

**Looking to the Future of Healthcare Assessment: An expert seminar on standards-based peer review:**

**Joint meeting of the Quality in Healthcare Forum and UKAF**

**26<sup>th</sup> September 2006**

**Introduction by Helen Crisp.**

The seminar was introduced as an opportunity to showcase the work of member organisations within voluntary standards based assessment and peer review awards of accreditation. It should provide an opportunity to keep all involved up to date with what is happening.

The objectives for the seminar are to show the wide range of voluntary standards-based accreditation and peer review assessment, to debate how these can work more closely with mandatory assessment, to encourage high standards in assessment, and to promote UKAF as the meeting place for all those interested in share in expertise and good practice in assessment.

**Healthcare Accreditation – the international perspective: Helen Crisp.**

More and more assessment of healthcare systems is taking place around the world and there is realisation that more formal assessments are required. It is not sufficient to assume that this is happening. Studies on efficiency, effectiveness and safety show that spending on healthcare systems does not mean there will be quality of provision. Funders want to see a measure of quality for money

Medical accidents get high coverage in the press and assessment is one way to reassure public that healthcare quality is happening. Eastern Europe is reforming its funding systems and rewarding efficiency hand in hand with the link between quality and efficiency. European countries are beginning standard based peer review process with volunteers seconded to their agencies to support. The situation in Britain, the first European country to explore accreditation, has been different and has been reluctant to endorse voluntary schemes. Assessment is not seen as necessary and has been rejected in favour of multiple mandatory assessment. Accreditation offers direct measures for quality and outcome issues, and gives a mechanism to monitor issues such as access, communications and links between services and the extent of patient choice and involvement.

The accreditation approach offers explicit standards, which are the basis of the framework. The implementation period involves self-assessment, action planning and development, external assessment by peer review and an accreditation award by independent committee. There are many international schemes that are looking across health economies and health sectors with a mechanism for getting beneath the rhetoric and see how healthcare is doing. The design of standards is to capture what is happening and how to measure it with an updating of standards every three years. It is important to make clear what is being assessed and what is happening. The CHI reviews provided clinical governance with a high level concept of the best organisations. Now we need standards well in advance of the visit to look at current practice. We need drivers of external assessment and the peer review is the most effective way by people who know the service and the accreditation award is the checking process.

Other international standards includes:

- ? France which has a mandatory programme and an annual inspection programme
- ? USA, which has a joint commission of 3000 staff and an innovative approach to secondments for two to three years to support accreditation programmes
- ? Italy has many regional schemes
- ? Ireland has a pattern of merging accreditation with other functions with broadly healthcare assessment, which is taken up by many hospitals.
- ? All of Eastern Europe is restructuring its healthcare and the World Bank is supporting this.

Programme legislation in Europe includes 20 programmes across national healthcare in which the standards framework provides the benchmark, good practice is formally recognised and services meet the standards. There is a strong emphasis on risk management. The benefits of accreditation include the guarantees of standards which provide a benchmark for quality, whole hospital/service is 'in it together', staff work to known, agreed procedures and not on assumptions, good practice is recognised and there is a greater awareness of patient safety.

### **The Future of Health and Adult Social Care Regulation: Gary Needle, Head of Improvement, Healthcare Commission.**

The focus of the presentation is to highlight examples of new and changing healthcare assessment, the key issues to be resolved and to help shape healthcare. The background is the merger between Healthcare Commission and Mental Health Commission. HCC is a regulator not an inspector and has an over all purpose to drive improvement. HCC has introduced a new approach for a careful assessment on a risk proportionate basis, to reduce the burden of inspection and to gain intelligent information to drive activity. HCC is Government funded and is answerable to the Dept of Health. HCC is responsible for NHS and independent sector, including:

173 Acute Trusts, 64 Mental Health Trusts, 31 Am Trusts, 300 PCTs and 200 independent acute hospitals, 190 independent mental health and 180 hospitals. It includes the small highstreet independent outlets and independent voluntary accreditation schemes. It does not assess SHAs.

The NHS Assessment is through the annual Health Check and publishes answers to two questions for each healthcare community:

- Are the organisations getting the basic right?
- Are the health organisations making and sustaining progress?

Core standards assessment embeds 24 standards across the NHS. Trust boards are accountable to assure themselves of quality. HCC assesses against a risk basis and sees where the outlying organisations are by following up 10% and 10% random sample. There is a web based national comparative performance data and a national comparative data. Emerging findings from the evaluation show:

89% of trusts have a positive result of good governance and 77% have positive results on patient care. The previous process was focussed on finance and now is focussed on safety and effectiveness.

