done *regularly*. There is a broad range of criteria, though they mainly focus on operational duties. | There is a formal set of criteria by which good clinicians are identified and it is done regularly and with a broad range of criteria. These include operational duties as well as leadership and teamwork. |
| 18.2: Development of good performers | e) What types of career and professional development opportunities are provided?<br>f) How do you tailor opportunities for particular clinicians? | There is no professional/career development for any clinicians. | Professional/career development opportunities exist for all clinicians, such as additional training, but these come only from mandatory government rules. Managers don't actively encourage clinicians to attend (don't discourage, but no encouragement either). | Professional/career development opportunities exist for all clinicians, such as additional training, but these come only from mandatory government rules. Manager actively encourages clinicians to attend these, but does not keep track. | Professional/career development opportunities exist for all clinicians, such as additional training, but these come only from mandatory government rules. Manager actively encourages clinicians to attend these, and the manager keeps track of each clinician's development. | Hospital provides professional/career opportunities for top clinicians, such as additional training as a reward for good performance. This includes not only government training, but also hospital initiatives. However, this does not happen very often or in a systematic manner. (ie. The hospital initiative has happened once/twice in the past few years). | Hospital provides professional/career opportunities for top clinicians, such as additional training as a reward for good performance. This includes not only government training, but also hospital initiatives. This is typically done once a year. | Hospital systematically provides professional/career opportunities for top clinicians based on their individual evaluation and professional development plan, such as additional training as a reward for good performance. This includes not only government training, but also hospital initiatives. The hospital allows these clinicians to determine which classes they want to attend and gives them leadership positions and additional responsibilities within the hospital. |
| 18.3: Reason for promotion | d) Which criteria do you use to make decisions about additional opportunities for clinicians within the hospital (performance, years of service, etc.)?<br>e) If we have two nurses, one has been at the hospital two years and the other for five years, and the nurse who is there for two years is better, who would be promoted faster? | There is no promotion of the clinicians, or promotion is based only on years of service (ie. experience). | Clinicians are promoted primarily based on years of service (experience), but some consideration for performance or qualifications is used if clinicians have similar years of service. | Clinicians are promoted with some consideration for years of service (experience) and also performance or qualifications. | Clinicians are promoted with consideration for their qualifications and some performance, but no consideration is given to years of service (experience). | Clinicians are promoted based on how good their performance is, with no importance given to years of service (experience), and less to qualifications. | Clinicians are promoted based on how good their performance is, and with some regard to qualifications. | Clinicians are promoted purely based on how good their performance is. |

| ITEM | Possible questions | 1 | 1.5 | 2 | 2.5 | 3 | 4 | 5 |
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| **19. Managing Talent** | | | | | | | | |
| 19.1: Who makes hiring decisions, how are they made | a) How do you ensure you have enough staff of the right type in the hospital? b) Who decides how many and which clinicians (full-time regular members of staff) to hire? | Hospital has no formal control over the number and type of staff needed to meet their goals. Ie. central authority of health system (such as government or governing board) decides how many staff the hospital gets | Hospital has no formal control, but can make suggestions regarding their needs. However, they don't often take an active role in trying to get the staff they need. | Hospital has no formal control, but can make suggestions regarding their needs and very actively engages with higher authorities to make sure they get the type and number of staff they need. | Hospital has some control over the number and type of staff they have in the hospital, but require approval/permission (sign-off) from higher authorities, which can take a while to come through. | Hospital controls the number and type of staff they have in the hospitall, but only make any changes after they witness a need for it at the end of the year. | Hospital controls the number and type of staff they have in the hospitall, and will review staffing needs yearly. Hospital will make a change if they witness a need for it an the end of the quarter. | Hospital actively controls the number and type of staff they have in the hospital, often making changes to ensure staff hiring strategies are well-aligned with the hospital goals and linked to patient outcomes. |
