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An EFQM excellence model for integrated healthcare governance

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Abstract

Purpose – The purpose of this paper is to account for a ten-year experience with the European Foundation for Quality Management (EFQM) Excellence Model implemented in the Trento Healthcare Trust.

Design/methodology/approach – Since 2000, the EFQM Excellence Model provided an overarching framework to streamline business process governance, to support and improve its enablers and results. From 2000 to 2009, staff performed four internal (self) and four external EFQM-based assessments that provided guidance for an integrated management system. Over the years, key controls and assurances improved service quality through business planning, learning and practice cycles.

Findings – Rising assessment ratings and improving results characterized the journey. The average self-assessment score (on a 1,000 points scale) was 290 in 2001, which increased to 610 in 2008. Since 2006, the Trust has been Recognized for Excellence (four stars). The organization improved significantly on customer satisfaction, people results and key service delivery and outcomes.

Practical implications – The EFQM Model can act as an effective tool to meet governance demands and promote system-level results. The approach to integrated governance discussed here may support similar change processes in comparable organizations.

Originality/value – The paper describes a unique experience when implementing EFQM within a large Italian healthcare system, which had a broader reach and lasted longer than any experience in Italian healthcare.

Keywords Governance, European Foundation for Quality Management, Management, Self-assessment, National Health Service, Quality frameworks

Paper type Case study



Introduction

Healthcare staff are often asked to garner stakeholder expectations (e.g. customer, personnel, government, partner and society) and improve accountability. The challenge

is to use the most appropriate governance and assurance tools to ensure that quality, performance, governance and risk management are aligned, coherent and intertwined in an integrated approach (Favaretti *et al.*, 2005a). Integrated governance is defined as systems, processes and behaviors by which trust staff lead, direct and control their functions to achieve organizational objectives, safety and quality services, which they relate to patients and carers, the wider community and partner organizations (Deighan *et al.*, 2004; Bullivant and Deighan, 2006). Integrated governance is a way to run healthcare organizations, linking governance domains (clinical, financial, information, etc.) and ensuring accountability (Bullivant and Deighan, 2006; Smyth, 2009). The European Foundation for Quality Management (EFQM) team developed a governance tool called the EFQM Excellence Model (Jackson, 1999; Naylor, 1999; Holland and Fennell, 2000). Staff at Trento Healthcare Trust (Trust for short) have used the EFQM Excellence Model since 2000 to develop a governance system (Favaretti and De Pieri, 2002). Other healthcare organizations in Italy, have used the model (Vernero *et al.*, 2004b, 2007), but they did not last long enough to support a corporate-wide quality system. Consequently, we review EFQM Excellence Model implementation through the past ten years, the broadest and the only long lasting experience of its kind to have been carried out in Italy to date.

Methods

EFQM excellence model

The EFQM Model is a total quality framework, widely applied in healthcare (Nabitz *et al.*, 2000; Moeller, 2001; Sánchez *et al.*, 2006; Vallejo *et al.*, 2007; Marques *et al.*, 2011; Vakani *et al.*, 2011). The Model is based on eight fundamental excellence concepts (European Foundation for Quality Management (EFQM), 2003) and nine dimensions, which are called criteria. Each criterion includes 32 sub-criteria (Nabitz *et al.*, 2000), which are grouped into five enablers and four results (EFQM, 2003). Enablers describe how staff improve: leadership, policy, strategy, people, partnerships and resources and processes; while the results cover what the staff achieve: customer, people and society and key performance results. The Model's key application is self-assessment, which helps to prioritize improvements (Nabitz *et al.*, 2000). Staff, committed to excellence and reach the recognized goals, are awarded a stage three, four- or five-star level rating, depending on the points achieved after an external assessment carried out by an independent EFQM accredited staff. Organizations with a mature quality management can apply for national or European quality awards (Nabitz and Klazinga, 1999). From 2000 to 2009, we used the 2003 EFQM Model version. In 2010, the model underwent some changes (i.e. criteria weighting; EFQM, 2010), which are yet to be implemented by Trust staff.