Regulation of independent healthcare provides national minimum standards as a growing part of HCC's work and is projected to grow. The nature of assessment is changing and is more focussed on inspection. The key driver is better outcomes for patients. The web-based information provides, for example, on Heart Surgery in GB and can provide comparisons of facilities and rates of survival and consultant details. There is a presentation of assessment information – the key public and patient questions. Ratings for CEO's are included and information for patients, which answers questions such as How long will I wait? How safe and clean is the hospital? How good is the treatment? Will I be treated with dignity?

Findings are explained in user-friendly language on how well Trusts are performing and there is a drilling down into layers of details. Issues for the future include:

- ? a regulatory framework against the 24 standards for the providers and not for the commissioners.
- ? There is now a need to look at an assessment system that looks at commissioning
- ? Licensing to bring together different models
- ? Cinderella services and how to improve the regulator.
- ? Regulation will provide much more information now.
- ? Competition
- ? Appropriate funding.
- ? Roles clarified
- ? Pressures of a merger

HCC evolved from the Bristol Inquiry and increased the regulatory process. There are plans for HCC to extend work with Cardiac Surgery outcomes to be extended to other areas of healthcare.

**Coordinating peer review and accreditation activity: expected outputs and outcomes: Alastair Cannon, Healthcare Commission.**

The Concordat development is the rationalising of quality assessment, coordinating peer review and accreditation activity, and making the case for peer review.

The background to the Concordat is in a voluntary agreement from June 2004 by 10, and now 20, implementers and led by Healthcare Commission to reduce duplication and to coordinate reviews of healthcare organisations. The Concordat website now lists all signatories. Much progress has been made and a variety of tools to help make regulators coordinate better activities. A set of recommendations has been made: for information sharing protocols to prevent barriers of working together, to put building blocks in place to raise the game and, by doing so, to raise expectations. Information is out there but there are many bodies to talk with. The public and private sector should not be burdened with regulatory activity. In addition, a programme of merger of inspectorates, i.e. Healthcare Commission, Health and Social Care and Mental Health Commission is taking place.

Anecdotally service continues to perceive the 'burden' as not yet coordinated but it is reducing non-statutory inspectorate, peer review service accreditation activity. Whilst there is much anecdotal evidence of progress there is a need for research for this, which HCC may fund.

Peer review and accreditation schemes – 256 clinical peer review schemes with a driver for more in the system. Payment by Results and practice based commissioning will require more accreditation for evidence of quality. Accreditation is focussed on quality but not well coordinated with a panoply of different methodologies, a variety of definitions, limited and overlapping evidence. Accreditation is used for a variety of purposes and display varying degrees of adherence to Concordat principles but currently no mechanism to coordinate activity. The ISO scheme is not integrated and there is scope for improving coordination and smarter use of information. There should be a shared view of definitions, e.g. for peer review, definitions and purposes, better targeting of activity to areas and topics of shared concern, and efficiency savings by streamlining design and delivery in line with best practice.

The next steps will be: to propose a seminar with workshops to test the appetite, to identify and share notable practice in the design and delivery of peer review and service accreditation activity. Identify findings that might be used more extensively including the HCC assessment system and others. As a first step for testing appetite and capacity for change, the potential outputs would be: ongoing arrangements/mechanisms for on going sharing of notable practice, mapping of individual schemes processes against Concordat principles, shared action plans to improve coordination, publication of planned activity on the Concordat website, and, in due course, a code of practice for kite marking of schemes. Potential outcomes would also include peer review and service accreditation activity, shared information and maximising existing information, proportionate to risk/performance/objectives, patient involvement (user focus), coherent programme.

Issues for discussions included the mutual benefit in exploring how to improve the Concordat. CHKS will be interested in supporting this work and a formal mapping against the Concordat would be the first work to be undertaken. There are difficulties of comparing extensive standards against smaller sets. HCC will not be imposing coordination to improve schemes and would not want to engage in activity unnecessarily. Safeguarding patient care as an issue is the challenge of achieving this.

### **What makes networks work? : Nick Goodwin, Senior Lecturer, London School of Hygiene and Tropical Medicine.**

The driving forces for networks in healthcare fields are very popular for the following reasons:

- ? The move away from treatment of acute illnesses to a chronic disease model of care.
- ? Information and technological advances
- ? Regulations on doctors' working hours.

A directory of networks is being created for the following purposes:

1. Information networks, i.e. sharing best practice. These are the most common networks and do not involve institutional change.
2. Coordinated networks, which are a form of integration and are new modes of operation linking between coordinated care but not tied into any formalised care, which is time for different coordinated care network.

