



# Standards for Health Promotion in Hospitals: Development of indicators for a Self- Assessment Tool

Report on 4<sup>th</sup> WHO Workshop  
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## ABSTRACT

. Usually formal hospital accreditations and quality assessments do not fully consider health promotion activities. To fill this gap and to support the evaluation of health promotion activities in hospitals five standards and complementary performance indicators were developed.

The standards address: hospital management policy; patients' assessment, information and intervention; a healthy workplace; and continuity and cooperation with other providers of health promotion services. To support the assessment of standards and indicators, participants in the workshop concluded to prepare two documents: a self-assessment tool and a manual.

The purpose of the self-assessment tool is to provide concrete guidance on the operational aspects of standard and indicator assessment. It was agreed by the participants in the meeting that the self-assessment tool was pilot tested to find out whether health professionals in hospitals are able to collect the information necessary to assess standard compliance and whether the documentation supports them in improving the quality of health promotion activities.

The purpose of the manual is to provide information in a comprehensive manner on the background, evidence, development process and terminology of standards and indicators for health promotion in hospitals

Further information on the progress of this project can be found on the Regional Office web site:  
<http://www.euro.who.int/healthpromohosp/>

## Keywords

HEALTH PROMOTION - standards  
HOSPITALS - trends  
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## **Introduction**

The objectives of the 4<sup>th</sup> workshop on standards for health promotion in hospitals were to develop a self-assessment tool to assess compliance with standards, including measurable elements and indicators, and to plan the pilot test of the self-assessment tool.

A working group of the Health Promoting Hospitals' network was set up in 2001 to develop standards for health promotion in hospitals and experts consulted during workshops in 2002-2003. The five final standards relate to hospitals' management policy, patient assessment, patient information and intervention, promoting a healthy workplace, and continuity and cooperation.

The aim is to provide hospitals with a tool for self-assessment so that they can improve their health care services through health promotion. Furthermore, quality improvement and accreditation bodies are encouraged to include the standards into existing standards sets.

The participants of the workshop were members of the core-working group on standards for health promotion in hospitals, network coordinators of Health Promoting Hospitals in European Countries, representatives from hospitals that piloted the standards, and experts in health promotion standards and indicators.

## Background and Methods

The World Health Organization initiated the Health Promoting Hospitals' (HPH) Project with the aim to reorient health care institutions to integrate health promotion and education, disease prevention and rehabilitation services in curative care. Many activities have been carried out and 693 hospitals in 25 European Countries and worldwide have joined the WHO network since the establishment of national and regional networks in 1997.

Health Promoting Hospitals have committed themselves to integrate health promotion in daily activities, i.e. to become a smoke-free setting, and to follow the Vienna Recommendations, which advocate a number of strategic and ethical directions such as encouraging patient participation, involving all professionals, fostering patients' rights and promoting a healthy environment within the hospital. However, so far no tool was available allowing for a systematic assessment and monitoring of health promotion activities in hospitals.

The predominant approach to quality management in hospitals is through setting standards for the services predominant. A review of existing standards for quality in health care for the inclusion of health promotion activities yielded little results. Nevertheless, members of the network felt that standards for health promotion in hospitals were necessary to ensure the quality of services.

Recognizing the need for standards for health promotion in hospitals, WHO established a working group at the 9th International Conference on Health Promoting Hospitals, Copenhagen, May 2001. Since then several working groups and country networks have been working on the development of standards.

- *A first workshop* took place in May 2002 in Bratislava, Slovakia in conjunction with the 10th International Conference on Health Promoting Hospitals with the purpose to a) identify relevant areas for the development of standards for disease prevention and health promotion in Health Promoting Hospitals, b) work out examples of draft standards demonstrating scope, type and content of these standards, c) work out proposals on the methodology used in the development of standards and d) to suggest the organization and a plan of action for further development of standards. Outcomes of the workshop were a series of technical documents on health promotion in hospitals, country reports on the state of regulation and quality management of health promotion in hospitals and a first draft of standards for health promotion in hospitals.
- *A second workshop* took place in November 2002 in Barcelona to address various issues related to the improvement of the standards and tools to guide users in assessing compliance with standards. The participants reviewed draft standards and incorporated comments from experts, discussed and further developed measurable elements and a model to assess compliance. A further important task of the workshop was the planning of the pilot testing of standards for health promotion in hospitals.
- *A third workshop* took place in April 2003 in Barcelona to review the results from the pilot test and to incorporate the comments and experiences from the piloting countries. The pilot test was carried out in Denmark, Germany, Ireland, Italy, Lithuania, Poland, Slovakia and Switzerland. Furthermore, the standards were disseminated to all Health Promoting Hospitals (HPH) Network Coordinators and quality agencies for information and comments. The results of the pilot test are documented in a report.<sup>1</sup>

After these three workshops the standards for health promotion in hospitals are considered to be in their final format (subject to future revision once new evidence emerges).