Setting

The Trust (located in an Alpine region in northeastern Italy, known as Trentino) is among the largest Italian healthcare authorities. It employs approximately 7,800 staff, who deliver public health services, primary healthcare (primary medical care, outpatient facilities and home care), hospital services (rehabilitation and long-term care), mental health care and ambulance services. The Trust includes four large healthcare districts, seven hospitals, seven private clinics, 22 outpatient facilities and 58 nursing homes. Universal healthcare is provided to 535,000 people, with a 128 aging index (National Institute of Statistics – Istituto Nazionale di Statistica, 2012a). The provincial government allocates resources to meet service demands and achieve desired performance. In 2012, the Trust's total annual turnover was over 1.1 billion euros and since 2001, its key business strategies

were continuous quality improvement and health promotion. The “building the network” vision was developed from 2001 to 2004 and strategic plans were developed between 2001 and 2009 after a four-month consultation process involving 500 staff and all community stakeholders.

Assessment methods

We implemented the EFQM Excellence Model to identify improvement opportunities. Alternating internal and external assessments, we measured yearly performance against the model's criteria. Self-assessments were performed in 2001 (involving 69 people), 2003 (178 people), 2005 (15 top managers), 2007 (67 people) and 2008 (40 people). For each survey, we set people engagement criteria and learning goals to capture information. We used a questionnaire developed by the Italian EFQM Network in Healthcare members (Vernero *et al.*, 2004b). We rated the answers using a four-point Likert scale ($A = 0$, $B = 33$, $C = 67$ and $D = 100$) according to each item's fulfillment level. The five enablers were rated as, A = not started; B = some progress; C = considerable progress and D = achieved. Similarly, the four results were ranked as: A = not measured; B = measured; C = positive trend and results and D = target achieved. We aggregated and weighted the scores to obtain the overall criteria ratings on a 0 to 1,000 point scale. Since 2005, we complimented the questionnaire-based surveys with workshops. Staff from the Italian EFQM National Partner Organization (Associazione Italiana Cultura Qualità) carried out the external assessments in 2004, 2005, 2006 and 2009. In 2005, we performed an external audit based on common assessment rules – a simplified EFQM assessment designed in Europe for the public sector (Common Assessment Framework Resource Centre, 2006). The internal and external assessment helped to address quality gaps and brought a focus to the results. We incorporated the outputs and priorities into business management processes for an effective governance delivery.

Improved enablers

We explicitly grounded the leadership and policies in complexity theory (Plsek and Wilson, 2001) to show that a systemic approach is crucial for guiding the whole organization toward better results. A cornerstone policy has been to develop competent, autonomous and responsible people for business processes and driving change. Leaders (i.e. senior physicians, nurse leaders and administrative clerks) were essential for engaging the staff promoting self-regulation and adopting practices that are most meaningful to professional contexts. The model provided an overarching infrastructure to shape corporate and clinical management systems, with the aim to connect processes and consolidate the link between managerial action and quality improvement. Since 2001, we trained 400 quality promoters to put quality improvement into practice. Involving 600 people (who cascaded to all the staff), a joint top-down and bottom-up approach for defining and implementing performance and improvement goals, enabled professionals to accept the quality challenge as a common interest and embed innovation into daily work. Over 100 working groups were formally instituted; thus, teamwork helped to identify shortcomings and implement best practices.

Redesigning work roles, educational plans and standards for individual performance review hinged on the EFQM framework (De Pieri *et al.*, 2004). A significant landmark in people management has been implementing an innovative corporate program for individual performances appraisal and competency development. We managed to get professionals broadly engaged in governance, with a strategic focus on young physicians. Analyzing stakeholder needs and expectations through direct communication (i.e. individual contacts,

working groups, conferences, complaints and commendations) and satisfaction surveys (i.e. mail questionnaires, phone interviews and focus groups) was essential for mastering and governing the processes. Systematic relationships with stakeholders reinforced the integrated nature and shared the quality responsibilities and accountability. Additionally, we carried out controls and assurances across multiple governance domains (Table I) for compliance with compulsory external requirements and implementing voluntary quality pathways and shared controls with community members (represented by 200 charities).

