

“Dials and Tin-openers”

Development of Hospital Wide Performance Indicator Programme

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- **Ireland**
 - Population: 3.6 million / GDP: 2002 - 6.9%
 - per capita spending on health service

	1998	2001
Ireland	1780	2097
EU	1457	2109
 - Life Expectancy – Females (79) – Males (73)
 - Major causes of mortality:

– Circulatory diseases	– 41%
– Cancer	– 23.5%
– Respiratory	– 16.4%



- **St James's Hospital**
 - largest acute general hospital in Ireland
 - established 1971 - €290m annual expenditure
 - 828 beds - 3500 staff - sixty acre site
 - comprehensive range of diagnostic / treatment services – many with regional / national status
 - strong academic commitment – Trinity Health Sciences Centre on campus



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- **Genesis of Programme – commenced late 2001**
 - **External requirements to satisfy**
 - public + paymaster demand measurement of performance
 - performance must be publically/politically understandable and publishable but
 - fiscal performance remains paramount
 - **Internal requirements to satisfy**
 - performance measures must extend beyond:

– (fiscal)	– variance against budget
– (volume)	– episodes of care delivered

 and include demonstration of
 - safety, effectiveness, efficiency
 - desired goals must be articulated in terms of measurable performance
 - drive to secure high performance is best achieved in a transparent, participate non statutory based environment / as is identification of poor performance
 - all stakeholders must engage in process



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- **Rationale for approach adopted**
 - “know yourself better and you will do better” (AIURIUS)
 - “statistical control of the process is the only way to build in quality” (DEMING)
 - “internal performance review coupled with comparative performance analysis enables triangulation of performance position” (CARTER)
 - “don't tell me all the things you are doing or all the extra money you are spending – tell me it's really getting better” (PATIENT)



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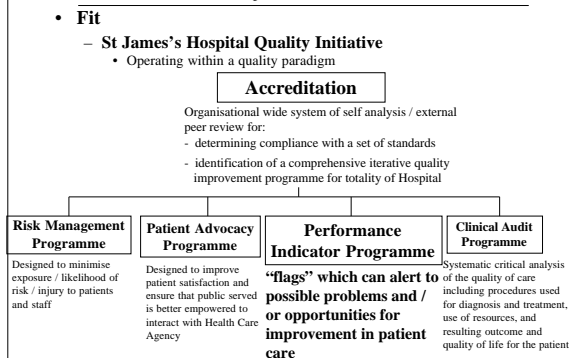
- **Approach adopted**
 - **key identifiers:**
 - What's important in terms of performance + why [What + Why]
 - for all stakeholders
 - how is performance in these key areas described [Description]
 - what is desired performance [Goal]
 - precise description of actual performance [Measurement]
 - comparison of actual .v. desired performance [Comp. analysis]
 - overall process must fit within existing QI programme

» many thanks to Australian PI Programme



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- **Progression**

- clinicians + managers tasked with objective of identifying:
 - What's important
 - What's desired performance
 - How is actual performance measured
 - focus on performance rather than description
 - each clinical team / Directorate / Corporate
 - Department asked to identify key performance areas
- process (start up) 6 – 9 months
 - fear of 'why are we doing this'
 - concerns relating to confidentiality / discoverability
 - if we determine 'poor performance' will management fix it – read - fund it!!

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- **Performance Indicator Structure**

- each indicator structured as follows:
 - **identification as to why process / activity / outcome is important**
 - includes implications should performance not be optimum / opportunities should performance be improved
 - **definition of exactly what process / activity / outcome is**
 - **identification of data to be collected**
 - **identification and provision of data collection systems to collect / collate / present information**
 - **identification of desired performance**
 - where possible using evidence-based best practice performance measures or benchmark from similar institution

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- **Performance Indicator grouping**