| 19.2: Ensuring senior managers show talent is a top priority for the hospital | c) How do senior managers show that attracting and developing talent is a top priority? | They don't. The manager is confused with the question. | The manager mentions that they do the best they can with what they are given, and that they try to give pats on the back of the best staff from time to time to recognize them. | The manager acknowledges that having talented people working in the hospital is very important, but there is no formal process to communicate this to the staff. | Senior management believes that attracting and developing talent is important and there is a regular *informal* statement of this to employees, but senior managers are not held accountable to the talent pool they build. | Senior management believes that attracting and developing talent is important and there is a regular *formal* statement of this to employees, but senior managers are not held accountable for the talent pool they build. | Senior management believes that attracting and developing talent is important and there is a regular *formal* statement of this to employees. Senior managers are held accountable for their talent pool, although this is not formalised through set targets. | Senior management believes that attracting and developing talent is important and there is a formal statement of this to employees. Senior managers are held accountable for their talent pool they build through actual targets and rewards and forms part of their appraisal. |
| 19.3: Seeking out talented candidates | d) Where do you seek out and find staff? How is this aligned with the hiring process implemented at the government levels? e) Do senior managers get any rewards for bringing in and keeping talented people in the hospital? | The reason for hiring new clinicians is not determined by the hospital (not done by the manager, but by a centralized committee). | Since hiring is out of their hands they do not actively engage in this, but if a current clinician refers another talented clinician the manager does pass it on to the higher authorities to try and hire that clinician if needed. | The manager actively asks for referrals from current clinicians, but does not go outside the hospital (such as placing ads in newspapers). | The manager primarily bases his/her search on current clinician referrals, but if none are made then places ads in newspapers (but as a last resort). | The manager follows a formal process of putting ads in newspapers, and actively encourages current clinicians to refer other talented clinicians. | The manager follows a formal process of advertising positions externally though job sites and job fairs, and actively encourages current clinicians to refer other talented clinicians. | The manager follows a formal process of doing a region-wide search, putting ads in newspapers, attending job fairs, and sourcing clinicians from the best universities. The manager actively encourages current clinicians to refer other talented clinicians from other hospitals and from their personal networks. |

| ITEM | Possible questions | 1 | 1.5 | 2 | 2.5 | 3 | 4 | 5 |
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| **20. Retaining talent** | | | | | | | | |
| 20.1: When a clinicians leaves/wants to leave, is there a formal process followed to understand the reason for leaving | a) When one of your best clinicians wants to leave the hospital, what do you do? | The manager does not question or care why the clinician is leaving, they just go. | The manager has an informal chat with the clinician to understand why they are leaving but does not take note of any feedback. | The manager does a somewhat formal "exit interview" to understand why the clinician wants to leave, but this does not happen in a structured manner and is ad-hoc. | The manager always does a structured and formal "exit interview" to understand why the clinician wants to leave but does not note anything for future learnings. | The manager always does a structured and formal "exit interview" to understand why the clinician wants to leave and takes note of what could be improved to avoid this happening again in the future. | The manager tries to keep an eye on his staff to ensure clinicians are satisfied with their job and with the hospital in order to avoid a clinician wanting to leave. In case this happens, the manager always does a structured and formal "exit interview" to understand why the clinician wants to leave and takes note of what could be improved to avoid this happening again in the future. | The manager is often doing evaluations to understand and forsee any problems that might arise and to make sure the clinicians are satisfied with their job and with the hospital in order to avoid a clinician wanting to leave. In case this happens, the manager always does a structured and formal "exit interview" to understand why the clinician wants to leave and takes note of what could be improved to avoid this happening again in the future. |
| 20.2: What can they offer (or do) to keep best clinicians who want to leave | b) What would you be able to offer to try and keep that best clinicians in your hospital?<br>c) Could you give me an example of a time when you were able to keep a top clinician? And what about a clinician that you could not convince to stay? | The manager cannot offer or do anything to try and keep a top clinician. | The manager cannot offer or do anything to try and keep a top clinician in terms of money, but they may offer them more responsibility or flexible time. | The hospital has an *informal* agreement that the manager can offer extra opportunities to try and keep top clnicians, but the manager only considers this if directly asked by the clinician. | The hospital has an *informal* agreement that the m anager can offer some extra opportunities to try and keep top clinicians, but rarely does so (ie. He/she can offer more money or class flexibility, but has only done it once or twice in the past few years). | The manager has the *formal* authority to offer some extra opportunities to try and keep top clinicians, and regularly does so. Their authority generally extends over schedules and minor monetary raises. | The manager has the *formal* authority to offer some extra opportunities to try and keep top clinicians, and regularly does so. Their authority generally extends over schedules and minor monetary raises, as well as promotions when basic HR requirements are met. | The manager will try to convince clinicians to stay by offering a range of extra opportunities and has *formal* authority to do so. Beyond simply offering more, the manager ensures they address the clinician's reason for wanting to leave and adjusts other top employees to prevent others from wanting to leave. |