The EFQM Model provided a good link to accreditation based on Joint Commission International standards in Trento's Santa Chiara Hospital (no public hospital in Italy has been accredited longer). The program was developed with several sector-based voluntary certifications, including ISO 9000, OHSAS 18000 (to date the Trust is the only Italian healthcare authority awarded this internationally recognized assessment specification for occupational health and safety management systems) and technical certifications of conformance to quality standards in laboratories. The corporate balance sheet was certified according to the rules and procedures set for public companies (among the few Italian healthcare authorities). Trust staff joined the International

Assessment	Development actions
2001	Arrangements for governance delivery and business management Systematic evaluation of customer other stakeholder needs and expectations Reframing core managerial processes to effectively engage staff people in commissioning decisions Disseminating learning and knowledge management tools
2003 and 2004	Scaling up patient identification needs and clinically based access to planned services prioritization Job description linked to performance appraisal and appointing clinical leaders Project management tools and methods to manage breakthrough innovation Collating organizational and clinical indicators for performance assessment Programs for professional accreditation (i.e. Joint Commission International) and sector-based certifications
2005	Mapping main corporate processes Implementing a major clinical information system Integrated program for environmental, occupational and clinical risk management Services development and networking with other healthcare organizations
2006	Redesigning processes and tools for human resources management and for individual competencies appraisal and development Balancing corporate social responsibility and reporting intellectual capital Acknowledging and encouraging for good practices with awards Integrated care pathways
2007 and 2008	Standards for health promotion in clinical settings developed by the International Network of Health Promoting Hospitals and Health Services Broad program for personnel welfare, centered reconciling work and family life Young physicians open group for engagement in governance delivery Aligning business processes review frameworks to make information derived from EFQM assessments more actionable
2009	Disseminating best practices to strengthen integration between care levels Balanced scorecards and external benchmarking for main results Kaizen lean events (Procurement services) for delivering value-based process improvement Major corporate reorganization aimed at enabling process management and patient centeredness

Table I.
Key development
actions to support
the improvement
journey

Network of Health Promoting Hospitals and Health Services and adopted its guidance, standards and best practices. Additionally, systematic project management methods and techniques to support breakthrough improvement (Favaretti *et al.*, 2005b), pioneered health technology assessment implementation at hospital-level (Fontana *et al.*, 2003) and promoted key educational initiatives for developing the Italian network (Favaretti *et al.*, 2009).

Along with the governance exercise, our quality system is based on needs assessment, community health profiles, tools for prioritizing access to services, clinical and administrative audit, risk management and people safety, care pathways, service utilization review and appropriateness, business process reengineering and civic audit. The scorecard complimented and strengthened our current measurement systems. To improve citizen access to services, ensure quality care and simplify administrative processes, we deployed information technology to provide answers to some relevant issues confronting healthcare staff. In approaching community stakeholders, governance was valued as sharing power and duty. Formal and informal networks established with other organizations enabled harvesting, sharing and implementing best practices (i.e. systems improvement, health promotion, technologies assessment, performance benchmarking and people safety). To manage weak areas, we established infrastructure and discipline for focussed and measurable improvement (Table I).

Results

Assessment scores

Staff reported positive self-assessments scores over time (Figure 1). In 2001, the average score obtained for all criteria was 290 (on a 0-1,000 scale). The 2003 and 2005 self-assessments revealed an average 470 score with no criterion exhibiting a score below 300. The 2007 assessment led to a 590-point rating for nine criteria and a score lower than 550 was achieved only for three criteria. Subsequently, the score was 610 points in 2008. We achieved lowest scores for people, customer results and people results. Among the enablers, we reached higher ratings for leadership, policy and strategy, partnerships and resources. Better scores were observed on key performance results,

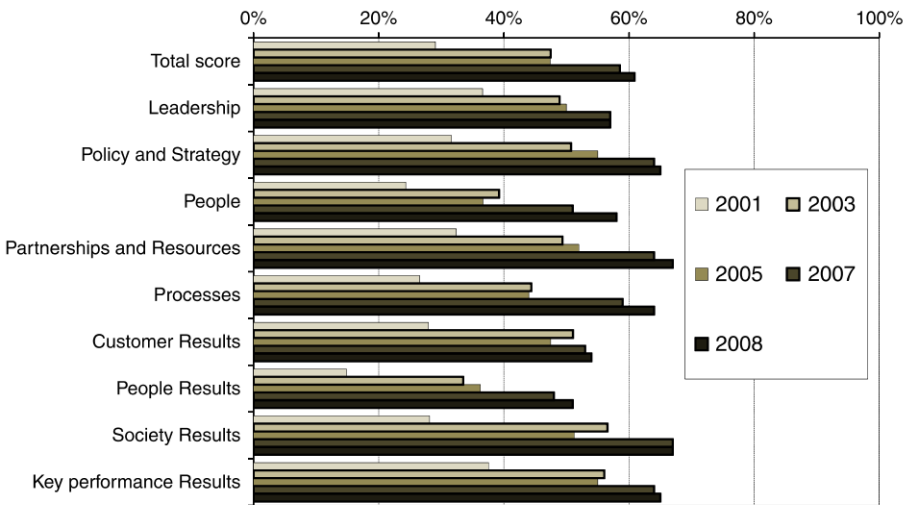


Figure 1.
Self-assessment
scores (maximum
score = 100 percent)

