A CORE MODEL FOR PROFESSIONALLY LED, CLINICAL SERVICE ACCREDITATION

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CONTENTS

1. INTRODUCTION

Professor Sir Bruce Keogh has proposed that the Academy of Medical Royal Colleges leads the development of "a core model of [clinical service] accreditation, shared across the health service". This request arose from the work led by Professor Peter Furness, on behalf of the Academy, that culminated in a one-day event on 29th June 2009 attended by a range of stakeholders. The Academy has asked the Healthcare Quality Improvement Partnership (HQIP) to coordinate its further development.

An earlier version of this paper was circulated to a limited number of interested parties (see annex 1) and revised on the basis of comments received. Version 2 is to be considered by the Academy at its meeting on December 11th 2009 and by the National Quality Board at its meeting on 17th December 2009. It is anticipated that there then will be further and fuller consultation about the proposals before they are adopted.

2. DEFINITIONS

The proposed core model applies to a particular approach to service accreditation that has developed in the United Kingdom under the leadership of professional associations. These schemes accredit widely differing types of service (see section 3 below). The definition proposed here describes common features of these schemes and also distinguishes them from other approaches to service accreditation.

2.1 Professionally led denotes that:

- Professional associations, including both medical and non medical colleges and faculties, lead the development of the accreditation scheme including the development of the standards;
- The development work is undertaken as a partnership between those professional associations whose members make a significant contribution to the work of the clinical service being accredited;
- Peer-review teams include health and social care practitioners;
- Health and social care staff in clinical services undergoing accreditation are willing and active participants.

2.2 The term **clinical service** describes a group of health and, when relevant, social care staff and facilities and the processes that link them; both with each other and with other components of the wider healthcare system. The focus of accreditation is a facility, a clinical team or a specific group of patients as opposed to a whole organisation. Although accreditation standards might include those that relate to broader organisational processes, such as training, recruitment and finance management, in clinical service accreditation the focus of these organisational standards will be on the impact that these processes have on the quality of clinical and social care.

The "clinical service" so defined must be meaningful to both clinicians and patients. It might:

- Be a single health care facility such as a ward, a clinical pathology laboratory[2] or a primary care centre; or,
- Comprise a group of staff and facilities that work together, as a 'virtual team' to provide care to a common group of patients; such as people who have had a stroke or those being assessed and investigated for memory problems. The staff and facilities that make up this 'virtual team' might either be co-located within a particular setting, such as a general hospital, or be distributed across a number of settings;
- Provide care to patients at a particular time-point and level of care, such as anaesthetic practice within a general hospital, or provide care to patients over time and across the boundaries between health and social care and between primary and secondary care. The latter might be defined as a care pathway.

2.3 For this purpose, **accreditation** is "a self-assessment and external peer assessment process used by [clinical services] to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve."[3] This definition is consistent with the proposal that, although it does involve making a summative judgement about the quality of a service, the primary purpose of this form of accreditation is quality improvement; as opposed to assurance that minimum standards are met.

3. EXISTING SCHEMES

A limited number of clinical service accreditation schemes meet the definition given above. Those operating now are:

- Clinical Pathology Accreditation (www.cpa-uk.co.uk/) which since 2009 has been owned by the United Kingdom Accreditation Service (UKAS) (see box 1).
- Schemes (with dates established) managed by the Royal College of Psychiatrists that accredit electro-convulsive therapy clinics (see box 2), psychiatric wards (2006), learning disability inpatient units (2008), psychiatric liaison services to general hospitals (2009), memory services for people with dementia (2009) and therapeutic communities (2002), including those in prisons (www.rcpsych.ac.uk/clinicalservicestandards/centreforqualityimprovement).
- UK Primary Immunodeficiency Network which is managed by a small stand-alone organisation with some funding from commercial sources. UKPIN accredits immunology centres (http://www.ukpin.org.uk/).
- The Joint Accreditation Committee-ISCT & EBMT which assesses and accredits services that undertake haematopoietic stem cell transplantation. This is a European programme founded by the European Group for Blood and Marrow Transplantation and the International Society for Cellular Therapy (http://www.jacie.org).

[2] For the purpose of this paper, facilities that do not directly provide patient care, such as medical laboratories, have been included in the definition.
[3] This definition is taken from the glossary of version 1 of the International Society for Quality in Health Care (ISQua) standards for accreditation programmes, 1999.

Those in an advanced stage of development are:

- Imaging Services Accreditation Scheme (www.isas-uk.org/default.shtml). The College of Radiographers and the Royal College of Radiologists have appointed UKAS to manage this new scheme for organisations that provide imaging and interventional radiology services. The pilot services are currently under assessment and it is expected that the first services will be fully accredited from April 2010.
- Stroke Services Accreditation; which is being developed by the Royal College of Physicians.
- Primary Medical Care Provider Accreditation which has been piloted by the Royal College of General Practitioners.

There are other professionally led, peer-review schemes whose purpose is quality improvement of clinical services that do not make a summative judgment about accreditation status. These include quality improvement networks managed by the Royal College of Psychiatrists for child and adolescent mental health services, forensic mental health services and perinatal mental health services.

Box 1: Overview of the Clinical Pathology Accreditation Scheme (CPA)

CPA was established by the Royal College of Pathologists in 1992. It was initially a voluntary scheme but now the Department of Health requires that all medical pathology laboratories register with CPA. Scotland has gone further and there accreditation is mandatory. CPA accredits more than 1200 medical and pathology laboratories in the UK and overseas. Ninety-six percent of all laboratories in UK participate in the scheme.

Assessments are conducted by a team of peers and assessors employed by CPA. CPA accredits to ISO 15189. Many of its customers require CPA to gain recognition that their accreditation is in line with ISO 17011 and the new EU regulation.

Annual costs are approximately £2500 per laboratory.