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<sup>1</sup> <http://www.euro.who.int/Document/IHB/hphstandardsfinrpt.pdf>

Each standard consists of standard formulation, description of objective and definition of substandards. The standards are related to the patient's pathway and define the responsibilities and activities concerning health promotion as an integral part of all services offered to patients in a hospital. The standards are mainly generic with the focus on patients, staff and the organizational management. The quality goals described in the standards address professional, organizational, and patient-related quality issues.

- *Standard 1* demands that a hospital has a written policy for health promotion. This policy must be implemented as part of the overall organization quality system and is aiming to improve health outcomes. It is stated that the policy is aimed at patients, relatives and staff.
- *Standard 2* describes the organizations' obligation to ensure the assessment of the patients' needs for health promotion, disease prevention and rehabilitation.
- *Standard 3* states that the organization must provide the patient with information on significant factors concerning their disease or health condition and health promotion interventions should be established in all patients pathways.
- *Standard 4* gives the management the responsibility to establish conditions for the development of the hospital as a healthy workplace.
- *Standard 5* deals with continuity and cooperation, demanding a planned approach to collaboration with other health service sectors and institutions.

The standards were presented to an international audience at the International Conference on Health Promoting Hospitals in Florence, May 2003 and the International Conference for Quality in Health Care in Dallas, November 2003. Health Promoting Hospitals Coordinators have initiated discussions on standard implementation in HPH member hospitals, and various countries, such as Denmark, Ireland and Slovenia, have started to adopt the standards as to include them in their national accreditation and quality management systems.

A *fourth workshop* on standards for health promotion in hospitals took place in October 2003 in Barcelona. Its specific objectives were to review and select indicators for health promotion, to review the amended self-assessment tool for the pilot test, to discuss the draft manual, to discuss and finalize the draft glossary, to prepare the logistics of the pilot test and to further plan collaboration with other international agencies in the field of indicator development for health promotion.

According to the International Society for Quality in Health Care, an indicator is a "performance measurement tool, screen or flag that is used as a guide to monitor, evaluate, and improve the quality of services". Indicators relate to structure, process, and outcomes and must use data that are collected promptly, systematically recorded, routinely reported and presented with measures of statistical significance. Indicators must further be comparable, use consistent definitions, numerators, denominators and adjustments, be accurate, timely and statistically valid, be cost effective and assist clinicians and managers to improve performance. They must provide incentives for quality improvement rather than perverse incentives for inappropriate activity or manipulation of data and enable the public as a whole to assess the service and the individual patient to make informed choices.

A number of indicators pertaining to health promotion can be identified from a review of indicators in use in current indicator development and performance assessment programmes (A-L Guisset, C Sicotte & F Champagne):

- Readmission rate, indicating the degree of continuity and integration of care and rehabilitation (Rationale: 5% overall patients are readmitted within 28 days (NHS), readmission rate for chronic obstructive pulmonary disease (COPD) 25%)

- Perceived outcomes assessed by survey methods to indicate the quality of patient education and involvement (“When you left the hospital, did you have a better understanding of your condition than when you entered?” ).
- Appropriate Care, e.g. % patients with history of smoking given cessation advice during hospital stay.

Since there is a lack of health promotion indicators in health care the workshop aimed at further developing indicators in that field. Five experiences were reviewed and, although all of them focus on quality improvement, represent different strategies and perspectives. The Danish Quality Indicator project focuses on benchmarking of indicators, the WHO PATH project focuses on the interpretation of indicators for quality improvement, the EUPHID project aims at developing indicators for health promotion, the JCAHO experience is about combining standards and indicators in accreditation and the ANAES presentation addressed the pros and cons of self-assessment procedures.

Various international agencies have experienced with the development of standards for accreditation programmes and have used self-assessment as part of the accreditation procedure. Standards focus on structure and process measures whereas indicators refer to process and outcome measures. Indicators have different metric properties and require a numerator and denominator. Standards need a clear definition but can not necessarily be expressed in numeric terms.

The relation between standards and indicators is complementary; they follow different philosophies and can - combined – support quality improvement activities in hospitals. Existing approaches towards accreditation through standards and performance assessment through indicators make little reference to health promotion activities and there is a need to further develop health promotion-related standards and indicators for hospital activities. Tools for the self-assessment of hospital services need to be constructed in a rigorous way in order to avoid biases stemming from differently developed quality cultures in organizations.

This report summarizes the discussions and outcomes of the workshop.