compared to that on customer and people results. Generally, a lower score was observed on people and people results criteria. The Trust was granted the Committed to Excellence award in 2004 and since 2006 and has been considered as Recognized for Excellence in Europe (four stars) by the EFQM Italy partner organizations. Further, external assessment scores have been rising consistently over the years. Except for people management, better scores have been observed on enablers rather than results, in both internal and external assessments. Ratings in external and internal assessments showed a similar profile, thus highlighting common improvement issues.

Client results

We evaluated user satisfaction through phone surveys (1,500 province residents). Since 2002, data are moving in the right direction. In 2009, the survey showed that 94 percent were satisfied with physicians and nurses (88 percent in 2002). Citizens were also satisfied with outpatient waiting times (diagnostic examinations and specialty ambulatory visits), which increased from less than 20 percent in 2002 to 57 percent in 2009 when the overall satisfaction index rose to 89 percent (77 percent in 2002) for inpatient and to 84 percent for outpatient care (70 percent in 2002). Key performance measures and targets were related to service accessibility. The average time waited between call to the emergency triage center and ambulance arrival has been regularly below five minutes for areas closer to ambulance stations and below 20 minutes for over 95 percent of the remaining provincial mountain territories. Around 85 percent of emergency room users were seen in an hour. For several years, less than 20 percent waited over 20 minutes, with a continued downward trend (National Institute of Statistics – Istituto Nazionale di Statistica, 2012b). According to the Italian National Institute of Statistics (2012b), citizen satisfaction levels improved and reached top position at the national level. Assessed items included wait for services, satisfaction with access, medical and nursing care, sanitary fittings and amenities and overall satisfaction with hospital services. Currently, the Trento province ranks first among Italian regions for health service satisfaction (Corriere della Sera, 2012). In the districts, elderly people were regularly assessed and assigned to the appropriate home care service in less than two days (averaging a 1.3 days waiting time in 2009). Additionally, 80 percent of all patients had to wait for less than three days after requesting admission to a hospice. Nearly 15 percent of the outpatients were benefitting from a well-established clinical prioritization system (Torri *et al.*, 2006; Mariotti *et al.*, 2008). In 2009, 95 percent agreed with the clinical prioritization process for access to outpatient care (76.9 percent in 2002). Wait for scheduled outpatient services without any priority, despite a strong surge in demand, has been reducing steadily (Table II). Client complaints fell from 1,306 in 2003, to 948 in 2009. Commendations rose from 202 in 2005, to 387 in 2009 and complaints about excessive waiting times dropped (15 percent in 2009 from 72 percent in 2003). Among other interventions to improve overall access, cultural mediation for immigrants increased from 296 in 2005, to 1,095 in 2009.

People results

We have measured staff opinions since 2002 using a questionnaire-based survey that enabled a customized large-scale self-assessment against the main model criteria. Satisfaction was evaluated on a 0–5 points scale. The response rate increased from 28 percent in 2006 to 34 percent in 2009 and the 2009 employee satisfaction index was 67, up from 56 in 2006 (Figure 2). Among people performance measures, investments in

Table II.
Performance
indicators from
2004/2005 to 2008

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Performance dimension	Metrics	Measurement	Desired direction	Values	
				2004 (2005)	2008
Public health – population health and prevention (National Health Observatory on Health Status in the Italian Regions, 2012)	Population (aged over 18 years) with body mass index equal to or greater than 25		Down	(34.4)	32.3
	Population (aged over 18 years) with body mass index greater than 30		Down	(9.5)	9.7
	Population (aged over three years) physically inactive		Down	(17.5)	14.4
	Population (aged over three years) that consumes vegetables at least daily		Up	(61.7)	65.4
Public health – prevention programs (National Health Observatory on Health Status in the Italian Regions, 2012)	Alcohol-attributable mortality calculated using Perrin's formula (percentage of total deaths)		Down	4.6	3.6
	Vaccinations – adults over 65 years immunized against influenza (percentage)		Up	57.8	68
	Screenings – crude compliance rate for mammography screening (targeting women aged 50–69 years)		Up	64.6	74.8
	Users undergoing multidimensional assessment by district (per 1,00,000 population)		Up	548.3	735.3
District care – service development and productivity	Patients in complex integrated home care (per 1,00,000 population)		Up	247	352
	Territorial pharmaceutical expenditure per capita reimbursed by the National Health Service (Euro)		Down	177	164.1
District care – medicines expenditure	Average waiting time for planned ambulatory visits (without any clinical priority (days)				
District care – accessibility to outpatients care	Colonoscopy		Down	(97)	37
	Head computerized tomography			(50)	16
	Abdominal ultrasound			(99)	22
	Spinal magnetic resonance			(85)	23
	Stress electrocardiography			(72)	32
	Ophthalmic visit			(104)	36
	Orthopedic visit			(72)	18
	Nephrology visit			(56)	14
					(continued)