Box 2: Overview of the Electroconvulsive Therapy Accreditation Service (ECTAS)

ECTAS was launched in May 2003 to assure and improve the quality of the administration of ECT. It is managed by the Royal College of Psychiatrists' Centre for Quality Improvement in partnership with the Royal College of Nursing and the Royal College of Anaesthetists. It was decided that an accreditation system was needed after repeated national clinical audits of ECT conducted over a 15 year period showed serious and persisting deficits in how this important but controversial treatment was being administered.

There have been numerous examples of ECT clinics rectifying deficits to meet the exacting accreditation standards. Over the years a substantial number of clinics have been closed down because they were unable to achieve the level of performance required; this has led to the administration of ECT being concentrated in fewer but better clinics.

The first 53 electro-convulsive therapy clinics to complete two full three-year cycles of the accreditation process met 87% of accreditation standards in cycle 1 and 95% of standards in cycle 2. During this time, 19 of the same clinics had moved from standard accreditation to being accredited as excellent.

ECTAS accreditation was one of the information sources that the Healthcare Commission used to direct its inspection activities in its core standards assessment of mental health services. It was also a criterion that the Healthcare Commission used in its review of inpatient mental health services.

The scheme is voluntary. At September 2009 108 ECT clinics in the UK were members of the scheme; More than 80% of all English clinics participate. The annual cost of participation is £2,200 per ECT clinic.

4. THE ROLE AND VALUE OF CLINICAL SERVICE ACCREDITATION

Existing schemes make a unique contribution to quality assurance and quality improvement in the few clinical areas that are currently covered.

4.1 Engagement of clinicians in service evaluation

It is a professional requirement that clinicians are self-reflective. Doctors, and perhaps other professional groups, will be expected to demonstrate this for the purpose of revalidation. The standards-based process of self and peer review that are required by clinical service accreditation creates a framework for such self-reflection. It requires clinicians to work with their multi-professional team to evaluate the service for which they are responsible and their own contribution to it. The evaluation also requires clinicians to seek structured feedback from patients and service users when this is appropriate. This effort rarely duplicates the statutory processes for regulation and performance management of healthcare organisations because few clinicians are involved actively in, for example, the self-assessment process required for registration by the CQC (see 4.6).

4.2 Facilitation of peer-review

The accreditation process includes a peer-review visit by clinicians that work in similar settings. This opens the service up to external scrutiny, provides external validation of the self-review and creates an opportunity for discussion with peers about strengths and weaknesses. The benefit is two-way; peer-reviewers often comment on the value for them of visiting another service. Some peer-review teams include patients or service users.

4.3 Stimulation of service improvement and development

The national standards that underpin accreditation schemes are in effect templates for the ideal clinical service. The assessment identifies what is deficient in a local service, as well as what is good or excellent, and makes this explicit to the local clinical team, the senior management and local commissioners. The summative decision about accreditation status and the recurring accreditation cycle create incentives to rectify deficiencies; often to a deadline. Clinical service accreditation schemes that promote excellence and quality improvement ensure that even good services strive continuously to do even better (see 6.4).

4.4 Networking between services

Although most clinical services that undergo accreditation are part of a larger organisation, they are often 'isolated' from other services that perform the same function. Thus, for example, outside of ECTAS (see box 2) there is little opportunity for staff involved in administering electroconvulsive therapy to communicate with their peers in other clinics. Clinical service accreditation schemes can enable exchange of information between services and sharing of good practice.

4.5 Enabling services to compare their performance with one another

This is both in terms of performance against the accreditation standards and potentially of performance on clinical indicators collected as part of the review process.

4.6 Complementing statutory regulation and performance management

Accreditation schemes can generate accurate and detailed information about quality that can feed into trust returns to regulators and into quality accounts.

They also provide information about quality at the level of the clinical service. NHS trusts are large and complex organisations and most provide a range of clinical services. It is likely that in all trusts some clinical services are of a high quality and some are not. Regulation and performance management generally work at the level of the whole organisation - whole NHS trusts register with the Care Quality Commission and apply for Foundation status. Although assessments for these purposes, and those used in the annual health check, say something about overall quality, they do little to evaluate the quality of the individual clinical services. The all or nothing decision to register or award Foundation trust status cannot reflect this 'granularity'. Clinical service accreditation can.

5. PRINCIPLES THAT UNDERPIN THE MODEL

It is proposed that clinical service accreditation schemes should:

a) Be **inclusive** of the range of interests in the clinical service that is the focus of accreditation;
b) Have a **patient-focus**;
c) Have **methodological rigour** and draw on the **evidence base** in the development of standards and in the processes used to assess levels of performance;
d) Be about **excellence** and show a **commitment to quality improvement**;
e) Have **sound governance**;
f) Be subject to **evaluation and external quality assurance**;
g) Be **aligned** with the system that regulates and performance manages healthcare and be **recognised** as being part of that system. In particular, they should be based on NICE quality standards and contribute information to support registration by the Care Quality Commission;
h) Demonstrate **value for money**.

The rest of the document will explain how these principles might be applied to clinical service accreditation.

6. THE MODEL

We have opted to draw on the standards for accreditation programmes devised by the International Society for Quality in Health Care (ISQua) for the purpose of describing high quality in clinical service accreditation schemes.

6.1 Inclusiveness

The development, delivery and governance of clinical service accreditation schemes should:

- Be a partnership between the medical and non-medical professions and professional associations whose members make a substantial contribution to the clinical service that is the focus of accreditation;
- Fully recognise the contribution of social care if this is relevant to the clinical service;
- Take account of the perspective of non-clinical managers, commissioners and policy-makers;
- Work in partnership with patients, carers and third sector organisations that represent patient and carer interests. This includes having patients as full members of project teams, advisory groups and peer-review teams and involving them fully in the development of standards and methods.