## Discussion

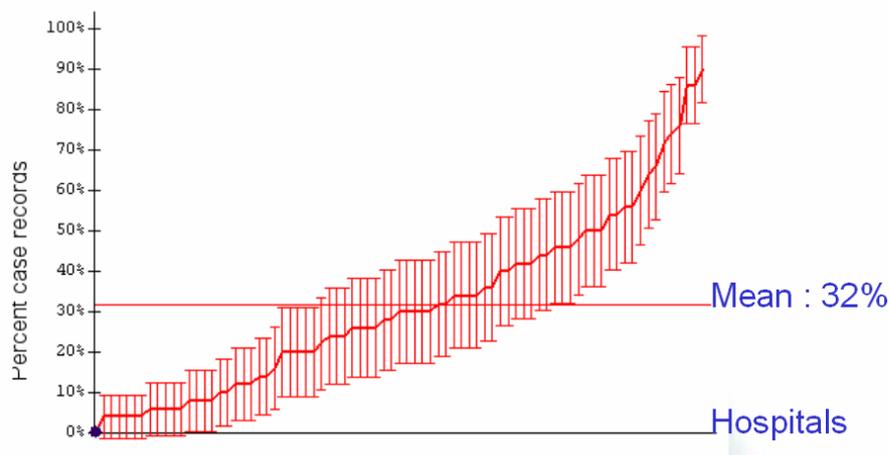
### International experiences with indicators development

#### *Indicator development in Denmark*

The Danish National Indicator Project (DGMA) has identified health promotion indicators for the following conditions: stroke, hip fracture, lung cancer, schizophrenia, emergency surgery and heart failure. For stroke, two indicators are health promotion relevant: secondary medical prophylaxis and assessment of rehabilitation needs. Hip fracture indicators include assessment of nutritional needs and schizophrenia indicators address family support and psycho-education of patients. Congestive heart failure indicators make reference to assessment of nutrition needs, physical exercise, patient education and readmission rate.

The Danish Indicator project has demonstrated that the documentation of health promotion-relevant information in patient records is highly variable (Figure 1). The graph demonstrates the percent of complete records on the y-axis and the current performance of all hospitals on the x-axis. The completeness of health promotion-relevant information in the patient records ranged from almost zero to more than 90%, reflecting great variation in hospital's performance on that indicator.

Figure 1: DGMA Project



A review of the current indicators in use in the Danish project illustrates, however, the lack of health promotion indicators and the need to further develop and introduce indicators for health promotion in hospitals.

#### ***Developing indicators in the performance assessment tool for quality improvement in hospitals (WHO - PATH) project***

The objective of the WHO - PATH project is to provide tools to support hospitals in assessing their performance, questioning their own results, and translating them into actions for improvement, with the support of other participating hospitals (benchmarks). Performance assessment is designed for internal use and on a voluntary basis only.

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 conceptual model encompasses four vertical dimensions (clinical effectiveness, staff orientation, efficiency and responsive governance) and two transversal perspectives (safety, patient centeredness). For each dimension, indicators were selected based on the importance and usefulness, potential impact and burden of data collection.

Indicators related to health promotion are:

- Percent discharge letters sent to GP within 2 weeks
- Percent women breastfeeding on discharge
- Number of days of staff short-term (1 to 3 days) & long-term (more 41 days) absenteeism on total number of days contracted (2 separate indicators)
- Budget dedicated to health promotion activities on number of employees on payroll
- Number of occupational percutaneous exposures (PCE) to blood or potentially infective biological fluids injuries/ Total number of exposed staff
- Staff survey (a number of survey instruments is available in the scientific literature, such as the Karasek Job content instrument, the Nursing Work Index, the Maslach Burnout Inventory scale; optional indicator)
- Percent of job description with risk assessment (optional indicator)
- Average score o items on perceived information and education, involvement in care, continuity and coordination of care, through patient surveys

Appropriation and interpretation of individual results by hospitals is the focus point of this project. Educational material and a dashboard for reporting results for individual hospitals are developed. This reporting scheme is called a “balanced dashboard”.

### ***Indicators for health promotion in the EUPHID project***

The European Health Promotion Indicators Development (EUPHID) project is an EU project whose aim it is to improve health promotion, and thereby improve population health, through the development of a common set of European health promotion indicators.

The project became fully operational in June 2002 and finished in January 2004. The full report is not available yet, but achievements so far reveal a detailed review of the state of art of health promotion indicators development internationally and model for the establishment of the indicator system.

The project recommends that a European Health Promotion Monitoring System be established, with a set of common health promotion indicators, suitable methodology and systems to collect data and a monitoring strategy. The project also recommends dissemination strategies for policy makers and practitioners at Community level within the EU member states.