Performance dimension	Metrics	Measurement	Desired direction	Values	
				2004 (2005)	2008
District and hospital care – quality of management of chronic conditions	Hospitalization rate for asthma (per 1,000 population aged 0-17 years)		Down	(0.87)	0.64
	Standardized hospitalization rate for asthma (per 1,000 population aged over 18 years)		Down	(0.19)	0.16
District and hospital care – effectiveness of demand management and quality of care	Hospitalization rate for urinary tract infections (per 1,000 population)		Down	0.83	0.53
	Hospitalization rate for bacterial pneumonia (per 1,000 population)		Down	2.12	1.89
	Ordinary hospital admissions (per 1,000 population)		Down	132.1	108.3
	Accident and emergency room admissions (per 1,00,000 population)		Down	48,159	41,932
	Hospital admissions from accident and emergency room (percentage of total attendances)		Down	12.9	11.3
	Repeated admissions occurring within 30 days (percentage of total hospital admissions)		Down	4.43	3.96
Hospital care – medical appropriateness and efficiency	Short-stay admissions (percentage of total ordinary admissions)		Down	15.8	15.4
	Hospital admissions for potentially inappropriate medical diagnosis-related groups (per 1,000 population)		Down	15.3	11.5
Hospital care – surgical appropriateness and efficiency	Day surgery admissions (percentage of total surgical admissions)		Up	52.3	73.7
	Average pre-operative stay (planned admissions, days)		Down	1.28	1.07
	Day surgery admissions for inguinal and femoral hernia (percentage of total interventions performed in adult patients)		Up	42.3	80.2
	Day surgery admissions for cataract (percentage of total cataract surgeries)		Up	96.5	99.8
Hospital care – risk management	Lawsuits (per 10,000 hospital admissions)		Down	14.3	10.8
	Lawsuits filed after in-hospital falls (per 10,000 hospital admissions)		Down	0.9	0.4
Hospital care – mortality outcomes (National Agency for Regional Healthcare Services – Agenzia Nazionale per i Servizi Sanitari Regionali, 2012)	Inpatient 30-day risk-adjusted mortality rate for acute myocardial infarction		Down	(14.8)	13.1
	Inpatient 30-day risk-adjusted mortality rate for acute myocardial infarction after percutaneous transluminal coronary angioplasty within 48 hours of admission		Down	(6.3)	0.86

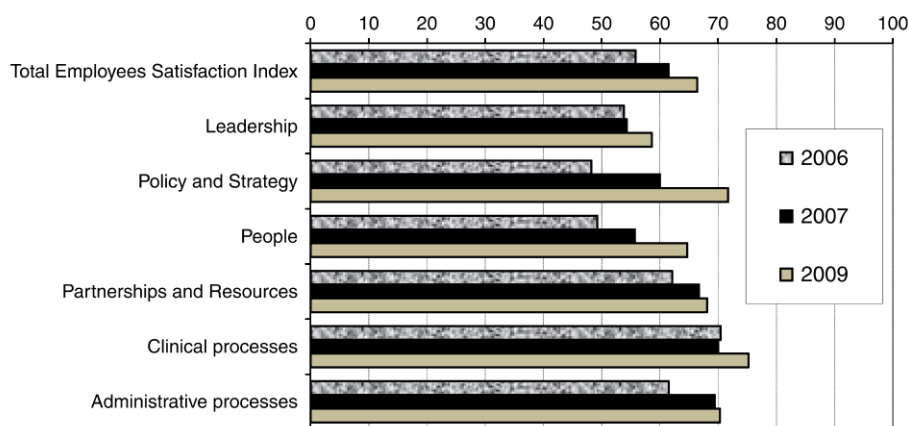
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Integrated
healthcare
governance

Table II.