6.2 Patient focus

When applicable, accreditation should consider clinical services from the perspective of patients, their families and their carers. Accreditation standards and performance assessment should:

- Cover the rights of patients to: dignity and respect, recognition of their cultural and spiritual needs, privacy, confidentiality, information about treatment and care, informed involvement in decision-making and the exercise of choice;
- Consider access to and discharge from clinical services; including for those with disabilities and special needs;
- Consider the patient journey through care with deliberate attention to the interfaces between different components and levels of clinical service;
- Require that treatment and care are individualised to the needs of each patient.

6.3 Methodological rigour

Accreditation is a formal judgment about a clinical service which cannot be regarded as reliable until the programme itself is validated. This requires that standards and procedures for assessment and reporting are developed systematically and tested thoroughly. This may take several years. This development and testing should be an ongoing process.

6.3.1 The accreditation standards

Clinical service accreditation schemes should apply the principle proposed by the International Society for Quality in Health Care (ISQua) that "standards are planned, formulated and evaluated through a defined and rigorous process" [4] (Box 3).

Standards should be reviewed regularly and, when necessary, revised in the light of, for example, new evidence or policy. To drive improvement, the level of performance stated by the standard might be raised between review cycles or new, more exacting standards added. Also, standards might be 'graded' into, for example, those that are: i. **essential** - failure to meet would result in a significant threat to patient safety, rights or dignity and/or breach of the law; ii**. expected** - standards that an accredited service would be expected to meet; iii. **desirable** - standards that an excellent service should meet.

The standards should specify patient or clinical outcomes whenever possible.

Box 3: ISQua criteria for standards development

- Relationships with the standards of other organisations and professional and regulatory requirements are considered;
- Standards are developed or revised in accordance with a plan that includes objectives, resources and timeframes;
- Government, professional, purchaser, provider and service user interests have adequate opportunity for input into the standards development and revision process through direct representation and formal consultation;
- There is a clear framework for the standards that makes them easy for services and assessors to use;
- The wording of the standards is clear and unambiguous;
- Standards are tested/piloted and evaluated by services and assessors prior to approval to ensure they are understandable, measurable, relevant and achievable.
- New and revised standards are approved by the standards setting body or appropriate authority before general implementation;
- Information and education are provided to users and assessors of the new and revised standards to enable interpretation and implementation;
- The views on standards and the satisfaction of users, assessors and stakeholder groups with them are obtained, documented and monitored and the analysed data are evaluated to assist with improving standards.

6.3.2 Assessment of performance

It is proposed that clinical service accreditation schemes adopt the ISQua principle that "standards enable consistent and transparent rating and measurement of achievement" (Box 4).

[4] International Society for Quality in Health Care (2007). International Principles for Healthcare Standards, Third Edition. ISQua: Victoria, Australia.

Box 4: ISQua criteria for standards measurement

- There is a transparent system for rating a [*clinical service's*] performance on each standard, criterion or element;
- Guidelines or other information are provided to assist assessors to rate consistently and [*clinical services*] to assess their own performance on the standards;
- There is a defined methodology for measuring overall achievement of a set of standards in a consistent way;
- The satisfaction of [*clinical services*] and assessors with the measurement and rating system is evaluated and results used to make improvements.

Clinical service accreditation schemes apply a range of measurement approaches including: examination of documents; surveys of patients, carers and staff; structured and unstructured interviews with patients, carers and staff; observation of practice and inspection of facilities and care environments. These measurement approaches might be undertaken by staff working in the clinical service, as part of the self-review, or by external peer assessors. Measurement of indicators that relate to performance against standards should be continuous when possible; as opposed to repeated, spot measurement at one stage of the accreditation cycle.

Although all measurement approaches should be as robust and replicable as possible, features of clinical care that patients consider to be very important should not be excluded because they are difficult to measure. These features include the humane, caring qualities of staff and the therapeutic relationship as perceived by the patient. Those making decisions about accreditation status should be fully aware of any limitations on the results of performance assessment due to sample size, response bias and reliability of measurement.

6.4 Commitment to quality improvement

The progress report one year after publication of 'High Quality Care for All' proposes that clinical service accreditation should both work at a level above that of assuring compliance with minimum standards and drive improvement in quality.

> *"While we have robust systems in place to ensure that minimum standards of care are met through regulation, there is no coherent or comprehensive approach to recognising leading teams that are providing excellent standards of care. One way of recognizing the teams that meet such levels of excellence is through greater use of accreditation. This has the potential to unleash healthy competition among clinicians across the country to provide the best care."*[5]

To achieve this vision that clinical service accreditation schemes are about excellence, the level of performance must be set at a level substantially above that required for registration by the Care Quality Commission. Schemes should also meet the ISQua principle that they have been "designed to encourage healthcare organisations to improve quality and performance within their own organisations and the wider healthcare system"[6] (Box 5).

[5] NHS Implementation Team (2009) High Quality Care for All: Our Journey so far. Department of Health: London, p.38.
[6] International Society for Quality in Health Care (2007). International Principles for Healthcare Standards, Third Edition. ISQua: Victoria, Australia.

As can be seen from Box 5, a model of accreditation that promotes continuous improvement requires more than a simple binary pass/fail outcome from the measurement of performance or from the decision about accreditation status. It is likely to require a more sophisticated outcome which might include:

- More than two classes of status that can be awarded to clinical services at the end of the assessment process. The simplest categorisation might be into fail/pass/excellent;
- The incorporation of indicators and other performance measures that assign a numerical "score" to one or more aspect of performance. These may be presented in comparison to benchmark scores or in relation to other clinical services participating in the accreditation scheme;
- A compound statement of performance incorporating both of the above that flags up both the overall performance of the clinical service and its particular areas of strength and weakness;
- A cyclical process of assessment that promotes improvement or the maintenance of excellence in those clinical services that have achieved it.