Plans for the future include to develop alliances with key and with the European Community Health Indicators (ECHI) framework to build upon and relate the model to their work, develop indicators that can be used in a variety of settings – schools; workplaces (hospitals/prisons); and communities. Since the EUPHID project aims to develop health promotion indicators in the domain of health care delivery a close collaboration and exchange of knowledge between this project and the WHO Health Promoting Hospitals Standards and Indicators programme will be important.

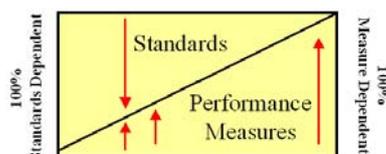
## ***Combining standards and indicators - the experiences of the Joint Commission for Accreditation for Health Care Organizations (JCAHO)***

The Joint Commission evaluates and accredits more than 16,000 health care organizations and programs within the United States and outside. JCAHO's evaluation and accreditation services are provided not only for hospitals, but also for organizations such as health care networks, ambulatory care providers or nursing homes.

The presentation demonstrated how standards and indicators can be combined in the accreditation process. Standards-based evaluation is based on an assessment whether appropriate structure, systems and processes are in place and functioning to achieve consistently favourable outcomes. Questions hence raised through the assessment of standards compliance are “Is the organization doing the *right thing*” and “Is it *doing the right thing* consistently?”. Performance assessment on the other hand is a measure of what was done and how well it was done. Performance leads to results such as health outcomes, health status, patient satisfaction and resource use associated with care. Performance measures are not necessarily used to assess standards compliance.

The use of performance measures is limited by the challenge to collect and analyse complex data that needs to be adjusted for possible confounding factors. Moreover, a single indicator is difficult to interpret and it is rather the interrelationship of selected indicators that reflect quality improvement potentials. But measurement of outcomes does not help to predict future outcomes unless care processes can be considered to be stable over time. Therefore the assessment of standards' compliance is also necessary. Standards and performance measures should therefore be considered complementary (Figure 2):

### Standards and Performance Measures Are Complementary



Complex interrelationships exist among any given standard and an array of relevant indicators

Figure 2: The relation between standards and performance measures

JCAHO does not use indicators for assessment of compliance with standards, but rather as a flag to identify priority areas for quality improvement. The WHO Health Promoting Hospitals Initiative should therefore consider how a selected number of health promotion indicators could best complement the standard assessment procedure for a quality improvement of health promotion activities in hospitals.

## ***The value of self-assessment for quality improvement in France – the experience of the l'Agence nationale d'accréditation et d'évaluation en santé (ANAES)***

The ANAES launched the national accreditation programme in 1999. It is based on the self-assessment of standards on a four-level rating scale ranging from A: achievement over B: moderate achievement and C: partial achievement to D: minimal or no achievement, which is followed by a survey of ANAES experts. Surveyors prepare a report which is commented on by the health care organizations. Finally, the definitive report is prepared.

Within the ANAES accreditation process the self-assessment is an important part of the accreditation process and requires a strong leadership of the board, the managers and consultative and deliberative bodies. It is based on a participative process and carried out in professional teams. The constitution of teams is based on a coordinated approach to patient care.

The experience of ANAES with the introduction of accreditation was positive. It raised the interest in quality among physicians and led to better institutional organization of quality improvement and risk reduction activities.

Questions that were raised with the introduction of accreditation and self-assessment were how to maintain the dynamics of improvement, how to promote the participation of professionals (in particular physicians), how to promote the culture of evaluation and the evaluation of clinical professional practices, how to ensure a more consistent and comprehensive approach to risk management and how to use the results to inform the public and decision-makers.

According to the experiences of ANAES, self-assessment can be improved through a stronger emphasis on communication of preliminary data, through diagnosis and reporting by type of care, through better guidance for health professionals and surveyors, through more emphasis on quotation and a universal electronic support.

A learning experience from the ANAES procedure was that well-performing hospitals were usually much more critical to themselves than those hospitals that were doing not so well. Hospitals that had adopted a culture of continuous quality improvement were more sensitive to their improvement potentials than those institutions that had not been exposed to these principles. A limitation of the self-assessment process is that the well-performing hospitals received on average more remarks than other institutions. The construction and analysis of self-assessment tools therefore needs to be carried out very carefully with well-detailed assessment criteria to keep this bias as low as possible.

### **Indicator selection**

Three working groups of experts worked on a draft proposal of health promotion indicators that could be used to complement the WHO Health Promotion Standards.

The working group members were asked to identify two indicators for each of the five standards. Indicators have to reflect the overall standard they are related to, not the substandards. Further, indicators are not supposed to measure compliance with the standard but should relate to outcomes, i.e. the results that could be achieved if compliance with a standard had been in place consistently. Participants were asked to keep in mind for the discussions the requirements of indicator development that were discussed earlier during the workshop (importance, usefulness, reliability, validity, and burden of data collection).