Performance dimension	Measurement		Values	
	Metrics	Desired direction	2004 (2005)	2008
Clinical performance – specific areas	Inpatient 30-day risk-adjusted mortality rate for coronary artery bypass graft surgery	Down	(1.09)	0.91
	Inpatient 30-day risk-adjusted mortality rate for hip fracture	Down	(4.04)	3.44
	Inpatient 30-day risk-adjusted mortality rate for non-oncology surgery	Down	(1.40)	1.42
	Inpatient 30-day risk-adjusted mortality rate for heart failure	Down	(9.1)	6.5
	Inpatient 30-day risk-adjusted mortality rate for acute stroke	Down	(10.3)	9.5
	Inpatient 30-day risk-adjusted mortality rate for acute chronic obstructive pulmonary disease	Down	(4.78)	4.05
	Caesarean sections (percentage of total births)	Down	29.1	23.4
	Laparoscopic cholecystectomy (percentage of total cholecystectomies)	Up	(91.3)	94.7
	Accident and emergency room and cardiology – door-to-balloon time in eligible acute myocardial infarction patients admitted to Trento's Hospital (from arrival at the accident and emergency room to percutaneous coronary intervention) (minutes)	Down	24	13
	Psychiatric compulsory admissions (per 100,000 population in the catchment area of Trento's mental health department)	Down	5.0	5.3
Internal efficiency	Interventions for confectioning arteriovenous fistulas in patients on hemodialysis (percentage of total procedures for permanent venous access)	Up	57	77
	Child appendectomies with normal histological exam (percentage of total appendectomies)	Down	23.2	19.4
	Donor utilization rate (per 1,000,000 population)	Up	6.3	18.9
	Effective donors (per 1,000,000 population)	Up	8.4	18.9
	Warehouse rotation index	Up	(4.37)	5.40

Figure 2.
Employee
satisfaction index:
total and partial
indexes (for each
main enabler factor)



education and training, mainly based on learning by doing, reached the 1 percent personnel expenditure target. Personnel safety has always been a top priority and occupational injuries reduced from 69.2 per 1,000 staff in 2003 to 53.7 in 2009. Steps were taken to improve staff welfare (i.e. house-job reconciliation, work-related stress management) and to promote a competence-based human resource development (Table I). On the information technology side, currently over 90 percent of healthcare services and functionality are managed by computerized procedures.

Society results

Hospital waste reduced from 2.04 kilograms per day of stay in 2003 to 1.39 in 2009. The Trust obtained more than 20 corporate prizes and awards (i.e. e-health, customer relationship, people welfare, clinical practices and new operational models), including the first Italian healthcare quality award in 2006.

Discussion

We describe how the EFQM Excellence Model has been applied as an integrated governance tool in Trento for a decade. The literature presents the model as a framework to deliver governance within the United Kingdom National Health Service (NHS) (Jackson, 1999, 2000; Holland and Fennell, 2000). However, little was written on how it can be applied for governance purposes in other countries, especially in the Italian NHS, which is modeled on the UK NHS and has undergone comparable reforms and innovation (Donatini *et al.*, 2009; Squires, 2010). Italy scores well on overall international healthcare comparisons (Nolte and McKee, 2008); however, healthcare satisfaction levels were reported to be below the European average and some results have raised concerns (Donatini *et al.*, 2009; Health Consumer Powerhouse, 2012). Health policies have not sufficiently stressed simultaneously pursuing quality management and financial performance (Macinati, 2008). Despite reforms that introduced managerial approaches and techniques into the Italian NHS, organizations lacked emphasis on implementing governance and actionable ideas to manage a change process (Lega, 2008).

Trento Healthcare Trust was among the few Italian healthcare organizations that embarked on a multifaceted, pragmatic, large scale and long lasting change management and improvement journey. Subsequent results were reported in journals, books and conferences (De Pieri *et al.*, 2002; Favaretti *et al.*, 2005a, b; Torri *et al.*, 2007;