Box 5: ISQua criteria for standards that support quality improvement

- The standards require [*clinical services*] to define, as appropriate to their size and scope, their: mission or purpose, values, ethics or code of behaviour and strategic objectives;
- The standards define responsibilities for quality and performance improvement at different levels of the [*clinical service*];
- The standards define the responsibilities of a [*clinical service*] for governance and organisational management;
- The standards require [*clinical services*] to inform the public of the services they provide and the quality and performance of the services;
- The standards require that policies, procedures or processes and plans for all key functions in the [*clinical service*] are documented, authorized, kept current and implemented;
- The standards require an approach to quality improvement that is systematic, is continuous, is organisation-wide, covers all aspects of performance, supports innovation and incorporates monitoring, including of all high risk processes and procedures, and evaluation;
- The standards require that key care and service processes and outcomes be measured through the use of performance indicators, patient/service user satisfaction, surveys/assessments and other performance measures;
- The standards require the evaluation and analysis of data from performance measurement and its use to improve performance and services;
- Law, regulations and health policy are recognised and integrated into the standards.

6.5 Governance

It is proposed that organisations that manage clinical service accreditation schemes should comply with the standards and supporting criteria developed by ISQua for such bodies. These cover the functions of leadership, support services and service delivery[7]. They must pay particular attention to criteria that ensure that:

- All decision making and behaviour are guided by a code of conduct that avoids conflicts of interest;
- The assessment process is transparent and independent;
- The determination of the outcome of the assessment is transparent, consistent, relevant to the scope of the accreditation, made purely on the basis of the assessment report and independent of the assessment process;
- Peer assessors are selected carefully, trained adequately and have their performance evaluated;
- Peer assessment teams provide a balance of skills and experience to match the needs and characteristics of the clinical service being accredited;
- There is an appeals process that is transparent and described clearly;
- The Public has access to information about which clinical services have been accredited.

[7] International Society for Quality in Health Care (2007). International Accreditation Standards for Healthcare External Evaluation Organisations, Third Edition. ISQua: Victoria, Australia.

6.6 Evaluation and external quality assurance

Organisations that manage clinical service accreditation schemes should 'practice what they preach' in terms of the quality of their work. They should:

- State explicitly the standards to which they aspire;
- Engage in self-review of their performance against these standards;
- Participate in external peer-review; both by being subject to assessment by peers and by contributing their staff to act as peer assessors of other clinical service accreditation schemes;
- Make public the results of assessment of their performance;
- Participate actively in research about the effectiveness of clinical service accreditation schemes in bringing about improvement in clinical services.

6.7 Alignment

Professionally led, clinical service accreditation must be aligned with other quality initiatives, and with the wider regulatory and performance management system if it is to maximise its impact on quality and minimise the burden of data collection. In particular, it should be a means of supporting the implementation of NICE quality standards.

6.7.1 Alignment of accreditation standards with NHS standards

NICE quality standards that relate to the clinical service being accredited should be at the heart of the accreditation system and should supersede standards from any other source. If applicable, and to minimise duplication of effort, the clinical service accreditation standards should also:

- Map onto Care Quality Commission registration standards using the same domains/headings (accreditation standards should cover all relevant registration domains; although as described in section 6.4 above they are likely to be set at a level well above the minimum required for registration);
- Map onto NHS Litigation Authority standards;
- Incorporate NICE guidance;
- Incorporate NHS Indicators for Quality Improvement, and other relevant assured indicators;
- Incorporate other recognized national and international standards.

6.7.2 Alignment with regulation and performance management of the NHS

Although the primary purpose of clinical service accreditation is quality improvement, the information generated must also contribute actively to the wider system that assures the quality of the NHS. Where possible it should be re-used to avoid duplication of the effort of collection. It should:

- Inform decisions by the Care Quality Commission to register health and social care organisations;
- Influence the Care Quality Commission's risk profile and 'special reviews' of health and social care organisations;
- Support Monitor to assess applications by trusts for Foundation status and support the subsequent performance management of Foundation trusts;
- Be used by commissioners in contracting for clinical services;
- Be incorporated into trust Quality Accounts;
- Provide evidence that informs the appraisal, re-licencing and re-certification of health and social care professionals (the evidence could be both of active participation in clinical service accreditation and of the results of the accreditation).

6.7.3 Alignment between clinical accreditation schemes

If the number of clinical service accreditation schemes increases, there is a risk of over-burdening provider organisations and of duplication of effort. This is a particular risk when different schemes accredit clinical services located in the same organisational environment; such as a general hospital. It is therefore proposed that:

- Those managing clinical service accreditation schemes work to develop a set of common standards that apply across schemes. These will include 'generic' standards that apply to all health and social care organisations covering issues such as personnel management, policies and procedures, equipment and facilities, resource management, and education and training;
- Common standards and approaches to assessment are used at the interfaces between clinical services that are subject to different accreditation schemes (overlaps between schemes are inevitable and often desirable because problems in patient care often happen at the interface of services);
- There is a central (national) schedule to coordinate the timing of accreditation visits so as not to over-burden health and social care organisations (the Concordat scheduling tool was set up partly for this purpose).

6.8 Value for money

The NHS will be required to make substantial efficiency savings from 2011/12. In this context, and assuming that participation is not mandated, clinical service accreditation schemes must demonstrate their value and affordability if they are to survive and succeed. Annex 2 is a paper prepared by the Department of Health that summarises the research evidence about accreditation in healthcare. It also comments on the costs and financial benefits of accreditation. The former include both cash costs - money to set up schemes and fees paid by participating services - and opportunity costs – mainly staff time in undertaking self and peer-assessments. The financial benefits include potential efficiency gains to the organisation and potential gains to society in terms of, for example, added quality adjusted life years for patients using clinical services. A third financial gain to healthcare organisations, and to the NHS as a whole, is the replacement costs of the benefits of participation listed in section 4 above. These include:

- The cost of providing alternative opportunities for clinical staff to engage in self-reflection and learning about their performance, and about the performance of their clinical service. This activity is required as part of continuing professional development and for the purpose of appraisal and revalidation;
- The replacement cost of providing opportunities for senior clinical staff to liaise with their peers working in similar services managed by other healthcare providers;
- The replacement cost of each NHS trust supporting clinical staff to engage in quality improvement as envisaged by High Quality Care for All;
- The replacement cost of collecting the data about performance of clinical services that trusts are required to include in their quality accounts. This applies particularly to clinical topics that are considered national priorities and that require benchmarking or national comparisons;
- The cost of setting up alternative sources of national and comparative data about clinical services for national performance management, to inform 'special reviews' by the Care Quality Commission and to provide information to the Public about the quality of local services.