It was not the task of the working group to discuss or question the standards or substandards. Although revision is planned in the future, for the moment the standards and substandards were considered to be in their final form.

A set of indicators was proposed which were discussed and partly amended by the experts in the working groups. Participants discussed the indicators according to the following questions:

1. Do the suggested indicators reflect the overall standard?
  - i. If yes → go to 2
  - ii. If no: Which additional/other indicators do you suggest?
2. How can the indicator be described in detail?
3. Is it important (in terms of health impact)?
4. Is it useful for quality improvement?
5. Is it reliable?
6. Is it valid?
7. What is the burden of data collection?
8. What is the numerator/denominator?
9. How can the data for the indicator be collected?
10. Is there routine data available?
11. Is a survey instrument available or should it be developed? What are its items?
12. Can the data be retrieved from audit of patient records (clinical and nursing records) or by management audit?

After working group sessions, the participants reported the following indicators back to the plenary (Table 1 to 5)..

Table 1: Indicators complementary to Standard 1, Management policy

Indicator	Description	Numerator	Denominator	Data source
Assess for health promotion skills	Staff identified after systematic assessment in need of health promotion skills (for patients and for themselves)	Staff identified in need of health promotion skills	Total number of staff	Survey, audit
Health promotion training	Staff receiving training for health promotion skills	Staff receiving training for health promotion skills	Total number of staff	Survey, audit
Health promotion audit	Systematic audit of health promotion activities in departments	Departments carrying out systematic audit of health promotion activities	All departments	Organizational audit
Staff awareness	Measures the awareness of staff for the content of the management policy on health promotion	Staff aware of health promotion policy	All staff	Audit or survey
Budget for health promotion	Direct financial resources available for health promotion-related training, meetings and infrastructures.	Direct costs for all activities dedicated to staff health promotion	Total number of full-time equivalent employees in last year OR total operating budget	Financial data

Table 2: Indicators complementary to Standard 2, Patient assessment

Indicator 1	Description	Numerator	Denominator	Data source
Assessment for risk factors	The indicator measures whether patients were assessed for risk factors. Note: To be stratified by age	Total number of patients with evidence in their records that they were assessed for risk factors, including smoking, nutrition, alcohol	Number of patients (in the random sample)	Clinical audit of medical or nursing records
Assessment against guidelines	The indicator measures whether patients were assessed for risk factors against guidelines	Total number of patients with evidence in their records that they were assessed for risk factors against guidelines, including smoking, nutrition, alcohol	Number of patients (in random sample) with a diagnosed condition	Clinical audit of medical and nursing records

Table 3: Indicators complementary to Standard 3, Patient information and intervention

Indicator 1	Description	Numerator	Denominator	Data source
Patients' self-management	Patients educated about specific actions (medication, care, awareness of symptoms, etc) for self-management of their condition. Note: Focus on general	Patients who can name actions for self-management for their condition	All patients	Survey, audit

	<b>health risks</b>			
Risk factor modification	Patients educated about risk factor modification and disease treatment option in the management of their condition. Note: Stratify by condition Focus on patients with diagnosed condition	Patients who can name actions in self-management for their condition	Patients diagnosed with a specific condition	Interviews or survey
Patients' awareness	In contrast to the provision of information, this indicator assesses whether patients have understood the information provided.	Patients who can name their disease, symptoms and risk factors	All patients	Interviews or survey
Patients' results	Assessed the proportion of patients for which the health promotion plan has actually been achieved.	Patients with planned results achieved	Patients with health promotion actions planned	Interviews or survey

Table 4: Indicators complementary to Standard 4, Promoting a Healthy Workplace

<b>Indicator 1</b>	<b>Description</b>	<b>Numerator</b>	<b>Denominator</b>	<b>Data source</b>
Staff absenteeism	Note: Stratified for length of absenteeism, 1-3days ; 4-41 days; 41 and more days	Total number of days out of work, excluding planned holidays	Total number of days contracted	Routine data, human resource department
Staff work-related injuries	Note: Stratified by type (HIV, hepatitis, TB, trauma, needle-stick injuries)	Total number of declared work-related injuries	Total number of staff	Insurance claims, human resource specific register, retrospective reporting through surveys

Table 5: Indicators complementary to Standard 5, Continuity and Cooperation

<b>Indicator 1</b>	<b>Description</b>	<b>Numerator</b>	<b>Denominator</b>	<b>Data source</b>
Assessment of communication with external partners	Note: to be assessed in clinical departments	Number of departments who assessed the communication with external partners (including HP activities)	Total number of departments who assessed their communication with partners during specified period.	Organizational audit
Discharge letters communicated	A reflective indicator for cooperation between institutions and continuity of care for patients.	Discharge letters sent to GP within 2 weeks	All discharge letters	Survey

## Using standards and indicators for quality management

The indicators identified through the working groups will be included in the self-assessment tool for health promotion in hospitals. This tool will be piloted in a number of hospitals to ensure that it is clearly understandable, appropriate and relevant for quality improvement. Hospitals participating in the pilot test will be asked to set up a coordinating team, to assess compliance with standards, to gather data for the indicators and to develop a quality improvement plan based on the information gathered. The results will be fed back to WHO for analysis. The working group discussed the procedure for the pilot test.

