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■ PROFESSIONAL ISSUES

Developing a strategy for accreditation of clinical services

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ABSTRACT – Accreditation is one method of assuring quality. Accreditation requires the setting of standards and the creation of a robust and reliable process for assessing them. Accreditation offers different advantages to different groups, eg quality assurance to commissioners and the boards of provider organisations, confidence and choice for patients, and a quality improvement pathway for services to follow. This paper is focused on service accreditation and it proposes that service accreditation be professionally led.

KEY WORDS: Accreditation, quality improvement, quality assurance, self-assessment, peer review

Accreditation and peer review assessment

Although accreditation will usually require a peer review process, accreditation must not be confused with peer review assessment, which is now commonplace in some services, such as cancer. Both processes demand absolute clarity of the standards against which a service will be assessed and a reliable process to assess the achievement of standards. As such, they both create a focus on quality and lead to improvements in patient care. The stakes are higher with accreditation because accreditation demands achievement of a set of standards before it is awarded. In contrast, peer review assessment will usually lead to recommendations to achieve standards, but there is no obligation for the service to respond to them.

It is possible that failure to achieve accreditation across services will lead to a prompter response from both within and from outside an organisation. For example, several services in the Mid Staffordshire NHS Foundation Trust were peer reviewed, but concerns raised about these services (which would never have achieved accreditation) did not reach the attention of the regulatory body. Finally, following peer review assessment, a service may report that it has responded to recommendations, but there is not a follow-up process that ensures that recommendations have been achieved. In contrast, accreditation demands that there is reliable evidence that recommendations have been acted upon. In many circumstances, this requires further review, which would be exceptional in a purely peer review assessment.

Historical context

Although there has been a greater interest in service accreditation in recent years, concerns raised about the burden of peer review in the late 1990s led to its almost complete cessation. The pathology accreditation scheme managed to resist the pressure to abandon peer review, and in the last decade, several peer review schemes, notably those in cancer and the service-based schemes administered by the West Midlands Quality Review Service, have been followed by the development of a variety of full accreditation schemes in mental health, diagnostics and surgery. The evidence base in support of service accreditation is mixed, but more recent experience indicates that frontline teams value the process to lever and accelerate improvements.

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In response to this, the Royal College of Physicians (RCP) is collaborating with the Royal College of Psychiatrists (RCPsych) and the Royal College of Surgeons (RCS) to develop a strategy for professionally led service accreditation. An agreement was reached on 20 June 2013 for the colleges to work with the Care Quality Commission (CQC), commissioners, the third sector, patient representatives and other key stakeholders, such as providers and local government organisations, to develop an overarching strategy for service accreditation: one that is able to meet the needs of patients and expectations of all the stakeholders in the system, and one that is aligned with policy, sustainable and not excessively burdensome.

This article explores the issues and proposes a way forward. It does not describe RCP policy or the views of the attendees of the June meeting. It is intended to develop understanding and provide a platform for future discussion.

Who benefits from service accreditation?

Patients – confidence, choice and influence

Service accreditation will make clear to patients what they should expect from a service. In addition, they should be reassured that an accredited service meets current standards of care. Where appropriate, they may choose to access only accredited services and if they exercise their choice in this way there will be a further lever for organisations to ensure that their services are accredited. If patients are aware of what to expect from a service, they will be able to raise concerns if an accredited service falls below standards – with the service itself, the host organisation, the newly formed health and wellbeing boards, the accreditation body or others, including the regulator or authority responsible for the service.

Health professionals – service improvement, leverage and recognition

The experience of current accreditation schemes, particularly accreditation of endoscopy services, indicates that accreditation provides service leaders with a clear map to improve services, and leverage on both the members of their team and their organisation to deliver the standards of care that they aspire to. Health professionals are strongly motivated to provide the highest standards of care, and service accreditation provides recognition of their work and achievements, which can feed into revalidation.

Hospital trusts – quality assurance of their services

Most hospital boards do not currently have a reliable method for ensuring that their services are providing adequate standards of care, unless there are clear quality indicators against which they can benchmark their services (for example, rates of methycillin-resistant *Staphylococcus aureus* [MRSA] infection or 30-day mortality rates for surgery). Although many quality indicators

exist, there is reliable benchmarking for only a small proportion of them, there are many aspects of care that cannot be quantified, and there are significant variations in context and case mix that make benchmarking unreliable. Service accreditation provides a method for hospital trusts to reassure themselves that their service lines are meeting acceptable standards.