6.8.1 Funding of accreditation

It is proposed that these general principles apply to professionally led, clinical service accreditation schemes:

- They are managed as non-profit making enterprises;
- Although set-up costs might be funded from a central source, the ongoing costs of participation are met by a fee for service, paid by the organisation whose clinical services are being accredited;
- That health and social care organisations that participate in clinical service accreditation schemes allow their staff time both to assess their own service and to act as a peer assessor of other clinical services in the scheme;
- That health and social care professionals employed by the NHS or local authority social services receive no additional payments for work done in NHS or local authority time on behalf of clinical service accreditation schemes;
- That self employed health or social care professionals should receive an agreed consultancy fee for their time, or payment to cover the cost of covering their duties;
- That service users and carers are paid an agreed consultancy fee for their contribution to developing and delivering the work of accreditation schemes;
- That the costs of participation are explicit, and subject to review for value for money.

6.8.2 Benefits of participation

To promote participation, clinical service accreditation schemes must demonstrate and deliver benefits at all levels of the health and social care system (see also section 4 above).

For the individual practitioner, participation and results should be:

- discussed at supervision and appraisal
- used as evidence to support revalidation
- considered in decisions about performance-based pay awards such as local and national clinical excellence awards;

For the clinical team, accreditation should bring recognition of achievement within their parent organisation.

For the parent health and social care organisation, accreditation should:

- result in better engagement by clinicians and social care workers in the process of quality improvement
- support the achievement of clinical excellence
- bring national recognition of clinical services that are accredited as excellent
- support an application for registration by the Care Quality Commission
- result in a lower risk profile with the Care Quality Commission
- provides information to support regulation and performance management by the Care Quality Commission and Monitor
- provide information to support the quality component of contract
- provide information for Quality Accounts
- reduce the need for inspection and cost of regulation by the Care Quality Commission and Monitor;

For regulation and local, regional and national performance management:

- the provision of new, more detailed and higher quality information
- better local engagement of clinicians and social care workers in the process of regulation, performance management and quality improvement
- closer partnership working with professional associations in standard setting and performance management.

6.8.3 Sustainability

A number of accreditation schemes started over the past decade have failed to establish themselves and have ceased to operate. It is likely that there is a combination of factors that determine whether a scheme will survive.[8] These relate to the quality of the governance arrangements (see section 6.5 above), the sustainability of funding, the receptiveness of parent health and social care organisations to support their staff's participation and the wider context including Government commitment to the scheme.

[8] Shaw C (2004) Toolkit for Accreditation Programmes. ISQua: Victoria, Australia.

Annex 1; Circulation List

A core model for professionally led, clinical service accreditation. Version 1: 26th October 2009

Adeagbo, Ade	National Voices
Bewick, Michael	Royal College of General Practitioners
Brownhill, Liz	Trent Accreditation Scheme
Burgess, Robin	HQIP
Burnett, David	Royal College of Pathologists
Cheshire, Michael	Royal College of Physicians
Crisp, Helen	The Health Foundation
Davies, Janet	Royal College of Nursing
Dixon, Anna	Kings Fund
Dodds, Chris	Royal College of Anaesthetists
Field, Steve	Royal College of General Practitioners
Furness, Peter	Royal College of Pathologists
Garvey, Conall	Royal College of Radiologists
Gilmore, Ian	Royal College of Physicians
Hardy, Dominic	Department of Health
Haslam, David	Royal College of General Practitioners
Hicks, Beth	Department of Health
Hitchcock, Paul	Allied Health Professions Federation
Hughes, Lauren	Department of Health
Ingham, Jane	Royal College of Physicians
Lelliott, Paul	HQIP
Leng, Gillian	NICE
Lester, Helen	Royal College of General Practitioners
Marshall, Martin	The Health Foundation
Mclaughlan, Charles	Royal College of Anaesthetists
Moyes, Bill	Monitor
Oldham, Robert	Department of Health
Poteliakhoff, Emmi	Department of Health
Rentoul, Jamie	CQC
Shaw, Charles	Independent Consultant
Shaw, Kirstyn	Academy of Medical Royal Colleges
Stennett, Paul	UK Accreditation Service
Stewart, John	Department of Health
Stout, David	NHS Confederation
Taunt, Richard	Department of Health
Wilson, Karen	CQC
Worrall, Adrian	Royal College of Psychiatrists
Young, Elaine	HQIP

Annex 2; Accreditation Review of Evidence

DH Office of the Chief Analyst October 2009

Emmi Poteliakhoff

The aim of this document is to provide a short summary of the evidence on the effectiveness of accreditation. Its target audience is the members of the working group set up to establish a core model of accreditation. This is a discussion paper which presents a review of available evidence by the Office of the Chief Analyst. Any inferences and conclusions are those of the authors and not the Department of Health. We ask that the paper is not shared more widely. There is a summary of key messages in section 5.

1. QUALITY IMPROVEMENT TOOL

Accreditation schemes can be used for either basic quality assurance or quality improvement. The review will focus on their use towards the latter end in order to avoid duplication with the work of the CQC on registration requirements.

2. THEORETICAL ADVANTAGES OF ACCREDITATION USING PEER REVIEW

Desired outcomes in healthcare include some which can be defined and measured and some which cannot. Where incentives are offered for high performance only on those outcomes which can be defined and measured, those which cannot will suffer from a lack of attention and focus. This is the problem of the unbalanced scorecard, which systematically undermines efforts to incentivise quality enhancements using financial incentives or targets. Accreditation using peer review can be designed to create a balanced scorecard using soft information to augment the imbalance of published information. Although it is also has imperfections, it is one of the few ways in which the unbalanced scorecard and its potentially harmful effects can be reduced. In addition to this, where effectively executed, peer review can harness the esteem of senior colleagues to motivate poorly measured behaviour. Many would agree that peer esteem is a strong motivating factor for clinicians. Esteem of colleagues is highly valued and the withdrawal of esteem feared.