### *Incentives for hospitals*

The group questioned the incentives for hospitals to undertake the self-assessment process and whether there would be any certification.

It is not the intention of WHO to develop an accreditation scheme with certification and passes or fails, but rather a continuous developmental process with action plans designed to meet the areas for improvement and for spreading models of good practice in the hospital and outside the hospital to others in the WHO network. These action plans can be fed into a hospital's existing management systems to support continuous quality improvement. By undertaking this process hospitals are checking that systems and processes are in place and when data has been collected by WHO, they will be able to benchmark against other hospitals.

### *Evidence section*

Discussion on evidence related to two issues: evidence on the effectiveness of health promotion and evidence on the effectiveness of self-assessment. The group suggested that it would be really helpful for hospitals if the evidence required to support compliance with the standards was described with the standards. It was also suggested that this evidence could be broken down further so that it was clear what was needed for e.g. a medical department, a surgical department, a paediatric/maternity/gynaecology department. The Health Development Agency has agreed to provide research evidence currently available that relates to the standards.

Discussions also related to queries about the evidence of the effectiveness of this self-assessment tool approach. Does it work, and how do we know that it works? Evidence from the accreditation programmes and other similar programmes suggests that it does work, and that change begins to take place when the organisations commit themselves to the project. However there appears to be no research data to support this. The validity of the tool / model and indicators should be evaluated – including its uptake and impact on health promotion in hospitals over a period of years.

### *Tools: Self-assessment and Manual*

It was agreed by the group that the project needed two documents, a self-assessment tool and a manual. The self-assessment tool needed to be user friendly, simple and easy to use with clear instructions of the process and a copy of the standards. It will be a brief document where the data on standard compliance and indicators can be entered. The manual needed to be a more comprehensive document to back up and complement the standards.

The group recommended that the tools should be available in electronic format, simple and practical and easy to use. It should describe who the tool is aimed at, and what the tool is and is not. It should emphasize that the process is developmental, and fits into existing quality management systems.

Some of the content to be included should be a background, description of the standards, some methodology for self assessment, including the description of the four levels, some information about indicators including developing expanded guidance on the collection and interpretation of individual indicators and a glossary.

The introduction to the tool needs to embrace the wider perspective of health promotion as the original Health Promoting Hospital Initiative is set out. This should include aspects of the environment and arts in health and should explain why these elements are not currently in the document.

### ***Indicators***

There was much discussion in the group about indicators and their relationship with standards. Initial discussion examined the differences between indicators and measurable elements. The WHO approach in this context is that the measurable elements are similar to accreditation programmes, and compliance with the standards relates to the answers to the questions, 'yes, partly and no'. Compliance is not measured with the indicators. Indicators on the other hand would reflect a desirable outcome the structure and process characteristics of standards intend to facilitate. In that sense standards and indicators are complementary: a self-assessment of standards to identify quality improvement potentials and data collection on indicators in order to assess progress.

### ***Training***

It is important that staff know how to collect data and there may be training issues related to the collection of data-not all staff will have the knowledge or skills to be able to do this.

Training material may be designed at a later date, but could be developed with local HPH network co-ordinators based on a template designed by the project group.

### ***Burden of data collection***

The group discussed the large burden of data collection already undertaken by many hospitals. It was suggested that the project needs to estimate the time that would be needed to collect the relevant data for this self-assessment so that hospitals would have a realistic idea of how long it would take and what resources they would need to allocate to the project for the initial self assessment, and then for ongoing action plans.

### ***Benchmarking of hospitals***

The main objective of the self-assessment tool is to identify potential for quality improvement. Standards and indicators should support continuous quality improvement with a special focus on health promotion activities. In the future a benchmarking of indicators may be considered, however, international experiences with performance assessment illustrate the complexity of external comparisons and requirements to adjust for differences in case-mix and resource use. Therefore the current focus will be on self-assessment only and no assessment of hospitals by external bodies will be carried out.