- **Hospital wide indicators** (16)
 - e.g. Unplanned readmission within 28 days of discharge
- **Specialty specific Indicators** (8)
 - e.g. Cardiac Surgery – CABG mortality / LOS
- **Operational Performance Indicators** (30)
 - e.g. waiting time to admission from Emergency Department
 - e.g. length of stay for non elective medical admissions
- **Non Clinical Indicators** (19)
 - e.g. staff turnover/absence/training
 - e.g. medical records availability

• total of 73 indicators now tracked

[- listed in presentation]

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- **Promulgation:**

- Performance Indicator reports are compiled / submitted to the peer review group / CQI team / departments / individuals monthly
 - exceptional adverse deviation from defined measures reviewed by and have remedies pursued through the Medical Board / EMG / Departments / Individuals
- **Continuous quality improvement:**
 - for each Performance Indicator Continuous Quality Initiative teams have been established to validate performance and where possible institute changes necessary to further enhance service / process / outcome.

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- **Examples**

- **Hospital Wide Clinical Indicator**

- **Non-elective medical readmissions within 28 days of discharge**
 - **Rationale:** may indicate sub-optimal discharge management / or sub-optimal post discharge care / support
 - **Analysis:**

% of all FCE's which are non elective medical readmissions – 98 - 02							
Period	98	99	00	01	02	Ave	02 % / Ave %
SJH	4%	4%	4%	4%	4%	4%	-
 - **Results:** value broadly unchanged overtime
 - **Benchmark UK:** values broadly similar
 - **CQI teams:** identify causal factors / effect change
 - **causal factors identified:**
 - » **history of Chronic Alcohol Abuse** (25%)
 - » **chronic illness exacerbation** (31%)
 - » **non compliance with medical advice / intervention / medication** (31%)
 - » **self discharged** (13%)
 - Teams currently developing / effecting initiatives that will provide focused support / intervention – mitigating against readmission
 - e.g. Respiratory Assessment Unit / Shared Care Discharge / Emergency General Medical Outpatient Clinic

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ISQUA DALLAS 2003

- Specialty Specific Clinical Indicator – Cardiac Surgery**
 - Mortality in Coronary Artery Bypass Graft (CABG) Surgery**
 - Rationale:** CABGs is the most commonly performed cardiac operation in adults – low mortality associated with this procedure is now achievable.
 - Analysis:** comparison of St James's CABG mortality rate with National Adult Cardiac Surgical Report from Great Britain / Ireland – 02

SJH (ave)	UK + IRL
1.3%	2.1%
 - Average Length of Stay (ALOS) for CABGs**
 - Rationale:** LOS greater than UK + IRL ALOS may indicate sub optimal clinical care / management
 - Analysis:** comparison of St James's post-op ALOS following first CABG with UK + IRL – 2002

SJH (ave)	UK + IRL (ave)
6.7 days	8.2 days

 - In conjunction with other PIs these results place SJH joint 4th amongst the 38 Cardiac Surgery Units reporting results in the UK + Ireland
- CQI Team – Cardio Thoracic Specialty Team**

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- Operational Indicator**
 - Length of stay for non elective medical discharges – July 02/03**
 - Rationale:** complex patients to treat + discharge requiring intensive multidisciplinary team focus + intervention – absence will lead to increased LOS
 - Analysis:** Hospital introduced Acute Medical Assessment Unit April 03 – designed to promote focused intervention for non elective medical admissions

July	LOS (DAYS)											
	1		2		3		4		5		>5	
	Nos	% of Total	Nos	% of Total	Nos	% of Total	Nos	% of Total	Nos	% of Total	Nos	% of Total
2002	80	17%	35	7%	27	5%	32	7%	23	5%	283	59%
2003	91	17%	53	10%	61	11%	44	8%	40	8%	246	46%
Val.Var	11		18		34		12		17		(37)	
% Var	14%		51%		126%		38%		74%		(13%)	

 - despite 11% increase in non elective medical admissions
 - » 54% patients discharged < 5 days LOS
 - 41% (02)
 - readmission value unchanged