3. WHAT EVIDENCE IS THERE OF BENEFITS?

3.1 There is generally a lack of good evidence either to show that accreditation is effective or that it is not

It is difficult to conduct research in this area which means that although there are a significant number of studies which have been carried out, the degree to which their findings actually provide good evidence as to the effectiveness or otherwise of accreditation is questionable. Ellie Scrivens (2008) has noted, however that lack of evidence on effectiveness is a common issue in most quality improvement initiatives. Difficulty in conducting research exists for the following reasons:

3.1.1. There is difficulty in defining and measuring the potential benefits of accreditation.

3.1.2. Most studies are limited to an observational design. In an observational study, a finding of a correlation between accredited status and high quality care at the organisational level may not be an indicator of causation. This is because where most schemes are voluntary, higher quality organisations will tend to choose to gain accreditation and lower quality to drop out or choose not to apply.

3.1.3. Randomised controlled trials randomly assign organisations to undergo accreditation and so overcome the problem of selection described above. They are however very few in number because they are administratively more difficult to conduct and can be expensive.

3.1.4. Case control studies, which use a control such as a comparable local organisation but are not necessarily randomised are also rare as the require “a large, supportive but uncontaminated universe” Shaw 2003.

3.1.5. Few evaluations manage to sample, compare and monitor performance over the long period of time which is likely to be needed to show any statistically significant change.

3.1.6. Accreditation schemes tend to undergo continuous change, evolving each year in the face of new demands and localised evidence as to what is working. Evaluators therefore are unable to consistently track the effects of any particular formulation of a scheme over time.

3.2 What evidence there is tends to show that:

3.2.1. Accreditation schemes can produce improvements in organisational process and compliance (some consensus on this) but not necessarily in clinical processes and patient outcomes apart from in so far as these facilitate clinician excellence.

3.2.1.1. A randomised controlled study from South Africa (Salmon et al 2003) showed significant positive effects of accreditation on compliance with standards but was inconclusive on quality indicators.

3.2.1.2. The NCROP project, a randomised controlled trial of peer review in COPD had mixed results. Intervention sites showed improvement in more outcomes than in control sites, but some did worsen and the difference between control and intervention sites was not statistically significant. Outcomes were measured less than one year after the peer review visits and the evaluation concluded that the results could indicate either that the scheme failed to influence service or that more time is needed for significant service change to come about.

3.2.1.3. A study from the US (Piontek et al 2003) examined the application of the American College of Surgeons (ACS) Level II verification in the Trauma department of a single hospital using a different hospital and a separate specialty within the same hospital as controls. Positive results of accreditation were found in terms of cost reductions, reduced length of stay and severity adjusted mortality for trauma patients.

3.2.1.4. Observational studies are numerous, particularly those looking at the correlation between JCAHO accreditation scores and outcomes such as mortality, medical error rates and patient satisfaction in the US. In this type of study correlation cannot be taken to indicate causation. Some find a positive association but mostly that association is weak and statistically insignificant. Many find no clear overall pattern. Sutherland and Leatherman (2006) report 'no correlation' as their verdict on this research.

3.2.1.5. A Systematic review of health sector accreditation research (Greenfield and Braithwaite 2008) examined the impact or effectiveness of accreditation classified into 10 categories. The analysis revealed a complex picture. In two categories consistent (and positive) findings were recorded: promote change and professional development. Inconsistent findings were identified in five categories: professions' attitudes to accreditation, organizational impact, financial impact, quality measures and program assessment. The remaining three categories—consumer views or patient satisfaction, public disclosure and surveyor issues—did not have sufficient studies to draw any conclusion. The authors identified a number of national health care accreditation organizations engaged in research activities in the search process and conclude that "the health care accreditation industry appears to be purposefully moving towards constructing the evidence to ground our understanding of accreditation".

3.2.2. Accreditation schemes differ significantly and the effectiveness of any one scheme will depend on exactly how it is structured. Trials comparing different types of accreditation do not exist so the degree to which any particular feature of an accreditation scheme can be held to be better is mostly based on educated conjecture. This is explored more below.

3.2.3. Accreditation schemes tend to lack clinician engagement. Increased clinician engagement may lead accreditation to make more impact on clinical processes and patient outcomes. Ellie Scrivens (2008) discusses the social and political context of accreditation. She notes a general lack of involvement or interest from physicians in accreditation and gives this topic significant attention. Physician disinterest is ascribed to the focus within accreditation on organisational and managerial issues and not on clinical care.