### *Frequency of self-assessments*

The current proposal is for a self-assessment to be completed by the hospitals on an annual basis. The process is intended to be developmental, so that hospitals are able to identify their good practice and where there are areas for development and improvement. The hospitals are able to develop action plans based on the findings from the self-assessment. These can be customized to fit in with the hospital's priorities and national or local targets and priorities. There are no 'passes or fails', this is not designed as an accreditation process with certification.

The process needs to be described in each of the 4 levels in the documents produced: the standard, the sub-standard, the measurable element which is the answer to the questions-'yes, partly or no', and the fourth level which is the indicator for that standard.

The results obtained relate to the measurable elements. Hospitals should be asked to describe what they are doing to achieve a standard, and what is in place to help them to do this.

### *Scheduling the pilot test*

The group discussed the next piloting stage and agreed that objectives need to be set so that everyone is clear about the process. The piloting would take place in the New Year in the same way as the previous pilot, with results ready by the end of 2004. It was agreed that there would be a self-assessment tool, a manual and a set of indicators ready for the pilot.

## Conclusions and recommendations

### Tools to assess health promotion in hospitals

The participants concluded to prepare two main documents to support implementation of health promotion activities in hospitals: a self-assessment tool (SAT) and a manual.

The purpose of the self-assessment tool is to provide concrete guidance on the operational aspects of standard and indicator assessment. As such it was concluded that the existing SAT should be amended, including information on how to carry out the self-assessment, information on carrying out a clinical audit and a frequently-asked questions.

The purpose of the manual is to provide information in a comprehensive manner on the background, evidence, development process and terminology of standards and indicators for health promotion in hospitals.

The participants concluded that a pilot test should be carried out. This aim of the pilot test is to assess whether health professionals in hospitals are able to collect the information necessary to assess standard compliance and whether the documentation supports them in improving the quality of health promotion activities.

Part of the pilot test should assess the burden of data collection related to gathering data for standards compliance.

### Responsibilities

It will be the role of WHO to produce the working materials for the pilot test, to encourage countries and hospitals to participate in the pilot test, to identify coordinators at regional and national level to coordinate the pilot test in the participating hospitals, and to analyse the results that will be fed back to WHO.

It will be the role of the regional and national coordinator to translate the working documents prepared by WHO if necessary, to encourage and identify hospitals to participate in the pilot test, to provide guidance to hospitals taking part in the pilot test and to feedback the results provided by the hospitals to WHO within the deadlines.

It will be the role of the hospital coordinator to set up an interdisciplinary review group for the assessment of standards and indicators, to establish a quality improvement plan based on this assessment and to feed back the results to the regional or national coordinator.

### Participating countries

Following countries have already confirmed interest in participating in the pilot test: Czech Republic, Denmark, Italy, Lithuania, Russian Federation, Slovenia, South Africa, Spain and Sweden. Additional countries may still join the pilot test. Contacts have been established with the coordinators of the International HPH Network. Furthermore, selected hospitals in countries not yet represented in the network may participate.

Hospitals accredited by the Joint Commission International (JCI) may additionally participate in the pilot test. These hospitals will be contacted directly through JCI, which then communicates the countries and hospital details to WHO.

## Suggested timetable for the pilot implementation

Date	Task
13 February 2004	Documents to be sent out by WHO NOTE: By this date, the workshop participants have received the report, the self-assessment tool, the manual and specific instructions for the pilot test. Workshop participants are asked to review the materials carefully and feedback their comments to WHO before 13 February. Participants are also asked to start identifying hospitals to participate in the pilot test.
13 February to 20 February 2004	Feedback by working group participants
23 February 2004	Final documents for translation sent out NOTE: WHO will incorporate the comments from the workshop participants. The 'final' version will be amended after the pilot test and then distributed in wider form.
23 February to 12 March 2004	Documents translated into local language NOTE: Not all documentation will need to be translated in all countries, however, WHO strongly encourages to translate at least the complete self-assessment tool. Translated documents, particularly the self-assessment tool, should be the same in layout as the original one. WHO will provide technical assistance on the layout if necessary.
April to 30 May 2004	Pilot test: assessing compliance with standards NOTE: The pilot test will be carried out including in each participating countries preferably between 5 and 10 hospitals. Participating institutions may be of public or private ownership and should vary in size and location. Psychiatric and paediatric institutions are excluded from the pilot test.
June 30 August 2004	Pilot test: gathering data for indicators
September to 30 October 2004	Development of quality improvement plan
November to December 2004	Reporting and analysis NOTE: Original documents do not have to be translated back to English, only a summary of the action plan and comments from the hospitals. The main results will be reported back in a standardized format and hence do not require translation. NOTE: Analysis will include an assessment of compliance with standards but will not report hospital details, country or network. Assessment of compliance is only carried out in the light of assessing applicability and burden of data collection of standards. A similar approach has used in the previous pilot test and anonymity of participating institutions has highest priority.