Future role of networks will include:

3. Procurement Networks – Government perceived networks in a regulatory role for brokering incentives, e.g. targets to gain contracts. Clinical networks for good practice arrangements are valued for good discussions with SHA's and patients but there is a need for networks to be more effective. Quality guidelines are perceived as a need for forging strategic commissions.

Future of managed clinical networks – functions of MCN begin to expand, prioritisation and shared strategy making and engaging clinicians. Healthcare networks are a mixture of forums for social regulation and for social integration.

Nature of networks –

Hierarchical networks – allow managerial control and suit predefined tasks  
Individualistic networks – fluid and flexible providing compliance by incentives.  
Enclave networks – strong in securing legitimacy and trust – not readily managed or regulated.

Strategies to ensure that networks are most effective.

Ten key lessons in networks:

- 1 Position of centrality, as a manager
- 2 Knowledge, resource reward accreditation and not reject professional freedom
- 3 Being inclusive
- 4 Avoid large networks which cause organisational inertia. These are the most expensive and can make the most loss.
- 5 Develop cohesive forces: joint finance and tie-ins, give roles and responsibilities to engage, knowledge mobilisation
- 6 Avoid mandated networks – they should be owned by network members.
- 7 Engage professional leaders to promote
- 8 Avoid organisational capture – by professional ethics or by a dominant institution taking over the network rather than fulfilling network.
- 9 Maintain 'net worth' and not survive forever. It should adapt, grow and endure and some have specific time frames.
- 10 Mandate to govern – potential solution to the governance gap in networks. Need members to sign up to what we hope to achieve and provide right incentives.

Accreditation of networks? This moves the network in the direction of hierarchy and the potential for network to be more productive but risks break up of network due to loss of professional mandate in the face of accreditation rules and protocols. It moves the network in the direction of procurement agency commissions – incentivises net work associate through rewards but potential leads to zero competition and quality system becomes contractual with an independent regulator, such as HCC.

### **Increasing the Success of Accreditation of NHS Health Libraries: Creating new Standards: Tricia Ellis, Accreditation Lead for NHS Library and Knowledge Development Network.**

The importance of access to high quality information is largely understood and the use of the best clinical evidence for decision-making has gained greater emphasis

since the Bristol Inquiry. There are 1200 plus health libraries in acute and mental health trusts in England. As they have become increasingly public facing they have been the subject of increasing scrutiny for their value for money and fitness for purpose. The development of standards to support the development of library and information services to be cost effective and client focussed. Minimum national standards for health libraries have been created in other countries. In UK standards have been largely regional or professional. From the time of the late 1990's the HeLicon/LKDN accreditation scheme with a self-evaluation checklist and toolkit evolved which was flexible enough to meet the needs of all health libraries. The achievements of the accreditation process were realised in the survey of health libraries that took place in 2005 which showed that there was better local coordination of services, increased funding, improvements in accommodation, enhanced IT and reader services and greater equity of access, such as 24/7 access.

The accreditation scheme is used in 92% of NHS Trusts and there is a need for further development and a major revision of the scheme is planned which are based on the strategic objectives of the National Knowledge Service and a National Service Framework for NHS Funded Libraries. A national consultation with stakeholders has taken place managed independently through University of Loughborough and the intention is to modernise the service and staff roles defining core and developmental standards. The aim is to ensure a more transparent accreditation process to evidence the experience of the client, whether the service meets the needs of the organisation and the impact upon patient care. There is also a rigorous training programme for assessors and surveyors planned.

**Measuring Success: Alun Davies, Regional Service Development Manager, South London, Kent, Surrey and Sussex National Lead for Measuring Success.**

Begun in 1997 following the publication of the Multiple Sclerosis Society's own standards on the Care of People with MS. The NICE Guidelines and Multiple Sclerosis Management of MS in primary and secondary care were published in November 2003. In 2004 MS Society developed and published a toolkit to assist healthcare professionals to audit their service against the NICE Guidelines. The activities were evaluated in 6 pilot sites for their success and a survey of the toolkit users was undertaken. The lessons learnt were that:

- ? Pilot NHS bodies need a clear contract of what is expected of them in a clear timescale
- ? Focus group selection needs to be specific to individual parts of the audit and 'one size does not fit all'.
- ? Service users need training to undertake facilitating focus groups and have an understanding of how the NHS works.
- ? Audit needs to be segmented to reflect Commissioning Primary, Secondary and Rehabilitation care.
- ? MS is a small part of NHS work and often the focus can be lost if there is not sufficient communication with the 'champion for the audit'.

