Definition of Clinical Governance

Clinical governance is defined as a system through which health service organisations are responsible and accountable for:

- continuously improving the quality of their services
- safeguarding high standards of care
- ensuring the best clinical outcomes for patient care

- by creating an environment in which excellence in clinical care will flourish.

This requires:

- Commitment at all levels of management within the organisation including the key providers of clinical care.

- The creation of an organisational culture that is conducive to the provision of high quality and safe care for patients and clients. This culture should be characterised by shared passion for quality, openness, respect, support and fairness- no blame or retribution.

- Procedures and practises to be put into place which ensures that all health care workers are informed of how well patient and client care is being provided by the organisation, understand their contribution in the provision of quality care and they can identify and act upon opportunities for improving the quality of care and safety.

- Effective teamwork, managing health and health care risks and ensuring clinical efficiency and effectiveness.

The system of governance includes:

- Mortality and morbidity reviews
- Patient/Client Record reviews
- Clinical audits
- Peer reviews
- Adverse events and near misses reporting and reviews
- Evidence based clinical practise - use of standard treatment guidelines
- Measuring clinical performance using indicators

The Department is currently engaged in a pilot project in colloboration with the World Health Organisation (WHO) and the Nelson Mandela School of Medicine- Departmnt of Public Health Medicine to determine a set of hospital performance indicators for quality improvement which includes clinical care. 3 hospitals in Pietermartizburg – Greys ,Northdale and Edendale- are the pilot sites and the pilot project will be complete by July 2005.Thereafter, further modifications and contextualisation will be undertaken for these indicators and then rolled out to theother hospitals in a phased manner. The relevant literature is enclosed.

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR EUROPE

WELTGESUNDHEITSORGANISATION
REGIONALBÜRO FÜR EUROPA

ORGANISATION MONDIALE DE LA SANTÉ
BUREAU RÉGIONAL DE L'EUROPE

ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ
ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

PATH
Performance Assessment Tool for quality improvement in Hospitals

World Health Organization
Regional Office for Europe

Presentation of the project

The ultimate goal is to support hospitals in defining quality improvement strategies by 1) identifying areas for further scrutiny and 2) sharing best practices. This is done by providing tools for performance assessment, supporting hospitals questioning their own results and translating them into actions for improvement. and by enabling collegial support and networking. Performance assessment tools are designed for internal use and on voluntary basis only. It is ment for external reporting or accreditation or restructuring purposes.
The general framework for the project and indicator selection is built on strong theoretical background and empirical material. It was elaborated by a group of international experts, with support from extensive reviews of the literature (more than 300 indicators initially identified) and a survey in 10 countries on data availability and perceived importance of pre-selected indicators. The detailed meeting reports and background papers are available upon request.

This framework for performance assessment encompasses six dimensions: four domains (clinical effectiveness, staff orientation, efficiency and responsive governance) and two transversal perspectives (safety, patient centeredness). This comprehensive and tightly integrated structure is a key feature of the project. For each dimension, indicators were selected based on their importance and usefulness, potential impact and burden of data collection. An operational model details how indicators relate to each other.

We advocate a flexible approach and distinguish between two sets of indicators. The "core set" includes indicators that are relevant to all contexts and represent a low burden of data collection. It is presented in annex 1. The "tailored set" includes indicators that either are relevant to a limited number of contexts, or, because of their higher burden of data collection, are suggested if congruent with the organisation or country's priorities.

The PATH framework includes 4 steps:

1. ***M*otivate**: Hospital participation is voluntary. PATH is designed around and for hospitals as the main users. It supposes their active involvement at all steps.

2. ***M*easure**: PATH framework relies on 20 indicators in a core set. Countries can pick additional indicators proposed in a tailored set. Operational definitions and recommendations for data collection are provided for indicators in the core set at annex 1.

3. ***M*ake sense**: One of the unique features of PATH is that indicators development and performance measurement is considered a prerequisite towards quality improvement but it is

not a goal in itself. Indicators do not make sense by themselves. They need to be compared to reference points and related to other performance indicators, explanatory variables and survey of practices. Indicators should be considered as a starting point to question practices.

4. **Move**: Support to quality improvement strategies is the final aim of PATH. It should ultimately impact on actions for quality improvement. A strategy and tools to support change management will be developed, within the PATH framework.

Unique features

This project focuses on the process of implementing measurement tools for quality improvement by using indicators and on the process of interpreting the results, and not on the indicators themselves. The expected outcomes can be summarized as:

Before data is collected:

- Dissemination of values such as adaptability and change, accountability towards patients or team work.

When data is collected:

- Improvement of information systems, motivated by data collection

After indicators are computed and explanatory variables are measured:

- Identification of areas for further scrutiny, strengths and weakness and development of a plan for quality improvement, including actions and targets.

  Ownership and interpretation of results by individual hospitals is the main focus of the project. Indicators are mostly use as flag, areas in need of further scrutiny. They can be considered as a screening test or a starting point to question current practices. With this view, educational material and a template for reporting results are being developed. This reporting scheme is called a "balanced dashboard". Each core indicator is related to complementary indicators, exogenous factors, reference points (e.g. median, professional norm, hospital's own results in the past or hospital self-set target) and an open question to allow hospitals to describe associated quality improvement strategies. The "balanced dashboard" (see annex 3) makes relations between dimensions and indicators explicit and facilitates the identification of the best strategies for improving the overall performance of the organization.