| 20.3: What do they do to ensure top clinicians *want* to stay in the hospital | d) How would you know if your top clinicians are happy working in this hospital? | The manager treats everyone equally, regardless of performance. The manager does not focus especially on retaining top clinicians. | The manager does not initiate conversations with clinicians and staff regarding their work satisfaction level, but has an open door policy where people can come and talk about it. | The manager has informal chats with clinicians and staff and has a general feeling of how satisfied their employees are. However, there is no formal check that (s)he does. | The manager has a set process that (s)he follows to ask the top clinicians how happy they are in their work environment. (S)he does this to try and fix any issues before clinicians want to leave. However, *this is not done regularly* and is not recorded anywhere. | The manager has a set process that (s)he follows to ask the top clinicians how happy they are in their work environment. (S)he does this to try and fix any issues before clinicians want to leave. *This is done fairly regularly*, but not recorded anywhere. | The manager has a set process that (s)he follows to ask the top clinicians how happy they are in their work environment. (S)he does this to try and fix any issues before clinicians want to leave. *This is done fairly regularly*, and is recorded, although it is not necessarily consulted often. | The manager has a set process during clinician evaluation that (s)he follows to ask the best clinicians how happy they are in their work environment. (S)he does this to try and fix any issues before clinicians want to leave. *This is done regularly* and is recorded in each clinician evaluation plan. |

| ITEM | Possible questions | 1 | 1.5 | 2 | 2.5 | 3 | 4 | 5 |
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| **21. Attracting talent** | | | | | | | | |
| 21.1: Why would clinicians want to work at your hospital | a) If I were a very good clinician considering working either at your hospital or a different one, what would you say to try and get me to work here? b) What are the professional benefits of working at your hospital? | The manager does not know how to answer this question as they have never thought about it before. | The manager recognizes that clinicians perhaps would not want to work there, as there are other, better hospitals nearby. | Despite acknowledging there aren't formal professional benefits that the hospital can offer, the manager believes the hospital has some informal benefits (such as being a "nice atmosphere" or "family environment"). | The manager believes there is a good atmosphere in the hospital, and there are professional benefits to working there (although (s)he cannot think of clear examples). | The hospital offers similar professional benefits as other hospitals nearby. However, there is usually a waiting list for junior clinicians wanting to join this hospital. | The hospital offers a range of better, more competitive professional benefits than most hospitals nearby. | The hospital offers a range of better, more competitive professional benefits than all other hospitals nearby. |
| 21.2: Clinicians are aware of the benefits of working at your hospital | c) How do clinicians know that working at your hospital is better than others? d) How do you communicate this to the clinicians? | The manager does not communicate at all that their hospital is a good place to work at. | The manager only communicates the value of working at their hospital during the first day of work of a new clinician, but not again. | The manager communicates during the first day of work of a new clinicians and rarely communicates that their hospital is a good place to work at after that, but has done so once or twice. | The manager communicates the value of working at their hospital in annual staff meetings (no more than once a year in special occasions). | The manager usually communicates that their hospital is a good hospital to work at during staff meetings and huddles, and informal staff gatherings/parties (any of these happening more than once a year). | The manager frequently and actively communicates the value of working at their hospital in regular clinician evaluation meetings, staff meetings, and informal gatherings. These take place on a quarterly basis. | The manager frequently and actively communicates the value of working at their hospital in regular clinician evaluation meetings, staff meetings, and informal gatherings. These happen very frequently. |
| 21.3: How do you keep track that the communication is effective | e) Do you check to see if clinicians are aware of the benefits of working at your hospital? | The manager does not keep track at all since there is no communication. | The manager does not keep track at all, only believes people know (ie. "oh, they know why it is good to work here"). | The manager has informal chats in the hallways about whether people are aware of the benefits of working in the hospital so (s)he believes that they are aware. | The manager has *informal* follow up conversations with clinicians either individually or in groups to ensure their beliefs are aligned. | The manager has *informal* follow up conversations with clinicians either individually or in groups to ensure their beliefs are aligned and *keeps a written record of this.* | The manager has *formal,* structured follow up conversations with clinicians either individually or in groups to ensure their beliefs are aligned and keeps a written record of this, but does not do this regularly. | The manager has *formal,* structured follow up conversations with clinicians either individually or in groups to ensure their beliefs are aligned and keeps a written record of this. |