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- Operational Indicator**
 - Emergency Department (ED) – Number of patients waiting for admission at 7am – Jan-Jul 02/03**
 - Rationale:** requirement to effect prompt admission / maintain access to ED
 - Target:** 7am = less than 10 patients waiting in ED - threshold compliance: 90%

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- Operational Indicator**
 - Inpatient Waiting List - target pathway from Jun 00 to Dec 02**
 - Rationale:** the hospital has a requirement to ensure that patients requiring elective treatment / surgery are admitted at the earliest opportunity
 - Target 2002 - 0 patients waiting > 1 year - achieved**

Comparison of WL at other similar Irish Hospitals:	
Irish Hospitals	% waiting > 12 mths
Hosp. A	24%
Hosp. B	36%
Hosp. C	42%
Hosp. D	12%
SJH	0%

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- Operational Indicator**
 - Availability of a Patient's Medical Records for an Outpatient Appointment - January – August 2002 / 2003**
 - Rationale:** the non availability of a complete medical record for patients attending OPD may result in poor evaluation of the patient's condition and / or necessary treatment not being undertaken

Monthly Average Jan – Aug:	No. of OPD Clinics Audited	No. of Booked Appointments	Charts Missing as % of Total Bookings	No. of Walk-Ins	Charts Not retrievable as % of Total Walk-ins
2002	111	2441	1%	122	7%
2003	99	2112	1%	88	8%

 - Audit carried out during first full week of each month
 - Analysis + Action**
 - initiative Commenced June 2002
 - initial work of Medical Records Group to secure improvement in chart availability has been successful
 - » Medical Records missing as % of total Bookings - 1%
 - » Medical Records not retrievable as % of total Walk-Ins: 8%
 - Focus 2003**
 - Medical Record "completeness" and "order", - reduce "walk-ins"

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- Problems - to be solved**
 - data collection requires utilisation of several IT data sources and sometimes manual collection of data
 - focus predominately process related – outcome collection more complex
 - know performance but not sure how to improve it
 - if benchmarking demonstrates similar performance - where next?
 - no one likes their performance aired – particularly if not very good (this is getting better)
 - (initial) degree of cynicism
 - difficulty in benchmarking in Ireland
 - finding like with like
 - unwillingness to share

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• What achieved

- verification + articulation in measurable terms of what's important (clarity of real, local, ownable goals)
- concept of performance management / measurement metrics introduced
- ownership of performance
- creation of "dials" / "tin openers"
 - dials
 - ability to set performance value (control) and constantly monitor e.g. patients waiting in ED for admission
 - tin opener
 - ability to open up a can of worms – prompt interrogation + analysis in an environment where positive change can be effected e.g. medical readmissions
- ability to demonstrate / validate performance
- ability to benchmark – demonstrates competitive advantage with regard to obtainment of scarce resources



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• Next Stage

- awaiting Health Research Board grant – enhance data collection systems
- International Performance Indicator Programme Benchmarking Initiative
 - Queens Medical Centre Nottingham (England)
 - University Hospital Brussels (Belgium)
 - Cardiff and Vale NHS Trust University Hospital of Wales (Wales)
 - Groningen University Hospital (The Netherlands)
 - Guy's & St Thomas' Hospital NHS Trust (England)
 - St Luke's Hospital, Malta (Malta)
 - Belfast City Hospital, Belfast (Northern Ireland)
 - St James's Hospital, Dublin – lead Hospital (Ireland)
 - benchmarking projects:
 - » Average Specialty Length of Stay Analysis
 - » Emergency Admission Pathway / Process
 - » Theatre Utilisation
 - » Patient Satisfaction
 - » Clinical Outcomes – unplanned readmission
- **we all do the same thing – but different paradigms, perspectives**
- **not all € related**



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• Conclusion

- performance indicator programme whilst imperfect is a useful instrument of control
- facilitates goal identification in measurable terms
- facilitates validation of performance in terms other than fiscal
- facilitates prompt enquiry / interrogation of data in a participate non threatening environment
- enables multiple stakeholder's goals to be incorporated



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