## *Annex 1*

### SCOPE AND PURPOSE

The WHO European Office for Integrated Health Care Services, Division of Country Support, is organizing the **4<sup>th</sup> workshop on Standards for Health Promotion in Hospitals**, taking place **from 24-25 October 2003 in Barcelona**.

#### **Background and preceding work**

The WHO European Office for Integrated Health Care Services set up a working group to develop standards for health promotion in hospitals in 2001. Draft standards have been discussed with experts in health promotion and standards development during previous workshops in Bratislava, May 2002 and Barcelona, November 2002 and April 2003, and **five standards have been elaborated**, each consisting of a standard formulation, objective, definition of criteria and measurable elements:

- Standard 1: *Management Policy*
- Standard 2: *Patient Assessment*
- Standard 3: *Patient Information and Intervention*
- Standard 4: *Promoting a Healthy Workplace*
- Standard 5: *Continuity and Cooperation*

The relevance and applicability of the standards was pilot tested and the standards were improved accordingly. The standards are now considered to be in the final form, although future revision is expected once new evidence emerges.

#### **Objectives of the 4<sup>th</sup> workshop**

The task is now to further develop the self-assessment tool, including measurable elements and indicators. In the previous workshop participants proposed a first list of indicators, but more work is needed in identifying further indicators of health promotion.

- a) To review and select indicators for health promotion
- b) To review the amended self-assessment tool for the pilot test
- c) To discuss the draft manual
- d) To discuss and finalize the draft glossary
- e) To prepare the logistics of the pilot test
- f) To further plan collaboration with other international agencies in the field of indicator development for health promotion

#### **Expected outcomes** of the workshop are:

- To agree on a list of indicators to be piloted.
- To agree on the glossary
- To set up the pilot test
- To improve the self-assessment tool

The participants of the workshop are members of the core-working group on standards for health promotion in hospitals, network coordinators of Health Promoting Hospitals in European Countries, representatives from hospitals that piloted the standards, and experts in health promotion standards and indicators.

The workshop will be an important milestone with regard to a comprehensive manual for health promotion in hospitals, including standards, indicators and self-assessment tool.

## Annex 2

### PROGRAMME

#### Friday, 24 October 2003

- 09.00 – 09.10 Opening: *Mila Garcia-Barbero, Head of the Office*
- 09.10 – 09.25 Background of the project and scope and purpose of the workshop: *Oliver Gröne*
- 09.25 – 09.40 Basic orientations and values of Standards for Health Promotion in Hospitals: *Svend Juul Jorgensen*
- 09.40 – 10.00 Developmental work on indicators for health promotion in hospitals in Denmark: *Svend Juul Jorgensen*
- 10.00 – 10.15 Discussion: Status quo of the project
- 10.15 – 10.30 Indicators for health promotion in the European Health Promotion Indicator Development (EUPHID) project: *John Davies*
- 10.30 – 10.45 Combining standards and indicators for health promotion in hospitals: *Jerod Loeb*
- 10.45 – 11.00 Discussion: Directions for the project
- 11.00 – 11.30 COFFEE BREAK**
- 11.30 – 11.45 Public health and continuity of care indicators in the Hospital Performance Assessment project: *Ann-Lise Guisset*
- 11.45 – 12.00 Discussion: Requirements for indicator development and selection
- 12.00 – 13.15 Discussion: Methods to develop and validate indicators for health promotion in hospitals: Chair: *Johannes Möller*
- 13.15 – 14.30 LUNCH BREAK**
- 14.30 – 16.15 Working groups: Identification of indicators to measure compliance with standards for health promotion in hospitals
- 16.15 – 16.30 **COFFEE BREAK**
- 16.30 – 17.45 Feedback on results from working groups and issues in further developing indicators: Chair: *Jerod Loeb*
- 17.45 Wrap-up and conclusions of day one: *Oliver Gröne*

#### Saturday, 25 October 2003

- 09.00 – 09.10 Debriefing and introduction
- 09.10 – 09.20 Presentation of the draft manual: *Oliver Gröne and Annette Rushmere*
- 09.20 – 09.50 Discussion
- 09.50 – 10.00 Presentation of self-assessment tool: *Svend Juul Jorgensen*
- 10.00 – 10.30 Discussion
- 10.30 – 10.45 COFFEE BREAK**
- 10.45 – 11.00 Using a self-assessment tool to improve quality: *Charles Bruneau*
- 11.00 – 11.30 Discussion
- 11.30 – 11.45 Piloting the indicators for health promotion in hospitals: *Chair: Viv Speller*
- 11.45 – 13.45 Discussion on Methods and logistics
- 13.45 – 14.00 Conclusions of the workshop: *Oliver Gröne*

*Annex 3*

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The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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