Baldantoni *et al.*, 2010). We used the EFQM Model as an explicit governance resource that provides strategic guidance to reframe management and integrate quality threads. Such a holistic frame developed an improvement system and process. Unlike some Italian managers, who focus only on a single quality approach, we adopt, early in a national context, many improvement techniques and tools recognized as effective for promoting system-wide results. Operationalizing a comprehensive governance approach, we alternated self and external assessments to identify governance silos to shake up and drive business planning. In 2001, the first self-assessment resulted in a 290-point average score. Such a rating was similar to self-assessed scores elsewhere in Europe (Moeller, 2001). Over time, assessment scores rose and outlined an overall profile characterized by narrowing variations among scores assigned to criteria, reflecting homogenous development in all management aspects. Such change patterns were similar to those observed in other healthcare organizations (Vallejo *et al.*, 2007). Self-assessed scores, although maintaining the same profile, exceeded external ratings, because external assessments are usually more demanding and strict (Sánchez *et al.*, 2006). In self-assessments, we scored low in people management (Figure 1), which was similar to that observed when others performed self-assessment (Vernero *et al.*, 2004a). Such results marked a difference from other European experiences where weakness in the people area was rarely observed and when observed, was soon corrected (Nabitz *et al.*, 2000; Moeller, 2001; Vallejo *et al.*, 2007).

We found a relatively similar profile between enabler ratings assigned during self-assessments (Figure 1) and satisfaction index scores related to each EFQM criterion (Figure 2). In Italian healthcare, despite attempts to measure organizational climate, the relationship between people satisfaction and the processes to meet personal needs and expectations has not been fully explored within a comprehensive quality framework (Wienand *et al.*, 2007). In our experience, leadership and people management have remained critical issues, a trend which was different from other enablers (Figure 2). In the international literature, it is widely recognized that self-assessment and business excellence can promote a journey from a mainly hierarchical, bureaucratic and individualist culture to one where the norms, values and beliefs reflect teamwork, involvement and empowerment (Jackson, 1999). The model can drive organizational change, develop assessment tools and promote effective personnel management (Naylor, 1999; Leigh *et al.*, 2005; Marques *et al.*, 2011).

Italian healthcare staff are moving from bureaucracy toward a functional approach to human resource management. Innovative practices for people management have been introduced (Lega and Vendramini, 2008). In Trento, we undertook many actions to improve people management and results, such as redesigning work roles, adopting job description and appraisal systems, educating leaders, establishing individual development plans, promoting behavioral approaches to safety management and welfare, and spreading shared decision-making mechanisms (Table II). The EFQM Model provided the framework to embed health promotion into management structures and to deploy related assessment tools. Over the years, our staff sharpened their focus on results and especially reducing waiting time and improving service accessibility (primarily for outpatients), user satisfaction and care effectiveness and efficiency. These issues were critical areas and remained priorities for the Italian NHS (Squires, 2010; Health Consumer Powerhouse, 2012).

No direct association between implementing the EFQM Excellence Model and achievements and can be inferred. However, it stimulated greater accountability and supported better performance results, which ultimately improved accessibility, safety, effectiveness, appropriateness and service efficiency. We aimed at framing a

practical and sustainable governance system and our practical and pragmatic EFQM approach means that many healthcare quality projects are not formally documented and published in the scientific English literature (Nabitz *et al.*, 2000). We intended to implement the model as a real world governance tool. We chose performance metrics from those available and used for accountability in Italy at national or regional level. Consequently, performance indicators, not among Italian stakeholder accountability measures, were excluded in our whole system measures, even if tested along the improvement journey. The model's benefits for driving improvement is reported in the international literature (Sánchez *et al.*, 2006; Minkman *et al.*, 2007), even if its specificity for the healthcare sector can make its application problematic. To bring it closer to healthcare, the EFQM reference tool was merged with the Performance Assessment Tool for Quality Improvement in Hospitals (Vallejo *et al.*, 2006), which can shed light on areas requiring improvement. Additionally, it allows us to understand enablers and results criteria to meet the fundamental quest for healthcare excellence. Currently, our staff are going through a broad and deep reorganization after enacting a new provincial law in 2010. We are working to hold our relative strengths and implement new measurement systems to make information more actionable.

Conclusions

Coping with stakeholder expectations and linking managerial and clinical processes is crucial to meet accountability issues and quality standards in healthcare. We developed a comprehensive governance approach for managing a large healthcare system in Trento. The model offered a framework for combining several quality control and assurance systems linked to corporate management. As an improvement tool, it can connect and align healthcare governance and organizational structures and processes. We advise applying the EFQM Excellence Model to healthcare staff willing to promote sustainable management. Mature and long lasting experiences using the EFQM Model for governance in Italy or other countries must be welcome.

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Further reading

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