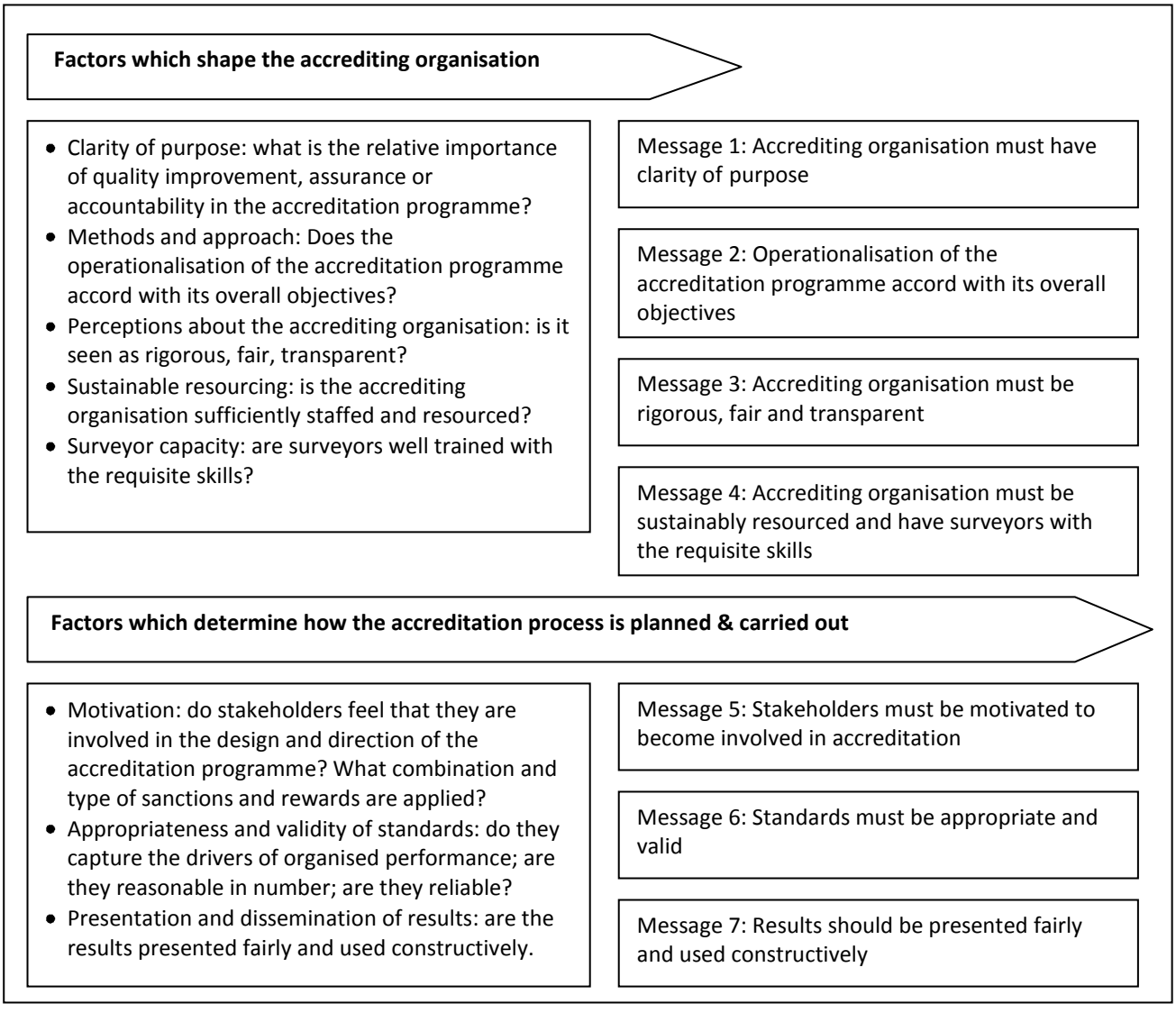
Some means by which physician interest may be increased are put forward by Scrivens who writes that "There is literature which suggests that clinicians would be more engaged if the standards were directed directly at patient outcomes". She goes on to discuss the pros and cons of accrediting on the basis of outcome rather than process measures. Physicians would prefer outcome measures, but it can be argued that process measures are actually a more sensitive measure of quality of care than outcomes though this is only true when a direct link between a given process and an outcome has been demonstrated.

Finally on this topic Scrivens argues that "The failure of accreditation systems to engage clinicians is not a function of accreditation per se, but appears to have more to do with a reluctance on the part of clinicians to engage with nationally set qualitative standards which impact on medical administration and clinically relevant organisational processes and may also be a function of how quality assurance programmes are organised within hospitals." This suggests that clinician engagement might be a function of the way in which standards are set and assurance programmes organised and that changes to these factors could increase engagement.

3.3 What can we draw from this evidence base?

3.3.1. For the purposes of informing the group which has been established to define a core model of accreditation, it is useful to try to identify the factors which evidence suggests contribute to accreditation schemes which are successful in improving outcomes. Sutherland and Leatherman discuss a number of factors which influence the effectiveness of accreditation, adapted from Shaw 2003. These can be loosely divided into two streams and key messages drawn as below:

Figure 1. Factors which influence the effectiveness of accreditation



3.3.2. Stakeholder involvement in the design and direction of the accreditation programme is held to be an important factor in determining their motivation to become involved, along with the sanctions and rewards applied.

3.3.3. Consideration of the appropriate combination of sanctions and rewards is noted as an important motivator. Within a more competitive health care market such as the US, accreditation status is valuable to providers in helping to attract patients. Within the NHS this concern is less pressing (especially in areas with few providers). However, the publication of accreditation status is likely to be a strong motivator to clinicians and managers where they tend to be competitive with one another but only where the standards are well regarded and results presented fairly and used constructively, factors set out in messages 6 and 7.

4. PRODUCTIVITY FOCUS

Going forward, new spending will be limited in the NHS and so new schemes will have to show minimal cost and maximum impact in order to be viable. The evidence on the cost effectiveness of accreditation is limited and no studies which look specifically at cost effectiveness have been found. Some rough outline estimates which put the potential costs in context, however, can potentially show the possibility that even small benefits, in the health care context where the additional life years which might be gained are valued highly, would produce favourable ratios of costs to benefits.

4.1 Estimating the costs of accreditation

4.1.1. The costs of accreditation are comprised of the costs of running the scheme, the cost of participation by organisations, which includes the opportunity cost of the time spent by those involved, for example time spent by clinicians within the organisation or service being accredited in preparing for the accreditation.

4.1.2. In 2000 ISQuA conducted a review of national accreditation organisations for WHO which found that accreditation fees for a 100 bed hospital ranged from US$1,000 to US$25,000 (Shaw and Kalo 2002). This does not include the cost to the organisation of preparation for accreditation which has been estimated at up to four times the cost of the survey process, though some proportion of this may be comprised of management activity which has value to the organisation outside of the accreditation process.