PATH has also an international component. Participating hospitals may compare their own results to international reference points (e.g. cross-national average). International comparisons should be interpreted with great caution because of varied national contexts but reference points is an interesting starting point for discussion and questioning within hospitals. By joining PATH, hospitals are part of an international network to share best practices for quality improvement. International networking will be fostered using different tools such as e.g. newsletter, list-server, or a web page. From the very start of implementation, hospitals will be invited to share on operational definitions, data collection issues and selection of tailored indicators and to present themselves to each other. After individual results are reported to hospitals, international networking will support comparisons of best practices and of quality improvement strategies.

PATH also advocatesa multidimensional approach of performance. All dimensions are considered inter-dependant and should be assessed simultaneously.

What PATH has to offer:

- A tool to disseminate values within hospital, and initiatiate or support quality improvement strategies,
- A tool to make the most of the large amount of data that is currently collected but very little used;
- Technical support for implementation of performance measurement within hospitals, including e.g. patient experience surveys
- An opportunity to question current information system and learn from experiences in other countries;
- Educational material, including general presentation of quality improvement principles and detailed description of indicators;
- Template for reporting results to individual hospitals;
- Voluntary participation in an (inter)-national benchmarking network to compare results and make sense out of them and share success stories; and
- Be part of an international "community" of hospitals with innovative managerial practices.

Indicators

Dimension / Sub-dimension	Core set	Tailored set
Clinical effectiveness and safety		
Appropriateness of care	Caesarean section rate	Results of audit of sample of medical records to evaluate appropriateness of C-section compared to guidelines
Conformity of processes of care	Prophylactic antibiotic use for tracers: results of audit of appropriateness	Door to needle time CT scan (3 hours) after stroke AMI patient discharged on aspirin
Outcomes of care and safety processes	Mortality rates for selected tracer conditions and procedures Readmission rates for selected tracer conditions and procedures Rate of admission after day surgery for selected tracer procedures Rate to return to higher level of care (e.g. from acute to intensive care) for selected tracer conditions and procedures within 48 hours Sentinel events: formal procedure to register and act upon sentinel even (Yes/No)	Ditto CORE, with more advanced risk-adjustment procedures and follow-up of patients (e.g. different hospitals for readmission and fixed follow-up for mortality) Post-tonsillectomy bleeding Rate of pressure ulcers for stroke and fracture patients Rate of hospital-acquired infections Rate of third degree perinea tear Rate of ureteric/bladder damage associated with hysterectomy
Efficiency		
Appropriateness of services	Day surgery rate, for selected tracer procedures	Score on Appropriateness Evaluation Protocol (AEP – European version)
Productivity	Median length of stay for selected tracers	LOS case-mix adjusted # Dosage unit (or cost) antibiotics per patient day Cost of corporate services per patient day

Use of capacity	Average inventory in stock, for pharmaceuticals Blood wastage Intensity of surgical theatre use	Operating Room utilization rate
Financial performance		Cash-Flow/Debt
Staff orientation and staff safety		
Economic factors		Percentage of wages paid on time or average delay for wages payments
Practice environment		Results of staff survey on job content
Perspective and recognition of individual needs	Training expenditures on total full time-equivalent staff	
Health promotion and safety initiatives	Budget for health promotion activities aimed at staff	Percent job descriptions with risk assessment
Staff experience		Results of staff survey on organizational climate
Behavioural responses	Number of days of short-term absenteeism (1 to 7 days) on total number of days contracted (stratify by department and profession) Number of days of long-term absenteeism (more than 30 days) on total number of days contracted (stratify by department and profession)	Staff turnover rate
Staff safety	Number of percutaneous injuries on average number of full-time equivalent staff Staff excessive weekly working time	Number of assaults on staff
Responsive governance and environmental safety		
System integration and continuity	Average score on perceived continuity items in patient surveys	Results of audit of discharge preparation Percentage of discharge letters sent to General Practitioner within 2 weeks or given to the patient within 3 days after discharge Results of AEP for geriatric patients
PHO: access		Perceived financial access through patient surveys Waiting time for selected tracers (median & variance)
PHO: Health promotion	Percentage of women breastfeeding at discharge	Percent AMI and CHF patients with lifestyle counselling documented in record
Equity and ethics		
Environmental concerns		
Patient centeredness	Average score on overall perception/satisfaction items in patient surveys	
Interpersonal aspects	Average score on interpersonal aspects items in patient surveys	
Client orientation: access	Last minute cancelled surgery	Average score on interpersonal aspects items in patient surveys
Client orientation: amenities		Average score on interpersonal aspects items in patient surveys

Client orientation: comprehensiveness		
Client orientation: information and empowerment	Average score on information and empowerment items in patient surveys	
Client orientation: continuity	Average score on continuity of care items in patient surveys	