Professional organisations – voice and influence

Royal colleges and subspecialist societies and associations have a major role to play in the setting of standards and the education of their members. Service accreditation provides a platform for definition of service standards and leverage to achieve them. Service accreditation will ensure that the skill mix required to achieve the standards is appropriate and, if assurance of training is included in the process, effective training of both undergraduates and postgraduates.

Commissioners – a method of commissioning high-value services

The principle of commissioning is changing from payment by activity to one of commissioning on the basis of clinical outcomes and quality standards. To support the new objective, high-level clinical outcomes have been created and a set of quality standards have been defined, and more will be created by the National Institute for Health and Care Excellence (NICE). The problem with this approach is that there are huge parts of clinical medicine that cannot be quality assured against such a limited list of outcomes and standards. To commission truly patient-centred services, and ones that are sensitive to local context, commissioners require a richer and more detailed set of standards, and ones that can be quality assured. Service accreditation provides this possibility. A prime concern of commissioners will be to extract as much value from the available resource as possible. Accreditation offers the prospect of providing patient-centred quality assurance, which will automatically demand a wider perspective of the health economy and beyond. It has the capability of achieving more effective collaboration within and between health and other agencies, with a stronger focus on preventive measures, self-care and care in the community. Thus accreditation will be able to improve value for money.

Regulators – assurance and reducing risk

The health services regulator in England, the CQC, has a sophisticated process for acquiring intelligence about services and organisations and has used this intelligence to target more detailed inspections. Service accreditation can provide the CQC with robust evidence of care that is well above the minimum level required for regulation, thereby minimising the risk that it will miss failing services or organisations. Furthermore, if there were a comprehensive suite of service accreditation schemes, the CQC would be able to call on fully trained specialist assessors working in these schemes. The CQC recognises the potential

value of accreditation and has highlighted its importance to regulation in its consultation document *A new start – consultation on changes to the way CQC regulates, inspects and monitors care.*[3]

Local government organisations – more effective collaboration

There are important interdependencies between healthcare providers and local government organisations. Better teamwork between these agencies will improve the experience of patients and their carers. A truly patient-centred service accreditation scheme that is focused on pathways, and not institutions, would assess the effectiveness of collaboration where this is important to patient care.

Disadvantages of accreditation schemes

There is no doubt that accreditation imposes a burden on services and hospitals. There are three types of burden. First, there is the burden of achieving a standard that will require considerable effort if a service is providing a low standard of care – *service delivery to an agreed standard*. The second burden is that of collecting, reviewing and acting on evidence – *service improvement*. Thirdly, there is the burden of presenting evidence for assessment to prove that a certain standard has been achieved – *quality assurance*.

The first burden can be justified on the basis that the service and organisation should be providing this standard of care. The first two components of the second burden (collecting and reviewing) do not, on the face of it, enhance patient care, but there is plenty of evidence that when things are measured they improve, even when 'acting on evidence' is not explicit. Constant measurement enables action to be prioritised, focused and, very importantly, monitored for effectiveness. There is no question that this process leads to enhanced patient care. The third burden has no direct impact on patient care. Assessment processes need to constantly balance the need to be certain that a standard has been achieved with the burden this imposes. It is likely that in the early phases of an accreditation scheme this balance might be weighted towards having certainty that standards have been achieved, but in time, with more experience and confidence in the process, a lighter-touch assessment will provide the necessary assurance. High-flying services that deliver consistently excellent outcomes should earn autonomy from the process.

Even when the burden of accreditation is kept to a minimum, there is an additive effect on an organisation as a whole if there are a multitude of schemes, all of which are slightly different. Thus every effort needs to be made to keep the number of schemes to a minimum, to have similar standards, processes and evidence requirements for the different schemes, to have a programme of accreditation that spreads the load over a number of years and to explore ways to reduce burden, such as having a parallel process for assessing core organisational policies and procedures.