**Sarah McCrutchon** took a workshop approach to discuss how to deal with awkward clients or surveyors.

**Adrian Worrell introduced the afternoon programme.**

**National Stroke Audit: Alex Hoffman, Stroke Programme Manager, Clinical Effectiveness and Evaluation Unit, The Royal College of Physicians.**

Clinical effectiveness and evaluation unit with an inter collegiate working party to coordinate all work. Guidelines are an essential part of the programme. The hospital audit is in two parts, i.e. changing data capture (via a web based form and clinicians have access to the data based on completing their data) and a patient/carer audit. There are currently 5 audits with 100% participation since 2004. The stroke units in hospitals are increasing and are compared over time to provide regional comparisons. The use of RCP data from audit and advice comes from the expert group. The audit has helped to shape services and evidence is a major lever for change. The factors contributing to success include the DH considers the data very positively and data is defined by clinicians. There are links with other initiatives, such as the NSF for Older People and new areas where evidence exists.

The national audits, the local perspective

Why participate? To develop the service through a lever to drive change and benchmarking service. It is a very creditable audit and highly recommended and is measured against the NICE standards and the computer system functions well. Results of the audit has impacted upon the length of stay in the stroke units

**Lessons learnt from delivering a National Audit Programme: Maureen McGeorge, Joint Head of the Centre for Quality Improvement, Royal College of Psychiatrists**

The key element of the Audit Programme include:

- ? National networking through events, newsletters, benchmarking, multiple
- ? Stakeholders' involvement
- ? Audit tools and guidance
- ? Multiple (challenging methods)
- ? Central data collection and reporting
- ? Systematic 'slice' of experiences.

The audit shows a snapshot of data, e.g. the experiences of violence and 20,000 lines of qualitative data, the fact that 425 of nursing staff received no training before going on the ward.

The value of the audit was to develop community base services had distracted from the unit services.

The key lessons learned:

- ? Too much work
- ? Too little time
- ? Lack of senior support
- ? Raised expectations
- ? Exposure, e.g. through the Freedom of Information requests.

## Key messages

- ? Subjects that matter, e.g. violence matters
- ? Multiple stakeholders
- ? Support from the top is required
- ? Flexible and engaging methods
- ? Focus on outcomes
- ? Visible improvement cycle.

### **Trent Accreditation Scheme: Colin Blackler**

The Trent Accreditation Scheme is a scheme for ongoing assessment and accreditation of NHS community hospitals and community services, which is a continuous process, based on peer review and self-assessment.

The more members in the scheme, the greater the strength of the scheme. There are 30 – 35 hospitals in the scheme and a family of community hospitals to share good practice. Recruitment and training of surveyors is very important. There is a two-year survey process for an organisation with a regular sharing of knowledge. Part of the scheme is to keep surveyors up to date and how the organisation interprets the scheme.

The core elements of the scheme includes:

- ? A peer review
- ? Accreditation by an independent board
- ? Regular sharing of information
- ? Training events for participation and surveyors
- ? Pre-survey visits
- ? Mentoring for the organisation
- ? Continuous development.

### **Health Care Quality Unit (formerly Health Quality Services): Jan Mackereth-Hill**

HCQU undertakes an extensive programme of surveyor training. The training includes a two-day programme and a selection event. There is an annual updating event. Training is continually assessed and surveyors are taught to understand that the standards and structure and the needs of the client. Jan's role is as a client manager and leads a survey team and interfaces between the survey planning and the preparing.

How the evidence is gathered. Surveyors are taught to observe the environment, effective communications in a non-threatening way, note taking and writing down information when talking, feedback, and many exercises are assessed to see if surveyors have relevant skills for HAQU.

The role of the surveyor is to assess compliance with HAQU criteria.

The client manager reads all reports and writes the exception report for the organisation and the action plan. The Accreditation Board makes the decision to make the award of accreditation. The Accreditation Board is the independent process of the assessment

**Summary of the Seminar: some of the key themes and messages:**

- ? There is a need for clarity and strategy for driving forward improvements
- ? There is a wide variety of peer review, standards-based assessments in practice. The accreditation programmes are all sizes, many models and a variety of voluntary and mandatory nature.
- ? Accreditation programmes need to be endorsed from the top down
- ? There needs to be support for peer assessment
- ? Healthcare Commission support can make an impact to the success of accreditation, e.g. funding, authority

**Tricia Ellis**  
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