4.1.3. Studies of JCAHO accreditation in the USA have estimated the total cost to the health care system at between $425 and $850 million per year (Walshe 2003), though much of this cost is comprised of routine management activity which would continue without accreditation. The JCAHO scheme is the state recognised accrediting organisation for healthcare providers in 40 of 52 US states.

4.1.4. Conover & Zeitler 2006, estimate the total hospital accreditation and licensure requirements for the USA at $8.6 billion. The figure is reported as net though expected benefits in the calculations are equal to zero. The figure is largely based on a Price Waterhouse Coopers (PWC) 2002 study which surveyed 25 hospitals, asking questions about the likely paperwork burden at each stage of a hypothetical patient journey for an 80 year old patient needing care from the emergency department, surgery and acute inpatient care, skilled nursing facility and home health. The PWC study finds a figure of 36 minutes of paperwork per hour of medical care. It seems that the Conover study then uses this figure together with an estimation that 20% of this paperwork is related to regulatory costs to produce the $8.6 billion figure. Scrivens discusses this work and notes the speculative methodology, with no account taken of the benefits of standardisation of practices and from defence against litigation by demonstration of adherence to agreed procedures. She notes that the value of this work lies in demonstrating

the considerable difficulties faced in undertaking cost benefit studies of regulatory processes including accreditation.

4.1.5. Better cost information for England (at least for direct administrative costs) is probably available within the Royal Colleges which have run/ are running accreditation schemes.

4.2 Comparing the potential benefits to the costs of accreditation

4.2.1. The evidence that accreditation can produce benefits is limited because most studies fail to show benefits with any statistical significance. Of the three studies described above which use controls (no more have been found for this review though they may exist) two show some statistically significant benefits and one shows weak evidence of benefits which is not statistically significant. Alone these studies do not provide a substantial body of evidence that accreditation can produce significant benefits. It remains useful, however, to think about the magnitude of benefits which would be required to match the likely costs of accreditation. Two ways to think about this are efficiency gains- producing more and/ or better quality healthcare for the same resources and in terms of gains in quality adjusted life years.

4.2.2. Using the former approach, the efficiency gain required to make a saving equivalent to the cost of the accreditation program at the individual Trust/ specialty level is likely to be very small. Consider a Trust with turnover of £200 million per year, where accreditation within one particular large specialty takes place and that specialty has a programme budget of £20 million per year. If the accreditation exercise costs £30,000 and has a resulting efficiency gain for the following 5 years over and above what would be the case with no accreditation, the efficiency gain would only have to equal 0.03% - an increase of three units of quality adjusted output per ten thousand units in order to make the benefits of accreditation match the costs.

4.2.3. A rough calculation based on the findings of Piontek 2003, shows how the magnitude of benefits from accreditation in terms of potential QALY gain need not be large for these to dominate costs. The Piontek study showed that following accreditation in one hospital, observed/ expected mortality in the trauma specialty improved from 0.81 to 0.59. Where this 27% decrease in severity adjusted mortality is scaled down by a factor of ten (a conservative adjustment), it could still produce an additional 42 life years over 3 years[9]. The paper does not include a cost estimate of participation but if it was $125,000 over 3 years (the maximum in the range given by Shaw and Kalo, again a conservative assumption) this would mean a rough cost per QALY of about $3,000. In other words, the benefits, if they exist, do not need to be vast for the intervention to achieve a relatively low cost per QALY.

4.2.4. The accreditation process could also improve the efficiency of decision making within a provider. Providers could be considering different options to improve quality in a specialty/ patient pathway. Each will have a cost and the provider may lack information as to which will be most beneficial per unit cost. The accreditation process, with an element of peer review could help the provider choose the improvement with the best value for money and therefore save money compared to a scenario where a different option is chosen.

[9] Based on 20 QALYs per patient life saved, 1,000 patients per year, death rate before accreditation of 2.7%.

5. SUMMARY OF KEY MESSAGES

5.1. For a variety of reasons the literature on the effectiveness of accreditation is not very informative as to the actual potential benefits of accreditation.

5.2. Overall the evidence suggests some benefit though mostly this is in processes rather than outcomes, with professional development and promoting change two key areas where accreditation has been shown to be effective (Greenfield and Braithwaite). For areas of benefit other than these, lack of statistical significance is an issue for several studies which show some benefit but which lacks sufficient power to be statistically significant.

5.3. Several factors which influence the effectiveness of accreditation are set out by Sutherland & Leatherman 2006 and Shaw 2003. Key messages drawn include the need for the accrediting organisation to have clarity of purpose, for its operationalisation to accord with its overall objectives, for it to be rigorous and fair, sustainably resourced and have surveyors with the requisite skills. Further, effective accreditation is deemed to be that where stakeholders are motivated to be involved, standards are appropriate and valid and results are presented fairly and used constructively.

5.4. The involvement of clinicians in the development of standards and the accreditation process, which builds a degree of clinician ownership, seems to be important in the effectiveness of accreditation. This may require a focus on outcomes rather than processes though the potential value of process measures should not be forgotten.

5.5. The evidence on costs suggests that these must include not only the administrative costs of accreditation but also the potentially hidden cost of participation. Costs are therefore complex to estimate and studies range in the figures they give.

5.6. Where benefits also are difficult to measure an estimate of a cost benefit comparison is very difficult. Rough estimates based on figures from existing small studies show, however, that where the likely costs are small in comparison both to healthcare budgets and to common values placed on additional life years, potential benefits may be large compared to these costs.

5.7. Such benefits would, however, be unlikely to be cash releasing and it is important to recognise in the context of pending budget constraints that the arguments above may not be sufficient to support new funding for accreditation schemes.

5.8. The balanced scorecard is a key argument in favour of accreditation involving peer review. Because some aspects of quality cannot be measured, both financial incentives and 'targets' are based on an unbalanced scorecard and deliver biased outcomes. Though also not perfect, accreditation using peer review can fill some of the gaps not measured by hard evidence, enabling a more balanced picture of quality to be drawn in a way that other quality measures cannot.

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