Accreditation schemes focused on organisations will not necessarily make sense for the patient who might have to navigate from self to primary care and then on to secondary care and back. Equally, an accreditation scheme focused on a provider organisation will not make sense for the wider health economy because it will not focus on things outside that organisation which could both improve care *and* save money, such as care delivered in the community or a focus on prevention. Thus accreditation schemes need to be first and foremost patient centred, and secondly ensure that they leverage maximum value for money.

The peer review component of accreditation imposes a burden on health professionals and, ultimately, on the organisations that they work for. In the West Midlands, there is agreement between the commissioners and provider organisations that peer review assessors will not be reimbursed for their time on the basis that the burden on individual organisations will be equivalent. Can this approach be adopted nationally? The evidence from current schemes – particularly that of endoscopy – is that assessors find the process of peer review personally and professionally rewarding: it is supportive of their personal and professional development, and therefore potentially eligible for continuing professional development (CPD) credits. In addition, they invariably bring back to their organisation new ideas and new ways of working. Thus the process of peer review can reduce variation by encouraging the development of professionals and the spread of service innovations.

The process

There are three core components to the process. The first is to create a standards framework and define the evidence required to demonstrate that each standard has been achieved. The second stage is to create and apply an assessment process (this is the accreditation step). The final stage is a light-touch monitoring process between accreditation assessments that ensures that services maintain standards of care.

Stage one

The first stage is a period of self-assessment using a standard framework as a template for quality improvement. In the endoscopy service, a rating scale was used in this stage. The rating scale took the form of a checklist, which ensured that services did not miss out key aspects of care and enabled them to prioritise work. Levels of achievement within each domain (such as patient information or safety) allowed tracking of progress, benchmarking against other services and, eventually, an assessment of readiness for stage two.

Stage two

The second stage involves a peer review assessment against clearly defined criteria. Endoscopy accreditation used the checklist of the rating scale as the defining criteria for peer review, but the Improving Quality in Physiological Diagnostic Services (IQIPS)

accreditation scheme uses a separate template for the peer review process. The second approach separates the 'quality improvement' self-assessment process from the 'quality assurance' peer review assessment. It ensures readiness for the quality assurance process, thereby maximising the chance of achieving accreditation. Ideally accreditation schemes should support services to prepare for accreditation with educational materials and events, and have a dialogue in the build up to an accreditation visit to maximise the chance of success. This supportive approach is more in keeping with the culture of health provision and one that is best able to minimise the stress involved with the process.

Stage three

This requires a process whereby the accredited service provides limited information on a regular basis, between peer visits, sufficient to satisfy the accrediting body that standards are being maintained. It necessitates clear triggers for intervention and consequences if the required information is not supplied, or if performance criteria are not met.

There is much detail underpinning these processes and the Healthcare Quality Improvement Partnership (HQIP) has created guidance for professionally led accreditation schemes that could eventually be used to quality assure them.[1] There needs to be clarity about the consequences of not achieving accreditation and with this a robust appeals process.

The standards framework

Current accreditation schemes all use slightly different standards frameworks. This not only has the potential to cause confusion for organisations that are being assessed, but also an unequal standard, or bar, to achieve between services. One way around this problem would be to create a generic standards framework so that the categories against which a service is being assessed, and the words used to describe what needs to be achieved, are similar or the same between different services. For example, a category such as safety will have a generic structure but be underpinned by service-specific aspirations or standards. A further advantage of the generic standards framework is that each service does not need to invent its own standards framework: its task is to underpin the generic framework with service-specific standards.

Service-specific standards that reflect local priorities

For most services there will be, at least, national standards and/or clinical outcomes created by the NHS Commissioning Board, NICE and/or professional organisations. There may also be European (EN) or international (ISO) standards. Clearly, service-specific standards must, as a minimum, include these standards. However, local clinical commissioning groups, health and wellbeing boards and local service teams will, inevitably, have their own standards that will be determined by local context. For example, different geographical areas will have different health needs, and in some areas some services may be historically under- or over-provided.

Thus there needs to be the possibility within the standards framework for customisation according to local context. This approach would resolve the tension between the requirement for commissioning against national standards and benchmarking of services across the nation, and the need for subsidiarity (local development and ownership of standards). It is proposed that service-specific standards are agreed at a national level between all the relevant professional stakeholders and patient groups, and NHS England. The derivation of local standards would be achieved with a similar spectrum of stakeholders, but at a local level.

The peer assessment process

There has been considerable experience of peer review in the United Kingdom in the last 20 years. Clear guidance was issued by the Concordat[2] and more recently by HQIP[1]. The key learning is that assessors need absolute clarity of the standards and the evidence requirements, assessors need to be trained, they need to undergo continuous assessment and they should be experts (essentially patients with experience of using that service and health professionals delivering that service). The peer review process for different services will have both common and specific components. This will mean that there will be processes and training modules common to all accreditation schemes, but there will also be processes and training specific to individual services.

Which services should be accredited?

On the one hand, many health professionals work in very discrete areas and there is a natural desire to create individual accreditation schemes for very specific components of the service. On the other hand, organisations and the local health economy will want to minimise the number of accreditation schemes in order to reduce the burden and impact on delivery of care. Clearly, a balance needs to be struck. On the basis that the maximum interval between peer review visits is 5 years, and that more than 10 peer review accreditation visits to a local health economy each year would be unreasonable, there should be a maximum of 50 such schemes.

Should accreditation schemes transcend traditional care boundaries?

If accreditation schemes are to be truly patient-centric, they need to involve more than secondary care, where service accreditation is currently focused. Patients benefit from integrated care, and sometimes this care will directly or indirectly involve organisations outside medicine, such as care homes, prisons and education establishments. For example, care of patients with dementia is heavily dependent on effective social care, prisons might have an important role in drug and alcohol rehabilitation, and schools might have an important role in supporting the health of children. Thus it can be seen that there will be merit in accreditation schemes having a wider perspective beyond hospitals and beyond the immediate health economy.

What should be accredited within a service?

The two most important underpinning principles are patient-centredness and value for money. Value for money is critical because more can be offered to patients if more value is extracted for a given investment. Value in this context encompasses many things including cost-effectiveness, quality, safety, prevention, efficiency and, critically, the way services are configured and delivered. With this in mind it makes sense to accredit a service across the entire patient pathway from preventive care through self-care to tertiary care. There are certain aspects of care such as information and communication, quality and safety that would be minimum components of any standards framework. In addition to these core components there might be those that apply only to particular services. For example, prevention would be a vital part of a stroke or respiratory disease service accreditation, but may be less important or not important at all for a dermatology service.

There are other components that might be included in an accreditation scheme such as leadership and organisation of the service, productivity, integration of care, infrastructure and facilities, training of students and trainees, training of health professionals entering the service, professional development of those who deliver the service and such things as the blend of skills required for the service. All of these things are necessary for the effective delivery of care, optimal use of resources and ensuring that the service has the workforce it needs in the future. A strong case can be made for including them in an accreditation scheme.

What next?

There needs to be collaboration to make the most of the opportunity to maximise the positive impact of service accreditation and minimise the risk that it will become over burdensome and not fit for purpose. It is proposed that the colleges, particularly the RCP, RCPsych and RCS, provide leadership and oversee this collaboration. The objective would be to ensure that service accreditation is professionally led and that it develops in an efficient and effective way through close working with commissioners, providers of care, specialist associations and patient groups (Box 1). If this leadership and collaboration is successful, service accreditation will be

> **Box 1. The RCP vision for accreditation.**
>
> - Accreditation has an important role in a quality-focused NHS
> - Professional bodies, such as the RCP, are ideally placed to drive an accreditation agenda
> - All professional leaders need to minimise unnecessary burden of their schemes
> - The use of generic standards that cross schemes is a priority
> - The RCP will take a leadership role to lead this agenda both:
>   - in the accreditation schemes it hosts
>   - by working in collaboration with other professionally led initiatives
>
> RCP = Royal College of Physicians.

patient-centred and meet everyone's needs. Equally importantly, it will be a huge lever to improve value for money.

At a recent stakeholder meeting hosted by the RCP, RCPsych and RCS, it was agreed that a strategy for accreditation of clinical services should be developed in collaboration with all of the key stakeholders, including patients, the CQC, commissioners and providers. The aim is to have a strategy available for consultation by June 2014.

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